

BASIC BENEFITS

PLAN CONTACTS

BOARD OF TRUSTEES

Jim Ashton – Chair

Dave Culbreth

William Meers

Steve Litton

Jeff Preheim

OTHER PLAN CONTACTS

Trust Administrative Office Public Employees Local 71 Trust Fund
General coverage or claim questions 2510 Arctic Blvd.
Anchorage, AK 99503
(800) 446-3671 or 276-7611 in Anchorage

Zenith Administrators Zenith Administrators
Medical and dental claims; PO Box 91013
Travel Preauthorization Seattle, WA 98111-9103
Customer Service (800) 557-8701

COBRA and HIPAA (800) 426-5980

Qualis Health Qualis Health
Precertification of Inpatient (800) 783-8606
Hospital Stays and Certain Medical Procedures

Caremark Caremark
Retail prescription drug (800) 600-0180
information www.caremark.com

Walgreens Mail Service Walgreens Mail Service
Mail order prescription drug (800) 635-3070
information www.walgreensmail.com

Vision Service Plan (VSP) Vision Service Plan
For vision claims PO Box 997105
Sacramento, CA 95899
(800) 877-7195
www.vsp.com

BeechStreet Provider Referral Line: (800) 877-1444
Nationwide PPO Network www.beechstreet.com

IMPORTANT PLAN PROVISIONS

PREFERRED PROVIDER ORGANIZATION

Please see page B-32 for more information on the Plan's preferred providers.

WITHIN THE MUNICIPALITY OF ANCHORAGE – *Alaska Regional Hospital* and *Chugach Physical Therapy* are the PPO providers. The Plan's reimbursement will be reduced if you use another provider for services that are available at Alaska Regional or Chugach Physical Therapy.

OUTSIDE OF THE MUNICIPALITY OF ANCHORAGE – You are encouraged to use providers in the *Beechstreet/First Choice* network to save money for yourself and the plan.

PRECERTIFICATION AND PREAUTHORIZATION

The Plan requires precertification of all inpatient Hospital stays and certain medical procedures. See page B-27 for more information.

If you must travel to obtain services not available locally, your travel may be covered by the Plan, **but you must obtain preauthorization before you travel**. See page B-42 for more information.

PATIENT AUDITOR PROGRAM

Your Medical Bill...it's worth a second look!

It's a fact of life, medical bills are sometimes wrong. Those mistakes can add up to substantial amounts of lost money for the Trust Fund. While there's no one reason why mistakes happen, there are some billing problems common to some hospitals. If, for some reason, tests are never performed or the medication is never given, the billing records may not be updated. Key punching errors are another common billing mistake. A misplaced decimal point can cost thousands of dollars.

What can you do? Be sure to ask your medical provider to send you an ITEMIZED BILL. Make sure the service dates are correct. Double check charges for tests and medicines. If you find errors or have questions about any charges, call the provider's billing office and ask them to review your records. In other words, if you find an overcharge, don't forget to obtain a corrected bill.

To encourage you to check your medical bills, **the Plan will reward you with 50% of your overcharged amount, up to a maximum reward of \$400** if you find an undetected error on a medical bill that has been audited and paid by the claim payor.

For example, if you find an \$800 overcharge undetected by the claim payor, once the Plan receives the overpayment back, you will get \$400 from the Plan. A second look can help control the cost of your health coverage and possibly put some dollars back in your pocket.

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WHO IS COVERED

ELIGIBILITY

Employees

Employees of the Haines Borough working in a job classification as described in the collective bargaining agreement with Public Employees Local 71 for whom the Trust receives contributions for coverage.

Dependents

Only the following are eligible for dependents' coverage:

- Your legal spouse (you may be separated, but not divorced)
- Children from birth up to age 23, if they are:
 - Either:
 - ✓ Your natural children or legally adopted children, or
 - ✓ Stepchildren, foster children placed through a state foster child program, or children for whom you are the legal, court-appointed guardian, who are living with you in a normal parent-child relationship and depend chiefly on you for support;
 - Unmarried; and
 - Attending school full- or half-time if they are age 19 to 23. Certification of student enrollment must be provided before eligibility is advanced.

When the parents of a child are covered under the Plan as employees or members, the child can be covered as a dependent of both parents.

Foster Child

A foster child is:

- A child you are raising as your own;
- A child who lives in your home;
- A child who is chiefly dependent on you for support; or
- A child for whom you have taken full legal parental responsibility and control. (Evidence of your assumption of legal responsibility for the child must be submitted with an updated enrollment change form to the Trust Administrative Office.)

A foster child is not:

- A child temporarily living in your home;

- A child placed with you in your home by a social service agency which retains control of the child; or
- A child whose natural parent is in a position to exercise or share parental responsibility and control.

Adopted Child

A child placed with you for adoption will be covered from the earlier of:

- The date of adoption; or
- The date the child is placed in your home.

Placed for adoption means assumption and retention by the employee of a legal obligation for total or partial support of such child in anticipation of adoption of the child.

Dependents Not Eligible for Coverage

The following are not eligible for dependents' coverage:

- Your divorced spouse or any married child;
- A child who has been legally adopted by another person (custody ends on the date custody is assumed by the adoptive parents); or
- A child who has attained the limiting age: The limiting age is:
 - The child's 19th birthday; or
 - The 23rd birthday if the child is a full-time or half-time student in any accredited high school, trade school, college or university and is chiefly dependent on you for support.

Handicapped Child

Coverage for a mentally or physically handicapped child who reaches the limiting age while covered under the Plan may be continued if the child:

- Is chiefly dependent on you for support; and
- Is not capable of self-sustaining employment.

The coverage will continue only if you give the Trust Administrative Office proof of the child's handicap:

- No later than 31 days after the child attains the limiting age; and
- Thereafter as we may require, but not more often than once every 2 years.

WHEN YOUR COVERAGE BEGINS

New Employees

You will become covered on the first day of the month which coincides with or follows the day you complete 30 calendar days of employment, provided you are actively at work on that day. If you are not actively at work on that day, your coverage will begin on the first day of the month which coincides with or follows the day you return to active work.

Rehired Employees

If you were previously covered, and you are rehired within 7 calendar days of the date your coverage terminated, your coverage begins on the day you return. If you were previously covered, and you are rehired more than 7 calendar days after your coverage terminated, you are considered a new employee and coverage for you and your dependent begins as described above.

Employees Returning from Leave Without Pay or Layoff

You will become covered on the day you return to work, provided you are actively at work on that day.

Active at Work Provision

Any requirement regarding eligibility, or that an otherwise eligible person be actively at work before coverage may begin or remain in force is not applicable to Health Coverage if the eligibility for the coverage or the absence is due to a Health Status-Related Factor.

Health Status-Related Factor means any of the following:

- Health Status;
- Medical Condition (including both physical and mental Sickness);
- Claims experience;
- Receipt of health care;
- Medical history;
- Evidence of insurability (including conditions arising out of acts of domestic violence);
- Disability; or
- Genetic information.

However, if on the day your coverage is to begin:

- You are on a regular paid day of vacation; or
- Such day is a regular non-working day;

You will still be considered actively at work if you were available for work on the last preceding regular work day.

