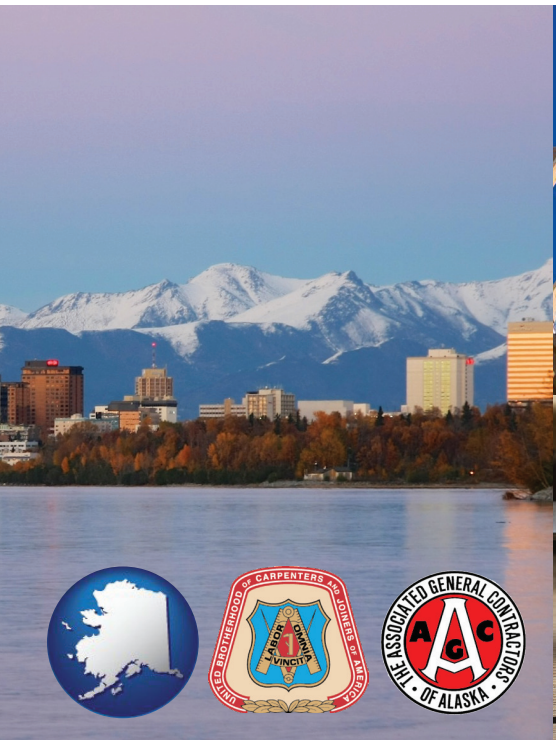
Alaska Carpenters



Health and Welfare Trust Fund

June 1, 2018

Alaska Carpenters Trust Funds

Health and Welfare – Defined Benefit – Defined Contribution

Physical Address 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing Address PO Box 34203, Seattle, WA 98124
Phone (800) 478-4431 • Fax (206) 505-9727 • Website www.alaskacarpenterstrusts.com

Administered by
Labor Trust Services, Inc.

December 1, 2023

TO: All Active Employees, Retirees and Eligible Dependents, Including COBRA Beneficiaries of the Alaska Carpenters Health and Welfare Trust Fund

PARTICIPANT NOTICE ABOUT BENEFIT MODIFICATIONS

This Summary of Material Modifications will advise you of certain changes that will be made to the Alaska Carpenters Health and Welfare Plan (the "Plan")**. This information is VERY IMPORTANT to you and your dependents**. Please take the time to read it carefully and keep it with your important paperwork.

The Plan's exclusion for the treatment of gender identity disorder including treatment, surgery, or complications is removed. The Plan will provide benefits for the medically necessary treatment diagnosis gender-related mental health conditions, such as gender dysphoria.

Additionally, the Plan's exclusion for counseling, education, or training services if amended to read:

> Medical benefits will not be paid for any of the following items:
>
> Counseling, education, or training services, except for the medically necessary treatment of a diagnosed behavioral health condition (mental health or substance abuse). Family counseling is not covered except when for treatment of a minor child.

Please contact the Trust's Administration Office, Welfare & Pension Administration Service, Inc. at (800) 478-4431, if you have any questions regarding this notice.

Sincerely,

Board of Trustees
Alaska Carpenters Health and Welfare Trust Fund

HG/PR: srw opeiu #8
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Alaska Carpenters Trust Funds

Health and Welfare – Defined Benefit – Defined Contribution

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Phone (800) 478-4431 • Fax (206) 505-9727 • Website www.alaskacarpenterstrusts.com

Administered by
Labor Trust Services, Inc.

September 8, 2022

TO: All Active Employees, Retirees and Eligible Dependents, Including COBRA Beneficiaries of the Alaska Carpenters Health and Welfare Trust Fund

PARTICIPANT NOTICE ABOUT BENEFIT MODIFICATIONS

This Summary of Material Modifications will advise you of certain changes that will be made to the Alaska Carpenters Health and Welfare Plan (the "Plan")**. This information is VERY IMPORTANT to you and your dependents**. Please take the time to read it carefully and keep it with your important paperwork.

SAVEONSP

Effective November 1, 2022, the Plan has adopted a new specialty medication program offered by SaveOnSP. The SaveOnSP program provides access to drug manufacturer financial support, lowering the cost of specialty medications for both you and the Plan.

To receive full Plan benefits for any specialty medication included on the SaveOnSP drug list, a participant must enroll in the SaveOnSP program. If you are currently on a specialty medication or start taking a new medication that is on the SaveOnSP specialty drug list, you will be contacted by Express Scripts and asked to enroll in the program. *If you enroll in the program, your copayment will be $0 for all* SaveOnSP *specialty medications; accordingly, it is very important that you enroll in the program*.

If you do not enroll in the program, your copay will be equal to the greater of the maximum plan benefit or the amount of the financial support available from the drug manufacturer and the amount you pay will not count toward your prescription drug out-of-pocket maximum.

The SaveOnSP drug list may be updated periodically. Once the program is in effect, you can call 1 (800) 683-1074 to enroll or ask questions regarding the SaveOnSP program. Please note, this program applies only to specialty medications that are on the SaveOnSP specialty drug list.

Sincerely,

Board of Trustees
Alaska Carpenters Health and Welfare Plan

CJ/AG: srw opeiu #8
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Alaska Carpenters Trust Funds

Health and Welfare – Defined Benefit – Defined Contribution

Physical Address: 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing Address: PO Box 34203, Seattle, WA 98124
Phone: (800) 478-4431 • Fax: (206) 505-9727 • Website: www.alaskacarpenterstrusts.com
Administered by
Labor Trust Services, Inc.

July 2, 2021

TO: All Active Employees, Retirees and Eligible Dependents, Including COBRA Beneficiaries of the Alaska Carpenters Health and Welfare Trust Fund

RE: Residential Care Treatment
Dental Personal Protection Equipment

PARTICIPANT NOTICE ABOUT BENEFIT MODIFICATIONS

This Summary of Material Modifications will advise you of certain changes that will be made to the Alaska Carpenters Health and Welfare Plan (the "Plan")**. This information is VERY IMPORTANT to you and your dependents**. Please take the time to read it carefully and keep it with your important paperwork.

Residential Care Treatment

The Plan has been amended to incorporate the following language, which supersedes any conflicting Plan provision:

Hospital, Residential Treatment Facility, Rehabilitative Facility - The Plan covers facility and related charges for Medically Necessary treatment received as an inpatient at a Hospital, Residential Treatment Facility, Rehabilitative Facility and Skilled Nursing Facility.

- Room and board, including general nursing care, not to exceed the semi-private room rate.
- Intensive and coronary care unit services.
- Other inpatient services and supplies including operating rooms and equipment; surgical dressings and supplies; x-ray and laboratory services; electrocardiograms; anesthesia, including administration and materials; tissue examinations; drugs; respiratory or other gas therapies; and physical, speech and occupational therapy necessary to restore or improve function.

Charges for services of a personal nature or non-medically necessary equipment, such as radio, television, telephone, guest meals, etc., are not covered under the Plan. Also, charges that involve room and board for treatment that is partially covered (such facilities that provide both services for covered treatment of a mental or physical condition and non-covered education or training services) will be pro-rated based on the Plan's discretion.

Mental Health Services

The Plan covers outpatient services and inpatient services at an approved Residential Treatment Facility or Hospital, including Physician services and prescription drugs. Preauthorization is required for inpatient Hospital and Residential Treatment Facility services. Treatment must be provided by a Physician or other licensed or certified Covered Provider acting within the scope of their license or certificate according to the laws of the issuing state.

Substance Abuse Services

The Plan covers outpatient services and inpatient services at an approved Residential Treatment Facility or Hospital, including Physician services and prescription drugs. Preauthorization is required for inpatient Hospital and Residential Treatment Facility services. Treatment must be provided by a Physician or other licensed or certified Covered Provider acting within the scope of their license or certificate according to the laws of the issuing state.

Residential Treatment Facility means an institution that meets all of the following requirements:

- The facility is licensed in the state where it operates and all charges are for items provided within the scope of that license.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).

- Admissions are approved by a Physician.
- Has access to necessary medical services 24 hours per day/7 days a week and 24-hours per day/7 days a week supervision by a physician with evidence of close and frequent observation.
- Provides indoor living arrangements, including room and board, at a physical facility. (Tents, yurts and similar structures with temporary or fabric walls are not considered indoor physical facilities.)
- Provides that any group therapy sessions are conducted at least by an RN or Masters-Level Health Professional.
- For mental health and substance abuse treatment, provides access to psychiatrist or psychologist.
- For mental health and substance abuse treatment, services are managed by a licensed Behavioral Health Provider acting within the scope of that license.
- For substance abuse admissions, if the patient requires detoxification services, must have the availability of on-site medical treatment 24 hours per day/7days a week, which must be actively supervised by an attending Physician.
- For substance abuse admissions, ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.

Pre-authorization Required
All inpatient patient admissions, including Hospital, Rehabilitative Facility, Residential Treatment, and Skilled Nursing Facility admissions, require preauthorization.

You or your Provider should contact the Utilization Review Manager, Comagine, at (800) 783-8606 for pre-authorization. Claims may also be submitted by mail or fax. By mail: Comagine, Attention: Utilization Management Division 10700 Meridian Avenue North, Suite 100 or P.O. Box 33400 Seattle, Washington 98133-0400. By fax: (206) 368-7236 or (877) 810-9265 or by phone: (800) 783-8606. The claim must identify the claimant, the claimant's specific medical condition or symptom, and the specific treatment, service, or product for which pre-authorization is requested.

Dental Personal Protective Equipment
The Plan is currently covering up to $20 per visit for personal protective equipment ("PPE") when billed by dental providers in conjunction with other covered in-office dental services. Dental PPE coverage will cease after September 30, 2021.

The Plan does not cover personal protective equipment related to services for medical coverage.

If you have any questions regarding this notice please contact the Administration Office at (800) 478-4431, option 1.

Board of Trustees
Alaska Carpenters Health and Welfare Trust Fund

Important Reminder - You must advise the Administration Office of any changes in your basic demographic data, including changes in your name, marital status, dependents, other insurance coverage available, designated beneficiary, home address, email address and telephone number. Provide information changes by completing and sending a new Enrollment Form to the Administration Office. If you have a change in dependents, divorce requires a complete filed copy of your divorce decree along with any accompanying court orders including the parenting plan. Marriage requires a copy of your marriage certificate, the parenting plan for stepchildren and their birth certificates.

Failure to update your information on file may interfere with our ability to process your benefits and provide timely communication of important Plan information.

JLH/AG: srw opeiu #8
S:\Mailings\Individual Trust Fund Mailings (SMM, Benefit Changes, COBRA, etc.)\F40-02\F40-02 - Mailing - 2021 - 07.02 - SMM - Residential Care Facilities and Dental PPE.docx

Alaska Carpenters Trust Funds

Health and Welfare – Defined Benefit – Defined Contribution

Physical Address: 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing Address: PO Box 34203, Seattle, WA 98124
Phone: (800) 478-4431 • Fax: (206) 505-9727 • Website: www.alaskacarpenterstrusts.com

Administered by
Labor Trust Services, Inc.

April 16, 2021

TO: All Eligible Plan Participants and Dependents of the Alaska Carpenters Health and Welfare Trust Fund

RE: Changes due to Coronavirus (COVID-19) Outbreak

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

COVID-19 Vaccine

During the Public Health Emergency ("PHE") declared by the United States Department of Health and Human Services ("HHS"), the Plan will cover reasonable costs of the COVID-19 vaccine without cost sharing when provided by an in-network or out-of-network provider or pharmacy.

When HHS declares the PHE has ended, the Plan will provide coverage for the COVID-19 vaccine as a Preventive Care benefit. Preventive Care benefits provided by an in-network Provider will be paid in full and will not be subject to the Calendar Year deductible or coinsurance. Preventive Care Services provided by an out-of-network Provider will be subject to the Plan deductible and coinsurance. Covered costs include the vaccine administration fee by a health care provider or pharmacy.

Important Information Relating to COVID-19 and Extension of Deadlines

The Department of Labor, on February 26, 2021, provided new guidance on the suspension of certain employee benefit time limitations during the COVID-19 Outbreak Period, which is the period beginning March 1, 2020 and ending 60 days after the national emergency ends. This supplemental notice explains how this affects your rights under the Plan.

Extensions of Time

Pursuant to federal guidance, the Plan has extended the following deadlines during the Outbreak Period beginning March 1, 2020:

- The 60-day period for individuals to notify the plan of a COBRA qualifying event.
- The 14-day period for plan administrators to provide an individual with a COBRA election notice.
- The 60-day period to elect COBRA continuation coverage after receiving a COBRA election notice.
- The date for making COBRA premium payments.
- The 30-day (or 60-day, as applicable) period to request special enrollment after a special enrollment event.
- The time limit for members to file a benefit claim, an appeal of an adverse benefit determination, or an external review request, under the plan's claims procedures.

The Department of Labor has authority to grant these extensions for **one year** only**.** The new Department of Labor notice dictates that the one-year extension should be applied separately to each deadline during the Outbreak Period. In effect, this adds one year to each one of the above deadlines until the Outbreak Period is over.

COBRA Examples

If you had a qualifying event in April 2020 and received a COBRA election notice on May 1, 2020, your 60-day period to elect COBRA coverage will begin running on May 1, 2021, one year later. You will have until June 29, 2021 to elect COBRA continuation coverage effective back to your qualifying event.

If you had a qualifying event in February 2021 and received a COBRA election notice on March 1, 2021, your 60-day period to elect COBRA coverage will begin one year later, on March 1, 2022, or at the end of the Outbreak period, whichever comes first.

COBRA premiums are generally due on the first of the month and subject to a 30-day grace period. During the Outbreak Period, the 30-day grace period for each monthly payment is extended by one year. For example, if you were receiving COBRA in April 2020, the 30-day grace period for the April premium payment begins on April 1, 2021, so your payment is due on April 30, 2021. The May 2020 premium payment similarly will be due by May 30, 2021, and so on.

Special Enrollment Examples

If you previously declined coverage for a dependent because the dependent had coverage under another employer health plan, but your dependent lost that coverage because of the end of that employment, then you have 30 days from the end of that coverage to request special enrollment for that dependent in the Plan. That 30-day time limit was suspended under the federal rule, but will begin or resume **one year** from the date of the event. For example, if your spouse's other employment-based coverage ended on January 1, 2021, you will have until January 30, 2022 to request special enrollment – one year, plus 30 days – unless the Outbreak Period ends earlier.

Important Note Regarding Retroactivity

Please note that while you may elect COBRA continuation coverage back to your COBRA qualifying event or special enrollment for a new dependent based on birth or adoption back to the date of birth or adoption, you must pay any required premiums for all months before retroactive coverage will be provided. Retroactive coverage must be continuous from the time of first retroactive eligibility. You may submit claims for services during the suspended period, but they will be pended until you make the necessary premium payments.

American Rescue Plan Act (ARPA) COBRA Subsidy

Effective **April 1, 2021,** employees (and their dependents) who lose coverage or who have lost coverage in the past 18 months due to an involuntary termination of employment or reduction in hours may be eligible for up to six months of free (fully subsidized) COBRA coverage (for coverage months April 2021 through September 2021). If you are eligible, free COBRA coverage will be available regardless of whether you previously elected COBRA or are currently on COBRA.

The Trust is waiting for guidance from the federal government before sending out formal notices and applications to potentially eligible participants and dependents. Please watch your mail closely for additional information. When you get the formal notice and application, please fill it out and return it to the Administration Office within 60 days of the date the notice is received to be eligible for free COBRA retroactive to April 1, 2021, if applicable. Free COBRA coverage will not be provided unless it is elected.

If you have any questions regarding your benefits or the content of this notice, contact the Administration Office at (800) 478-4431, option 0 or visit the Trust website at www.alaskacarpenterstrusts.com.

Board of Trustees
Alaska Carpenters Health and Welfare Trust Fund

Alaska Carpenters Trust Funds

Health and Welfare – Defined Benefit – Defined Contribution

Physical Address: 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing Address: PO Box 34203, Seattle, WA 98124
Phone: (800) 478-4431 • Fax: (206) 505-9727 • Website: www.alaskacarpenterstrusts.com

Administered by
Labor Trust Services, Inc.

December 22, 2020

TO: All Active Employees and Eligible Dependents, Including COBRA Beneficiaries of the Alaska Carpenters Health and Welfare Trust Fund

RE: Benefit Changes due to COVID-19

PARTICIPANT NOTICE ABOUT BENEFIT MODIFICATIONS

This Summary of Material Modifications will advise you of certain changes that will be made to the Alaska Carpenters Health and Welfare Plan (the "Plan")**. This information is VERY IMPORTANT to you and your dependents**. Please take the time to read it carefully and keep it with your important paperwork.

Dental Personal Protection Equipment

Effective **August 1, 2020 through June 30, 2021** the Plan will cover up to $20 per visit for personal protective equipment ("PPE") when billed by dental providers in conjunction with other covered in-office dental services.

The Plan does not cover Personal Protection Equipment related to services for medical coverage.

Please contact the Trust's Administration Office at (800) 478-4431, option 1, if you have any questions regarding this notice.

Board of Trustees
Alaska Carpenters Health and Welfare Trust Fund

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Alaska Carpenters Trust Funds

Health and Welfare – Defined Benefit – Defined Contribution

Physical Address: 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing Address: PO Box 34203, Seattle, WA 98124
Phone: (800) 478-4431 • Fax: (206) 505-9727 • Website: www.alaskacarpenterstrusts.com
Administered by
Labor Trust Services, Inc.

September 25, 2020

TO: All Active Employees, Retirees and Eligible Dependents, Including COBRA Beneficiaries of the Alaska Carpenters Health and Welfare Trust Fund

RE: Benefit Changes

PARTICIPANT NOTICE ABOUT BENEFIT MODIFICATIONS

This Summary of Material Modifications will advise you of certain changes that will be made to the Alaska Carpenters Health and Welfare Plan (the "Plan")**. This information is VERY IMPORTANT to you and your dependents**. Please take the time to read it carefully and keep it with your important paperwork.

Dental Personal Protection Equipment

Effective August 1, 2020 through December 31, 2020, appropriately billed charges by a licensed dental office for dental personal protective equipment services will be covered up to $20 per visit.

Acupuncture Benefit

Effective October 1, 2020, the Plan is adding acupuncture to its chiropractic benefits. The following is the new Plan language:

> Chiropractic and Acupuncture services are covered if medically necessary and part of a formal treatment plan prescribed by a Physician acting within the scope of his or her license. Chiropractic and acupuncture services which are not part of a formal treatment plan are subject to the following limits: $500 per person and $1,000 per family each calendar year. The $15 physician copayment does not apply.

Please contact the Trust's Administration Office, Welfare & Pension Administration Service, Inc. at (800) 478-4431, option 1, if you have any questions regarding this notice.

Sincerely,

Board of Trustees

CJ/AG: srw opeiu #8
S:\Mailings\Individual Trust Fund Mailings (SMM, Benefit Changes, COBRA, etc.)\F40-02\F40-02 - Mailing - 2020 - 09.25 - SMM - Dental PPE and Acupuncture Benefits.docx

Alaska Carpenters Trust Funds

Health and Welfare

Physical Address: 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing Address: PO Box 34203, Seattle, WA 98124
Phone: (800) 478-4431 • Fax: (206) 505-9727 • Website: www.alaskacarpenterstrusts.com

Administered by
Labor Trust Services, Inc.

March 18, 2020

To: All Eligible Plan Participants and Dependents of the Alaska Carpenters Health and Welfare Trust Fund

RE: Response to Coronavirus (COVID-19) Outbreak

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

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

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

- The Trust will temporarily waive any out-of-pocket costs associated with diagnostic testing for COVID-19 for both PPO and non-PPO providers. At this time, the waiver only applies to the test. For those testing positive, treatment of COVID-19 will still be subject to applicable cost sharing and PPO/non-PPO benefits depending on the provider's status.
- The Trust will temporarily suspend any prior authorization requirement for treatment or testing of COVID-19.
- Express Scripts is **temporarily relaxing refill-too-soon guidelines** on 30-day maintenance medications at any in-network pharmacy. You may also choose to use mail order to receive delivery of your medications at home.

Active participants, Non-Medicare Retirees and their eligible dependents have access to **Teladoc** for 24/7 care via telephone at (855) 332-4059 or video chat at no cost to you. A Teladoc doctor can discuss any symptoms you are having and help determine the right treatment or next steps, including providing a prescription if appropriate. Please visit **Teladoc.com/Premera** for more details.

If you have any questions regarding the contents described in this notice, please contact the Administration Office at (800) 531-5357, option 1. Please also reference the trust website, alaskacarpenterstrusts.com, for additional notices.

If you have questions about your prescription drug benefits, please contact Express Scripts at (800) 935-0153.

Board of Trustees
Alaska Carpenters Health and Welfare Trust Fund

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Alaska Carpenters Trust Funds

Health and Welfare – Defined Benefit – Defined Contribution

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Phone: (800) 478-4431 • Fax: (206) 505-9727 • Website: www.alaskacarpenterstrusts.com

Administered by
Labor Trust Services, Inc.

February 28, 2020

To: All Eligible Participants of the
Alaska Carpenters Health and Welfare Trust Fund

RE: New Opioid Management Program - Effective April 1, 2020

PARTICIPANT NOTICE ABOUT BENEFIT MODIFICATIONS

This Summary of Material Modifications will advise you of certain changes that will be made to the Alaska Carpenters Health and Welfare Plan (the "Plan") **effective April 1, 2020. This information is VERY IMPORTANT to you and your dependents**. Please take the time to read it carefully and keep it with your important paperwork.

Advanced Opioid Management Program

The Advanced Opioid Management Program is a safety program designed to prevent first-time opioid users from receiving too many opioid drugs or too high a dose of opioid drugs. This program aims to prevent the misuse or abuse of opioids by limiting first-time opioid users to short-term prescriptions. The program continuously evaluates use of opioids for each patient and provides patient counseling and physician alerts about proper prescribing of opioids and help identifying members at risk of developing an addiction.

The program will limit the first four fills of an opioid prescription to no more than a 7-day supply (for a total supply of 28 days) in a 60 day period for adults. For pediatric patients, the opioid therapy will be limited to a 3-day supply for the first four fills, requiring authorization to exceed a 12-day supply in a 60-day period.

The program will limit the morphine equivalent dosing to 90 morphine milligram equivalent (MME) for patients starting on opioids. Existing users are limited to 200 MME without prior authorization for a higher dose.

The program includes a prior authorization process if you need longer acting opioids or opioids in excess of the limitations set forth above. To request prior authorization, please contact your medical provider or call Express Scripts at (800) 935-0153. If you have any questions regarding the contents in this notice, please contact the Administration Office at (800) 531-5357, option 1.

Board of Trustees
Alaska Carpenters Health and Welfare Trust Fund

Alaska Carpenters Trust Funds

Health and Welfare – Defined Benefit – Defined Contribution

Physical Address: 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing Address: PO Box 34203, Seattle, WA 98124
Phone: (800) 478-4431 • Fax: (206) 505-9727 • Website: www.alaskacarpenterstrusts.com

Administered by
Labor Trust Services, Inc.