If, on the day your coverage is to begin you do not report to work, you will be considered actively at work if you are available for work on that day.

Dependents

If you want to cover your eligible dependents, you must complete an enrollment/record change form and provide the documentation requested on the form to the Trust Administrative Office before any dependent claims will be paid.

If you do not have a dependent until after you are covered, you must submit an updated enrollment/record change form and provided the required documentation requested on the form no later than 60 days from the date you acquire the dependent. The dependent is eligible for coverage on the date you acquire the dependent. However, plan changes will be effective on the first day of the month after the Trust Administrative Office receives the required enrollment/record change form and requested documentation.

Your newborn or newly adopted child will be automatically covered for 31 days, regardless of your plan election. If you are covered under an employee only plan option, you must notify the Trust Administrative Office of the birth or adoption and elect a family plan option within 60 days of the date of the child's birth or adoption, unless your newly acquired dependent has other health coverage. If you change your plan election, the change will be effective retroactive to the date of the birth or adoption. Coverage beyond the first 31 days will be continued only if an updated enrollment/record change form and the required documents are sent to the Trust Administrative Office within the 60 days of the birth or adoption of the new dependent.

Medical Child Support Order

If your child is not covered because you did not enroll your child for dependent coverage, such child may be enrolled after we:

- Receive a final medical child support order which requires enrollment; and
- Determine that the order is qualified.

Our Procedures for Determining if a Medical Child Support Order is Qualified:

When we receive a proposed or final medical child support order, we will notify you and each child named in the order, at the addresses shown in the order, that we have received it. We will then review the order to

decide if it meets the definition of a Qualified Medical Child Support Order. Within 30 days after we receive the order (or within a reasonable time thereafter), we will give a written notice of our decision to you and each child named in the order. We will also send our notices to each attorney or other representative who may be named in the order or in other correspondence filed with the Trust. If we decide that the order is not qualified, our notice will provide the specific reasons for our decision and the opportunity to correct the order or appeal our decision by contacting us within 30 days. If we decide that the order is qualified, our notice will provide instructions for enrolling each child named in the order. The Plan provisions that apply for other eligible dependents (such as the exceptions for when dependents' coverage begins and the rules for determining when dependents' coverage ends) will also apply for each child named in the order. We must receive a certified copy of the entire Qualified Medical Child Support Order before enrollment can occur. Also, if the cost of each child's coverage is to be deducted from your pay, the Trust Administrative Office must receive proper authorization in the order or otherwise.

As part of our authority to interpret the Plan, we have the discretion and final authority to decide if an order meets or does not meet the definition of a Qualified Medical Child Support order so as to require the enrollment of your child as an eligible dependent. Our reasonable decision will be binding and conclusive on all persons. If, as a result of an order, benefits are paid to reimburse medical expenses paid by a child or the child's custodial parent or legal guardian, these benefits will be paid to the child's custodial parent or legal guardian.

The Plan will treat each child enrolled because of a Qualified Medical Child Support Order as a participant for the purposes of reporting and disclosure requirements of ERISA, if applicable.

Medical Child Support Order is defined by Section 609 of ERISA. In general, a Qualified Medical Child Support Order means any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which:

- Either:
 - (1) Relates to medical benefits under the Plan and provides for your child's support or health benefits coverage pursuant to a state domestic relations law (including a community property law); or
 - (2) Enforces a law relating to medical child support described in Section 1908 of the Social Security Act;
- Creates or recognizes the existence of your child's right to be enrolled and receive medical benefits under the Plan;

- States the name and last known mailing address (if any) of you and each child covered by the order;
- Reasonably describes the type of medical coverage to be provided by the Plan to each child, or the manner in which this type of coverage is to be determined;
- States the period to which the order applies;
- States each Plan to which the order applies; and
- Does not require the Plan to provide any type or form of benefit or any option not otherwise provided by the Plan, except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act for medical child support orders.

CHANGES TO YOUR COVERAGE

If you experience a Qualifying Event and wish to change your plan selections or elect coverage for the first time, please contact the Trust Administrative Office. You will be required to submit new enrollment forms and proof of the qualifying event within 60 days of the event, or you must wait until the next open enrollment or another event to make a change. Changes will be effective on the first day of the month after the Trust Administrative Office receives your revised forms and proof of the Qualifying Event.

Eligible Qualifying Events

- Marriage;
- Birth or adoption of a child;
- Divorce or legal separation;
- Death of a dependent;
- Dependent ceases to be an eligible dependent;
- Loss, gain, or significant change in other coverage;
- Declaration of an open enrollment period by the Board of Trustees; and
- Changing from full-time to part-time status or vice versa.

Reminder: If you are enrolled in Plans 102, 103 or 105 and any family member loses other coverage, you must notify the Trust Administrative Office.

ENROLLMENT ELECTION REVIEW PROCEDURE

If you disagree with the implementation of your enrollment election upon new hire or upon Open Enrollment, you must follow the procedures below. These procedures are the sole and exclusive procedures available to you. You must follow the enrollment appeal process within the time periods designated or you will lose your right to appeal the matter.

Appeals of election choices must be submitted in writing to the Public Employees Local 71 Trust Administrator at 2510 Arctic Boulevard, Anchorage, AK 99503 within 45 days after the first payroll deduction resulting from the enrollment election or default election. You or your representative may submit pertinent issues and comments in writing and provide evidence supporting your position that you were improperly enrolled.

The Board of Trustees or a committee of Trustees, will consider the appeal as expediently as possible, and will issue a written decision no later than 75 days after the first payroll deduction resulting from the Plan election, or default election.

The Board of Trustees has the sole and exclusive authority to make decisions regarding the Open Enrollment and Mid-Year election appeals, and its decisions will be considered final and binding.

WHEN COVERAGE ENDS

Employees and Dependents

Coverage will end at midnight on the earliest of:

- The day the Plan ends;
- The day any premium for coverage is due and unpaid;
- The day before you enter the Armed Forces on active duty (except for temporary active duty of 2 weeks or less);
- The last day of the month in which you are no longer eligible under the Plan;
- For a dependent, the day employee coverage ends;
- For a dependent, the day before the dependent enters the Armed Forces on active duty (except for temporary active duty of 2 weeks or less); or
- For a dependent, the last day of the month the dependent is no longer eligible.

Employees on Leave Without Pay or Layoff

Coverage ends at the end of the month in which you were last in pay status. For example, if you worked or were on paid leave status on January 15 and then placed on leave without pay or layoff, coverage ends on January 31.

Continuation of Coverage

Refer to the How to Continue Health Coverage section found on page B-60 of this booklet for a description of circumstances for which coverage may be continued for you or your dependents.

PREEXISTING CONDITIONS PROVISION

The Preexisting Conditions Provision will apply if a person:

- Becomes covered under the Plan and was not covered under Creditable Coverage; or
- Becomes covered under the Plan and was covered under Creditable Coverage for an aggregate period of fewer than 12 months.

The Preexisting Conditions Provision will not apply if a person was covered under Creditable Coverage for an aggregate period of 12 months or more.

PREEXISTING CONDITIONS BENEFIT LIMITATION

If a covered person receives treatment or service for a Preexisting Condition, the Plan will not pay benefits of more than \$1,000 for such condition until the day after a 12 consecutive month period has passed from the covered person's enrollment date. Payment will be in accord with the provisions of the Plan.