November 1, 2019

TO: All Active Employees, Retirees and Eligible Dependents, Including COBRA Beneficiaries of the Alaska Carpenters Health and Welfare Trust Fund

PARTICIPANT NOTICE ABOUT BENEFIT MODIFICATIONS

This Summary of Material Modifications will advise you of certain changes that will be made to the Alaska Carpenters Health and Welfare Plan (the "Plan"). **This information is VERY IMPORTANT to you and your dependents**. Please take the time to read it carefully and keep it with your important paperwork.

CHANGES TO DEDUCTIBLE

Effective January 1, 2020, the Plan's Calendar Year deductible will increase from $400 per individual / $1,200 per family **to $525 per individual / $1,575 per family**. This applies to all active employees (including COBRA) and non-Medicare eligible retirees, other than retirees participating in the catastrophic plan. Deductibles apply on both a per individual and per family basis. Once the deductible amount you (or any other individual family member) pay in a Calendar Year reaches the individual deductible of $525, no deductible will apply for you (or that family member) for the rest of the Calendar Year. Once the total deductible amount you pay for three or more family members in a Calendar Year reaches the family deductible of $1,575, no deductible will apply for any eligible family member for the rest of the Calendar Year.

The annual deductible does not apply to: preventive care, immunizations, physician visits, preadmission testing, second surgical opinions, Medicare eligible retirees, Medicare eligible dependents of retirees, and well-baby/child and physical exams. For all other covered services, you must pay the deductible before the plan pays benefits.

NUTRITIONAL COUNSELING

Effective October 1, 2019, the Plan will provide benefits for medically necessary nutritional counseling for pregnant women with gestational diabetes.

CORRECTION TO SUMMARY PLAN DESCRIPTION

Hearing Benefits
The first sentence of the section Hearing examination and hearing aid devices on page 52 of the June 2018 Summary Plan Description should read:

> Hearing examination and hearing aid devices (no coverage for Medicare eligible Retirees or Medicare eligible dependents of Medicare eligible Retirees) are covered at 80% up to $1,000 per **ear** per person once every 36 months.

Accident and Sickness Benefits
The Accident and Sickness Benefit available to Active employees as adopted by the Trustees effective January 1, 2018 is added to the June 2018 Summary Plan Description as follows:

If you become disabled while eligible for benefits and are unable to work at your occupation or employment because of your own sickness or non-occupational injury or illness, and you are being treated by a licensed physician who confirms your disability, you will be entitled to receive an accident and sickness benefit of $400 per week.

Benefits begin:

- The 14th day of disability caused by sickness
- The 14th day of disability resulting from an accident

The Plan will pay you a benefit of $400 per week for a maximum of 26 weeks for any one period of disability. No benefits will be paid for any period of disability during which you are not under the care of a physician (M.D. or D.O.) or you do not remain disabled.

Benefit Payment

Submit a claim form to the Plan Administrator to request benefits. You may obtain a claim form from the local union or from the Trust Administration Office or online at www.alaskacarpenterstrusts.com.

Disability or Disabled: for accident and sickness coverage, the terms "disability" and "disabled" mean your complete inability as an active employee to work at your occupation or employment.

Exclusions:

No accident and sickness benefits will be payable for:

1. Conditions caused by or arising from an act of war, armed invasion of aggression.
2. Any disability beginning prior to the effective date of coverage.
3. Any period during which you are eligible for or entitled to any sick leave or disability benefits from any other source, including, but not limited to, Social Security disability benefits, employer provided sick leave or short-term disability or workers compensation disability benefits.
4. Any period during which you have applied for or are receiving unemployment compensation.
5. Any injury sustained while committing or attempting to commit a crime.

New Period of Disability

Accident and sickness benefits will be restored for each new period of disability. A new period of disability begins:

1. When you become disabled after you have been back to work full time for at least 30 consecutive working days since the previous disability; or
2. When you become disabled due to a cause not related to any cause of the previous disability, and the new disability begins after you have been back to work full time for at least 30 days.

Taxation of Benefits

Benefits paid by the Plan are subject to Social Security (FICA) taxation. The Plan is required by federal law to withhold and deposit with the appropriate depository your share of the tax from each accident and sickness benefit payment. Accident and sickness benefits provided by the Plan are also subject to federal income tax. You have the option of having the Trust withhold federal income taxes from your weekly benefit. At year-end, the Plan will send you a W-2 form so that you will be able to file your federal income taxes.

Dependents, associate employees, and retirees are not eligible for accident and sickness benefits.

TELEMEDICINE

The Plan covers providers who provide medically necessary medical consultations through telephone or video access, to the extent permitted by the State where the provider is licensed. Additional information for this benefit through Teladoc will be mailed to you by the first week of November. This benefit applies to all active employees (including COBRA) and non-Medicare eligible retirees and does not apply to Medicare Retirees or eligible dependents of Medicare retirees.

If you have questions regarding your benefits, contact the Administration Office at (800) 478-4431, option 1.

Board of Trustees
Alaska Carpenters Health and Welfare Trust Fund

Alaska Carpenters Trust Funds

Health and Welfare – Defined Benefit – Defined Contribution

Physical: 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing: PO Box 34203, Seattle, WA 98124
Phone: (800) 478-4431 • Fax: (206) 505-9727 • Website: www.alaskacarpenterstrusts.com

Administered by
Labor Trust Services, Inc.

March 21, 2019

TO: All Active Employees, Non-Medicare Retirees and Eligible Dependents, Including COBRA Beneficiaries of the Alaska Carpenters Health and Welfare Trust Fund

PARTICIPANT NOTICE ABOUT BENEFIT MODIFICATIONS

This Summary of Material Modifications will advise you of certain changes that will be made to the Alaska Carpenters Health and Welfare Plan (the "Plan") **effective June 1, 2019. This information is VERY IMPORTANT to you and your dependents**. Please take the time to read it carefully and keep it with your important paperwork.

Telemedicine

Previously, the Board of Trustees added a new benefit that provides telephone or video access to a doctor through Teladoc, which provides access to a network of Alaska licensed doctors and pediatricians who are available on-demand 24 hours a day, 7 days a week, 365 days a year to diagnose, treat and prescribe medication for many simple and routine medical issues via phone, mobile app or online video consultations.

Effective May 1, 2019, the Board of Trustees is expanding for providers who provide medically necessary medical consultations through telephone or video access, to the extent permitted by the State where the provider is licensed. Accordingly, the following paragraph is added to the Plan's coverage for Physician Services:

- *Medically necessary physician audio and/or visual visits where the patient is not physically seen but which are appropriately billed and comply with applicable state and federal law*.

BridgeHealth Surgery Benefit

As health care costs continue to increase, the Board of Trustees have noticed that there are many medical procedures that can cost considerably less (with comparable or better quality) when done outside the State of Alaska. Accordingly, effective June 1, 2019, the Trust has contracted with BridgeHealth to provide non-Medicare eligible participants with access to high quality providers across the United States who perform certain surgeries. This includes access to centers of excellence as well as surgeons who are highly rated in the United States for their specialty.

You should contact BridgeHealth or BridgeHealth may contact you, if you have any planned major surgeries, such as:

- Cardiac surgery
- Vascular surgery
- Spine surgery
- Joint surgery
- Specific cancer treatments

Upon acceptance of your case, the following enhanced Plan provisions will apply when you utilize a BridgeHealth network provider:

- Your Medical Plan Deductible and Coinsurance will be waived; and
- A BridgeHealth Care Coordinator will help coordinate all aspects of your surgery by helping collect the required medical records, assisting with provider selection and making travel arrangements.

To obtain more information about this benefit on or after June 1, 2019, contact BridgeHealth at (800) 680-1366 and identify yourself as a participant in the Alaska Carpenters Health and Welfare Plan or go online to *www.BridgeHealthMedical.com*.

BridgeHealth is an independent third-party contractor to the Trust. Neither the Trust nor BridgeHealth provide medical services and neither are engaged in the practice of medicine. The BridgeHealth Surgery Benefit program is entirely voluntary.

Related Travel Expenses – If BridgeHealth determines that you have a covered surgery that is eligible for its program, in addition to covering the surgery, the Trust will cover the following related travel expenses:

1. Transportation: Amounts paid for transportation primarily for, and essential to, medical care. This includes:

- Bus, train, or plane fares by a regularly scheduled commercial carrier from the employee's place of residence to the city where the treatment is provided. The plan will cover the cost of documented travel expenses, not exceeding the cost of coach class commercial air transportation between the major airport nearest to the member's residence and the major airport nearest to the location the treatment was provided;
- Taxi fares;
- Transportation expenses of a parent who must go with a child who needs medical care;
- Transportation expenses of a spouse, nurse or other person who can give injections, medications, or other treatment required by a patient who is traveling to get medical care and is unable to travel alone;
- Transportation expense for regular visits to see a mentally ill dependent, if these visits are recommended as a part of treatment; and
- Parking fees and tolls.

2. Lodging: The cost of lodging not at a hospital or similar institution not to exceed $200 per night. This expense is reimbursable if:

- The lodging is primarily for and essential to medical treatment,
- The medical care is provided by a doctor in a licensed hospital or in a medical care facility related to, or the equivalent of, a licensed hospital,

- The lodging isn't lavish or extravagant under the circumstances, and
- There is no significant element of personal pleasure, recreation, or vacation in the travel away from home.

3. Per Diem: In addition to the foregoing, for everyday of medically necessary travel, you are eligible for reimbursement of incidental travel related expenses up to the per diem amount of $75.

Medical Travel Benefit Exclusions – The following items are excluded:

Travel for medical treatment outside of the BridgeHealth program;

Travel for dental treatment.

Travel for treatment of services or conditions not covered by the Trust.

Travel or expenses incurred prior to June 1, 2019;

Vacations or travel where the primary purpose is not for medical treatment;

Travel for a change in environment, improvement of morale, or general improvement of health even if the trip is made on the advice of a doctor;

Transportation on a non-regularly scheduled commercial carrier;

Travel for treatment in Hawaii or a country or territory outside the continental United States;

First class airfare; and

Travel expenses for which the member was not responsible to pay or which were not actually incurred (airfare purchased using frequent flyer miles, donated lodging, etc.).

Please contact the Trust's Administration Office, Welfare & Pension Administration Services, Inc. at (800) 531-5357, if you have any questions regarding this notice.

Sincerely,

Board of Trustees
Alaska Carpenters Health and Welfare Trust

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Alaska Carpenters Trust Funds

Health and Welfare – Defined Benefit – Defined Contribution

Physical: 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing: PO Box 34203, Seattle, WA 98124
Phone: (800) 478-4431 • Fax: (206) 505-9727 • Website: www.alaskacarpenterstrusts.com

Administered by
Labor Trust Services, Inc.

December 4, 2018

TO: All Active Employees, Retirees and Eligible Dependents, Including COBRA Beneficiaries of the Alaska Carpenters Health and Welfare Trust Fund

PARTICIPANT NOTICE ABOUT BENEFIT MODIFICATIONS

This Summary of Material Modifications will advise you of certain changes that will be made to the Alaska Carpenters Health and Welfare Plan (the "Plan") **effective January 1, 2019. This information is VERY IMPORTANT to you and your dependents**. Please take the time to read it carefully and keep it with your important paperwork.

CHANGES TO DEDUCTIBLE

Effective January 1, 2019, the Plan's Calendar Year deductible will increase **from $275** per individual / **$825** per family **to $400 per individual / $1,200 per family**. This applies to all active employees (including COBRA) and non-Medicare eligible retirees, other than retirees participating in the catastrophic plan. Deductibles apply on both a per individual and per family basis. Once the deductible amount you (or any other individual family member) pay in a Calendar Year reaches the individual deductible of $400, no deductible will apply for you (or that family member) for the rest of the Calendar Year. Once the total deductible amount you pay for two or more family members in a Calendar Year reaches the family deductible of $1,200, no deductible will apply for any eligible family member for the rest of the Calendar Year.

The annual deductible does not apply to: preventive care, immunizations, physician visits, preadmission testing, second surgical opinions, Medicare eligible retirees, Medicare eligible dependents of retirees, and well-baby/child and physical exams. For all other covered services, you must pay the deductible before the plan pays benefits.

Board of Trustees
Alaska Carpenters Health and Welfare Trust Fund

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Alaska Carpenters Trust Funds

Health and Welfare – Defined Benefit – Defined Contribution

Physical: 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing: PO Box 34203, Seattle, WA 98124
Phone: (800) 478-4431 • Fax: (206) 505-9727 • Website: www.alaskacarpenterstrusts.com

Administered by
Labor Trust Services, Inc.

May 25, 2018

TO: All Active and Non-Medicare Retirees of the Alaska Carpenters Health and Welfare Trust

RE: Benefit Changes Effective July 1, 2018 and New Summary Plan Description

New Prescription Drug Out-of-Pocket Maximum

Effective July 1, 2018, the Alaska Carpenters Health and Welfare Trust will include a Prescription Drug Out-of-Pocket Maximum of **$5,075 per person / $9,875 per family**. All prescription copays will be included in the Prescription Drug Out-of-Pocket Maximum.

The Medical Out-of-Pocket Maximum is set at $2,275 per person / $4,825 per family and includes the deductible and medical copayments.

New Summary Plan Description
The Board of Trustees is pleased to present you with this new and up-to-date June 2018 edition of the Summary Plan Description (Plan booklet) for the Alaska Carpenters Health and Welfare Trust. This Plan booklet supersedes all previous versions of the Plan booklet.

This revised booklet describes the benefits available to eligible participants and their dependents. From time to time the Plan has issued a Summary of Material Modification (SMM) to provide notice of material benefit changes to the Plan. This Plan booklet has incorporated all the SMMs issued through March 29, 2018.

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

Please refer to this booklet when health plan questions arise and keep it with your records for future reference. If you have any questions regarding your benefits, please contact the Administration Office at (800) 478-4431, option 1.

Board of Trustees
Alaska Carpenters Health and Welfare Trust

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Alaska Carpenters Trust Funds

Health and Welfare – Defined Benefit – Defined Contribution

Physical: 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing: PO Box 34203, Seattle, WA 98124
Phone: (800) 478-4431 • Fax (206) 505-9727 • Website: www.alaskacarpenterstrusts.com

Administered by
Labor Trust Services, Inc.

March 29, 2018

TO: All Active Employees, Retirees and Eligible Dependents, Including COBRA Beneficiaries of the Alaska Carpenters Health and Welfare Trust Fund

PARTICIPANT NOTICE ABOUT BENEFIT MODIFICATIONS

This Summary of Material Modifications will advise you of certain changes that will be made to the Alaska Carpenters Health and Welfare Plan (the "Plan") **effective June 1, 2018. This information is VERY IMPORTANT to you and your dependents**. Please take the time to read it carefully and keep it with your important paperwork.

CHANGES TO DEDUCTIBLE

Effective June 1, 2018, the Plan's Calendar Year deductible will increase **from $150** per individual **to $275 per individual and $825 per family**. This applies to all active employees (including COBRA) and non-Medicare eligible retirees. This change does not apply to retirees participating in the catastrophic plan. Deductibles apply on both a per individual and per family basis. Once the deductible amount you (or any other individual family member) pay in a Calendar Year reaches the individual deductible of $275, no deductible will apply for you (or that family member) for the rest of the Calendar Year. Once the total deductible amount you pay for two or more family members in a Calendar Year reaches the family deductible of $825, no deductible will apply for any eligible family member for the rest of the Calendar Year.

The annual deductible does not apply to: preventive care, immunizations, physician visits, preadmission testing, second surgical opinions, Medicare eligible retirees, Medicare eligible dependents of retirees, and well-baby/child and physical exams. For all other covered services, you must pay the deductible before the plan pays benefits.

Special Note Regarding Transition to New Deductible- Any deductible amount you have paid in 2018 prior to June 1, 2018 will be credited against the new deductible. If you satisfied the Plan's previous $150 deductible before June 1, 2018, you will need to satisfy an additional deductible of $125 (bringing the total deductible to $275 with a maximum of $825 per family).

NEW PREVENTIVE BENEFITS

The Plan currently covers some preventive care (immunization, well-baby care and physicals) without cost sharing. However, with the increase in the Plan's deductibles, the Plan is no longer grandfathered under the Affordable Care Act. Accordingly, effective June 1, 2018, the Plan will cover additional preventive care services in full (not subject to the calendar year deductible or coinsurance). Preventive care includes:

- Evidence-based tests or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force. These recommendations include blood pressure and cholesterol screening, diabetes screening for individuals with hypertension, various cancer and sexually transmitted infection screenings, and counseling in defined medically appropriate areas.
- For infants, children, and adolescents, such other evidence informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings not described above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive care will be limited to Medically Necessary and appropriate services. Where the recommended preventive care comes with recommendations regarding coverage or frequency, these will be followed. If no guidance on coverage or frequency is given, the Plan may adopt or utilize reasonable medical management techniques to determine the coverage and frequency limit. Unless otherwise agreed to by the Board of Trustees, any additions to the above list of preventive care will be effective on the first day of the plan year beginning 12 months after the new preventive service is listed.

NEW EMERGENCY MEDICAL CARE PROVISION

Effective June 1, 2018, Emergency Care of an Emergency Medical Condition by a Non-PPO provider or facility within the emergency department of a hospital will be payable at the PPO coinsurance rate applied to the UCR Amount.

Emergency Care means, with respect to an emergency medical condition, (as defined by the Affordable Care Act):

- A medical screening examination to evaluate a medical emergency that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department to evaluation such emergency medical condition.
- Further medical examination and treatment to stabilize the participant to the extent the services are within the capabilities of the hospital staff and facilities or, if necessary, to make an appropriate transfer to another medical facility. "Stabilize" means to provide such medical treatment of the medical emergency as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the participant from a medical facility.

COVERAGE OF CLINICAL TRIALS

Effective June 1, 2018, the Plan will provide coverage for items and services furnished in connection with an approved clinical trial that would otherwise be covered by the Plan for a participant who is not participating in a clinical trial.

For clinical trials, the Plan will not cover:

- The investigational item, device, or service itself.
- Items and services solely for data collection that are not directly used in the clinical management of the patient, or
- Services which are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

An approved clinical trial is: 1) a phase I, II, III, or IV federally-funded clinical trial or drug trial that is conducted under an investigational new drug application reviewed by the FDA or is a drug trial which is exempt from an investigational new drug application; and 2) conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.

NEW EXTERNAL REVIEWS

Effective June 1, 2018, if the Board of Trustees denies a participant's appeal for a claim involving medical judgment or the retroactive rescission of health coverage, the participant may request an external review of the Board of Trustees' decision by an Independent Review Organization ("IRO"). There is no external review for non-healthcare claims, such as weekly disability, accidental death and dismemberment, or life insurance.

A request for external review must be filed with the Administration Office within four months from the claimant's receipt of the Trustees' decision on appeal. Requests for external review may be mailed to the following address:
Attn: Appeals
WPAS, Inc.
PO Box 34203
Seattle, WA 98124-1203

Failure to file a request for external review within the four-month period will end the claimant's ability to seek external review. See the 2018 Plan Booklet for additional information regarding external review.

NON-GRANDFATHERED STATUS UNDER THE AFFORDABLE CARE ACT

Effective June 1, 2018, the Plan is no longer considered "grandfathered" under the Affordable Care Act.

Please keep this important notice with your Plan Document/Summary Plan Description (SPD) for easy reference to all Plan provisions. If you have any questions or need any additional information, please contact the Administration Office.

Receipt of this notice does not constitute a determination of benefits or your eligibility. If you wish to verify benefits or eligibility, or if you have any questions regarding medical benefit changes, please contact the Administration Office at (800) 531-5357, option 1.

Board of Trustees
Alaska Carpenters Health and Welfare Trust Fund

This booklet is the benefit plan and summary plan description (the Plan) for the Alaska Carpenters Health and Welfare Trust Fund medical, vision, prescription drug, dental, life insurance, and accidental death & dismemberment insurance benefits as of June 1, 2018. The booklet describes the benefits available to eligible employees, retirees and their dependents.

Medical, vision, prescription drug and dental benefits are self-funded by the Trust Fund. Life insurance and accidental death and dismemberment insurance benefits are provided through insured arrangements and are governed by separate insurance contracts.

Authority to Interpret and Amend the Plan

The Board of Trustees ("Trustees") expressly reserves the right, in its sole discretion at any time:

1. To interpret any and all provisions of the Plan;
2. To determine eligibility and entitlement to Plan benefits;
3. To terminate or amend any benefit or the Plan, in whole or in part, even though a termination or an amendment may impact claims which have already accrued;
4. To alter or postpone the method of payment of any benefit; and
5. To amend or rescind any other provision of this Plan.

Trust Agreement Governs

The provisions of this Plan are subject to and controlled by the provisions of the Trust Agreement, and in the event of any conflict between the provisions of this Plan and the provisions of the Trust Agreement, the provisions of the Trust Agreement will prevail.

Trust Administration Office

The Trustees have delegated to the Trust Administration Office and other designated third-party service providers the authority to administer the plan and to provide information relating to the amount of benefits, eligibility, and other Plan provisions. The One entity, other than the Board of Trustees, has the authority to change any provisions of the plan. Any interpretation of the Plan by the

Trust Administration Office or any third-party is subject to review by the Trustees. No participating employer, employer association or labor organization is authorized to represent the Trust in relation to the terms and conditions of this plan.

The Trustees reserve the right to make any changes they deem necessary to promote efficiency, economy, and better service for the Participants and their covered dependents. The Trustees have no obligation to furnish benefits beyond those that can be supported by the Trust Fund.

We encourage you to become familiar with your benefits and the valuable protection they offer. Please keep this booklet for future reference. If you have questions about eligibility or coverage, please contact the Trust Administration Office.

Alaska Carpenters Health and
Welfare Trust Fund Office
375 W. 36th Ave, Suite 200
PO Box 93870
Anchorage, AK 99503-5814
(907) 561-7575
(800) 478-4431
(800) 531-5357 (WA)

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements
Discrimination is Against the Law

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

Alaska Carpenters Health and Welfare Trust Fund:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you or your Dependents need these services, contact Heidi Campbell, PO Box 34203, Seattle, WA 98124-1203, (800) 531-5357, extension 3500, Fax (206) 441-9110.

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

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

Complaint forms are available at:

http://www.hhs.gov/ocr/office/file/index.html.

Tagalog – PAUNAWA**:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-531-5357.

Spanish – ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-531-5357.

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-531-5357 번으로 전화해 주십시오.

Hmong – LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-531-5357.

Russian – ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-531-5357.

Samoan – MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-800-531-5357.

Chinese –注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-531-5357。

Laotian – ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-531-5357.

Japanese – 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-531-5357まで、お電話にてご連絡ください。

Ilocano – PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-800-531-5357.

Vietnamese – CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-531-5357.

Ukrainian – УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-531-5357.

Thai – เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-531-5357

German – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-531-5357.

Polish – UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-531-5357.

CONTENTS

SUMMARY OF BENEFITS

Active Employees

Medical Benefits

Calendar year deductible	$275 per person/$825 per family
Copayments	$15 per physician visit
Calendar year out-of-pocket maximum (does not include deductible and copayments)	$2,000 per person $4,000 family maximum
Coinsurance	For In-network (Preferred) Providers, the Plan pays 80% of the allowed amount for most covered expenses until your out-of-pocket maximum is reached, your coinsurance is the remaining 20% of the allowed amount. Once your out-pocket-maximum is reached the Plan pays most covered expenses at 100% of the allowed amount for the rest of the calendar year (some exceptions apply). For Out-of-Network (Non-Preferred) Providers, the Plan also pays 80% of the allowed amount and you are responsible for the remaining 20% of the allowed amount. You may also be responsible for any amounts billed that exceed the allowed amount.

Prescription Drug Benefits	**Retail 30-day supply**	**Mail Order 90-day supply**
Generic	$7 copayment	$14 copayment
Preferred brand-name	$25 copayment	$50 copayment
Non-preferred brand-name	$40 copayment	$80 copayment

Dental Benefits

Calendar year deductible	$10 per person
Calendar year maximum	$2,000 per person
Payment Level	Schedule of allowances (see pages 78-82)
Orthodontia	70% to a lifetime maximum of $1,500 per person (children under age 19 only)

Vision Benefits

Coinsurance	Plan pays 80% of usual, customary and reasonable (UCR) charges. Your coinsurance is the remaining 20%.
Eye Exam	One exam per person per calendar year
Lenses and Frames	$200 maximum per person every two calendar years

Life Insurance Benefit	$10,000
Accidental Death and Dismemberment Benefit	$10,000

Non-Medicare Eligible Retirees

If you are eligible to enroll in Medicare Part B, see Medicare Eligible Retirees beginning on next page.

You may choose coverage for yourself and your eligible dependents from the following options:

- Medical (standard or catastrophic), and prescription drug
- Medical (standard or catastrophic), prescription drug, and vision.

Medical Benefits

Calendar year deductible	Standard - $275 per person/$825 per family Catastrophic - $5,000 per person
Copayments	$15 per physician visit
Calendar year out-of-pocket maximum (does not include deductible and copayments)	Standard – - $2,000 per person - $4,000 family maximum Catastrophic – - $10,000 per person - $20,000 per family

Coinsurance	For In-network (Preferred) Providers, the Plan pays 50% of the allowed amount for most covered expenses until your out-of-pocket maximum is reached, your coinsurance is the remaining 50% of the allowed amount. Once your out-pocket-maximum is reached the plan pays most covered expenses at 100% of the allowed amount for the rest of the calendar year (some exceptions apply). For Out-of-Network (Non-Preferred) Providers, the Plan also pays 50% of the allowed amount and you are responsible for the remaining 50% of the allowed amount. You may also be responsible for any amounts billed that exceed the allowed amount.

Prescription Drug Benefits	**Retail 30-day supply**	**Mail Order 90-day supply**
Generic	$ 7 copayment	$14 copayment
Preferred brand-name	$25 copayment	$50 copayment
Non-preferred brand-name	$40 copayment	$80 copayment

Vision Benefits (optional)	
Coinsurance	Plan pays 80% of usual, customary and reasonable (UCR) charges. Your coinsurance is the remaining 20%.
Eye Exam	One exam per person per calendar year
Lenses and Frames	$200 maximum per person every two calendar years

Retiree Benefits Are Not Guaranteed

Retiree benefits are not guaranteed to continue indefinitely, and may be terminated or modified at any time by the Board of Trustees.

Medicare Eligible Retirees

You may choose coverage for yourself and your eligible dependents from the following options:

- Medical and prescription drug
- Medical, prescription drug, and vision.

IMPORTANT – If you are Medicare Eligible you must enroll in both Medicare Part A and Medicare Part B. Benefits are paid under this Plan as if you are enrolled in Medicare Part B. **If you fail to enroll in Medicare Part B, you will have significant out-of-pocket medical expenses that will not be covered by this Plan.**

If you enroll in a Medicare Part D prescription drug plan you will not have prescription drug coverage under this Plan. There will be no reduction in your contribution rate.

Medical Benefits

Annual Deductible	None
Coinsurance	Plan pays 100% of Part A deductibles, Part B deductibles, and any Medical Part B coinsurance amounts that are allowable charges under this Plan.

Prescription Drug Benefits	**Retail 30-day supply**	**Mail Order 90-day supply**
Generic	$ 7 copayment	$14 copayment
Preferred brand-name	$25 copayment	$50 copayment
Non-preferred brand-name	$40 copayment	$80 copayment

Vision Benefits (optional)

Coinsurance	Plan pays 80% of usual, customary and reasonable charges. Your coinsurance is the remaining 20%.
Eye Exam	One exam per person per calendar year
Lenses and Frames	$200 maximum per person every two calendar years

Retiree Benefits Are Not Guaranteed

Retiree benefits are not guaranteed to continue indefinitely, and may be terminated or modified at any time by the Board of Trustees.

ELIGIBILITY

Active Employees

You are an active Employee if you meet one of the following: (1) you work for a covered employer in a job classification covered by a collective bargaining agreement; (2) you work for a covered employer under a special agreement for non-bargained or associate employees; or (3) you are an owner/operator covered by a special agreement with the Trust Fund. A covered employer is an employer obligated by a collective bargaining agreement or special agreement to contribute to the Alaska Carpenters Health and Welfare Trust Fund.

Initial Eligibility – Hour Bank Employee

If you are covered by a collective bargaining agreement when you begin working for a covered employer, the Trust Administration Office will set up an Hour Bank on your behalf. The Trust will credit to your Hour Bank all hours worked in a job classification covered by a collective bargaining agreement and contributed on by your employers.

As a new active Employee, you will become eligible for benefits after you have 300 or more hours credited to your Hour Bank within the preceding six month reporting period.

Once you have 300 hours reported to your Hour Bank within the preceding six month reporting period, coverage will begin the first day of the following month. The work month is the month the hours are actually worked, the reporting month is the following month (lag month) and the eligibility month is month of coverage. The lag month provides sufficient time for receiving and processing employer reports. The following examples illustrates how initial eligibility and the lag month work:

Example 1							
Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8
You work 300 covered hours						Lag month	Coverage begins

Example 2			
Month 1	Month 2	Month 3	Month 4
You work 300 covered hours		Lag month	Coverage begins

Ongoing Eligibility

Each month after you have satisfied the initial eligibility requirements, 120 hours will be deducted from your Hour Bank to maintain coverage under the Plan. You will continue to be covered as long as you have 120 hours or more in your Hour Bank.

Maximum Hour Bank

If you work more than 120 hours in a month, the additional hours are added to your Hour Bank. Here's an example:

Hours worked in month	160
Minus hours required for current month's coverage	- 120
Hours added to your hour bank account for future coverage	40

After deducting 120 hours for the current month, you may accrue a maximum of 720 hours in your account at any given time – enough hours for six months of additional coverage. Any hours above the maximum of 720 hours will not be added to your Hour Bank.

Suspension of Benefits

The Trust Fund relies on a stable contribution base to ensure that the Plan can continue to provide benefits for future members. Accordingly, if you leave the employment of a contributing employer and begin working for an employer in the carpentry industry that is not subject to a collective bargaining agreement or special agreement requiring contributions to the Alaska Carpenters

Health and Welfare Trust Fund (non-contributing employer), your accrued Hour Bank eligibility will be suspended the first day of the second month following your receipt of notification from the Trust Administration Office. If you continue to work for a non-contributing employer for more than 30 days after your benefits are suspended, your Hour Bank will be forfeited and you will lose all accrued hours.

If your hours were forfeited and you return to work for an employer subject to a collective bargaining agreement or special agreement, for purposes of establishing eligibility, you will have to meet the initial eligibility requirements. In this case, you will become covered on the first day of the second month following an accumulation of 300 or more hours in your Hour Bank within the preceding six months.

Associate Employee Eligibility

If you are covered by a special agreement you will not have an Hour Bank. If you work the required number of hours indicated in the special agreement your employer will make contributions to the Trust at a flat monthly rate. Your initial eligibility will begin the first of the second month following the month for which contributions are received.

If you are covered under a special agreement, your ongoing eligibility will be determined based on the requirements in the special agreement.

When Active Coverage Ends

Your eligibility for coverage will end on the earliest of these dates:

- At the end of the second calendar month following the calendar month during which your Hour Bank is reduced to less than 120 hours;
- If you are covered by a special agreement, the first day of the month following the month in which no contributions are received;
- The first day of the month your benefits are suspended;

- The first day of the month you are inaccurately reported to the Plan as an eligible employee and such inaccurate reporting is the result of fraud or intentional misrepresentation; or
- The date the Plan ceases to provide benefits or changes these eligibility rules resulting in a termination of eligibility.

In the event your coverage ends, you may be able to continue coverage by self-paying the cost. See "Continuing Health Care Coverage" on pages 31-37.

Reinstatement of Eligibility

If your coverage ends because your Hour Bank has less than 120 hours, any hours remaining in your account will be maintained for 12 months. If you work and hours are credited to your hour bank, your eligibility will be reinstated on the first day of the second month after you work enough hours to have 120 hours in your Hour Bank.

If your eligibility is not reinstated during the 12-month period, any hours remaining in your account will be forfeited. If you return to work after your hours are forfeited, you will need to satisfy the initial eligibility rules to be covered. Here is an example: your coverage ends January 1 because you only have 60 hours in your hour bank. These 60 hours are carried forward through October 31 (eligibility for December). If you do not work at least 60 hours by October 31, the 60 hours remaining in your account will be forfeited.

Dependent Eligibility

Your eligible dependents include your:

- Legal Spouse
- Natural children, stepchildren, adopted children and children placed with you for adoption, who are:
  - Under age 26; or
  - Turned age 26 while covered under this program and who are incapable of self-sustaining employment by reason of

developmental disability or physical handicap. Proof of such incapacity and dependency must be furnished to the Plan Administrator within 30 days of the child's attainment of age 26 and periodically thereafter as the Plan Administrator may require.

- Foster children, and children for whom you have legal custody who are:
  - Under age 18; or
  - Under age 26 and: 1) are financially dependent on you or your dependent spouse; and 2) reside with you or your spouse or are enrolled in college or trade school.
- A dependent child covered Qualified Medical Child Support Orders (QMCSO). A QMSCO is any judgment, decree or other (including a domestic relations settlement agreement) issued by a court or by an administrative agency under applicable state law which:
  - Provides child support or health benefit coverage to a dependent child, or
  - Enforces a state law relating to medical child support.

To be qualified, an order must clearly specify:

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

An order will not be qualified if it requires the Plan to provide any type or form of benefit or any option not otherwise provided under this Plan.

If a proposed or final order is received, the Claims Administration Office will notify the parties named in the order. A child may designate a representative to receive copies of notices with respect to the order. A proposed or final order will be reviewed to determine if it meets the definition of a QMSCO. A properly completed National Medical Support Notice issued by a state agency shall be deemed to be a QMSCO. Within a reasonable time, the parties named in the order will be notified of the decision.

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

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

Enrollment

You and your dependents must be enrolled for the same health care benefits including, as applicable, medical, prescription drug, dental and vision care. No dependent coverage is available for life insurance or accidental death and dismemberment insurance, which covers only active employees.

If you have eligible dependents, it will be necessary to complete an enrollment form within 30 days of your enrollment in order to avoid delay in processing claims. Enrollment forms can be obtained from the Trust Administration Office. Coverage will not begin and claims will not be paid until a completed enrollment form and all requested supporting documentation is received by the Trust Administration Office. In no event will claims be paid more than 12 months after the claims are incurred.

If you acquire new dependents while you have coverage, a new enrollment form must be completed and submitted along with the appropriate documentation. You should complete a new enrollment

form and supply an appropriate marriage or birth certificate within 30 days of your marriage, the birth of the child, or adoption or placement for adoption or as soon as reasonably practicable.

When Dependent Coverage Begins

Once all enrollment material is received and processed, eligibility for your dependents will be effective:

- On the date you become covered.
- On the date of birth, adoption, placement for adoption, placement of foster child or the date legal custody is awarded.
- On the first day of the first calendar month following the date of your marriage for your new spouse and stepchildren.
- If your coverage has lapsed, your dependent's coverage will begin on the first day of the month when your eligibility is reinstated.

Although your dependents may be eligible on the dates identified above, claims for dependents will be suspended until all required enrollment documentation has been received by the Trust. If the required documentation is not received within 12 months after the date the claims were incurred, the claims will be denied.

When Dependent Coverage Ends

All benefits for your dependents will end on the earliest of these dates:

- The date you are no longer covered.
- The last day of the month the dependent ceases to meet the eligibility requirements for dependent coverage.
- On the date the Plan ceases to provide benefits.

Your dependent may be eligible to extend coverage after it would otherwise end. For more information, see "Continuing Health Care Coverage" on page 31-37.

Changes in Status

You must notify the Trust Administration Office if you have a change in family status such as:

- Marriage or divorce.
- Birth of a child.
- Child no longer meets definition of an eligible dependent.
- Death of employee or eligible dependent.

Continuation and Self-Pay Options

In the event you lose coverage, you may be able to continue coverage and/or self-pay for coverage if you qualify for one of the following continuation and self-pay options. There are no other continuation rights, self-pay options or individual plan conversion options except those provided below.

If Your Employer Is Delinquent

If your employer is delinquent in submitting plan contributions for hours you work under a collective bargaining agreement, you will may lose eligibility under the Plan. However, the plan does allow a grace period, and will credit your Hour Bank for hours worked in the first 60 days of the employer's delinquency. In order to receive credit for these hours, you are required to provide pay stubs or other valid proof of the hours worked. The Trust Administration Office and the Union will attempt to notify you if your eligibility will end due to the delinquency of employer contributions. If you suspect that your employer is delinquent, you should contact the Trust Administration Office immediately to see if your eligibility is in jeopardy.

Continuation of Dependent Coverage after Your Death

If you die while you are an active employee or retiree in the Plan, your spouse and dependent children may be eligible to continue medical, prescription drug and vision coverage. To qualify for extended coverage:

- Your surviving spouse and any children must be covered under the plan at the time of your death.

To receive these benefits, your surviving spouse must:

Have premiums for health care coverage submitted monthly or deducted from your surviving spouse's monthly pension check. The premium amount of the deduction is based on your surviving spouse's age and Medicare status. Your surviving spouse will be notified in advance of any premium change. Certain categories of retirees may be eligible for a partial subsidy of retiree premiums. To determine if you are eligible, contact the Trust Administration Office.

Eligibility for a surviving spouse and dependent children ends as indicated under "When Retiree Coverage Ends" on page 43 or, if earlier, on the last of the month following the date your spouse remarries or your dependent children cease to meet the definition of dependent children under the plan. Your surviving spouse must notify the Trust Administration Office upon remarrying.

Family and Medical Leave

Under the Family and Medical Leave Act ("FMLA"), you may be entitled to:

- Twelve workweeks of leave in a 12-month period for:
    - The birth of a child and to care for the newborn child within one year of birth;
    - The placement with the employee of a child for adoption or foster care and to care for the newly-placed child within one year of placement;
    - The care of the employee's spouse, child, or parent who has a serious health condition;
    - To care for your own serious health condition that makes you unable to perform the essential functions of your job; or
    - Any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty"

(a qualifying exigency includes things such as needing to make arrangements for child or parental care, financial support or counseling, or attend ceremonies, rest and recuperate); or

- Twenty-six workweeks of leave during a single 12-month period to care for a covered serviceman with a serious injury or illness if the eligible employee is the service
- member's spouse, son, daughter, parent, or next of kin (military caregiver leave).

If you think you are eligible for FMLA leave, you should contact your employer as soon as possible. Your employer can tell you of your other obligations under the FMLA.

While you are on FMLA leave, your employer is required to continue contributions for your (and your dependents') medical, dental, and vision coverage during your leave.

The FMLA applies directly to employers, not to this Trust. For clarification and/or additional information on your rights under the FMLA, contact the Department of Labor, Wage and Hour Division, at http://www.wagehour.dol.gov or call 1-866-487-9243. States may provide additional entitlements and protections.

Uniformed Services Employment and Reemployment Rights (USERRA)

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

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

Notice of Military Service

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

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

Election of USERRA Continuation Coverage

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

Length of USERRA Continuation Coverage

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

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

If you decide to run-out your Hour Bank before commencing USERRA continuation coverage, USERRA continuation coverage

will begin the first of the month following depletion of your Hour Bank, provided the required self-payments are made.

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

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

Available Coverage

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

You and/or your eligible dependents may elect any of the self-pay options offered by the Plan.

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

Monthly Self-Payments Required

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

The initial payment for USERRA coverage is due within 45 days from the date the Trust Administration Office receives a completed election form. The first payment must cover all months for which coverage is sought through the month in which the first payment is made. Eligibility will not commence, nor will claims be processed

until the initial payment has been made, at which time eligibility will be retroactive to the date your hour bank coverage ended (or was frozen).

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

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

Reinstatement of Eligibility Following Military Service

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

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

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

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

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

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

Relationship of USERRA Continuation Coverage to COBRA

You may have the right to elect COBRA continuation coverage in lieu of USERRA continuation coverage. The length of USERRA continuation coverage may be different from that of COBRA continuation coverage. If you have questions regarding election or duration of COBRA continuation coverage, please see page 31 or contact the Trust Administration Office.

Continuing Health Care Coverage Through COBRA Self-Payment

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

What is COBRA Coverage?

COBRA coverage is a continuation of group health coverage under the plan when coverage would otherwise end because of a life event known as a "qualifying event." See "Qualifying Events" below for information on specific qualifying events. After a qualifying event occurs and any required notice of that event is provided in a timely manner to the Trust Administration Office, COBRA coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if group health coverage under this plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA coverage must pay for COBRA coverage.

Qualifying Events

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

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

- The participating Employee's termination of employment or reduction in hours of employment, leaving fewer than 120 hours in the Employee's Hour Bank.
- Death of the participating Employee.
- Divorce from the participating Employee.

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

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

COBRA Notification Responsibilities

The Trust offers continuation coverage only after it has been notified of a qualifying event. Your employer is responsible for informing the Trust if your employment is terminated.

The Trust Administration Office will determine when the Employee's Hour Bank falls below 120 hours.

If you or your eligible dependents have a loss of coverage because of divorce, death, or a child losing dependent status you must notify the Trust Administration Office in writing within 60 days of the date of the qualifying event. You must provide this notice in writing to:

Alaska Carpenters Health and Welfare Trust Fund
PO Box 34203
Seattle, WA 98124-1203

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

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

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

Election of COBRA

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

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

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

Adding New Dependents

COBRA is only available to individuals who were covered under the Plan at the time of the qualifying event.

If you elect COBRA and acquire a new dependent through marriage, birth, adoption, or placement for adoption, you may add the new dependent to your COBRA coverage by providing written notice to the Trust Administration Office within 60 days of acquiring the new dependent.

The written notice must identify the participating employee, the new dependent, the date the new dependent was acquired and be mailed to the Trust Administration Office.

Children acquired through birth, adoption, or placement for adoption are entitled to extend their continuation coverage if a second qualifying event occurs as explained on page 36.

Continuous Coverage Required

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

Cost

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

The Trust uses a composite rate, which means that you pay the same monthly rate if you are covering one person or an entire family. The cost for the coverage available through the Trust is set annually.

Monthly Self-Payments Required

COBRA self-payments are due on the first of each month for that month's coverage and must be sent to the Trust Administration Office (see address on page 134).

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

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

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

Length of Continuation Coverage

Continuation of coverage may last for up to 18 months following loss of coverage as a result of a termination of employment or reduction in hours.

For all other qualifying events (death of Employee, divorce or legal separation from Employee, or a child no longer qualifying as a dependent under the Plan) continuation coverage may last for up to 36 months. However, continuation coverage will end on the last day of the monthly premium payment period if any one of the following occurs before the maximum available continuation period:

- A required self-payment is not paid to the Trust Administration Office on a timely basis for the next monthly coverage period.
- You or your eligible dependent becomes covered under any other group health plan after the date of your COBRA election (unless the other group health plan limits or excludes coverage for a preexisting condition of the individual seeking continuation coverage).
- You or your eligible dependent provides written notice that you wish to terminate your coverage.
- You or your eligible dependent becomes entitled to Medicare benefits after the date of your COBRA election.
- The date the Plan terminates or the date your employer no longer participates in the Plan unless your employer or its successor does not offer another health plan for any classification of its Employees that formerly participated in the Trust.

Length of Continuation Coverage—Disabled Participants

If you, your spouse, or any dependent covered by the Trust is determined by the Social Security Administration to be disabled within the first 60 days of continuation coverage, the entire family of the disabled individual can receive an additional 11 months of continuation coverage for up to a maximum of 29 months. You must notify the Trust Administration Office of your eligibility for this extension before the expiration of the first 18 months of your COBRA continuation coverage.

If you are eligible for an extension of coverage as a result of you or a dependent being disabled, the cost of the coverage will be 150%

of the COBRA self-payment rate for the additional 11 months of coverage provided as a result of your disability.

Second Qualifying Event Extension

An 18-month extension of COBRA coverage will be available to spouses and dependent children who elect COBRA coverage on account of the participating employee's termination of employment or reduction in hours if a second qualifying event occurs during the first 18 months of COBRA coverage (or, in the case of a disability extension, during the period of that extension). The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of the covered employee, divorce from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the plan, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred. You must notify the Trust Administration Office in writing within 60 days after a second qualifying event occurs.

Relationship between COBRA and Medicare or Other Health Coverage

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

If you have coverage under a Trust-sponsored Plan based on COBRA and you are entitled to Medicare based on age or disability and no longer have current employment status, Medicare will pay first and the Trust will only pay secondary and coordinate with Medicare.

Current employment status means you are still at work or have received short-term disability benefits for less than six months.

If you have Medicare coverage based on end stage renal disease and have Trust coverage (based on COBRA or otherwise), the Trust will pay primary during the 30-month coordination period provided for by statute.

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

Effect of Not Electing Continuation Coverage

If you do not elect continuation coverage:

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

Additional Information

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

To help ensure you receive necessary notices, you should notify the Trust Administration Office if your address or that of any family member changes. You should retain this notice and also keep a copy of any written notices you send the Trust.

Continuation of Life Insurance by Self-Payment

If your hour bank account is insufficient to continue your life insurance coverage, you may self-pay the full cost of life insurance for up to six months. To qualify, you must:

- Have been continuously covered under the plan for at least six months
- Be available for active work (on the "Out of Work List")
- Not have your benefits suspended at the time your hour bank becomes insufficient.