EFFECT OF CREDITABLE COVERAGE

If a person becomes covered under the Plan and was covered under Creditable Coverage for an aggregate period of fewer than 12 months, the Plan will credit the time the person was covered under Creditable Coverage.

A period of Creditable Coverage will not be credited if, after such period and before the enrollment date, there was a period of 90 consecutive days during all of which the individual was not covered under Creditable Coverage; however, any waiting period under the Plan will not count as a break in the period of Creditable Coverage.

DEFINITIONS FOR TERMS IN THIS SECTION

Creditable Coverage means coverage of an individual under any of the following prior to the enrollment date under the Plan:

- (a) An employee group health plan;
- (b) Health Insurance Coverage;
- (c) Medicare;
- (d) Medicaid;
- (e) Military health care;

- (f) A medical care program of the Indian Health Service or of a tribal organization;
- (g) A state health benefits risk pool;
- (h) A health plan offered under the Federal Employee Health Benefits Program;
- (i) A public health plan as defined under Federal regulations;
- (j) A health benefit plan under Section 5(e) of the Peace Corps Act; or
- (k) Any other health coverage considered to be Creditable Coverage under state or federal laws or regulations.

Creditable Coverage does not include benefits under one or more of any combination of the following:

- (a) Coverage only for accident, disability income insurance, or both;
- (b) Coverage issued as a supplement to liability insurance;
- (c) Liability insurance, including general liability insurance and automobile liability insurance;
- (d) Workers' compensation or substantially similar insurance;
- (e) Automobile medical payment insurance;
- (f) Credit-only insurance;
- (g) Coverage for on-site medical clinics;
- (h) Other similar insurance coverage, as specified in federal law, under which benefits for medical care are secondary or incidental to other insurance benefits;
- (i) If offered as a separate insurance policy and otherwise not an integral part of a health care insurance plan, benefits under:
 - (1) Limited scope dental or vision coverage;
 - (2) Coverage for long-term care, nursing home care, community-based care, or any combination; or
 - (3) Other similar limited benefits as specified in federal law;
- (j) If offered as independent noncoordinated benefits, benefits under coverage only for a specified disease or illness, or Hospital indemnity or other fixed indemnity insurance; as used in this paragraph "independent, noncoordinated benefits" means benefits that are provided under a separate policy if:

- (1) There is no coordination between the provision of the benefits and an exclusion of benefits under a health care insurance plan maintained by the same plan sponsor; and
 - (2) The benefits are paid with respect to an event without regard to whether benefits are provided for the event under a health care insurance plan maintained by the same plan sponsor;
- (k) If offered as a separate insurance policy, benefits under:
- (1) Medicare supplement health insurance as defined in 42 USC 1345ss(g)(1)(Social Security Act);
 - (2) Coverage supplemental to the coverage provided under 10 USC 1071-1090; or
 - (3) Similar supplemental coverage provided to coverage under a health benefit plan.

Enrollment date means the date of enrollment of an eligible person under the Plan or, if earlier, the first day of the waiting period for such enrollment.

Health Insurance Coverage means benefits consisting of medical care (provided directly through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any Hospital or medical service policy or certificate, Hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.

Preexisting Condition means a Sickness, Injury, or related condition for which medical advice, diagnosis, care or treatment was recommended by a Physician or received within the 90 consecutive days before the most recent date you became covered under this Plan.

Waiting Period means a period of time that must pass before Health Coverage begins for an eligible person who enrolls under the Plan.

EXCEPTIONS

This provision does not apply to:

- (a) Pregnancy, including complications, if such condition is covered by the Plan;
- (b) Genetic information, in the absence of a diagnosis of a condition related to such information;
- (c) A covered newborn dependent child who, as of the last day of the 30-day period beginning with the date of birth, is covered under Creditable Coverage; or

(d) A covered adopted dependent child under the age of 18, who, as of the last day of the 30-day period beginning on the date of adoption or placement for adoption, is covered under Creditable Coverage (except this shall not apply to coverage the adopted child may have had before such adoption or placement).

Exceptions (c) and (d) above shall not apply to an individual after the end of the first consecutive 90-day period during all of which the individual was not covered under any Creditable Coverage.

SCHEDULE OF BENEFITS

PLANS 101 AND 105

Plan 101 offers medical, hearing, dental, and vision benefits for members and their families.

Plan 105 is an employee-only plan identical to Plan 101. In order to enroll in Plan 105, you must verify you are single and have no dependents or that your dependents have other coverage. If you acquire dependents or if any of your dependents lose other coverage, you must notify the Trust Administrative Office in writing within 60 days.

Medical Benefits

	Plan 101 (Family)		Plan 105 (Member Only)	
Calendar Year Deductible	<u>PPO</u> \$250 Individual \$500 Family	<u>Non-PPO</u> \$500 Individual \$1,000 Family	<u>PPO</u> \$250	<u>Non-PPO</u> \$500
Plan's Reimbursement (applies to all Allowable Expenses, unless otherwise noted)	<u>PPO</u> 80% of the Allowable Expense until the Out-of-Pocket Limit is reached; 100% of the Allowable Expense thereafter, for the remainder of the calendar year	<u>Non-PPO</u> 60% of the Allowable Expense until the Out-of-Pocket Limit is reached; 100% of the Allowable Expense thereafter, for the remainder of the calendar year	<u>PPO</u> 80% of the Allowable Expense until the Out-of-Pocket Limit is reached; 100% of the Allowable Expense thereafter, for the remainder of the calendar year	<u>Non-PPO</u> 60% of the Allowable Expense until the Out-of-Pocket Limit is reached; 100% of the Allowable Expense thereafter, for the remainder of the calendar year
Out-of-Pocket Limit (does not include the deductible)	<u>PPO</u> \$1,000 Individual \$2,000 Family	<u>Non-PPO</u> \$2,000 Individual \$4,000 Family	<u>PPO</u> \$1,000	<u>Non-PPO</u> \$2,000
Lifetime Maximum Benefit (medical and prescription drugs combined)	\$1,000,000 per person while covered under the Plan		\$1,000,000 while covered under the Plan	
Penalty for Non-precertification	\$400 Hospital \$200 Medical Procedure		\$400 Hospital \$200 Medical Procedure	
Pre-admission Testing Benefit	100% of the Allowable Expense		100% of the Allowable Expense	
Mental/Nervous	Inpatient: Up to 30 days per year Outpatient: Constant 80% of the Allowable Expense up to 30 visits per year		Inpatient: Up to 30 days per year Outpatient: Constant 80% of the Allowable Expense up to 30 visits per year	
Alcohol/Drug Abuse Treatment	Maximum of \$11,350 every 2 consecutive calendar years, \$22,700 while covered under the Plan		Maximum of \$11,350 every 2 consecutive calendar years, \$22,700 while covered under the Plan	

	Plan 101 (Family)	Plan 105 (Member Only)
Hearing/Audio Services	Maximum of \$1,150 every 3 consecutive years, not subject to the deductible	Maximum of \$1,150 every 3 consecutive years, not subject to the deductible
Routine Wellness Exams (covers exam, vaccinations, and immunizations)	100% of the Allowable Expense up to a \$350 maximum benefit, not subject to the deductible ...every 3 calendar years for ages 5 to 40 ...every 2 calendar years for ages 41 to 50 ...every calendar year age 51 and over	100% of the Allowable Expense up to a \$350 maximum benefit, not subject to the deductible ...every 3 calendar years for ages 5 to 40 ...every 2 calendar years for ages 41 to 50 ...every calendar year age 51 and over
Routine Mammograms	Every calendar year over age 35	Every calendar year over age 35
Routine Pap Smears	Every calendar year	Every calendar year
Routine Prostate Specific Antigen Tests	Every calendar year over age 40	Every calendar year over age 40
Skilled Nursing Facility	100% of the Allowable Expense, subject to the deductible	100% of the Allowable Expense, subject to the deductible
Outpatient Ambulatory Surgical Facility	<u>PPO</u> : 100% of the Allowable Expense <u>Non-PPO</u> : 80% of the Allowable Expense until the Out-of-Pocket Limit is reached; 100% of the Allowable Expense thereafter, for the remainder of the calendar year	<u>PPO</u> : 100% of the Allowable Expense <u>Non-PPO</u> : 80% of the Allowable Expense until the Out-of-Pocket Limit is reached; 100% of the Allowable Expense thereafter, for the remainder of the calendar year
Treatment of Spinal Disorders	Maximum of \$1,000 per calendar year	Maximum of \$1,000 per calendar year
Donor Benefit	Maximum of \$5,000 per occurrence	Maximum of \$5,000 per occurrence
Self-inflicted Injuries or Sicknesses, as a Result of Attempted Suicide	\$25,000 lifetime maximum while covered under the Plan	\$25,000 lifetime maximum while covered under the Plan
Non-Emergency Services obtained outside the US	\$150,000 lifetime maximum benefit per person while covered under the Plan, including treatment of complications	\$150,000 lifetime maximum benefit per person while covered under the Plan, including treatment of complications

The Calendar Year Deductible is the amount you pay for Allowable Expenses each year before the Plan starts to pay benefits. In the event of a common accident involving 2 or more family members, only 1 deductible is required.

The Out-of Pocket Limit is the maximum amount you pay for Allowable Expenses in a calendar year, not including your deductible. Plan 101 and

Plan 105 pay 80% of most Allowable Expenses. You usually pay 20%. When your Out-of-Pocket expenses total \$1,000 for one person or \$2,000 for the family, the Plan pays 100% of most Allowable Expenses for the rest of the calendar year. Certain expenses are not credited to the Out-of-Pocket Limit and the Plan will not pay these expenses at 100% after the Out-of-Pocket Limit is reached.

For a definition of Allowable Expense, see page B-82.

For information regarding the PPO Provisions, see page B-32.

Prescription Drug Benefits

	Plan 101 (Family)	Plan 105 (Member Only)
Plan's Reimbursement	75% until the Rx Out-of-Pocket Limit is reached; 100% of the Allowable Expense thereafter, for the remainder of the calendar year	75% until the Rx Out-of-Pocket Limit is reached; 100% of the Allowable Expense thereafter, for the remainder of the calendar year
Prescription Drug (Rx) Out-of-Pocket Limit	\$1,000 per person	\$1,000

The Prescription Drug Out-of-Pocket Limit is the maximum amount you pay for Allowable Expenses for prescription drugs in a calendar year. It is separate from the Out-of-Pocket Limit for medical expenses. Plan 101 and Plan 105 pay 75% of most Allowable Expenses for prescription drugs. You usually pay 25%. When your Out-of-Pocket expenses total \$1,000 for one person, the Plan pays 100% of most Allowable Expenses for the rest of the calendar year.

Non-network pharmacy prescriptions will not apply to your Out-of-Pocket Limit and the Plan will not pay these expenses at 100% after the Out-of-Pocket Limit is reached. If you obtain a prescription in an area with no network providers nearby (within a 25-mile radius from where the prescription is obtained), you must pay for the prescription yourself and then you may submit the claim to Zenith Administrators to be processed under the medical plan.

Lifetime Maximum Benefit for Medical and Prescription Drug

The maximum benefit for one person for all covered medical and prescription drug expenses is \$1,000,000 while covered under the Plan. At the end of each calendar year, up to \$5,000 of the Lifetime Maximum is automatically restored, regardless of your physical condition.

Dental Benefits

	Plan 101 (Family)	Plan 105 (Member Only)
Calendar Year Deductible	\$50 Individual \$100 Family	\$50
Preventive	100% of the Allowable Expense (no deductible)	100% of the Allowable Expense (no deductible)
Restorative	85% of the Allowable Expense	85% of the Allowable Expense
Prosthetic	50% of the Allowable Expense	50% of the Allowable Expense
Orthodontic (for dependent children only)	50% of the Allowable Expense, up to \$500 per year, \$1,000 while covered under the Plan; not subject to the deductible	No coverage
Calendar Year Maximum Benefit	\$1,500 per person	\$1,500

Vision Benefits

	Plan 101 (Family)		Plan 105 (Member Only)	
Deductible (applies to lenses and frames only)	\$25 Individual		\$25	
Frequency of Service Exam	Every 12 months		Every 12 months	
Lenses	Every 12 months		Every 12 months	
Frames	Every 24 months		Every 24 months	
Contacts*	Every 12 months		Every 12 months	
Reimbursement Exam	<u>PPO</u> 100%	<u>Non-PPO</u> \$45	<u>PPO</u> 100%	<u>Non-PPO</u> \$45
Lenses				
Single Vision	100%	\$45	100%	\$45
Lined Bifocal	100%	\$65	100%	\$65
Lined Trifocal	100%	\$85	100%	\$85
Frame	\$120*	\$47	\$120*	\$47
Contacts*	\$170	\$170	\$170	\$170

*If you choose contacts instead of glasses.

PLANS 102 AND 103

Plans 102 and 103 offer reduced benefits for members and families with other health coverage. These plans are designed to provide close to 100% coverage between the Trust benefits and your other health plan. In order to elect Plan 102 or Plan 103, you must verify that you and your dependents have other coverage. If you or any of your dependents lose other coverage, you must notify the Trust Administrative Office in writing within 60 days.