You may self-pay the cost of continued life insurance for up to six months or until the earliest of the following dates:

- The last day of the month you're no longer available for active work
- The last day of the month that you make the required self-payment
- The date you become eligible for life insurance under another group plan
- The date the group policy ends.

The Trust Administration Office must receive your self-payment by the first of the month for which your life insurance is to be continued.

Certificate of Creditable Health Coverage

Upon written request to the Trust Administration Office, the Plan will provide a certificate of creditable health coverage. The certificate provides information about your coverage period under this plan.

Retired Employees

Retiree Benefits Are Not Guaranteed

The Board of Trustees provides a Retiree Health and Welfare Benefit Plan to eligible retirees and their dependents. This Plan is provided to the extent that monies are currently available, and may be available in the future, to pay the cost of such Plan.

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

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

Choice of Coverage upon Retirement

When you retire, you have the choice of continuing coverage as a retiree (if you meet eligibility requirements) or through COBRA. For more information, see "Continuing Health Care Coverage through COBRA Self-Payment" on pages 31-37.

If you elect COBRA coverage you will be allowed to continue retiree coverage once your COBRA coverage is exhausted (see "Delayed Enrollment Rules for Retirees" on page 41). However, in order to continue retiree coverage, you must have met all retiree eligibility requirements at the time of your retirement.

Eligibility for Retiree Coverage

You and your eligible dependents are eligible for retiree benefits under this plan if you meet **all** of the following six requirements:

1. You retire with at least 10 years of credited service in one or a combination of the following:
   - The Alaska Carpenters Retirement Plan (prior to January 1, 1987)
   - The Southern Alaska Carpenters Retirement Plan (on or after January 1, 1987)
   - The Southern Alaska Carpenters Pension Plan (prior to July 1, 2006)
   - The Northern Alaska Carpenters Pension Plan (prior to July 1, 2006)
   - The Alaska Carpenters Defined Contribution Plan (on or after July 1, 2006).

   A year of credited service is a year in which you work at least 435 covered hours for a contributing employer who makes contributions on your behalf to one of the plans listed above. If a consecutive five-year break in credited service is incurred prior to meeting the 10-year requirement, or if you work in the

building and construction industry for a non-contributing employer, only credited service earned after a return to work for a contributing employer will be counted toward the 10-year requirement.

2. You are:
   - Totally disabled and receiving disability retirement income from any of the plans listed on page 39, or
   - Age 53 or older and receiving or have received an early retirement income from any of the plans listed on page 39, or
   - Age 60 or older and receiving or have received a normal or late retirement income from any of the plans listed on page 39.
3. You have had health coverage under this plan or a plan provided by a contributing employer, for at least 12 of the 48 months immediately preceding retirement.
4. You complete an enrollment application.
5. You pay the monthly health care premium for retiree coverage or have the health care premiums deducted from your monthly pension check.
6. You are a dues paying member of a participating Union, or pay a service fee to a participating Union equal to the amount of dues required by retired members.

In addition to the above requirements, all retirees, spouses and dependents who are eligible for Medicare due to age or disability must enroll in Medicare Parts A and B. See the important note on page 45 regarding Medicare eligibility.

When Retiree Coverage Begins

Coverage for eligible retirees becomes effective the first of the month after the date of your retirement, provided the appropriate premium amount is paid or deducted from your pension check. If you are still eligible for benefits as an active employee on your

retirement date, retiree health care coverage will begin on the first day of the month after your active coverage ends.

Enrollment

Eligible retirees may enroll for medical and prescription drug coverage or medical, prescription drug and vision coverage. Vision coverage may be dropped at a later date but may not be added after the original election.

To be covered, you must return a completed enrollment form to the Trust Administration Office within the first three months following the date you are first eligible for retiree coverage. After you enroll, coverage is retroactive to your retiree coverage eligibility date. You will be required to pay the premium for any retroactive coverage. Retiree coverage is not available after this three-month initial enrollment period except during a special enrollment period.

If you enroll in a Medicare Part D prescription drug plan, you will not have prescription drug coverage under this plan. There will be no reduction in your contribution rate.

Delayed Enrollment Rules for Retirees

If a retiree chooses not to enroll on the date first eligible because the retiree has other health coverage under another individual health insurance policy or through spousal employment-based coverage, and the retiree or a spouse ceases to be covered by that other coverage, the retiree and any eligible dependents may, on a once per lifetime basis, request enrollment in this Plan within 31 days after termination of the other coverage.

Enrollment Rules for Dependents of Retirees

Eligible dependents under the Retiree Plan are the same as those under the Active Plan.

Your eligible dependents may enroll when you first become eligible by completing an enrollment form within 30 days of your eligibility date. If an enrollment form is not on file at the Trust Administration Office, claims for that dependent will not be paid until a completed enrollment form is returned to the Trust Administration Office.

If an eligible dependent does not enroll when first eligible, the dependent will not be able to enroll at a later date unless you have a right to delay enrollment.

Coverage for your eligible dependents begins when your coverage begins. Dependents you acquire after your coverage is effective may be covered on the date they become an eligible dependent.

You and your dependents must be enrolled for the same health care benefits including, as applicable, medical, prescription drug, dental and vision care except as provided by law. No dependent coverage is available for life insurance or AD&D insurance, which covers only the active employee. Enrollment forms are available from the Trust Administration Office.

Delayed Enrollment Rules for Dependents of Retirees

If you are an enrolled retiree and you do not enroll your spouse and eligible children because they have other group health coverage, you may enroll your dependents in the retiree plan at a later date provided:

- You enroll them within 30 days after the other health coverage ends.
- They meet the eligibility requirements of this plan.

If your dependents' other coverage was under COBRA, their COBRA coverage must be exhausted to be eligible for the special enrollment period. COBRA coverage is not considered exhausted if you lose coverage solely because the applicable COBRA premium was not paid on a timely basis. For other than COBRA coverage, the loss of coverage must be due to loss of eligibility for the other coverage (including divorce, death, termination of employment or reduction in hours of employment or termination of employer contributions toward coverage).

Changes in Status

You must notify the Trust Administration Office if you have a change in family status such as:

- Marriage or divorce.

- Birth of a child.
- Child no longer meets definition of an eligible dependent.
- Death of retiree or covered spouse.
- Remarriage of surviving spouse of a retiree.
- Retiree returns to work or returns to retired status after a period of working.
- Retiree becomes eligible for Medicare and cancels his or her coverage, but wishes to continue coverage for a spouse until the spouse is eligible for Medicare.

Accurate and efficient claims processing depends on the Trust Administration Office having current information. Remember to advise the Trust Administration Office promptly of these changes by completing a revised enrollment form.

Cost of Coverage

Health care premiums for retiree coverage must be submitted monthly or deducted from your monthly pension check. The premium amount is based on the number of dependents enrolled, you and your dependents' ages, Medicare eligibility, and the coverage elected: medical and prescription drug or medical, prescription drug and vision coverage. Certain categories of retirees may be eligible for a partial subsidy of retiree premiums. Retirees who only meet the eligible requirements for the Retiree Plan because of months reported as an associate employee (rather than a collectively bargained employee) are not eligible for a retiree subsidy. To determine if you are eligible, contact the Trust Administration Office.

Premiums for retiree coverage are reviewed and adjusted periodically by the Board of Trustees. You will be notified in advance of any premium changes. Current rates are available by contacting the Trust Administration Office.

When Retiree Coverage Ends

Retiree coverage will end for you or your dependent on the earliest of these dates:

- The date you, as the retiree become eligible for coverage as an active employee.
- The last day of the month after the Trust Administration Office receives written instruction from you to end your coverage and, if applicable, stop pension check deductions.
- The first day of the month for which premium is not paid.
- The date the Trust terminates retiree coverage.
- The date the plan terminates.
- The date of your death.
- The date the individual ceases to be a dependent as defined by the Plan.

If you or your dependents terminate coverage under the Trust's Retiree Plan, either voluntarily or by not paying the required premiums, you or your dependents **will not** be able to enroll at a later date. The only exception is when a retiree returns to active employment. See "Retiree Returns to Active Employment" below for more information.

Retiree Returns to Active Employment

A retiree who returns to active employment will continue to be eligible for retiree benefits until he or she meets the active employee initial eligibility requirements and becomes eligible for benefits as an active employee. During this time, the retiree premium must continue to be submitted monthly or deducted from your monthly pension check.

If the retiree reestablishes eligibility as an active employee, the retiree coverage will end. Retiree coverage will resume after eligibility for coverage as an active employee ends or the end of the COBRA eligibility period if COBRA is elected when active coverage terminates.

A retiree who returns to active employment in the building and construction industry for a non-contributing employer will lose all future retiree eligibility under this plan.

Important Note for Those Participants Eligible for Medicare

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

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

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

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

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

MEDICAL BENEFITS

How Your Medical Benefits Work

How the Annual Deductible Works

A deductible is the amount you must pay toward certain covered services before the plan pays benefits. The annual deductible is $275 per person/$825 per family each calendar year for active employees, dependents of active employees, non-Medicare eligible retirees and non-Medicare dependents of retirees.

Non-Medicare eligible retirees and non-Medicare dependents of retirees who elect the catastrophic benefit will have an annual deductible of $5,000 per person.

The annual deductible does not apply to:

- immunizations
- physician visits
- preadmission testing
- second surgical opinions
- Medicare eligible retirees
- Medicare eligible dependents of retirees
- well baby/child and physical exams.

For all other covered services, you must pay the deductible before the plan pays benefits. Only charges to which the annual deductible applies can be used to satisfy the annual deductible. **Copayments cannot be used to satisfy the annual deductible.**

Common Accident Provision

Only one medical deductible will apply during a calendar year if two or more family members are injured in the same accident. This provision will not apply if higher medical benefits would be paid without it.

How Coinsurance Works

If applicable, you must first meet the annual deductible before the Plan pays benefits. When the Plan pays benefits, the Plan pays a coinsurance based on the Allowable Amount. The Allowable Amount is the Preferred Provider's discounted amount or the Usual, Customary and Reasonable (UCR) rate for Non-Preferred Providers (not the billed amount).

You pay the remaining percentage until you reach the out-of-pocket limit. Benefits are payable only for expenses incurred while an individual is covered under the Plan.

Co-insurance is based on the following payment levels for most covered expenses:

Active employees and dependents	Plan pays 80% of the allowed amount for most covered expenses and you pay 20%
Non-Medicare eligible retirees and dependents	Plan pays 50% of the allowed amount for most covered expenses and you pay 50%
Medicare eligible retirees and dependents	Plan pays 100% of: - Medicare Part A deductibles (inpatient hospital, skilled nursing facility and home health care) - Medicare Part B deductibles (physician services, outpatient hospital, home health and durable medical equipment), and - Any covered charges which, due to Medicare Part B coinsurance, are not payable under Medicare

The Allowed Amount for non-Preferred Providers is limited to the UCR charge, as determined by the Plan. If a provider charges more than the UCR amount, the coinsurance will be based on the UCR amount. You will then be responsible for your coinsurance portion of the UCR amount ***plus*** 100% of the charges in excess of the UCR amount. These additional charges are commonly referred to as balance billing. You can avoid balance billing and save money by using a Preferred Provider and Preferred Facility. Please contact Premera at (800) 810-BLUE (2583) or visit www.premera.com (select Find a Doctor from the top menu, go to the Visitor section

and click on "Search for provider" from the Heritage & Heritage Plus 1 network option) to determine whether your provider and/or facility are preferred. Please note that using a Preferred Provider at a facility does not guarantee that the facility is also Preferred.

How Copayments Work

A copayment is an amount you pay each time you receive a specified service. Under this plan, a $15 copayment applies to: physician, inpatient or outpatient visits.

How the Annual Out-of-Pocket Maximum Works

The annual out-of-pocket maximum is the maximum you will pay each calendar year. Once you reach the out-of-pocket limit, most covered expenses are paid at 100% for the rest of that calendar year. The out-of-pocket maximum is $2,000 per person in a calendar year or $4,000 per family in a calendar year.

Non-Medicare eligible retirees and non-Medicare dependents of retirees who elect the catastrophic benefit will have an annual out-of-pocket maximum of $10,000 per person and $20,000 per family.

The out-of-pocket maximum does not apply to:

- Any charges you are required to pay because they are determined not to be medically necessary.
- Copayments.
- Deductibles.
- Expenses in excess of UCR.
- Expenses which are not covered.

Expenses for these services will not be paid at 100%, even after you reach the out-of-pocket maximum.

Medical Pre-certification

You should obtain pre-certification for any inpatient hospital stay prior to being admitted. Contact Qualis Health at (800) 783-8606 to obtain pre-certification of hospital admissions. Hospital charges

for days determined by Qualis Health not to be medically necessary under the plan rules will not be covered.

Case Management

The plan has contracted with Qualis Health to provide case management services for certain illnesses or injuries. Qualified nurses from Qualis Health will work with you and your physician to ensure that you get the most of your benefits and receive appropriate and cost effective medical care. In some cases, this may mean that medical benefits may be authorized that are not normally covered by the plan.

Case management services are voluntary — decisions regarding your treatment are always up to you and your physician. However, these services can offer you potential cost savings and assistance with understanding your treatment options.

Taking Care of Us – Maternity Resource Program

Qualis Health provides education, resources and risk screening services for female Trust participants, including active employees, retirees and spouses, during pregnancy. The program is telephonic and available 24 hours a day, 7 days a week, 365 days a year. Registered nurses with extensive experience in pregnancy, childbirth and obstetrical care are available to answer your questions, provide information on wellness and healthy lifestyles and guide you to community resources when appropriate. Be sure to contact Qualis Health at (866) 898-6588 when you first become pregnant to enroll in the program and start receiving monthly information. There is no cost to you.

Using the Preferred Provider Network Can Save You Money

The plan has contracted with Premera Blue Cross for access to their preferred provider network. The plan allows you to use any covered provider you wish, but there are financial advantages when you use a preferred provider.

First, preferred providers have agreed to discounted fees for their services. This means your out-of-pocket expenses may be less than if you are treated by a non-preferred provider.

Second, preferred providers have agreed to accept negotiated fees as payment in full for their services. You will only be responsible for the plan deductible, copay and coinsurance. If you use a non-preferred provider, the plan will apply benefits based on UCR charges. In addition to the deductible, copayment and coinsurance, you will be responsible for paying any amount billed by the provider that is over the UCR amount.

Finding a PPO Network Provider Near You

For a list of preferred providers, contact Premera Blue Cross toll-free at (800) 810-BLUE (2583), or visit their website at www.premera.com.

Covered Medical Expenses

The following is an alphabetical list of some of the medical services covered by the Plan. Unless otherwise specified, the services are subject to the out-of-pocket maximum and covered up to the Allowed Amount and are subject to the deductible and office visit copay.

- **Assistant Surgeon**. For medically necessary surgical assistance by a physician or a physician assistant (PA), the benefit payable will be based on 20% of the Allowed Amount for the corresponding surgery.
- **Birthing Centers** are covered when utilized as an alternative to hospitalization for maternity.
- **Childhood immunizations** are covered at 100% with no deductible based on the Department of Health and Human Services/Center for Disease Control recommended schedule.
- **Chiropractic services** which are part of a formal treatment plan prescribed by a physician are covered without limits; chiropractic services which are not part of a formal treatment

plan are subject to the following limits: $500 per person and $1,000 per family each calendar year. The $15 physician copayment does not apply.

- **Diagnostic services** for laboratory tests and x-rays.
- **Durable medical equipment** for rental or purchase. Cost of rental is covered up to purchase price only. Durable Medical Equipment is equipment that meets all of the following requirements:
  - Designed for repeated use.
  - Mainly and customarily used for medical purposes.
  - Not generally of use to a person in the absence of a disease or injury.
  - Not for use in only certain activities such as sports or performance equipment.
  - Usable only by the patient.
  - Not for preventive purposes.
  - Manufactured solely for medical use.

  Durable Medical Equipment includes, but is not limited to, such items as: hospital bed, wheelchair, traction apparatus, intermittent positive pressure breathing machine, brace crutches.

  Durable Medical equipment does not include deluxe items, duplicate equipment, exercise equipment or air purifiers.
- **Emergency transportation** within the continental United States and Canada, and within the geographic boundaries of Puerto Rico and Hawaii by:
  - Professional ambulance service (other than air ambulance) to and from a hospital.
  - Regularly scheduled airline, railroad or by air ambulance from the location where the participant became ill or

injured, to and from the nearest accredited hospital qualified to treat the condition.

To be covered, the disease or injury must have occurred suddenly and unexpectedly; must be life endangering and require immediate attention; the participant must be admitted immediately after the trip as an inpatient to a hospital; and the trip must begin within 72 hours of diagnosis of the disease or injury.

Return transportation charges will be covered if return transportation starts within 72 hours of discharge and the participant returns directly to the originating location, or location of permanent residence.

- **Hearing examination and hearing aid devices** (no coverage for Medicare eligible Retirees) are covered at 80% up to $1,000 per year per person once every 36 months. Benefit includes hearing evaluation examinations and hearing aid device. Benefits are not paid for repairs, servicing, alterations, batteries or other related equipment not obtained when purchasing the hearing aid device.

  The Trust contracts with Epic Hearing Service Plan (HSP) to assist you in locating quality hearing care professionals and in most cases, reducing your cost for hearing devices.

  To learn more, contact the Epic Hearing Service Plan at (866) 956-4500. Be sure to identify yourself as being covered under the Alaska Carpenters Health and Welfare Trust Fund.

- **Home health care** including:

  – Part-time or intermittent services of a home health aide up to 130 visits of four hours or less per calendar year.

  – Psychiatric treatment by a licensed social worker who is practicing within the scope of their license.

  – Physician services.

  Home health care services are covered only if:

- Medical care is furnished by or through a home health agency to a participant in their home,
- The home health care plan is written or approved by the participant's physician,
- Home health care is medically necessary, *and*
- In the absence of home health care, the participant would be an inpatient at a hospital, rehabilitation facility, or skilled nursing facility.

- **Hospice care**. To be covered, hospice care services must be provided by an agency or facility approved by the plan as meeting established standards, including any legal licensing required by the state or region in which it operates. The following services are covered during a period in which the plan validates a physician's certification that the participant is terminally ill and expected to live 6 months or less—and during the bereavement period following the patient's death:
  - Confinement of a terminally ill patient as an inpatient, including up to 5 days of inpatient respite care every 3 months.
  - Home health care for the terminally ill patient in the patient's home, including the services of a home health aide, professional services of a nurse, physical or other therapy, nutrition counseling and special meals and medical supplies.
  - Medical social services for the terminally ill patient or for covered family members.
  - Bereavement counseling for covered family members during the 12 months beginning on the date of the terminally ill patient's death.

  For hospice care only, the custodial care exclusion does not apply. Medically necessary includes medical social services, bereavement counseling, respite care, and palliative care, as well as treatment or diagnosis.

- **Inpatient Hospital** room and board up to the average semi-private room rate including necessary services and supplies. Covered services include an intensive care unit not to exceed three times the hospital's average semiprivate room rate, outpatient services and supplies furnished by a hospital.

  You should obtain pre-certification for hospital admissions (see "Medical Pre-certification" page 48). Services furnished by a Premera Blue Cross preferred provider are based on discounted rates and can save you and the plan money (see "Using the PPO Network Can Save You Money" on page 49).

- **Mammography services** are covered under physical exam/screenings benefit if part of a physical exam (see page 55); otherwise covered the same as diagnostic services.

- **Mastectomy and breast reconstruction services** are provided for a mastectomy necessary due to disease, illness or injury. For any participant electing breast reconstruction in connection with a mastectomy, this benefit will cover:

  – Reconstruction of the breast on which the mastectomy was performed.

  – Surgery and reconstruction of the other breast to produce a symmetrical appearance.

  – Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

  Services are to be provided in a manner determined in consultation with the attending physician and patient.

- **Maternity benefits** are provided for female employees/retirees or female spouses of employees/retirees only. This benefit is not available to dependent children. The plan does not restrict benefits for hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarian section. However, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or

96 hours). The plan does not require pre-authorization for a length of stay not in excess of 48 hours (or 96 hours).

See "Taking Care of Us - Maternity Resource Program" on page 49 for information about prenatal education, resources and risk screening services.

- **Medical supplies** that require a physician's prescription such as oxygen, blood, blood products, and anesthetics.
- **Mental health services**: Both inpatient and outpatient services are covered. Inpatient services are subject to preauthorization and benefits are limited to a semi-private room rate.
- **Physical exams/screenings** for active employees, retirees and their eligible spouses. The following services are covered at 100% with no deductible once per calendar year for employees, retirees and eligible spouses:
  - Physician charges associated with routine physical exam.
  - Lab or x-ray charges associated with a routine physical exam.
  - Cancer screenings according to the American Cancer Society guidelines or physician recommendation.

  Dependent children are not eligible for this coverage (see "Well Baby/Child Exam Benefit" on page 60).
- **Physical therapy** when referred by your physician. The $15 physician copayment does not apply.
- **Physician services** including:
  - Home, office or hospital visits (limited to one visit per day). Physician visits are subject to a $15 copayment per visit and are not subject to the annual deductible.
  - Inpatient and outpatient surgery, including normal follow-up care and administration of any local, digital block, or topical anesthesia. Inpatient services require preauthorization.
  - Reduced benefits may be paid for administration of anesthetics if done by the operating or assisting surgeon.

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

- 100% of the preferred provider's fee or the non-preferred provider's usual, customary and reasonable allowance for the primary procedure.
- 50% of the preferred provider's fee or the non-preferred provider's usual, customary and reasonable allowance for the secondary or any additional procedures.

- **Preadmission testing** is covered at 100% with no deductible including lab tests and x-ray exams that are prerequisites to surgery and are performed on an outpatient basis within seven days before a scheduled admission to a hospital for surgery.
- **Prescription drugs** administered by the facility while you are an inpatient are covered under the Hospital benefit. See "Prescription Drug Benefits," on page 67, for coverage of outpatient prescriptions purchased at retail pharmacies or through mail order.
- **Preventive treatment** will be paid in full and will not be subject to the calendar year deductible or coinsurance. Preventive treatment includes:
  - Evidence-based tests or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force. These recommendations include blood pressure and cholesterol screening, diabetes screening for individuals with hypertension, various cancer and sexually transmitted infection screenings, and counseling in defined medically appropriate areas.
  - For infants, children, and adolescents, such other evidence informed preventive care and screenings provided for in the

comprehensive guidelines supported by the Health Resources and Services Administration.

- With respect to women, such additional preventive care and screenings not described above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. These guidelines describe recommended coverage of items such:
  - Well-woman visits;
  - Gestational diabetes screening;
  - Human papillomavirus DNA testing, every three years for women age 30 or older;
  - Sexually transmitted infections counseling for sexually-active women;
  - Human immunodeficiency virus (HIV) screening and counseling for sexually active women;
  - Access to all Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs;
  - Breastfeeding support, supplies, and counseling;
  - Interpersonal and domestic violence screening and counseling;
  - Mammograms; and
  - Cervical cancer screenings.

Preventive treatment will be limited to Medically Necessary and appropriate services. Where the recommended preventive treatment comes with recommendations regarding coverage or frequency, these will be followed. If no guidance on coverage or frequency is given, the Plan may adopt or utilize reasonable medical management techniques to determine the coverage and frequency limit. Unless otherwise agreed to by the Board of Trustees, any additions to the above list of preventive treatment will be effective on the first day of the plan year beginning 12 months after the new preventive service is listed.

- **Private duty nursing** during a period the plan validates your physician's certification that private duty nursing services are

medically necessary and, for outpatient nursing, that services are received instead of inpatient care.

- **Prosthetic devices**, except the replacement or repair of a prosthetic device, duplicate items and items only intended for certain activities such as running or swimming.

- **Rehabilitative/Habilitative Therapy**

  Habilitative therapy services, including occupational therapy, speech therapy, physical therapy and related therapies, to improve a mental health condition or congenital birth defect.

  Rehabilitative therapy services on an outpatient basis, including occupational therapy, speech therapy and physical therapy, to the extent that the therapy will significantly restore an improve a lost function(s) following a severe illness, injury or surgery.

  Habilitative and rehabilitative services are subject to the following conditions:

  – The service must be necessary to improve function or to maintain function where significant deterioration in function would result without the therapy;

  – The services must be prescribed by the attending physician and administered by a physician or covered licensed therapist. The Plan may periodically request a review of the services by a physician and the patient must continue under the care of the attending physician during the time the therapy is being provided; and

  – The services must not be custodial in nature.

  Benefits for rehabilitative and habilitative therapy services will end when the Plan determines that no additional clinical improvement is expected as a result of the therapy.

- **Second surgical opinions** including professional services of a physician and appropriate lab tests or x-ray exams that do not duplicate a prior test or exam will be covered at 100%, with no deductible. If the second surgical opinion does not confirm that

the surgery is medically necessary, charges for a third surgical opinion also are paid at 100% with no deductible.

A second or third opinion provided by a physician who later performs the surgery will be paid the same as other covered medical expenses, after the deductible.

- **Skilled nursing facility** covered at 50% for room and board up to the average semi-private room rate, including services and supplies. Limited to 120 days per calendar year.
- **Sterilization procedures** including vasectomies and tubal ligation, but not reversal.
- **Substance abuse treatment** Both inpatient and outpatient services are covered. Inpatient services are subject to preauthorization and benefits are limited to a semi-private room rate.
- **Transplant expenses** are covered provided:
  - Your provider submits a written recommendation, supporting documentation and preauthorization is obtained.
  - Your medical condition requires the requested transplant based on medical necessity.
  - The requested procedure is not considered experimental or investigational.

  Covered transplants include but are not limited to:
  - Heart
  - Heart/lung (combined)
  - Kidney
  - Kidney/pancreas (combined)
  - Lungs (single/bilateral)
  - Liver.

Benefits are not provided for:

- Organ donor expenses, or any expense arising from or related to organ donation or organ receipt regardless of whether the participant is the donor or the recipient of the organ.
- Experimental or investigational procedures as defined on page 148.
- Lodging, food or transportation costs, unless specifically approved by the Trust Administration Office.

- **Well baby care** including routine nursery care to a newborn while the mother and child are inpatients in a hospital and circumcision of a male newborn.
- **Well baby/child exams** are covered according to recommended guidelines from the Health Resources and Services Administration (HRSA). If you or your provider has questions about the recommended guidelines, please contact the Administrative Office or review the HRSA's recommendations at: www.healthcare.gov/center/regulations/prevention.html

What the Medical Plan Does Not Cover – Exclusions

Medical benefits will not be paid for any of the following items:

- Acupuncture.
- Arch supports, corrective shoes, and elastic stockings; nail trimming and paring of corns or calluses; foot orthotics except as specifically provided.
- Bariatric surgery or surgical treatment of obesity, including but not limited to gastric restrictive procedures (lap band surgery), intestinal bypass, reversal procedures or complications

resulting from surgical treatment of obesity; weight loss treatment services and supplies.

- Behavior modification therapy, except as necessary to treat a documented medical or mental health condition.
- Charges for missed appointments, telephone or internet consultations when patient is not physically seen by a physician.
- Charges for bed and board by a school or other institution for training, rest or the aged.
- Charges for services or supplies which are not provided or billed in accordance with generally accepted professional standards and/or medical practice, including up-coding, unbundling, duplication, excessive or improperly coded billing charges.
- Charges that are not permitted to the provider's network agreement or charges made in violation of the provider's network agreement.
- Chelation therapy and associated lab expenses, except for acute arsenic, gold, mercury or lead poisoning.
- Chiropractic supplies.
- Cochlear implants.
- Completion of claim forms.
- Contraceptives or contraceptive devices except to treat a documented medical condition.
- Cost of blood replaced by voluntary means.
- Counseling, education, or training services. This includes vocational assistance and outreach, smoking cessation programs; and marital, social, sexual, nutritional, fitness counseling, or relaxation therapy. Family counseling not covered except when for treatment of a minor child.
- Custodial care or a nursing home except as described under the hospice benefit.

- Dental services except for:
  - Surgical removal of impacted teeth (partial or full bony impactions only)
  - Treatment of tumors
  - Repair of damage to teeth if the damage is sustained in an accident and charges are incurred within one year from the accident.
- Diabetic education.
- Donor transplant expenses.
  - Organ donor expenses, or any expense arising from or related to organ donation or organ receipt regardless of whether the participant is the donor or the recipient of the organ.
  - Lodging, food or transportation costs, unless specifically approved by the Trust Administration Office
- Driver's physical exams or employment-related physical exams.
- Duplicate charges.
- Educational services or treatment of a learning disability. Except as described in habilitative coverage.
- Expenses for an illness or injury caused by the act or omission of a third party if the costs associated with the illness or injury are potentially recoverable from a third party or other resource. See "Right of Recovery/Reimbursement" on page 104 for more details.
- Expenses for exams needed to obtain insurance, to travel or for marriage or adoption, judicial or administrative proceedings, medical research, to obtain or maintain a license or official document.
- Expenses not specifically adopted by the Board of Trustees as a covered expense.
- Expenses incurred for surgery for dental implantology.

- Experimental or investigational drug, device, treatment or procedure
- Extra charges for a lab test or x-ray exam performed by a lab outside of normal operating hours or automated lab tests.
- Fees in excess of usual, customary and reasonable (UCR) charges.
- Gender identity disorder including treatment, surgery, or complications.
- Genetic testing except when there are symptoms or signs presented indicating a possible disease presence and testing is needed to identify the disease in order for the physician to prescribe covered appropriate treatment, provided such testing is not experimental or investigational.
- Helmet therapy.
- Infertility treatment, including:
  - Artificial insemination.
  - In vitro fertilization or other procedures involving the eggs and sperm.
  - Implantation of an embryo developed in vitro.
  - Drug therapy.
  - Ovulation induction therapy and
  - Monitoring lab, radiology, and ultrasound studies; however, diagnostic testing to determine the cause of infertility is covered.
- Illness or injury covered by workers' compensation, employer's liability or occupational disease law or in connection with any illness or injury resulting from past or present employment or occupation or self-employment for compensation or profit whether or not a claim was filed or such coverage was declined or not purchased.

- Illness or injury that results from any war, act of war, armed invasion or aggression (declared or undeclared) or service in the armed forces of any country.
- Insurance billing fees, special reports, claim forms, mailing and handling charges and late charges.
- Intentionally self-inflicted injuries, and injuries or illnesses sustained in the following circumstances:
  - Suicide or attempted suicide, unless due to a documented mental illness;
  - While engaged in any activity that results in being charged with a criminal act, unless acquitted or the Trustees decide the facts and circumstances justify waiver of the exclusion;
  - While performing any acts of violence that would not be performed by a reasonably prudent person in similar circumstances, except situations involving domestic violence that do not result in being charged with a criminal act.
- Massage therapy except when prescribed by an MD or Chiropractor (DC). If provided by a DC, then covered up to the benefit maximum for chiropractic treatment.
- Maternity benefits for a dependent daughter's pregnancy, maternity care, miscarriage or abortion.
- Modifications to your home, property or vehicle.
- Nonsurgical treatment of feet.
- Nutritional counseling.
- Personal convenience items while hospitalized.
- PPO network provider fees that exceed contracted preferred provider rates.
- Procedures provided primarily to improve appearance except to repair damage as a result of an accident or breast reconstruction following mastectomy. See "Mastectomy and Breast Reconstruction" services, on page 54, for more information.

- Recreational or leisure therapy; exercise or physical conditioning programs including health club dues.
- Repair or replacement of prostheses or durable medical equipment.
- Residential facilities, other than hospitals and skilled nursing facilities
- Reversal of sterilization.
- Routine physical exams, except as specifically described on page 55.
- Services provided by a local, state or federal government agency, a hospital owned or run by the US government except for services reimbursable to the Veterans' Administration for non-military service related illness or injury or services reimbursable under the Indian Health Care Act or otherwise required by law.
- Services and supplies received while not eligible under the plan.
- Services for which no charge is made or that would not have been charged if you were not covered by the plan.
- Services and supplies that are not medically necessary, not prescribed by a physician acting within the scope of their license or not approved in the United States.
- Services provided by a resident of the patient's home or an immediate family member, including stepchildren.
- Services or treatment for developmental disabilities or delays, except as provided under the habilitative benefit.
- Sexual dysfunction medications and treatments, except as provided under the mental health services for a diagnosed mental health condition.
- Shipping fees.

- Travel expenses, including lodging, car rentals, and meals, and travel except as specifically provided for ambulance service as described under Emergency Transportation.
- Treatment or surgery for malocclusion or other abnormalities of the jaw, including services for temporomandibular joint disorder (TMJ) and myofascial pain disorder, and related appliances.
- Vision care not due to an illness or injury and vision therapy, training or orthoptics; radial keratotomy or other refractive eye surgery.
- Vitamins, vitamin injections, herbal remedies, and nutritional supplements.
- Weight loss treatment services and supplies.
- Wigs or hairpieces.

PRESCRIPTION DRUG BENEFIT

The plan includes a prescription drug benefit for retail pharmacy and mail-order services managed through Express Scripts.

Retail and Mail Order Pharmacy Benefits	
Retail Pharmacy – up to a 30-day supply of covered medication	
Generic drugs	$7 copay
Preferred brand-name drugs	$25 copay
Non-preferred brand-name drugs	$40 copay
Express Scripts By Mail – up to a 90-day supply of covered medication	
Generic drugs	$14 copay
Preferred brand-name drugs	$50 copay
Non-preferred brand-name drugs	$80 copay

Generic Prescription Drugs

You are not required to use generic drugs, however, if you purchase a brand-name drug and a generic alternative is available, you will pay the appropriate copayment, plus the difference in cost between the brand-name medication and the generic medication. The Food and Drug Administration (FDA) requires that the active ingredients of generic drugs have the same strength, purity and quality as brand-name alternatives.

How Retail Pharmacy Works

Retail pharmacy is a convenient way to fill your short-term prescriptions (such as antibiotics to treat an infection). If you use a participating retail pharmacy, show your prescription ID card at the pharmacy and pay your copay for each prescription. There are no claim forms to fill out or submit.

To find a participating retail pharmacy near you:

- Ask your retail pharmacist if they participate in the Express Scripts network, or

- Log on to www.express-scripts.com and select "Locate a Pharmacy."

If you use a nonparticipating retail pharmacy, you must pay the entire cost of the prescription and then submit a claim for reimbursement to Express Scripts. Claim forms are available on www.express-scripts.com, under "Forms and cards," or from the Trust Administration Office. When you use a nonparticipating retail pharmacy, you will be reimbursed the amount the drug would have cost at a participating pharmacy minus your retail copayment.

How Mail Order Pharmacy Works

If you need medication on a long-term basis (medications taken for 3 months or more), consider using mail order pharmacy. You can get a larger supply of medication through mail order than at a participating retail pharmacy, and you may save money.

Mail order medications are dispensed through the Express Scripts network of mail order pharmacies. With Express Scripts you get the following services:

- Registered pharmacists are available 24 hours a day, 7 days a week at (800) 935-0153 to answers your questions.
- Medications are shipped to you by standard delivery for free. Express shipping is available for an added charge.
- You can order refills online, by mail or by phone anytime day or night. (800) 935-0153 or to order online, register at www.express-scripts.com. Refills are usually delivered within 3 to 5 days after your ordered is received.
- You can pay for your prescription by money order, personal check, credit card or through an automatic payment program.

To use mail order pharmacy:

1.) Ask your physician to write a prescription for up to a 90-day supply of each medication (plus refills for up to 1 year, if appropriate).

2.) Fill out an Express Scripts order form. Order forms can be obtained online at www.express-scripts.com, or by calling Express Scripts at (800) 935-0153.

3.) Send the completed order form, your prescription, and your payment option to:

Express Scripts
PO Box 747000
Cincinnati, OH 45274-7000

4.) You may also have your doctor fax your prescription. Ask your doctor to call (888) 327-9791 for faxing instructions. Your medication will usually be delivered within eight days after Medco receives your order. If you are currently taking a medication, be sure to have at least a 14-day supply on hand when ordering.

Medications Preferred by the Plan – Formulary

The prescription drug benefit includes a list of prescription drugs that are preferred by the Plan because they are less costly or have been shown to be most effective. This list, called a formulary, offers access to safe and effective medications in all therapy classes based upon guidance from an independent group of expert health professionals. However, drug choices in some classes are larger than ever with many products costing more with no additional health benefit. The annual review targets higher cost brand name drugs being potentially excluded in favor of lower cost, but just as safe and effective, alternate brand name options. This provides greater savings/lower costs to participants and the Trust.

Every year Express Scripts reviews the formulary options and determines any changes/drug exclusions. Drugs on the formulary that will no longer be covered on formulary platform are typically removed as the manufacturers of these products use copayment cards and coupons to promote their products to consumers, which drive up plan costs unnecessarily.

Every year, members will be notified if a medication they are currently filling will be excluded and offers alternate options. This provides members an opportunity to discuss with their provider an appropriate alternative.

Members who are prescribed non-formulary drugs will experience a claim reject at the point of sale and will be required to pay 100% of the full, non-discounted cost of the medication.

Step Therapy

Step therapy is a program that requires appropriate, and at times less expensive, medications be tried first before certain other medications are covered. Medications subject to step therapy will require a review of your claims history to see if the necessary criteria have been met before the prescription can be filled. If you are currently taking a prescription subject to step therapy or are prescribed a drug subject to step therapy, you should talk with your physician before going to the pharmacy. Most physicians are familiar with the requirements of step therapy programs. To find a current list of drugs that are subject to step therapy, log on at www.express-scripts.com.

Prior Authorization

There are a few classes of medication that the pharmacist must get approval before dispensing. This can cause a delay in processing your prescription. To find a current list of drugs that require pre-certification, log on at www.express-scripts.com.

Quantity Limits

Quantity limits and duration of therapy limits apply to certain prescription drugs. Quantity limits restrict the number of pills you may receive per prescription or within 30 days. Duration of therapy limits restrict how long the plan will cover certain drug treatments. These limits apply to drugs that are frequently taken inappropriately or in amount that exceed the dosage or recommended length of treatment. If you require one of these drugs in a larger quantity or for a longer period of time than recommended, your physician will need to contact Express Scripts to receive an authorization for you. To get a complete list of

prescription drugs with quantity limits, log on and visit the "Prescriptions & Benefits" section of www.express-scripts.com.

Review Process

A review process can be done on any medication requiring prior authorization (PA), excluded from the formulary, subject to step therapy or other limitations. The process participants should follow is outlined below for claims that are rejecting for Prior Authorization required or Not Covered:

1. Contact Express Scripts Customer Service to determine why the claim is rejecting
   - At this point, an Express Scripts customer service representative will advise the participant on why the claim was rejected and what the participant's options are (i.e., advising your physician to contact Express Scripts' PA department or contacting the Trust Administration Office because there is no exception process)
2. Physician contacts Express Scripts to initiate review process
3. Request is either approved or denied
   - If approved, the PA team will input the override on the rejection and then the pharmacy can reprocess the claim
   - If denied, the participant and physician will receive a letter explaining the denial and next options (which is to contact the administrative office to appeal)

As provided above, the first review needs to be initiated by the physician contacting Express Scripts. If your physician refuses to initiate the review or if Express Scripts denies the request after the review, then the participant or physician may appeal to the Board of Trustees pursuant to the appeal procedures on page 117. Failure to follow this procedure will result in continued denial of the claim.

What the Prescription Drug Benefit Does Not Cover –Exclusions and Limitations

The prescription drug benefit will not be paid for any of the following items:

- Allergens and allergy sera
- Anabolic steroids for body-building
- Charges for the administration or injection of any drug. The charges may be covered under the plan's medical benefits.
- Contraceptives or contraceptive devices except to treat a medical condition
- Dietary supplements
- Drugs for cosmetic purposes only, including drugs whose sole purpose is to promote or stimulate hair growth
- Drugs that are not medically necessary
- Expenses for an illness or injury caused by the act or omission of a third party if the costs associated with the illness or injury are recoverable from a third party or other resource
- Experimental, investigational and unproven drugs, indications, dosage regimens and therapies
- Immunization agents, biological sera, blood or blood plasma
- Infertility treatments
- Medical appliances and devices, other than covered diabetic supplies
- Medications used to treat sexual dysfunction
- Medications without FDA approval indications
- More than a 30-day supply except for mail-order pharmacy
- Non-federal legend drugs

- Non-formulary drugs
- Non-sedating antihistamines such as Allegra, Clarinex or Zyrtec
- Medication for which the cost is recoverable under any workers' compensation or occupational disease law or any state or governmental agency, or medication furnished by any other drug or Medicare service for which no charge is made to the individual.
- Medication which is to be taken by or administered to an individual, in whole or in part, in a physician's office, hospital, extended care facility, nursing home or other similar institution. These charges may be covered under the medical plan
- Off-label medication use (using a medication to treat something other than what is approved by the FDA)
- Over-the-counter medications
- Prescriptions refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order
- Replacement of prescription drugs due to loss, theft or breakage
- Vitamins taken orally, except for federal legend vitamins
- Weight loss medications.

VISION BENEFITS

The Vision Plan, administered by VSP, provides benefits for an eye exam, lenses and frames or contact lenses. You do not need to satisfy a deductible before the Plan pays the amount listed in the tables below. (This is an optional benefit for non-Medicare and Medicare Retirees.)

If you see a VSP Member Doctor….	
Feature	**Vision Benefit**
Eye Exam (once every 12 months)	Paid in full
Lenses (once every 12 months)	Paid in full
Frames (once every 24 months)	$150 allowance for select frames $170 allowance for featured frame brands 20% savings on the amount over your allowance $80 Costco frame allowance
Lens Enhancements Standard progressive lenses Premium progressive lenses Custom progressive lens	 $55 copay $95 - $105 copay $150 – 175 copay
Contacts (instead of glasses) Contact Lens exam (fitting and evaluation)	$200 allowance Up to $80 copay

If you see a non-VSP provider….*	
Feature	**Vision Benefit (what VSP pays)**
Eye Exam	up to $92
Frames	up to $89

Lenses	
Single	Up to $38
Bifocal	Up to $60
Trifocal	Up to $73
Progressive	Up to $60
Contact Lenses	Up to $185.
**If you see a non-VSP doctor, you will pay the provider in full and have 12 months to submit a claim to VSP for reimbursement.*	

Covered Expenses

For maximum benefits, it is to your advantage to see a VSP member doctor.

When you go to a VSP member doctor, there are no claim forms for you to file. When you go to a non-VSP provider, you must pay for the vision services at the time you receive them and then file a claim with VSP.

To locate a VSP doctor, contact VSP at www.vsp.com or call (800) 877-7195.

What the Vision Benefit Does Not Cover – Exclusions

Vision benefits will not be paid for any of the following items:

- Charges for cancelled or missed appointments.
- Charges for materials and supplies ordered before your coverage effective date or ordered while you are covered but delivered more than 30 days after the date your coverage ends.
- Eye exam ordered as a condition of employment or by a government agency.
- Expenses that exceed usual, customary and reasonable (UCR) charges.
- Experimental or investigational service.

- Nonprescription glasses.
- Replacement of lost or broken lenses except at normal frequencies when benefits are otherwise available.
- Special vision services or supplies such as orthoptics, visual training, subnormal vision aids or as part of medical or surgical treatment.
- Service or supply that is not medically necessary or does not meet professionally recognized standards.
- Service or supply for which no charge is made or that would not have been charged if you were not covered by the plan.
- Service or supply from a resident of the patient's home or an immediate family member.
- Sunglasses.
- Surgery to correct refractive error (lasik procedures).
- Vision insurance plan premiums.

DENTAL BENEFITS

The chart below highlights key features of your dental benefits. (This benefit is not available to non-Medicare or Medicare Retirees.)

Feature	Dental Benefit
Calendar year deductible	$10 per participant
Calendar year maximum	$2,000 per participant
Covered services	Based on Schedule of Dental Allowances on pages 78-82
Orthodontia for eligible dependent children	70% up to $1,500 lifetime maximum

How Your Dental Benefits Work

After the deductible, the plan covers services up to the amounts shown in the Schedule of Dental Allowances — as long as they are incurred while you or your eligible dependents are covered by the plan. Except as noted in the schedule, the incurred date is the date the service or surgery is actually performed.

For a covered dental service not shown in this schedule, the plan will determine a maximum amount for the procedure consistent with the schedule.

How the Calendar Year Dental Deductible Works

A deductible is the amount you must pay toward certain covered dental services before the plan pays benefits. The dental deductible is $10 per person each calendar year. This means you pay the first $10 of covered expenses for each person in any calendar year. Non-covered services and orthodontia do not count toward the dental deductible.

How the Calendar Year Maximum Works

The calendar year maximum is the maximum dollar amount the plan will pay toward the cost of dental care in a calendar year. You

are responsible for paying any costs above the annual maximum. The calendar year maximum for dental care is $2,000 per person. There is a $1,500 lifetime maximum for orthodontia for eligible dependent children.