Medical Benefits

	Plan 102 (Family)	Plan 103 (Family)
Calendar Year Deductible	None	None
Plan's Reimbursement	20% of the Allowable Expense	30% of the Allowable Expense
Out-of-Pocket Limit	None	None
Maximum Benefit (medical and prescription drugs combined)	\$10,000 per Family per calendar year	\$15,000 per Family per calendar year
Penalty for Non-precertification	\$400 Hospital \$200 Medical Procedure	\$400 Hospital \$200 Medical Procedure
Pre-admission Testing Benefit	20% of the Allowable Expense	30% of the Allowable Expense
Mental/Nervous	Inpatient: Up to 30 days per year Outpatient: Up to 30 visits per year	Inpatient: Up to 30 days per year Outpatient: Up to 30 visits per year
Alcohol/Drug Abuse Treatment	Maximum of \$11,350 every 2 consecutive calendar years, \$22,700 while covered under the Plan	Maximum of \$11,350 every 2 consecutive calendar years, \$22,700 while covered under the Plan
Hearing/Audio Services	Maximum of \$1,150 every 3 consecutive years, not subject to the deductible	Maximum of \$1,150 every 3 consecutive years, not subject to the deductible
Routine Wellness Exams (covers exam, vaccinations, and immunizations)	20% of the Allowable Expense up to a \$350 maximum benefit, not subject to the deductible ...every 3 calendar years for ages 5 to 40 ...every 2 calendar years for ages 41 to 50 ...every calendar year age 51 and over	30% of the Allowable Expense up to a \$350 maximum benefit, not subject to the deductible ...every 3 calendar years for ages 5 to 40 ...every 2 calendar years for ages 41 to 50 ...every calendar year age 51 and over
Routine Mammograms	Every calendar year over age 35	Every calendar year over age 35
Routine Pap Smears	Every calendar year	Every calendar year

	Plan 102 (Family)	Plan 103 (Family)
Routine Prostate Specific Antigen Tests	Every calendar year over age 40	Every calendar year over age 40
Skilled Nursing Facility	20% of the Allowable Expense	30% of the Allowable Expense
Outpatient Ambulatory Surgical Facility	20% of the Allowable Expense	30% of the Allowable Expense
Treatment of Spinal Disorders	Maximum of \$1,000 per calendar year	Maximum of \$1,000 per calendar year
Donor Benefit	Maximum of \$5,000 per occurrence	Maximum of \$5,000 per occurrence
Self-inflicted Injuries or Sicknesses, as a Result of Attempted Suicide	\$25,000 lifetime maximum while covered under the Plan	\$25,000 lifetime maximum while covered under the Plan
Non-Emergency Services obtained outside the US	\$150,000 lifetime maximum benefit per person while covered under the Plan, including treatment of complications	\$150,000 lifetime maximum benefit per person while covered under the Plan, including treatment of complications

For a definition of Allowable Expense, see page B-82.

Prescription Drug Benefits

	Plan 102 (Family)	Plan 103 (Family)
Plan's Reimbursement	20% of the Allowable Expense	30% of the Allowable Expense
Prescription Drug Out-of-Pocket Limit	None	None
Maximum Benefit (medical and prescription drugs combined)	\$10,000 per calendar year	\$15,000 per calendar year

Dental Benefits

	Plan 102 (Family)	Plan 103 (Family)
Calendar Year Deductible	\$50 Individual \$100 Family	None
Preventive	100% of the Allowable Expense (no deductible)	25% of the Allowable Expense
Restorative	85% of the Allowable Expense	25% of the Allowable Expense
Prosthetic	50% of the Allowable Expense	25% of the Allowable Expense
Orthodontic (for dependent children only)	50% of the Allowable Expense, up to \$500 per year, \$1,000 while covered under the Plan; not subject to the deductible	25% of the Allowable Expense, up to \$500 per year, \$1,000 while covered under the Plan
Calendar Year Maximum Benefit	\$1,500 per person	\$750 per person

Vision Benefits

	Plan 102 (Family)		Plan 103 (Family)	
Deductible (applies to lenses and frames only)	\$25 Individual		None	
Frequency of Service Exam	Every 12 months		Every 12 months	
Lenses	Every 12 months		N/A	
Frames	Every 24 months		N/A	
Contacts*	Every 12 months		N/A	
Reimbursement Exam	<u>PPO</u> 100%	<u>Non-PPO</u> \$45	<u>PPO</u> 100%	<u>Non-PPO</u> \$45
Lenses				
Single Vision	100%	\$45	N/A	N/A
Lined Bifocal	100%	\$65	N/A	N/A
Lined Trifocal	100%	\$85	N/A	N/A
Frame	\$120*	\$47	N/A	N/A
Contacts*	\$170	\$170	N/A	N/A

*If you choose contacts instead of glasses.

UTILIZATION MANAGEMENT PROVISIONS

In order to provide cost effective health coverage, the Plan contains the following Utilization Management Provisions:

- Hospital Confinement Review
- Medical Procedure Review
- Case Management
- Preadmission Testing Benefits

Note: We encourage you to read these provisions thoroughly. In some cases, the Plan provides more favorable benefits if you follow the Utilization Management Provisions. In some instances, less favorable benefits are provided if the Utilization Management Provisions are not used.

HOSPITAL CONFINEMENT REVIEW (PRECERTIFICATION)

The Plan requires review of all Hospital and Treatment Center Confinements. **It is your responsibility to initiate the Hospital review.** If your Hospital Confinement is not reviewed according to these procedures, your benefits will be reduced.

Effect on Benefits

1. Reviewed and Certified: Allowable Expenses for Hospital Confinements which are certified by Qualis Health (or by the participant's primary health plan) as Medically Necessary will be considered according to Plan provisions.
2. Not Reviewed: If the Hospital Confinement is not reviewed timely (see Rules for a Hospital Review, below), any benefits payable for that period of Hospital Confinement will be reduced by \$400. No benefits will be payable unless the services are Medically Necessary and all other Plan requirements are satisfied.
3. Reviewed and Not Certified: If the Hospital Confinement is reviewed timely, but inpatient care is not certified as Medically Necessary:
 - Benefits for Hospital room and board will not be payable; and
 - Expenses for other covered Hospital services will be considered according to Plan provisions.

When benefits are reduced in accordance with 2 or 3 above, the:

- \$400 reduction for unreviewed Confinements; or

- Hospital expenses for services which are not Medically Necessary; will not be used to satisfy your deductible or Out-of-Pocket Limit.

Certification does not automatically mean benefits are payable. No benefits will be payable for services which are not Medically Necessary or are not covered by the Plan. PPO provisions may apply.

Rules for a Hospital Review

1. For a Non-emergency Admission. You or your Physician must notify Qualis Health by phone *prior to* the scheduled Hospital admission. Qualis Health will send you, the Physician, and the Hospital written notice of certification or non-certification of the Hospital admission. Please allow sufficient time to process your Hospital review – do not wait until the last minute to contact Qualis Health.
2. For an Emergency Admission or Childbirth. You or the attending Physician must notify Qualis Health by phone *no later than the second business day following admission.* Qualis Health will send you, the Physician, and the Hospital written notice of certification or non-certification of the Hospital admission.
3. For Continued Confinement. If your Physician is considering lengthening your Hospital stay past the period which was originally certified, you, your Physician or the Hospital must call Qualis Health to request certification of the additional days.

Exception

These provisions will not apply when Medicare or another health plan has primary responsibility for the patient's claims.

MEDICAL PROCEDURE REVIEW PROGRAM (PRECERTIFICATION)

It is your responsibility to initiate the Medical Procedure Review. If your medical procedure is not reviewed according to these procedures, your benefits will be reduced.

Medical Procedures which MUST be Reviewed

- Carpal Tunnel Release – surgery to relieve a pinched nerve in the hand;
- Colonoscopy – examination of the bowel by inserting a tube into the rectum;
- Hemorrhoidectomy – surgical removal of hemorrhoids;
- Hyperbaric Oxygen Chamber treatment;

- Knee Arthroscopy (Diagnostic and Repair) – an examination of the inside of the knee;
- Pelvic Laparoscopy – examination of female organs by a scope;
- Reduction Mammoplasty – surgical removal of breast tissue to decrease the size of the breasts;
- Upper Gastrointestinal Endoscopy – an examination of the stomach by inserting a tube down the throat;
- Uvulopharyngoplasty (UPPP) – plastic reconstruction of the palate.

Effect on Benefits

1. Reviewed and Certified: Allowable Expenses for medical procedures which are certified by Qualis Health (or by the participant's primary health plan) as Medically Necessary will be considered according to Plan provisions.
2. Not Reviewed: If the medical procedure is not reviewed timely (see Rules for a Medical Procedure Review, below), any benefits payable for that procedure (including related covered expenses) will be reduced by \$200. No benefits will be payable unless the services are Medically Necessary and all other Plan requirements are satisfied.
3. Reviewed and Not Certified: If the medical procedure is reviewed timely, but is not certified as Medically Necessary, benefits for all Hospital, surgical, medical and other related services will not be payable.

When benefits are reduced in accordance with 2 or 3 above, the:

- \$200 reduction for each unreviewed procedure; or
- expenses for services which are not Medically Necessary;

will not be used to satisfy your deductible or Out-of-Pocket Limit.

Certification does not automatically mean benefits are payable. No benefits will be payable for services which are not Medically Necessary or are not covered by the Plan. PPO provisions may apply.

Rules for Medical Procedure Review

1. For a Non-emergency Medical Procedure. You or your Physician must notify Qualis Health by phone *prior to* the scheduled procedure. Qualis Health will send you, the Physician, and the Hospital written notice of certification or non-certification of the

procedure. Please allow sufficient time to process your review – do not wait until the last minute to contact Qualis Health.

2. For an Emergency Medical Procedure. You or the attending Physician must notify Qualis Health by phone *no later than the second business day following the day the procedure was performed.* Qualis Health will send you, the Physician, and if applicable, the facility, written notice of certification or non-certification of the procedure.

Exception

These provisions will not apply when Medicare or another health plan has primary responsibility for the patient's claims.

CASE MANAGEMENT PROGRAM

If you have injuries or illness that may extend for some time, the Plan provides for services through case management. For example, if you are facing an extended period of care or treatment and these services may be accomplished in a skilled nursing facility, or in your home, the case management program may be helpful in facilitating and coordinating this care. This can be beneficial to you because these settings may offer cost savings as well as other advantages to you and your family.

When reviewing claims for the case management program, the case management provider always works with you, your family, and your Physician so you receive close, personal attention.

Through case management, the case management provider can consider recommendations involving expenses usually not covered for reimbursement. This includes suggestions to use alternative medical management techniques or procedures, or suggestions for cost-effective use of existing Plan provisions such as home health care and convalescent facilities. In order to be considered for payment under the Plan, the alternative care must result in savings without detracting from the quality of care. All parties must approve alternate care before it is provided.

Case management is voluntary. There is no penalty for not participating in case management or for leaving the program during its course.

Examples of conditions that may qualify for case management include, but are not necessarily limited to:

- Amputations;
- Burns;
- Cancer;
- Central nervous system diseases;
- Chronic Infections;

- Chronic pulmonary diseases and conditions;
- Coagulation defects;
- Coma;
- Diabetes;
- Immune disorders;
- Intestinal disorders;
- Multiple fractures;
- Organ transplants;
- Paralysis;
- Radical surgeries;
- Renal diseases;
- Spinal cord injuries;
- Stroke;
- Tumors;
- Any confinement exceeding 30 days; and
- Conditions or injuries requiring substantial medical resources over a long period of time or those where another cost effective alternative may be available.

If you have questions regarding case management and its possible application to you, call the Trust Administrative Office.

PREADMISSION TESTING BENEFITS

If you or your dependent receives preadmission tests, the Plan will pay the Allowable Expenses according to the Schedule of Benefits.

Conditions

Benefits will only be payable under the Preadmission Testing Benefit if:

- Your Physician determines that Hospital Confinement is required, before the tests are performed;
- The tests would be covered if performed during Hospital Confinement;
- The tests are performed:
 - On an outpatient basis;
 - Within 7 days of admission as an inpatient; and
 - In connection with a covered Hospital Confinement; and
- The Hospital where the covered person is confined:
 - Accepts the preadmission testing in lieu of tests which would have been performed during Hospital Confinement; and
 - Does not repeat the tests upon admission, unless your medical record shows both:
 - ✓ The results of the preadmission tests; and
 - ✓ That repeated tests are Medically Necessary.

PREFERRED PROVIDER ORGANIZATION (PPO) PROVISIONS

When you or your dependents require health care, you may choose any Physician, Hospital or other health care provider you wish. If you use the services of a preferred provider, however, you may receive a discounted rate for services and Plan benefits may be more favorable. Regardless of the provider you choose, benefits will be subject to all terms, conditions, and limitations of the Plan. The Plan does not supervise, control, or guarantee the health care services of any provider (Preferred or Non-Preferred).

HOSPITAL AND PHYSICAL THERAPY PPO WITHIN THE MUNICIPALITY OF ANCHORAGE

Alaska Regional Hospital is the preferred Hospital within the Municipality of Anchorage for both inpatient and outpatient services. Chugach Physical Therapy is the preferred provider within the Municipality of Anchorage for physical therapy services. Through the Health Care Cost Management Corporation, Public Employees Local 71 is able to get substantial discounts at these providers, which reduces overall health costs for our members while maintaining high standards of care. If you are in Plans 101 or 105, it's important that you use the preferred providers within the Municipality of Anchorage. **If you use a non-preferred provider for physical therapy or inpatient or outpatient Hospital services within the Municipality of Anchorage, you will be subject to a lower reimbursement percentage, as well as increased deductibles and out-of-pocket limits.** Members in Plans 102 and 103 are encouraged to use the preferred providers, but will incur no penalties for noncompliance.

Description	PPO and Out-of-Area Benefit	Non-PPO Benefit
% Payable	80% (100% at outpatient surgery center)	60% (80% at outpatient surgery center)
Deductible per Year Individual Family	\$250 \$500	\$500 \$1,000
Out-of-Pocket Limit per Year Individual Family	\$1,000 \$2,000	\$2,000 \$4,000

*Out of area means any area outside of the Municipality of Anchorage.

If you use a provider for in- or outpatient services within the Municipality of Anchorage other than Alaska Regional Hospital or Chugach Physical

Therapy, your Allowable Expenses will be the amount that would have been charged by Alaska Regional or Chugach Physical Therapy. For non-PPO services within the Municipality of Anchorage, the Allowable Expense for inpatient Hospital services will be limited to the Contracted Rate at the preferred provider Hospital. The Allowable Expenses for outpatient Hospital charges at a non-PPO provider within the Municipality of Anchorage will be the case rate at the preferred provider Hospital, if any, or 50% of the billed charges. Any amount charged in excess of the Allowable Expense will be your responsibility and will not apply to your annual Out-of-Pocket Limit. See the example below for a comparison.

Example

The following example assumes the charges at a non-PPO Hospital are greater than the charges at the PPO. The most important number is your "out-of-pocket expense."