Schedule of Dental Allowances

ADA Code	Procedure	Maximum Allowance
	DIAGNOSTIC	
	Examinations (one every 6 months)	
00120	Periodic oral exam	$60.00
	X-Rays For all covered dental charges incurred for complete mouth surveys or panoramic x-rays during any three consecutive calendar years, the benefit is limited to the amount payable for the charges incurred for one complete mouth survey x-ray or one panoramic x-ray, but not both	
00210	Intraoral complete series, including bitewings	$144.00
00220	Intraoral periapical – Single, first film	$28.80
00230	Intraoral periapical – Each additional film	$23.20
00240	Occlusal	$41.60
00270	Bitewing – Single film (2 per calendar year)	$29.60
00272	Bitewing – Two films (2 per calendar year)	$47.20
00274	Bitewing – Four films (2 per calendar year)	$66.40
00330	Panoramic	$111.20
	PREVENTIVE	
	Prophylaxis (one every 6 months)	
01110	Adult	$107.20
01120	Child	$73.60
	Fluoride Treatment (under age 18 only)	
01208	Topical application of fluoride – 4 treatments per year	$38.40
	Sealants	
01351	Topical application of sealants (per tooth) Allowed on 3 permanent molars on each side only once every 3 years (tooth must be free of previous restoration)	$50.40
	Space Maintainers	
01510	Fixed – unilateral	$321.60
01515	Fixed – bilateral	$424.00

ADA Code	Procedure	Maximum Allowance
	MINOR RESTORATIONS	
	For acrylic or plastic restorations, 2-surface anterior restorations are limited to benefits for a 1-surface restoration if the incisal surface is not involved. 3-surface anterior restorations are limited to benefits for a 2-surface restoration	
	Amalgam Restorations	
02140	One surface	$116.50
02150	Two surfaces	$151.00
02160	Three surfaces	$182.50
02161	Four or more surfaces	$222.50
	Other Minor Restorations	
02330	Resin – one surface anterior	$108.00
02331	Resin – two surfaces anterior	$138.00
02332	Resin – three surfaces anterior	$169.00
02335	Resin – four or more surfaces anterior	$199.50
02391	Resin – one surface posterior	$126.50
02392	Resin – two surfaces posterior	$165.00
02393	Resin – three surfaces posterior	$206.00
02394	Resin – four or more Surfaces posterior	$252.00
	MAJOR RESTORATIONS	
	Services related to, inlays, onlays and crowns are considered to be rendered on the date the teeth are first prepared	
	Inlays and Onlays	
	Gold inlay restorations are only provided with an onlay on the same tooth	
	Implants are covered up to the usual and customary charges	
02510	Gold inlay – one surface	$433.00
02520	Gold inlay – two surfaces	$491.00
02530	Gold inlay – three surfaces	$566.00
02910	Re-cement inlay	$65.50
	Crowns	
02740	Porcelain/ceramic noble	$653.00
02750	Porcelain fused to high noble metal	$644.50
02751	Porcelain to predominately base metal	$600.00
02752	Porcelain fused to noble metal	$614.50
02790	Full cast high noble metal	$622.00

ADA Code	Procedure	Maximum Allowance
02791	Full cast predominately base metal	$589.00
02792	Full cast noble metal	$600.00
02920	Re-cement crown	$66.50
02930	Stainless steel (primary tooth)	$181.50
02950	Crown buildup	$173.50
02970	Temporary (fractured tooth)	$164.50
	ENDODONTICS	
03110	Pulp Cap – Direct (excluding final restoration)	$49.50
03120	Pulp Cap – Indirect (excluding final restoration)	$41.00
03220	Therapeutic Pulpotomy	$117.00
	Root Canal Therapy (includes treatment plan, clinical procedures, and follow-up care; excludes final restoration) Root canal treatment is considered to be rendered on the date the pulp chamber is opened and canals explored to the apex.	
03310	Single rooted (Anterior)	$495.50
03320	Bi-rooted (Bicuspid)	$605.50
03330	Tri-rooted (Molar)	$781.50
03410	Apicoectomy (performed as a separate surgical procedure)	$567.00
	PERIODONTICS	
	Periodontal prophylaxis is covered only after comprehensive periodontal therapy. Then, benefits are limited to 4 procedures in any 12 months, for 3 years after the therapy. Afterward, periodontal prophylaxis is covered only with an approved treatment plan, and only up to 2 routine procedures in a calendar year Benefits for gingivectomy, gingival curettage, mucogingival surgery, and osseous surgery are limited to 1 of these procedures per area of the mouth in a calendar year Scaling and root planing are limited to 2 of these services per quadrant in a calendar year	
	Nonsurgical Services	
04341	Periodontal scaling and/or root planning per quadrant	$145.00
04910	Periodontal maintenance	$87.00
	Surgical Services	
04210	Gingivectomy per quadrant	$429.00
04260	Osseous surgery per quadrant	$823.50

ADA Code	Procedure	Maximum Allowance
04271	Free soft tissue grafts	$626.00
	PROSTHODONTICS	
	Dentures (includes six months post delivery care) Expenses covered only if incurred: - To replace an existing denture that is more than 5 years old - To replace a temporary denture within 6 months of installation - To repair or add teeth to an existing denture. Denture adjustment or relining in the six months after insertion is not covered. Then, covered charges for denture adjustment or relining are limited to 1 procedure in 12 consecutive months Repair to complete or partial denture is covered only if performed more than 1 year after initial insertion Specialized techniques involving precision dentures for personalization or characterization are not covered	
05110-120	Complete upper or lower	$1151.50
05130-140	Immediate upper or lower	$1255.00
05211-212	Partial upper or lower resin base (including any conventional clasps and rests)	$971.50
05213-214	Partial upper or lower cast base with resins saddles (including any conventional clasps and rests)	$1272.00
05710	Rebase denture	$467.50
05730-731	Reline denture – office	$263.50
05750-751	Reline denture – lab	$352.00
05410-422	Denture adjustment (complete or partial)	$63.00
05610	Repair denture (no teeth damage)	$136.50
05640	Replace missing or broken tooth (per tooth)	$115.50
06010	Implants	$1,923.50
	Bridgework Repair to complete or partial bridge is covered only if performed more than 1 year after initial insertion Services related to fixed bridges is considered to be rendered on the date the teeth are first prepared	
06210	Pontic – cast high noble metal	$835.00
06240	Pontic – porcelain fused to high noble metal	$824.50
06250	Pontic – resin with high noble metal	$814.00
06930	Recement bridge	$110.50

ADA Code	Procedure	Maximum Allowance
	ORAL SURGERY	
	Extractions (includes local anesthesia and routine post operative care) For surgical removal of impacted teeth (partial or full bony impactions only), see the medical benefit. A separate dental benefit is paid for general anesthesia only when required for complex oral surgery	
07140	Single tooth (uncomplicated)	$114.50
07210	Erupted tooth – surgically removed	$165.50
07220	Impacted tooth – soft tissue	$207.50
	ADJUNCTIVE GENERAL SERVICES	
	A separate dental benefit is payable for a sedative filling or palliative treatment only if no other dental service (except x-rays) is performed during the visit	
09110	Palliative treatment of dental pain	$86.50
09220	General anesthesia – first 30 minutes (only when required for complex oral surgery)	$348.00

Orthodontia Benefits for Eligible Children

The plan covers orthodontia treatment for your eligible dependent children. Orthodontia treatment is defined as the movement of teeth through the bone by use of an active appliance to correct a malocclusion of the mouth. Covered services include:

- **Initial evaluation, x-rays, initial appliance insertion, first six months of treatment**, excluding extractions, covered at 70%, up to a lifetime maximum of $525.
- **Treatment after the sixth month**, covered at 70%, up to $52.50 per month.
- **Orthodontia Lifetime maximum benefit** of $1,500.

To be covered, orthodontia treatment must:

- Be incurred by a dependent child while eligible for benefits under the plan. For treatment up to and including initial insertion of bands or appliance, treatment is considered to be incurred on the insertion date of the band or appliance. Subsequent treatment is considered to be incurred on the date

the treatment is performed if completed on the same date, or the date the treatment is completed.

- Not be listed as an exclusion under the dental/orthodontia or medical plan benefits.

Benefits After Dental Coverage Ends

After your dental coverage ends, the plan will only pay for covered prosthetic devices (including bridges and crowns) :

- Ordered while you had dental coverage, and
- Installed or delivered within three months of the date your coverage ends.

After a dependent child's eligibility ends, the plan will only pay for covered orthodontia charges incurred while the dependent child was eligible.

What the Dental Benefit Does Not Cover – Exclusions and Limitations

Dental benefits including orthodontia will not be paid for any of the following listed items:

- Adult orthodontia treatment
- Appliances for treatment of bruxism
- Athletic mouthguards
- Broken or missed appointments, internet or when the patient is not physically seen.
- Charges for consultation or planning of orthodontic treatment, except preparation of a treatment plan for predetermination of benefits
- Charges from someone other than a dentist or physician, except for dental hygienists
- Crowns for a tooth that can be restored by other means or for a tooth that does not demonstrate excessive decay or fracture

- Denture adjustment or relining in the six months after insertion
- Duplicate dentures
- Experimental or investigational treatment
- Facings on crowns and plastic or composite restorations when the crown or restoration is on a molar
- Myofunctional therapy
- Oral exams and prophylaxis not separated by six months
- Oral hygiene instruction
- Orthognathic surgery
- Precision or semi-precision appliances
- Procedures covered under the medical plan or any other part of the dental plan, or used to satisfy a deductible under either plan
- Procedures for changing vertical dimension, restoring occlusion, bite registration, or bite analysis
- Procedures provided primarily to improve appearance, except charges for related extractions or space maintainers
- Procedures that are not medically necessary or that do not meet professionally recognized standards
- Replacement of a bridge, partial denture, full denture, crown or inlay within five years of installation or if they can be repaired to meet professionally recognized standards. The five-year exclusion will not apply if the replacement is necessary due to accidental injury to sound natural teeth or an extraction of a sound natural tooth
- Replacement or repair of an orthodontic appliance furnished as part of a treatment program
- Replacement of a lost or stolen item
- Replacement of a temporary denture after six months of installation

- Services for which no charge is made or that would not have been charged if you were not covered by the plan
- Services or supplies provided by a hospital owned or run by the US government, unless required by law
- Services from a resident of the patient's home or immediate family member
- Specialized techniques involving precision dentures for personalization or characterization
- Specialized appliances
- Temporomandibular joint treatment
- Treatment of fractures

Benefits for the following services will be determined under your medical coverage:

- Biopsies
- Excisions of tori
- Excisions of a tumor, cyst, or foreign body
- Removal of salivary stones
- Surgical removal of impacted teeth (partial and bony impactions only)
- Treatment of a fractured jaw
- Treatment of damage to a sound natural tooth from an accident when charges are incurred within one year of the accident.

Dental Benefit Definitions

- **Maximum allowance** – Maximum dollar amount that will be allowed toward reimbursement for any covered dental service
- **Covered dental service** – A service that is:
  - Essential for necessary care of the patient's teeth and supporting tissue

- Performed by a dentist or dental hygienist
- Considered to have a reasonably favorable prognosis
- Generally accepted professional practice and meets professionally recognized standards
- The least expensive procedure that will produce a result that meets professionally recognized standards

A temporary dental service will be treated as part of the final dental service rather than a separate covered dental service.

- **Covered orthodontia service** – A cephalometric x-ray, movement of a tooth for periodontal purposes, surgical exposure of an impacted tooth, orthodontia treatment.
- **Dental hygienist** – A person who:
  - Has trained at an accredited school
  - Is licensed by the state in which they practice the art of dental prophylaxis
  - Practices under a dentist's direction and supervision
- **Dental treatment program** – All treatment in the oral cavity at one or more sessions as the result of the initial diagnosis. This includes treatment for any complications that arise during the program.
- **Dental treatment plan** – Dentist's recommended program of treatment. The written plan must:
  - Itemize proposed procedures
  - List the charge for each procedure
  - Be accompanied by any required diagnostic materials
- **Dentist** – A person who is:
  - Licensed to practice dentistry
  - Acting within the scope of their license

  - A physician who provides dental services within the scope of the physician's license

- **Professionally recognized standards** – Standards of quality determined by the plan. Professional groups such as the American Dental Association, affiliates and successors, peer review groups and professional review groups may be used to determine these standards.
- **Sound natural tooth** – A tooth that is organic and formed by natural development of the body (not manufactured), not extensively restored, and not extensively decayed or involved in periodontal disease.

LIFE INSURANCE AND AD&D BENEFITS

Eligible active employees receive group life and accidental death and dismemberment (AD&D) insurance coverage (coverage is not provided for dependents or retirees). These benefits are underwritten and administered by ReliaStar Life Insurance Company.

Schedule of Benefits	
Life insurance benefit	$10,000
AD&D insurance benefit	$10,000
Accelerated death benefit	50% of your life insurance amount

How the Life Insurance Benefit Will Be Paid

Your life insurance pays a benefit to your beneficiary if you die for any reason while covered by the plan. Normally, life insurance benefits are paid in one lump sum. Contact the Trust Administration Office for information about alternate payment options.

How the Accelerated Death Benefit Will Be Paid

If you become terminally ill, you may receive 50% of your life insurance benefit while you are alive. This is called an accelerated death benefit. If you qualify for an accelerated death benefit, a lump sum payment will be made to you or your legal representative. The accelerated death benefit is paid in a lump sum and is paid only once. This lump sum payout is the only payment option of life insurance benefits available to you prior to your death.

At your death, life insurance benefits payable to your beneficiaries will be reduced by the amount of the accelerated death benefit you received. Accelerated death benefits may be subject to federal income tax. You may want to consult your tax advisor about any possible tax implications.

To receive this benefit, you must be covered for life insurance under the plan and meet all of the following conditions:

- Request the benefit in writing while you are living. If you are unable to request this benefit yourself, your legal representative may request it for you.
- Have life insurance coverage of at least $10,000.
- Provide ReliaStar Life Insurance Company with a doctor's statement of your diagnosis and life expectancy of no more than six months. ReliaStar Life Insurance Company may require you to be examined by a doctor of its choosing. If ReliaStar Life Insurance Company requires an examination, ReliaStar Life Insurance Company will pay for the exam.
- Provide ReliaStar Life Insurance Company with written consent from any irrevocable beneficiary, assignee, and in community property states, your spouse.

ReliaStar Life Insurance Company pays the accelerated death benefit to you unless both of the following conditions are true:

- It is shown to the satisfaction of ReliaStar Life Insurance Company, that you are physically and mentally incapable of receiving and cashing the lump sum payment.
- A representative appointed by the courts to act on your behalf does not make a claim for the payment.

If ReliaStar Life Insurance Company does not pay you because the two above conditions apply, payments instead will be made to one of the following:

- A person who takes care of you.
- An institution that takes care of you.
- Any other person ReliaStar Life Insurance Company considers entitled to receive the payments as your trustee.

ReliaStar Life Insurance Company will not pay benefits for a terminal condition if the required accelerated death benefit premium or life insurance premium is due and unpaid.

If accelerated death benefits are paid, your life insurance coverage is affected in the following ways:

- Your total available life insurance benefit equals your amount of life insurance coverage at the time you apply for the accelerated death benefit.
- Your life insurance benefit is reduced by the amount of the accelerated death benefit paid.
- The amount of life insurance benefit that you may convert is reduced by the amount of the accelerated death benefit paid.
- If you recover from the condition, you will not be able to reinstate your life insurance coverage to the full amount.

Your AD&D insurance benefits will not be affected by accelerated death benefits paid to you.

How the AD&D Benefit Will Be Paid

Your AD&D benefit is paid in addition to any life insurance benefit for any of the following covered losses due to an accident:

- Loss of life: $10,000 – paid to your beneficiary.
- Loss of both hands, both feet, sight of both eyes, one hand and one foot, speech and hearing in both ears, one hand and sight of one eye or one foot and sight of one eye: $10,000 – paid to you.
- Loss of one hand, one foot or sight of one eye: $5,000 – paid to you.
- Loss of speech, hearing in both ears or thumb and index finger of same hand: $2,500 – paid to you.

To qualify for benefits, the hand or foot must be permanently severed at or above the wrist or ankle, the thumb and index finger must be permanently severed, or loss of sight or loss of speech and hearing must be total and permanent. No benefits are paid for loss of use of the hand or foot or thumb and index finger. The loss must occur within 180 days of the accident, and you must be covered by

the plan at the time of injury. The most this plan will pay one person for any combination of injuries is $10,000.

AD&D Exclusions

The AD&D benefit will not be paid for a loss due to:

- Suicide or intentionally self-inflicted injury, while sane or insane.
- Physical or mental illness.
- Bacterial infection or bacterial poisoning, except infection from a cut or wound caused by an accident.
- Riding in or descending from any aircraft as a pilot or crew member.
- Any armed conflict, whether declared as war or not, involving any country or government.
- Injury suffered while in the military service for any country or government.
- Injury that occurs when you commit or attempt to commit a felony.
- Use of any drug, narcotic, or hallucinogenic agent that is illegal, not prescribed by a doctor, or not taken as directed by a doctor or the manufacturer.
- Your intoxication defined as blood alcohol content that meets or exceeds the legal limit for intoxication according to laws of the state where the accident occurred.

Your Beneficiary

Your beneficiary for life and AD&D insurance benefits is the person or persons that you name on your enrollment/beneficiary form.

If you name more than one beneficiary, each receives an equal share unless you state otherwise in writing. If you don't designate a beneficiary or if your beneficiary is not living on the earlier of the date ReliaStar Life Insurance Company receives proof of your

death or the 10th day after your death, payment will be made to the first survivor from the following list:

- Your spouse
- Your children
- Your parents
- Your estate.

You may also choose to name a beneficiary that you cannot change without his or her consent. This is an irrevocable beneficiary.

You may change your beneficiary at any time by making a written request to the Trust Administration Office. To change your beneficiary, you must currently be covered as an eligible employee, have written consent from all irrevocable beneficiaries and have not assigned the ownership of your insurance (see page 96). All requests are subject to the approval of ReliaStar Life Insurance Company. A change will take effect on the date it is signed but will not affect any payment ReliaStar Life Insurance Company makes or any action it takes before receiving your notice.

If You Become Totally Disabled

If you become totally disabled, your life insurance coverage, but not AD&D insurance coverage, may continue at no cost to you until age 65. To qualify, you must meet all of the following conditions:

- Your disability must begin before age 60, and you must be approved by ReliaStar Life Insurance Company for a waiver of premium
- You must be insured on the day you became disabled
- You continue to be totally disabled
- Premiums are paid up to the day you became disabled.

ReliaStar Life Insurance Company requires written notice of the claim and proof of total disability to waive your premium. You

must apply for waiver of premium within one year of the date you became totally disabled (or as soon as reasonably possible). ReliaStar Life Insurance Company may require you to have a physical exam by a doctor it chooses at ReliaStar Life Insurance Company's expense. After premiums have been waived for two full years, ReliaStar Life Insurance Company can require only one exam per year.

If ReliaStar Life Insurance Company approves your proof of total disability, premiums are waived as of the date you became totally disabled. Premiums already paid for that period will be refunded to the Trust and the Trust Administration Office will refund the portion that you paid, if any.

Waiver of premium ends on the earliest date any of the following occur:

- You are no longer totally disabled.
- You fail to provide proof of total disability on request.
- You reach age 65.

If ReliaStar Life Insurance Company stops waiving your premiums, your coverage may continue only if you are otherwise eligible for life insurance coverage under the plan and premium payments are made. If you are no longer eligible, you may be able to continue coverage by converting to an individual life insurance policy. See "Converting to an Individual Policy if You Lose Coverage" on page 94.

If you convert to an individual policy during the first year of your disability, your life insurance may be restored. ReliaStar Life Insurance Company will cancel this individual policy as of its issue date if within 12 months of becoming totally disabled you:

- File a claim that is approved, and
- Surrender the individual policy without claim, except for a refund of premium.

When your individual policy is cancelled, you will receive a refund of all premiums, your life insurance under the Trust plan will be

restored and the beneficiary designated under your individual policy will be your beneficiary for the Trust plan.

When Coverage Ends

Your life and AD&D insurance coverage under the plan will end on the earliest of the following dates:

- You are no longer an active employee or you retire.
- You are no longer eligible for coverage.
- You or the Trust fail to pay a required premium.
- Your hour bank is insufficient and you choose not to self-pay the premium.
- The group policy ends, unless you are totally disabled.
- For life insurance, if you are totally disabled, the date ReliaStar Life Insurance Company stops waiving premiums.
- For the accelerated death benefit, the date your life insurance coverage ends. The accelerated death benefit stops at the beginning of the period in which you are eligible to convert your group life insurance coverage to an individual policy.
- For AD&D insurance, the date your life insurance stops or the date life insurance premiums are waived under the waiver of premium disability benefit. AD&D insurance stops at the beginning of the period in which you are eligible to convert your life insurance.

Converting to an Individual Policy if You Lose Coverage

If your life insurance ends or is reduced, you have a 31-day period during which you may convert to an individual life insurance policy, without proof of good health.

To convert this insurance, you must apply and pay the first premium for an individual policy within 31 days after your life insurance ends or is reduced. ReliaStar Life Insurance Company will supply you with a conversion form to complete and return. If

you do not receive written notice of your conversion right before the 31-day conversion period ends, the period will be extended to the earlier of 15 days after written notice is received or 60 days after the original conversion period ends. You may purchase any type of individual nonparticipating policy offered by ReliaStar Life Insurance Company except term insurance. Your new insurance policy must provide for a level amount of insurance and have premiums at least equal to those of ReliaStar Life Insurance Company's whole life plan with the lowest premiums. Your new policy will not include disability, AD&D insurance or accelerated death benefits.

The individual policy will become effective 31 days after your life insurance ends or is reduced.

If you die within the 31-day period allowed for applying to convert, ReliaStar Life Insurance Company will pay a death benefit to your beneficiary in the amount you were entitled to convert. ReliaStar Life Insurance Company will pay the amount whether or not application was made. ReliaStar Life Insurance Company will return and premium paid for the individual policy to your beneficiary named under the group policy.

If your life insurance is changed or cancelled because the group policy changes or is cancelled, and your life insurance under the group policy has been in effect for at least 5 years in a row, the amount of your individual policy will be the lesser of:

- $5,000 or
- The amount of your life insurance that stops, minus the amount of other group insurance for which you become eligible, within 31 days of the date your insurance stops.

If your life insurance ends for any other reason, the amount of your individual policy may be any amount up to the amount of your life insurance that stopped.

Premiums for the new policy are based on your age on the date of conversion.

AD&D coverage cannot be converted to an individual policy.

Contact the Trust Administration Office for assistance if you are interested in converting to an individual policy.

Life Insurance Assignment

You can change the owner of your life insurance under the group policy by sending ReliaStar Life Insurance Company written notice. This change is an absolute assignment. You cannot make an absolute assignment to the Trust or your employer. You transfer all your rights and duties as owner to the new owner. The new owner can then make any change the group policy allows. A request for an absolute assignment:

- Does not change the insurance or the beneficiary.
- Applies only if ReliaStar Life Insurance Company receives your notice.
- Takes effect from the date signed.
- Does not affect any payment ReliaStar Life Insurance Company makes or action ReliaStar Life Insurance Company takes before receiving your notice.