Example: Claims Comparison of a PPO vs. non-PPO Claim within the Municipality of Anchorage

	<u>PPO</u>		<u>Non PPO</u>
AK Regional Hospital Bill	\$15,000	Non PPO Hospital Bill	\$30,000
Less Non-covered Expense	-\$0	Less Non-covered Expense	-\$15,000
Equals Covered Expense	\$15,000	Equals Covered Expense at PPO Hospital	\$15,000
Less Deductible	-\$250	Less Non-PPO Deductible	-\$500
Equals	\$14,750	Equals	\$14,500
Multiplied by % Payable 80% to maximum out-of-pocket 100% of remainder		Multiplied by % Payable 60% to maximum out-of-pocket 100% of remainder	
Equals Total Payment Made	\$13,750	Equals Total Payment Made	\$12,500
Your Out-of-Pocket Expense (Total Hospital bill less payment made by the Plan)	\$1,250	Your Out-of-Pocket Expense (Total Hospital bill less payment made by the Plan)	\$17,500

Exceptions

No penalty will be assessed for emergency services at a non PPO emergency facility; however the patient must be transferred to a preferred provider as soon as medically possible. Services incurred after the patient is able to be transferred will be subject to non-PPO reimbursement. No penalty will be assessed for services unavailable at a PPO or for services performed in your doctor's office, with your doctor's

staff, using your doctor's equipment. Penalties for services at a non-PPO provider apply only within the Municipality of Anchorage.

NATIONWIDE BEECH STREET PPO

Beech Street is the nationwide Preferred Provider Organization (PPO) network for your Plan. The network includes Hospitals, Physicians, and specialty providers nationwide so you have a wide selection of network providers available. Through Beech Street you will also have access to the First Choice network, with a variety of providers in the Pacific Northwest. *You are not required to use network providers if you obtain services outside the Municipality of Anchorage, but by utilizing the Beech Street/First Choice network, you will save yourself and the Trust money.*

Please note: The Beech Street PPO network is separate from and in addition to the Alaska Regional Hospital and Chugach Physical Therapy preferred provider arrangements within the Municipality of Anchorage. Within the Municipality of Anchorage, the Plan's reimbursement will be reduced if a provider other than Alaska Regional Hospital or Chugach Physical Therapy is used for services available through these providers, even if the provider is in the Beech Street/First Choice network.

COVERED MEDICAL EXPENSES

The Plan provides extensive and valuable benefits for you and your eligible dependents. Benefits are available for Medically Necessary services and supplies needed to diagnose, care for, or treat a physical or medical condition. The service or supply must be widely accepted professionally in the United States as effective, appropriate and essential, based upon recognized standards of the health care specialty involved.

Services that are NOT considered Medically Necessary are:

- Services rendered by a provider but not requiring the technical skills of the provider;
- Services and supplies furnished mainly for the personal comfort or convenience of the patient, care provider or family member;
- Services and supplies furnished solely because the individual is an inpatient on a day on which the physical or mental condition could safely and adequately be diagnosed or treated while not confined; or
- Any part of the cost for services or supplies exceeding that of any other service or supply that would have been sufficient to safely and adequately diagnose or treat the patient.

PHYSICIAN'S SERVICES

The Plan pays for covered medical treatment and surgery performed by a qualified Physician. Physician's services include any sterilization procedure and oral surgical procedures which are covered under the Plan.

HOSPITALIZATION

Remember to precertify any Hospital admission. The lack of Hospital Confinement review may result in a reduction of your benefits. See page B-27 for more information.

The Plan covers Hospital room and board charges only while you are necessarily confined as a registered bed patient and under the care of a Physician. Coverage includes room, board, general duty nursing, intensive care and other services regularly rendered by the Hospital to its occupants, but does not include private duty or special nursing services rendered outside of an intensive care unit. You must pay the difference in charges between a private room and a semiprivate room, unless the Plan determines a private room is Medically Necessary.

The Plan also provides for Hospital services and supplies, those charges made by a Hospital on its own behalf for necessary medical services and

supplies actually administered during Hospital Confinement other than for room and board, intensive care unit, private duty nursing, or physicians' services. Services of a personal nature, including radio, television, and guest trays are not included.

HOME HEALTH CARE

The Plan pays for the charges of a Home Health Care Agency for services and supplies furnished to you at home for care in accordance with a home health care plan.

A home health care plan provides for the treatment of disease or Injury in a place of confinement other than a Hospital or skilled nursing facility. The attending Physician must prescribe care and treatment in writing. Treatment may include:

- Part-time or intermittent nursing care by a registered graduate nurse (RN) or by a licensed practical nurse (LPN);
- Part-time or intermittent home health aide services which consist primarily of caring for the patient;
- Physical, occupational, or speech therapy;
- Medical supplies, drugs and medicines prescribed by a Physician if they would have been covered if the patient had been confined in a Hospital or skilled nursing facility; and
- Laboratory services provided by or on behalf of a Home Health Care Agency if they would have been covered had the patient been confined in a Hospital or skilled nursing facility.

Up to 120 home health care visits to your home are covered in any one calendar year. Visits by a registered graduate nurse (RN) or licensed practical nurse (LPN) to provide skilled nursing care, visits from therapists to provide physical, occupational, or speech therapy, and up to 4 hours of assistance by a home health aide are considered as one visit.

Non-covered home health care expenses are:

- Services or supplies not included in the home health care plan;
- Services of a person who ordinarily resides in your home, or is a member of your family or the family of your spouse;
- Services of any social worker; and
- Transportation services.

SKILLED NURSING CARE

The Plan pays for charges by a registered nurse (RN), licensed practical nurse (LPN), or nursing agency for skilled care.

Covered services are:

- Visiting nursing care of an RN or LPN of not more than 2 hours to perform specific skilled nursing tasks; and
- Private duty nursing by an RN or LPN if your condition requires skilled nursing services and visiting nursing care is inadequate.

Non-covered services are:

- Nursing care that does not require the skills of an RN; and
- Care given in a health care facility that could safely and adequately be furnished by the facility's general staff if the facility were fully staffed.

SKILLED NURSING FACILITY

The Plan pays covered expenses according to the Schedule of Benefits, after the deductible, for charges of a skilled nursing facility while you are confined for recovery from a disease or Injury. A skilled nursing facility is a licensed institution providing the following on an inpatient basis for persons convalescing from disease or Injury:

- 24-hour professional nursing care by a registered nurse (RN) or a licensed practical nurse (LPN), if directed by a full-time RN;
- Physical restoration services to help a patient meet a goal of self-care in daily living activities;
- Full-time supervision by a Physician or RN;
- A complete medical record on each patient; and
- A utilization review plan;

It is not an institution for rest, the aged, drug addicts, alcoholics, mentally retarded, or care of mental disorders.

Specifically covered are:

- Room and board, including charges for services, such as general nursing care in connection with room occupancy, except charges for daily room and board in a private room exceeding the facility's semiprivate room rate;
- Use of special treatment rooms, x-ray and laboratory examinations; physical, occupational or speech therapy; oxygen and other gas

therapy; and other medical services that a skilled nursing facility customarily provides, except private duty or other special nursing services or Physician's services; and

- Medical supplies.