A collateral assignment is not allowed.

ReliaStar Life Insurance Company is not responsible for the validity of any assignment. You are responsible to see that the assignment is legal in your state and that it accomplishes the goals that you intend.

Legal Action

Legal action may not be taken to receive benefits until 60 days after the date proof of loss is submitted according to the requirements of the group policy. Legal action must be taken within three years after the date proof of loss must be submitted.

If any state requires longer time limits, ReliaStar Life Insurance Company will comply with that state's time limits.

Exam and Autopsy

For AD&D insurance, when reasonably necessary, ReliaStar Life Insurance Company may require an autopsy while a claim is pending. ReliaStar Life Insurance Company pays for the initial exam. ReliaStar Life Insurance Company may have an autopsy made if you die, if not forbidden by state law.

Incontestability

Your insurance has a contestable period starting with the effective date of your insurance and continuing for two years while you are living. During those two years, ReliaStar Life Insurance Company can contest the validity of your insurance because of inaccurate or false information received relating to your insurability. Only statements that are in writing and signed by you can be used to contest the insurance.

Life Insurance and AD&D Definitions

- **Accident** — An unexpected, external, violent and sudden event.
- **Employee** — An active employee residing in the United states who is employed by an employer who participates in and contributes to the Alaska Carpenters Health and Welfare Trust Fund.
- **Group Policy** — the written group insurance contract between ReliaStar Life Insurance Company and the Alaska Carpenters Health and Welfare Trust Fund.
- **Nonworking Day** — a day on which the employee is not regularly scheduled to work, including time off for the following:
  - Vacations
  - Personal holidays
  - Weekends and holidays
  - Approved nonmedical leave of absence

Nonworking day does not include time off for any of the following:

- Medical leave of absence
- Temporary layoff
- The employer suspending operations, in part or total
- Strike

- **Terminal Condition** — an injury or sickness which is expected to result in your death within 6 months and from which there is no reasonable chance of recovery. ReliaStar Life Insurance Company, or a qualified party chosen by ReliaStar Life Insurance Company, will make this determination.
- **Total Disability, Totally Disabled** — your inability, due to sickness or accidental injury, to work at any job suited to your education, training or experience, as approved by ReliaStar Life Insurance Company.
- **Written, In Writing** — signed, dated and received at ReliaStar Life Insurance Company's Home Office in a form ReliaStar Life Insurance Company accepts.
- **You, Your** — an employee insured for employee's insurance under the group policy.

CLAIMS PAYMENT PROVISIONS

Coordination of Benefits (with Other Plans)

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

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

Since it is not intended that you receive greater benefits than the actual expenses incurred, the amount payable under this Plan will take into account any coverage you or your dependents have under other plans. This means the benefits under this Plan will be coordinated with the benefits of the other plans. When coordinating with other plans, this Plan will pay either its regular benefits in full, or a reduced amount. This reduced amount plus the benefits payable by the other plans will not exceed 100% of expenses incurred.

If, because of the coordination provision, this Plan does not pay its regular benefit, a record is kept of the reduction. This amount will be used to increase your later claim payments under the Plan in the same calendar year, to the extent there are allowable expenses that otherwise would not be fully paid by this Plan and the other plans. Therefore, on a later claim you may receive a greater benefit under our Plan than would be normally allowed.

Definition of Other Plans

For the purpose of this coordination of benefits provision "other plan" means any of the following coverages, including policy coverage and any coverage which is declared to be excess to all other coverages, which provide benefit payments or services to an insured person for hospital, medical, surgical, dental, or vision care:

- Group, blanket, or franchise insurance (except blanket accident-only coverage or student accident insurance).
- Group Blue Cross and/or Blue Shield and other prepayment coverage on a group basis, including HMOs (Health Maintenance Organizations).
- Coverage under a labor-management trustee plan, a union welfare plan, an employer organization plan or an Employee benefits plan.
- Coverage under government programs, other than Medicare or Medicaid, and any other coverage required by law.
- Group or individual automobile "fault or no fault" coverage.
- Other arrangements of insured or self-insured group coverage.

Order of Benefit Determination

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

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

The primary plan is determined as follows:

- Plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform set of order of benefit determination rules that are applied in the specific sequence outlined below. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-funded plans. Any group plan that does not use these same rules always pays its benefits first.

- When two group plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. These rules are:

▪ Rule 1: Non-Dependent or Dependent

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

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

▪ Rule 2: Dependent Child Covered Under More Than One Plan

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

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

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

first; and the Plan that has covered the other parent for the shorter period of time pays second.

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

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

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

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

   1. The Plan of the custodial parent;
   2. The Plan of the spouse of the custodial parent;
   3. The Plan of the non-custodial parent;
   4. The Plan of the spouse of the non-custodial parent pays;
   5. The Plan that covers the parent whose Birthday falls earlier in the calendar year; and

6. The Plan that has covered the parent longest.

- **Rule 3: Active/Laid-Off or Retired Employee**

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

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

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

- **Rule 4: Continuation Coverage**

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

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

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

- **Rule 5: Longer/Shorter Length of Coverage**

A. If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period

of time pays first; and the plan that covered the person for the shorter period of time pays second.

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

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

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

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

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

Right of Recovery/Reimbursement

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

- If a participant is pursuing or investigating a claim or lawsuit against a third party or insurer for an illness or injury caused by the act or omission of the third party, the Plan may agree to advance payment for benefits related to the third party illness or injury subject to a right to reimbursement. By accepting advance payment for benefits, the participant agrees that the

plan's payment related to the illness or injury is conditioned on reimbursement from any recovery from the third party, the third party's insurer, under an automobile policy (including first party automobile insurance, uninsured and underinsured motorist policy), commercial premises policy, homeowner's policy, medical malpractice policy, renter's policy, or any other liability policy.

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

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

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

- The participant and/or the participant's attorney or personal representative also agree that in the event of a dispute as to the amount of the Plan's claimed reimbursement, the Plan's reimbursement amount will be paid into a trust account and held there until the Plan's claim is resolved by mutual agreement or court order. The obligation to place the reimbursement amount in trust is independent of the obligation to reimburse the Plan. If the funds necessary to satisfy the Plan's reimbursement amount are not placed in trust, the participant or the individual named to hold the funds in trust shall be liable for any loss the Plan suffers as a result.
- If the Plan is forced to bring a legal action against the participant to enforce the terms of Plan provisions, it shall be entitled to its reasonable attorney fees, costs of collection and court costs.
- If there is a reasonable basis to believe that this provision or any agreement to reimburse the Plan is not enforceable or that the participant will not honor the terms of this provision or any agreement to reimburse, the Plan will deny coverage and may seek refunds of overpaid benefits from providers. The Plan may also cease advancing benefits and exclude future expenses incurred after a judgment, settlement, or proposed settlement of the claim, irrespective of the amount of the recovery, if such expenses are related to the third party recovery.
- If the participant fails to honor the terms of this provision or any agreement to reimburse, any advanced benefits will be treated as overpaid benefits and the Plan may take appropriate action to collect the overpaid benefits, including, but not limited to, seeking refunds from providers, offsetting future benefits, including those of family members, denying future payments, bringing a breach of contract action in state court to enforce the Plan's right to reimbursement under this Plan provision and seeking a constructive trust in Federal court under ERISA § 502(a)(3). In addition to the overpaid benefits, the participant will be liable for interest, and all costs of collection, including reasonable attorney fees and court costs.

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

Motor Vehicle Accidents

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

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

Repayment of Improperly Paid Benefits

If the Plan mistakenly makes a payment for the participant to which they are not entitled, if the Plan pays a participant who is not eligible for benefits at all or if a participant fails to observe the Plan's Reimbursement provision, the Plan has the right to recover the payment from the participant paid or anyone else who benefited from it, including a provider of services. The Plan may also pursue recovery from any individual or entity responsible for providing misinformation to or failing to provide necessary information to the Plan which has resulted in the payment of improper benefits. The Plan's right of recovery includes the right to deduct the amount paid by mistake from future benefits payable

to the affected participant or any other individual where eligibility is established through the same participant. The Plan may also recover benefits from the person responsible for misreporting any person for eligibility purposes.

HOW TO FILE A CLAIM

Filing Instructions for Medical, Dental, and Vision Claims

A claim is a request for plan benefits made according to the Alaska Carpenters Health and Welfare Trust Fund's claim procedures. The timeframes and rules for making decisions on claims and appeals of denied claims vary, depending on the type of claim and the benefit involved. This section provides information about the specific timelines and information requirements that apply to your claims and appeals filings and the claim administrator's claims and appeals determinations.

Requests for pre-certification, claims and/or appeals should be sent to the following:

Benefit	Company Responsible
Requests for pre-certification Pre-Service	Qualis Health PO Box 33400 Seattle, WA 98133 (800) 783-8606
Medical and Dental claim inquiries	Alaska Carpenters Health and Welfare Trust Fund (800) 531-5357
Medical Claims – Provider Submitted	Local Blue Cross and/or Blue Shield Plan Providers: (800) 713-5373
Medical (member submitted), Dental, and Hearing claims	Alaska Carpenters Trust Fund PO Box 34867 Seattle, WA 98124-1867 (800) 531-5357
Vision Claims – (Non-VSP provider)	Vision Service Plan (VSP) PO Box 385018 Birmingham, AL 35238-5018 (800) 877-7195

Benefit	Company Responsible
Prescription drug claims – Member Submitted (Only for non-participating retail pharmacies)	Express Scripts (800) 935-0153
Life insurance and Accidental Death and Dismemberment insurance claims	ReliaStar Life Insurance Company PO Box 1548 Minneapolis, MN 55440 (888) 238-4840

Claims should be submitted within 90 days after services are rendered or a period of disability commences, or as soon as reasonably possible. All claims, supporting documentation and additional information that is requested to process the claims must be submitted to complete the claim. Incomplete claims will not be considered until all the required information has been provided. The Board of Trustees reserves the right to deny claims filed or completed one year after the date services are rendered unless you are not legally capable of submitting or completing the claim. Claims for Life and AD&D insurance benefits should also be filed within 90 days of the loss, or as soon as reasonably possible.

The claim review and appeal procedures apply to these types of claims:

Urgent Health Care Claim	A claim or pre-approval request for a medical, dental, or vision benefit where treatment delay could seriously jeopardize life, health, the ability to regain maximum function or, in the opinion of a physician who knows the medical condition, would subject the patient to severe pain that cannot be adequately managed without care or treatment that is the subject of the claim.
Pre-Service Health Care Claim	Any claim or pre-approval request for a medical benefit, where receipt of benefit is conditioned, in whole or in part, based on advance approval.
Concurrent Health Care Claim	Any claim that is reconsidered after initial approval by the plan that later results in a reduction, termination or extension of an approved benefit.
Post-Service Health Care Claim	Any claim for a medical, dental or vision benefit that is not a pre-service or a concurrent claim.

If you have questions about filing claims, or want to check on the status of your claim, call the Trust Administration Office at: (800) 531-5357.

Procedures for Processing Claims

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

Post-Service Health Claims

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

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

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

Pre-Service Health Claims

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

- A pre-service claim will be processed once all relevant information has been received. Claimants will be notified within five days if additional information is required to complete a pre-service claim or to allow processing. Claimants will be provided 45 days to submit any additional information. If the requested information is not received within 45 days, your claim will be processed based on the information provided to the Pre-certification Provider.
- Once all relevant information has been received, a decision on a pre-service claim will ordinarily be made within 15 days. If additional time is necessary, the claims administrative agent may extend this 15-day period by an additional 15 days by

providing notice to the claimant prior to the expiration of the initial 15-day period.

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

Urgent Care Health Claims

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

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

Claim Denials

A denial of benefits will provide the following information:

- The reason for the denial.
- A reference to the Plan provision relied on.
- A description of any additional material needed to perfect the claim.
- An indication if any internal guidelines or protocols have been relied on in denying the claim and statement that any such internal guidelines are available on request.
- If the denial is based on medical necessity, the service or supply being experimental or investigational in nature or an

equivalent exclusion, a statement that an explanation of the medical judgment will be provided upon request.
- An explanation of the Trust's appeal procedures.

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

Appeal Procedures

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

These procedures must be exhausted before a claimant may file suit under Section 502(a) of ERISA. **Claimants have 180 days from the date of denial to appeal an adverse benefit determination**.

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

It must be submitted to the proper address for the Trust Administration Office (see page 134).

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

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

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

Information to Be Provided upon Request

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

Relevant documents shall include information relied upon, submitted, considered, or generated in making the benefit determination. It will also include internal guidelines, procedures, or protocols concerning the denied treatment option without regard to whether such document or advice was relied on in making the benefit determination. Absent a specific determination by the Trustees that disclosure is appropriate, relevant documents do not include any other individual's medical or claim records or information specific to the resolution of other individuals' claims.

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

Conduct of Hearings by the Appeal Committee

Except for urgent care and pre-service health claims, an appeal will be presented to the full Board of Trustee or the Trustees designated Appeals Committee at its next quarterly meeting. If an appeal is received less than 30 days before the next quarterly meeting, consideration of the appeal may be postponed until the second quarterly meeting following receipt of the appeal.

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

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

The Trustees may have an individual with a different licensure review a matter if they are trained to deal with the condition

involved. The health care professional consulted will not be the individual who made the initial benefit determination nor the subordinate of that individual. The Trustees will identify by name any individuals consulted for medical or vocational advice.

The claimant or his/her representative will be allowed to appear before the Trustees in person or by telephone and present any evidence or witnesses.

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

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

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

Issuance of a Decision

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

The decision will include the following points:

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

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

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

Pre-Service Claims

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

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

Urgent Care Claims

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

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

- A decision will be issued within 72 hours of an appeal of an initial denial.

External Review of Denied Claims

External review by an Independent Review Organization ("IRO") is available if the claim on appeal involves medical judgment or the retroactive rescission of health coverage. There is no external review for non-healthcare claims, such as weekly disability, accidental death and dismemberment, or life insurance.

A request for external review must be filed with the Administration Office within four months from the claimant's receipt of the Trustees' decision on appeal. Requests for external review may be mailed to the following address:

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

Failure to file a request for external review within the four-month period will end the claimant's ability to seek external review.

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 request. The preliminary review will be expedited if the request satisfies the requirements for an urgent care claim. 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 IRO.

Review by an IRO

If a properly filed request for external review is received, the Plan will provide the IRO with the required documentation in the time required by applicable federal regulations. The IRO will provide a response to the claimant within 45 days after it has received the request to review. The Plan's existing Claim and Appeal Procedures provide for an expedited review of an urgent care claim. If an urgent care claim is submitted to an IRO, a decision will be made within 72 hours.

If the IRO directs that benefits be paid, benefits will be provided under the Plan in accordance with the decision. If the decision continues to be adverse, the claimant has the right to bring a civil action under ERISA § 502(a).

Civil Action to Review Denied Claims

The denial of a claim to which the right to review has been waived or the decision of the Board of Trustees is final and binding upon all parties. The Board of Trustees has the sole and exclusive authority to interpret the terms of this policy, all plan rules and any evidence submitted by you.

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

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

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

Life Insurance/Accidental Death and Dismemberment (AD&D) Claims

The claim administrator for life and AD&D insurance benefits is ReliaStar Life Insurance Company.

You, your dependent, or someone on your behalf must send ReliaStar Life Insurance Company a written notice if a covered loss occurs. Your claim for benefits will be based on this written notice. The notice must:

- Include information to identify you, such as your name, address and group policy number
- Be submitted within 20 days after the loss for which the claim is based occurred, or as soon afterwards as reasonably possible.

Once your notice is received, ReliaStar Life Insurance Company or its authorized agent will send claim forms to you or to the Trust Administration Office to give to you. ReliaStar Life Insurance Company will send the forms within 15 days after ReliaStar Life Insurance Company receives your notice of claim.

You or someone on your behalf must return the completed claim forms to ReliaStar Life Insurance Company within 90 days of the loss. Even if you do not receive the forms, written proof of loss must be sent to ReliaStar Life Insurance Company within 90 days after the loss or as soon as reasonably possible.

Written proof of loss includes details of how the loss occurred and copies of itemized doctor, hospital and prescription drug bills or receipts.

ReliaStar Life Insurance Company has 90 days to determine initial claims. If ReliaStar Life Insurance Company determines that an extension of time is necessary under certain circumstances, then the initial decision period may be extended for an additional 90 days.

If ReliaStar Life Insurance Company denies the claim, you'll receive written or electronic notice containing:

- Specific reasons for the denial

- References to specific plan provisions on which the denial is based
- Description of any additional material or information necessary for you to perfect the claim and an explanation of why it's necessary
- Description of the claim appeal procedure (and applicable time limits), including a statement of your right to bring a civil action under ERISA Section 502(a) if your appeal is denied.

If the claim is denied, in whole or in part, or if you believe plan benefits have not been properly provided, you, your beneficiary (if applicable), or your authorized representative may appeal the denial. ReliaStar Life Insurance Company will provide details about your right to appeal, along with the appeals process, address for filing an appeal, and timeframes. If you don't appeal within the designated timeframes, you may lose your right to later file suit in court.

The appeal must set forth all the grounds on which it is based, all the facts in support of the request, and other matters which you deem pertinent. Plan provisions require that you pursue the claim and appeal rights described here before seeking other legal recourse.

For Life and AD&D claims you have 60 days from the date you receive notice of a claim denial to file an appeal. ReliaStar Life Insurance Company must make a decision within 60 days after receiving your written appeal. If ReliaStar Life Insurance Company determines that an extension of time is necessary under certain circumstances, then the 60-day decision period may be extended for another 60 days. If an extension is necessary, you'll be notified within the initial decision timeframe.

The decision on appeal will be written in an understandable way, and will include:

- Reasons for the decision

- References to specific provisions on which the decision is based.

If ReliaStar Life Insurance Company does not respond within the applicable timeframe, you should generally consider the appeal denied.

YOUR RIGHTS

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.

Pursuant to regulations issued by the federal government, the Alaska Carpenters Health and Welfare Trust ("Trust") is providing you this Notice about the possible uses and disclosures of your health information. Your health information is information that constitutes protected health information (PHI) as defined in the Privacy Rules of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Protected Health Information

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

As required by law, the Trust has established a policy to guard against unnecessary disclosure of your health information. The Trust is required by law to maintain the privacy of protected health information, to provide individuals with notice of its legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured health information.

This Notice describes the circumstances under which and the purposes for which your health information may be used and disclosed and your rights with regard to such information.

Use and Disclosure of Health Information

Your health information may be used and disclosed without an authorization in the following situations:

To Make or Obtain Payment. The Trust may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive, to determine benefit responsibility under the Trust's Plan or to coordinate Plan coverage. For example, the Trust may use health information to pay your claims or share information regarding your coverage or health care treatment with other health plans to coordinate payment of benefits. The Trust may also share your protected health information with another entity to assist in the adjudication or reimbursement of your health claims.

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

To Conduct Health Care Operations. The Trust may use or disclose health information for its own operations, to facilitate the administration of the Trust and as necessary to provide coverage and services to all of the Trust's participants. Health care operations includes: making eligibility determinations; contacting health care providers; providing participants with information about health-related issues or treatment alternatives; developing clinical guidelines and protocols; conducting case management; medical review and care coordination; handling claim appeals; reviewing health information to improve health or reduce health care costs; participating in drug or disease management activities; conducting underwriting; premium rating or related functions to create, renew or replace health insurance or health benefits; and performing the general administrative activities of the Trust (such as providing customer service, conducting compliance reviews and auditing, responding to legal matters and compliance inquiries, handling quality assessment and improvement activities, business planning and development including cost management and

planning related analyses and formulary development, and accreditation, certification, licensing or credentialing activities). For example, the Trust may use your health information to conduct case management of ongoing care or to resolve a claim appeal you file.

If the Trust discloses protected health information for underwriting purposes, the Trust is prohibited from using or disclosing protected health information that is genetic information of an individual for such purposes.

For Disclosure to the Plan Trustees. The Trust may disclose your health information to the Board of Trustees (which is the Plan sponsor), or any insurer or HMO with which the Trust contracts, and to necessary advisors which assist the Board of Trustees in performing Plan administration functions, such as handling claim appeals. The Trust also may provide Summary Health Information to the Board of Trustees so that it may solicit bids for services or evaluate its benefit plans. Summary Health Information is information that summarizes participants' claims information but from which names and other identifying information have been removed. The Trust may also disclose information about whether you are participating in the Trust or one of its available options.

For Disclosure to You or Your Personal Representative. When you request, the Trust is required to disclose to you or your personal representative your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. Your personal representative is an individual designated by you in writing as your personal representative, attorney-in-fact. The Trust may request proof of this designation prior to the disclosure. Also, absent special circumstances, the Trust will send all mail from the Trust to the individual's address on file with the Trust Administration Office. You are responsible for ensuring that your address with the Trust Administration Office is current. Although mail is normally addressed to the individual to whom the mail pertains, the Trust cannot guarantee that other individuals with the same address will not intercept the mail. You have the right to

request restrictions on where your mail is sent as set forth in the request restrictions section below.

Disclosure Where Required By Law

In addition, the Trust will disclose your health information where applicable law requires. This includes:

In Connection With Judicial and Administrative Proceedings. The Trust will in response to an order from a court or administrative tribunal disclose protected health information in accordance with the express terms of such an order. The Trust may also disclose protected health information in response to a subpoena or other lawful process if the Trust receives satisfactory documentation that you have received notice of the subpoena or legal process, the notice provided sufficient information to allow you to raise an objection and the time for raising an objection has passed and either no objections were filed or were resolved by the court or administrative tribunal. Alternatively, the party requesting disclosure may provide satisfactory documentation you have agreed to the disclosure or that it has obtained a qualified protective order which meets the requirements of the Privacy Rules and which allows for disclosure. For example, if the Trust receives a court order requiring it to disclose certain information, it will respond to the court order.

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

When Legally Required and For Law Enforcement Purposes. The Trust will disclose your protected health information when it is required to do so for law enforcement purposes. This may

include compliance with laws which require reporting certain types of injuries, pursuant to court issued legal process; or a grand jury subpoena or other administrative requests if satisfactory documentation is provided that the request is relevant to a legitimate law enforcement purpose, the request is reasonably tailored to meet this legitimate law enforcement purpose and de-identified individual cannot be reasonably provided as an alternative. Additionally, limited disclosure may be made for purposes of identifying or locating a suspect, fugitive, material witness or missing person, identifying a victim of a crime or in connection with a criminal investigation that occurred on Trust premises. For example, the Trust could upon request of a law enforcement agency provide information concerning the address of a fugitive.

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

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

For Specified Government Functions. In certain circumstances, federal regulations require the Trust to use or disclose your health information to facilitate specified government functions related to

the military and veterans, national security and intelligence activities, protective services for the President and others, and correctional institutions and inmates.

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

Authorization To Use Or Disclose Health Information

Other than as stated above, the Trust will not disclose your health information without your written authorization. Generally, you will need to submit an Authorization if you wish the Trust to disclose your health information to someone other than yourself. Authorization forms are available from the Privacy Contact Person listed below. If you have authorized the Trust to use or disclose your health information, you may revoke that Authorization in writing at any time. The revocation should be in writing, include a copy of or reference to your Authorization and be sent to the Privacy Contact Person listed on page 130.

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

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

Your Rights With Respect To Your Health Information

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

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Trust's disclosure of your health information to someone involved in payment for your care. The Trust is not required to agree to your request unless the protected health information pertains solely to a health care item or service for which you, or a person on your behalf, has paid the provider or Plan in full, and the disclosure at issue is for the purpose of carrying out payment or health care operations.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. This right, however, does not extend to psychotherapy notes or information compiled for civil, criminal or administrative proceeding. The Trust may deny your request in certain situations subject to your right to request review of the denial. A request to inspect and copy records containing your health information must be made in writing to the Privacy Contact Person. If you request a copy of your health information, the Trust may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. Notwithstanding the foregoing, the fee for a copy of your health information in electronic form shall not be greater than the labor costs in responding to the request.

Right to Receive Confidential Communications. You have the right to request that the Trust communicate with you in a certain way if you feel the disclosure of your health information through regular procedures could endanger you. For example, you may ask that the Trust only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing to the Privacy Contact Person listed on page 130. The Trust will attempt to honor reasonable requests for confidential communications.

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

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

Right to Opt Out of Fundraising Communications. In the event that the Trust engages in a fundraising activity, you have the right to opt out of any fundraising communications.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the individual listed below. You will also be able to obtain a copy of the current version of the Trust's Notice at its website,

www.alaskacarpenterstrusts.com. If this Notice is modified, you will be mailed a new copy.

Privacy Contact Person/Privacy Official. To exercise any of these rights related to your health information you should contact:

Privacy Contact Person
Assistant Claims Manager
c/o Welfare & Pension Administration Service, Inc.
PO Box 34203
Seattle, WA 98124-1203
Toll Free: (800) 531-5357
Fax No: (206) 441-9110

Privacy Official
Claims Manager
c/o Welfare & Pension Administration Service, Inc.
PO Box 34203
Seattle, WA 98124-1203
Toll Free: (800) 531-5357
Fax No: (206) 441-9110

Duties Of The Trust

The Trust is required by law to maintain the privacy of your health information as set forth in this Notice, to provide to you this Notice summarizing its privacy practices and duties, and to notify you following a breach of unsecured protected health information. The Trust is required to abide by the terms of this Notice, which may be amended from time to time. The Trust reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Trust changes its policies and procedures, the Trust will revise the Notice and will provide you a copy of the revised Notice within 60 days of the change. You have the right to request a written copy of the Notice at any time.

You have the right to express complaints to the Trust and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any

complaints to the Trust should be made in writing to the Privacy Official. The Trust encourages you to express any concerns you may have regarding the privacy of your health information. You will not be retaliated against in any way for inquiring about or filing a complaint about privacy matters.

Newborns' and Mothers' Health Protection Act

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

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

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

Women's Health and Cancer Rights Act

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

What benefits does the law guarantee?

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

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

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

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

Life and Accidental Death & Dismemberment Benefits Plan Disclosures

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

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

PLAN INFORMATION

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

Plan Name

The Plan is known as the Alaska Carpenters Health and Welfare Trust Fund.

Name and Address of Plan Sponsor

The Plan is sponsored and administrated by a joint labor-management Board of Trustees.

Board of Trustees
Alaska Carpenters Health and Welfare Trust Fund
375 W. 36th Ave Suite 200
PO Box 93870
Anchorage, AK 99503-5814

(800) 478-4431
(907) 561-7575
(800) 531-5357 (WA)

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

Employer Identification Number

The employer identification number assigned to the Plan by the Internal Revenue Service is: EIN 92-6002106.

Plan Number

The Plan number is: 501.

Type of Plan

This plan is a health and welfare plan providing medical, prescription drug, vision, dental, life insurance and accidental death and dismemberment insurance benefits. Life insurance and accidental death and dismemberment insurance benefits are provided under a policy with ReliaStar Life Insurance Company Insurance Company, P.O. Box 20, Minneapolis, MN 55440.

Type of Administration

The Plan is administered by the Board of Trustees with assistance of the following administrative organization:

Labor Trust Services, Inc.
375 W. 36th Ave Suite 200
PO Box 93870
Anchorage, AK 99503-5814

(800) 478-4431
(907) 561-7575
(800) 531-5357 (WA)

The life insurance and accidental death and dismemberment group policy is issued in the governing jurisdiction of Alaska. Its terms are governed by and will be interpreted according to the laws of the governing jurisdiction.

Name and Address of Agent for Service of Legal Process

The administrative manager at the Trust administrative office is designated as agent for purposes of accepting legal process on the behalf of the plan. The name, address and telephone number of the administrative office is listed below:

Board of Trustees
Alaska Carpenters Health and Welfare Trust Fund
375 W. 36th Ave Suite 200
PO Box 93870
Anchorage, AK 99503-5814

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

Board of Trustees

The names of the Trustees are as follows:

Management Trustees	Union Trustees
John Eng, Co-Chairman Cornerstone Construction Company PO Box 111391 Anchorage, AK 99511-1391 P. (907) 349-6907 F. (907) 561-7899	**E. Scott Hansen, Co-Chairman** Pacific Northwest Regional Council of Carpenters 407 Denali St, Suite 100 Anchorage, AK 99501-2646 P. (907) 276-3533
Bert Bell Ghemm Company, Inc. PO Box 70507 Fairbanks, AK 99707-0507 Street: 3861 Schacht St Fairbanks, AK 99701 P. (907) 452-5191 F. (907) 451-7797	**Steve Abel** Pacific Northwest Regional Council of Carpenters 825 E. 8th Ave Suite 6 Anchorage, AK 99501-3877 P. (907) 230-6232 F. (907) 277-8967
Robby Capps F & W Construction Company, Inc. 3821 Dee Circle Anchorage, AK 99516-1528 P. (907) 248-3666 F. (907) 243-0145	**Laird Grantham** Pacific Northwest Regional Council of Carpenters 25 Timberland Drive Fairbanks, AK 99701-3143 P. (907) 452-3862 F. (907) 456-3582

Management Trustees	Union Trustees
Jed Shandy Davis Constructors & Engineers, Inc. 6591 A St, Suite 300 Anchorage, AK 99518-1866 P. (907) 562-2336 F. (907) 561-3620 ALTERNATE TRUSTEE **John MacKinnon** AGC of Alaska 8005 Schoon St Anchorage, AK 99518-3045 P. (907) 561-5354 F. (907) 562-6118	**Doug Tweedy** Pacific Northwest Regional Council of Carpenters 25120 Pacific Hwy S, Suite 200 Kent, WA 98032-5436 P. (253) 945-8813 F. (253) 945-8879 ALTERNATE TRUSTEE **Dan Hutchins** Pacific Northwest Regional Council of Carpenters 25120 Pacific Hwy S, Suite 200 Kent, WA 98032-5436 P. (253) 945-8847 F. (253) 945-8879

Source of Contributions

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

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

Plan Year

The fiscal year for the plan is January 1 through December 31.

Description of Collective Bargaining Agreements

This plan is maintained under one or more collective bargaining agreements between employers and the local unions listed below. A copy of these agreements may be obtained by Participants and Beneficiaries upon written request to the Plan Administrator.

As there may be a reasonable charge for this document, you may wish to determine what the charge will be before making such a request. These agreements are also available for examination by Participants and Beneficiaries at the respective Local Union Office.

Eligibility and Benefits

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

The eligibility rules that determine which participants are entitled to benefits are set forth in this booklet. The benefits to which participants are entitled are also set forth in this booklet.

Circumstances That May Result in Ineligibility or Denial of Benefits

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

- The failure to work the required hours to maintain 120 or more hours in his or her Hour Bank. See the "When Active Coverage Ends" section, page 19.
- The failure of the employee's employer to report the hours and remit contributions on his or her behalf to the Trust.
- In the case of beneficiaries who are dependents of an eligible Employee, they may become ineligible if:
  - They are no longer dependents.
  - They have attained the disqualifying age.

See the "When Dependent Coverage Ends" section beginning on page 23.

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

- The failure of the participant to file a complete claim for benefits.
- The failure of the participant to file a complete and truthful benefit application.

- Where the participant has other group insurance coverage, it is possible that benefits payable under this Plan may be reduced or denied due to coordination of benefits between the two plans. See the "Coordination of Benefits" section, page 99.

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

In the event of the termination of the Trust Fund, any and all monies and assets remaining in the Trust Fund, after payment of expenses, will be used for the continuance of the benefits provided by the then-existing health plans, until such monies and assets have been exhausted.

Statements Not Warranties

All statements made by the Trustees or the Trust Administration Office will, in the absence of fraud, be deemed representations and not warranties. No statement made by the Trustees or the Trust Administration Office to obtain coverage will be used to avoid or reduce the coverage unless it's made in writing and signed by the Trustees or Trust Administration Office, with a copy sent to the Trustees and the Trust Administration Office or beneficiaries.

Claim Filing Procedures

To file a claim for benefits under this Plan, follow the instructions described in the "How to File a Claim" section.

Hearings Before the Board of Trustees

Any participant who applies for benefits and is ruled ineligible by the Trustees (or by a committee of Trustees, an administrative agent, insurance carrier, or other organization acting for the Trustees), or who believes he or she did not receive the full amount of benefits to which he or she is entitled, or who is otherwise adversely affected by any action of the Trustees, shall have the right to request the Trustees to conduct a hearing on the matter.

The request must be made in writing within 180 days after being apprised of or learning of the action. The Trustees shall then conduct a hearing at which the participant shall be entitled to present his or her position and any supporting evidence. The participant may be represented at any such hearing by an attorney or by any other representative of his or her choosing. Thereafter, the Trustees shall issue a written decision affirming, modifying, or setting aside the former action.

Authority to Interpret and Amend the Plan

The Board of Trustees expressly reserves the right, in its sole discretion at any time:

1. To interpret any and all provisions of the Plan;
2. To determine eligibility and entitlement to Plan benefits;
3. To terminate or amend any benefit or the Plan, in whole or in part, even though a termination or an amendment may impact claims which have already accrued;
4. To alter or postpone the method of payment of any benefit; and
5. To amend or rescind any other provision of this Plan.

ERISA RIGHTS

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

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

Receive Information about Your Plan and Benefits

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

Continue Group Medical, Dental and Vision Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

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

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ReliaStar Life Insurance Company
www.ing.com
Phone: (206) 676-6105

Pharmacy Benefit Manager
Express Scripts
www.express-scripts.com
Phone: (201) 269-5874
Member Service: (800) 935-0153

Case Management and Utilization Management
Qualis Health
(800) 783-8606

Epic Hearing Service Plan
www.epichearing.com
(866) 956-5400

Vision Service Provider
VSP
(800) 877-7195
www.vsp.com

BENEFIT DEFINITIONS

The following definitions apply whenever the term is used, regardless of whether capitalized (unless an alternative definition in the dental or life/AD&D section applies):

- **Accident or accidental –** An unexpected, external, violent and sudden event.
- **Allowed amount** – the fee negotiated by the preferred provider or preferred facility, if a service or supply is provided by a preferred provider or preferred facility or if no PPO agreement exists (non-PPO), the **Usual, Customary and Reasonable** amount.
- **Bereavement counseling** – Counseling by a social worker or pastoral counselor, practicing within the scope of their license.
- **Birthing Center** – A birthing center is a facility that meets professionally recognized standards and all the following:
  - It mainly provides an outpatient setting for childbirth following a normal, uncomplicated pregnancy
  - It has (a) at least two birthing rooms; (b) all the medical equipment needed to support the services furnished by the facility; (c) laboratory diagnostic facilities; and (d) emergency equipment trays, and supplies for use in life threatening events
  - It has medical staff that (a) is supervised full time by a physician; and (b) includes a registered nurse at all times when patients are in the facility
  - It has written agreements with the local acute care hospital and a local ambulance company for the immediate transfer of the patients who require greater care than can be furnished at the facility

- It admits only patients who (a) have undergone an educational program to prepare them for the birth; and (b) have records of adequate parental care

- It schedules stays of not more than 24 hours for a birth

- It maintains medical records for each patient

- It complies with all licensing and other legal requirements that apply

- It is not (a) the office or clinic of one or more physicians; (b) an acute care hospital; or (c) a specialized facility other than a birthing center

- **Calendar year** – Period that starts on January 1 and ends on December 31 of each year.
- **Coinsurance** – Percentage of an allowed amount paid by you and the plan. For example, if you are an active employee, the plan's coinsurance for many services is 80% and your coinsurance is the remaining 20%.
- **Copay** – the amount in addition to the amount you are required to pay for certain services and supplies provided under this Plan. You are responsible for the payment of any copay directly to the provider of the service or supply.
- **Covered expense or covered medical expense** – Medically necessary service or supply provided to a participant that meets the following requirements:

  - Incurred by a participant while enrolled for medical benefits. A charge is incurred when the service or supply is provided

  - Not listed under "What the Medical Plan Does Not Cover – Exclusions" beginning on page 60

- Does not exceed the maximum limits that apply to the service or supply for which the charge is made.

- **Custodial care** – Service, procedure or supply that is provided primarily:

  - For ongoing maintenance of the individual's health and not for its therapeutic value in the treatment of an illness or injury

  - To provide room and board

  - To assist the individual in meeting the activities of daily living such as help in walking, bathing, dressing, eating, preparing special diets, and supervising self-administration of medication.

- **Deductible –** The amount of covered charges that you must pay each calendar year before the plan pays benefits.

- **Durable medical equipment –** Items able to stand repeated use, mainly used for medical purposes, and not generally of use in the absence of a disease or injury. Examples of items not considered durable medical equipment are:

  - Air conditioner
  - Air purifier
  - Heat lamp
  - Heating pad
  - Bed board
  - Orthopedic shoes
  - Orthotics
  - Corrective device for use in shoes
  - Exercise bicycle
  - Weight lifting equipment
  - Specially equipped van.

- **Experimental or Investigational Treatment** means any of the following:
  - The drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given for regular nonexperimental or noninvestigational purposes at the time the drug or device is furnished;
  - The drug, device, medical treatment, or procedure has been determined experimental or investigational 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 investigational program;
  - Reliable evidence shows 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, toxicity, safety, efficacy, or efficacy compared with standard means of treatment or diagnosis (except as provided below); or
  - Chemotherapy drugs that have not been granted FDA approval for general public use in the treatment of a condition. If the claims administrator or Qualis Health determines that available scientific evidence demonstrates that a drug is effective or shows promise of being effective for a condition, the drug may be covered by the plan.

  Experimental or Investigation Treatment does not include routine patient costs for items and services furnished in connection with an approved clinical trial that would otherwise be covered by the Plan for a patient (or participant) who is not participating in a clinical trial. For clinical trials the Plan will not cover:

  – The investigational item, device, or service itself.

- Items and services solely for data collection that are not directly used in the clinical management of the patient, or
- Services which are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

An approved clinical trial is a phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.

The Board of Trustees has the discretion and authority to determine if a service or supply is or should be considered experimental or investigational. That determination is based on the information and resources available when the service is performed or the supply is provided.

For 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 (except as provided below).

- **Federal legend drug** – A drug that by law can be obtained only by prescription and bears the label "Caution: federal law prohibits dispersing without a prescription."
- **Fund, Plan or Trust** – The Alaska Carpenters Health and Welfare Trust Fund.
- **Home health agency** – An agency licensed to provide home health care by the proper authority of the state or region in which it operates.
- **Hospice care** – Care that:
  - Is furnished or arranged by a hospice approved by the plan

- Is provided as part of a coordinated plan of home and inpatient care to meet the special needs of the terminally ill patient and covered family members due to the terminal illness
- For the terminally ill patient, may include medical care, palliative care, respite care, and medical social services
- For covered family members, may include medical social services and bereavement counseling.

- **Hospital** – An institution that:
  - Is primarily for medical treatment to inpatients
  - Maintains facilities for diagnosis and permanent facilities for surgery
  - Provides treatment only by or under a staff of physicians and care by registered nurses 24 hours a day
  - Keeps a daily medical record for each patient
  - Complies with all licensing and other legal requirements
  - Is not a skilled nursing facility or a specialized facility
  - Is not, other than incidentally, a nursing home, hotel, or similar institution or a place for custodial care, the aged, care of persons addicted to or dependent on a drug or chemical, including alcohol, or care of persons with mental, nervous, or emotional disorders or conditions.
- **Inpatient and Outpatient** – Either the setting where medical care is given or a person receiving care in that setting.
  - When the terms describe the setting, inpatient means the care is furnished while the person is confined in a facility as a registered bed patient and outpatient means the care is furnished while the person is not so confined.
  - When the terms refer to a person, inpatient means a person confined in a facility as a registered bed patient and outpatient means a person who is not so confined.

- **Intensive care unit** means a separate, clearly designated service section that's part of a hospital and:
  - Is solely to treat patients in critical condition
  - Provides constant special nursing care and observation not available in other sections of the hospital
  - Contains special life-saving equipment ready for immediate use
  - Has at least two beds for critically ill patients
  - Maintains at least one registered nurse in constant attendance
  - Meets the standards for an intensive care unit set by the Joint Commission on Accreditation of Hospitals.

  An intensive care unit includes a burn unit or cardiac care unit that meets all of the above conditions. The term does not include a non-hospital unit for intensive alcoholism or psychiatric treatment.
- **Medically necessary** – service or supply that meets all of the following requirements:
  - Rendered to treat or diagnose an injury or disease including premature birth, congenital defects, and birth defects;
  - Appropriate for the symptoms, consistent with the diagnosis, and otherwise in accordance with generally accepted medical practice and professionally recognized standards;
  - Not mainly for the convenience of the participant or their physician or other provider; and
  - The most appropriate supply or level of service needed to provide safe and adequate care. When applied to confinement in a hospital or other facility, this means the participant needs to be confined as an inpatient due to the nature of the services or the participant's condition and that

safe, adequate care cannot be given through outpatient treatment.

- **Medical social services** – Counseling to assist in coping with the dying process provided by a social worker or pastoral counselor practicing within the scope of their license.
- **Mental health services** – Services and supplies furnished to diagnose or treat a mental, nervous, or emotional disorder or condition.
- **Mental Disorder** – Mental disorder includes only those disorders listed in the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM).
- **Nurse** – A registered nurse (RN), a licensed vocational nurse (LVN), or a licensed practical nurse (LPN).
- **Out-of-Pocket** -- The amount that you are responsible to pay during a Calendar year after the Plan has paid its share of charges. After you have reached the out-of-pocket limit, the Plan will pay most benefits at 100% of the allowed amount for the remainder of the calendar year. Some benefits are not subject to the out-of-pocket provision, as specified in the benefits section; these benefits will always remain payable at the percentage level listed in the benefits section. In addition, the following do not count towards the out-of-pocket limit: your annual deductible; any copays; the difference between the allowed amount and the providers actual charge; any balances that remain after benefit limits have been reached; expenses this Plan does not cover.
- **Palliative care** – Rendered to relieve the symptoms or effects of a disease without curing the disease.
- **Participant** – Eligible employee, retiree or dependent enrolled in the plan.
- **Physician** – Any of the following licensed practitioners who perform a service covered under the plan:

- Doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC)
- Licensed doctoral clinical psychologist
- Master's level counselor and licensed or certified social worker who is acting under the supervision of a doctor of medicine or a licensed doctoral clinical psychologist
- Licensed physician's assistant (PA); or
- Where required to cover by law, any other licensed practitioner who:
  - is acting within the scope of his/her license; and
  - performs a service which is payable under the plan when performed by an MD.

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

- **Professionally recognized standards** – Standards of quality determined by the plan. Professional groups such as the American Medical Association, affiliates and successors, peer review groups and professional review groups may be used to determine these standards.
- **Respite care** – Care for a terminally ill patient to give covered family members relief from the stress of caring for the patient.
- **Second surgical opinion** – A physician's opinion of whether surgery is medically necessary.
- **Skilled Nursing Facility and Rehabilitation Facility** – An institution that meets all the following conditions:
  - Is primarily for skilled nursing care or rehabilitation care to registered inpatients
  - Offers care supervised, 24 hours a day, by a physician or a registered nurse

- Has available at all times a physician who is a staff member of a hospital
- Maintains a registered nurse, licensed vocational nurse, or licensed practical nurse on duty 24 hours a day and a registered nurse on duty at least 8 hours a day
- Keeps a daily medical record for each patient
- Complies with all licensing and other legal requirements
- Is not a specialized facility
- Is not, other than incidentally, a nursing home, hotel, or similar institution or a place for custodial care, the aged, care of persons addicted to or dependent on a drug or chemical, including alcohol, or care of persons with mental, nervous, or emotional disorders or conditions.

- **Specialized Facility** – A facility that primarily provides one of the following services, whether physically or legally part of another facility:
  - Substance abuse treatment facility
  - Ambulatory outpatient surgical facility
  - Birth center facility for outpatient childbirth following a normal, uncomplicated pregnancy
  - Psychiatric hospital facility
  - Urgent care center for urgent or emergency medical treatment of acute conditions.

  Specialized facilities must meet professionally recognized standards and comply with all licensing and other legal requirements. Specialized facilities must be under the supervision of a physician and not a home for care of the aged, or a rest home or place for custodial care.

- **Substance Abuse** – Psychological or physical dependency on alcohol, a controlled substance or other mind-altering drugs that requires diagnosis, care and treatment. It does not include addiction to or dependence on food.

- **TMJ disorder** – A disease or dysfunction of the TMJ (temporomandibular joint) regardless of the diagnosis.
- **Usual, customary and reasonable charge (UCR)** –
  - Usual, Customary and Reasonable (UCR) Charge means a charge by a professional service provider for a covered service which is no higher than the 90th percentile identified by a commercially available database selected by the Plan.
  - When there is, in the Plan's determination, minimal data available from the database for a covered service, the Plan will determine the UCR charge by calculating the unit cost for the applicable service category using the database, and multiplying that by the relative value of the covered service assigned by the Medicare resource based relative value scale (supplemented with a commercially available relative value scale selected by the Plan where one is not available from Medicare).
  - In the event of an unusually complex covered service, a covered service that is a new procedure or a covered service that otherwise does not have a relative value that is in the Plan's determination applicable, the Plan will assign one.
  - In no event will the UCR charge exceed the amount billed by the professional service provider or the amount for which the covered person is responsible. The term "usual and customary charge" may not reflect the actual charges of the professional service provider, and does not take into account the professional service provider's training, experience or category of licensure.

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