OUTPATIENT AMBULATORY SURGICAL FACILITY

The Plan pays covered expenses according to the Schedule of Benefits for same day ambulatory surgery with no deductible if you are an outpatient. The surgery must take place in a freestanding surgical facility or outpatient department of a Hospital.

NURSE MIDWIFE SERVICES

The Plan pays for covered services during pregnancy, childbirth, and the period following childbirth if performed by a state certified nurse midwife or registered midwife acting within the authorized scope of practice.

PRESCRIPTION DRUG BENEFITS

When you or your dependents require drugs and medicine requiring a Physician's written prescription, you may choose any pharmacist you wish. However, you are encouraged to use a pharmacy in the pharmacy network.

Retail Prescriptions

The Plan uses the Caremark retail pharmacy network. You may obtain up to a 30-day supply of medication at one time at a retail pharmacy.

If you visit a participating network pharmacy and present your prescription drug card, your claim will be processed when your prescription is dispensed and you will only be responsible for your coinsurance.

If you don't use your prescription drug card or if you purchase your prescription from a non-network pharmacy, you must pay for the prescription yourself and you may submit a claim to Caremark. Non-network pharmacy prescriptions will not apply to your copay maximum. The Allowable Expense for the prescription will be the participating network pharmacy rate.

If you obtain a prescription in an area with no network providers nearby (within a 25-mile radius from where the prescription is obtained), you must pay for the prescription yourself and then you may submit the claim to Zenith Administrators to be processed under the medical benefit.

For a list of participating network pharmacies, please contact the Trust Administrative Office. Regardless of the provider you choose, benefits will

be subject to all Plan terms, conditions, and limitations. The Plan does not supervise, control, or guarantee the services of any prescription drug provider.

Mail Order Prescriptions

The Plan uses Walgreens Mail Service for mail order prescriptions. If your Physician orders more than a 30-day supply of medication or you are taking the same medication on a regular basis, you can order your prescriptions by mail and obtain up to a 100-day supply.

If your Physician is prescribing a medication you will be taking over an extended period of time (more than 30 days), have your Physician write one prescription for your immediate needs (30 days or less) to be filled locally and the second for you to submit to the mail order provider.

Contact the Trust Administrative Office for a mail order form.

Types of Drugs Covered

- Brand name prescription drugs;
- Generic prescription drugs;
- Insulin; and
- Diabetic supplies:
 - Needles and syringes;
 - Lancets; and
 - Test tablets, sticks, tapes and strips.

Prescription drugs are medical substances which cannot be dispensed in the United States without a prescription.

A generic prescription drug is:

- Produced and sold under the chemical name or shortened version;
- Approved by the US Food and Drug Administration as safe and effective;
- Produced after the original patent expires;
- Produced by a company different from the one that first patented the chemical formulation; and
- Priced less than the product produced by the company that first patented the formulation.

RADIATION, X-RAYS AND LABORATORY TESTS

The Plan covers radium treatments, diagnostic x-rays, lab tests, radioactive isotope treatments and TENS therapy and analysis if you have specific symptoms, whether in- or outpatient.

REHABILITATIVE CARE

The Plan covers inpatient or outpatient rehabilitative care designed to restore and improve bodily functions lost due to Injury and illness. Such care is considered Medically Necessary only if significant improvement in bodily function is occurring and is expected to continue. The Plan also covers care (excluding speech therapy) aimed at slowing deterioration of body functions caused by neurological disease.

Rehabilitative care includes:

- Physical therapy and occupational therapy;
- Speech therapy if existing speech function (the ability to express thoughts, speak words, and form sentences) has been lost and the speech therapy is expected to restore the level of speech the individual had attained before the onset of the disease or Injury; and
- Rehabilitative counseling or other help needed to return the patient to activities of daily living but excluding maintenance care or educational, vocational or social adjustment services.

Rehabilitative care must be part of a formal written program of services consistent with your condition. Your Physician or therapist must submit a statement to the claim payor outlining the goals of therapy, type of program and frequency and duration of therapy.

ANESTHETIC

The Plan covers the cost of anesthetic and its administration. This includes injections of muscle relaxants, local anesthesia and steroids. When billed by a Hospital or Physician, the services of an anesthesiologist are covered.

PREGNANCY

Pregnancy and childbirth are covered like any other medical condition while you are covered under the Plan.

If you or your dependent are confined to a Hospital as a resident inpatient for childbirth, the Plan will pay benefits in the same manner and subject to the same conditions and limitations as any other Sickness, but in no event will benefits be less than:

- 48 hours following a vaginal delivery; or

- 96 hours following a cesarean section;

for the mother and the newborn infant(s), unless the attending Physician, in consultation with the mother, recommends an earlier discharge.

Miscarriage and other pregnancy problems are covered only if you are eligible at the time they occur. If you are totally disabled as a result of a pregnancy problem and your coverage ends, you may be eligible for extended benefits. See the "Disabled Employees or Dependents" section on page B-67. You may also be eligible for COBRA Continuation Coverage described under the section of this booklet entitled, "How to Continue Health Coverage" beginning on page B-60.

BENEFITS FOLLOWING MASTECTOMY

After a mastectomy for which benefits are paid by this Plan, the Plan will cover:

- The cost and fitting of external breast prostheses, to restore and achieve symmetry for the patient, but not more than 2 prostheses in any calendar year for each breast;
- Inpatient or outpatient chemotherapy; and
- Reconstructive breast surgery on the diseased breast or on the nondiseased breast to achieve symmetry.

SUPPLIES

When Medically Necessary, the Plan covers supplies prescribed by a Physician, including:

- Drugs and medicines requiring a Physician's written prescription;
- Artificial limbs and eyes;
- Bandages and surgical dressings;
- Orthopedic shoes, once per year, for certain medical conditions;
- Purchase or rental (up to purchase price) of automatic repositioning appliances, eyes, casts, splints, trusses, braces, crutches and other similar durable medical or mechanical equipment. Durable medical and mechanical equipment is that which bears repeated use. It primarily and customarily serves a medical purpose, is of little use to a healthy or uninjured person, and must be ordered or prescribed by a Physician.
- Rental (up to purchase price) or purchase of a wheelchair or hospital-type bed;

- Rental or purchase of mechanical equipment required for respiratory treatment;
- Blood transfusions, including the cost of blood and blood derivatives;
- Oxygen or rental of equipment for which benefits are paid under this Plan; and
- Cranial prosthesis required as a result of medical treatment causing the loss of hair. Benefits for a cranial prosthesis are limited to \$500 per person while covered under the Plan.

At its option, the Plan may purchase rather than rent medical equipment.

TRANSPORTATION BENEFITS

Emergency

If you have an emergency condition requiring immediate transfer to a Hospital with special facilities for treating your condition, your transportation expense will be covered by the Plan, as described in this section.

Non-Emergency

Non-emergency transportation is covered only if you have a condition which cannot be treated locally and the travel has been preauthorized.

Transportation benefits during any calendar year for a condition that cannot be treated locally are limited to:

- One visit and one follow-up visit for a condition requiring therapeutic treatment or surgery;
- One visit for prenatal or postnatal maternity care and one visit for the actual maternity delivery;
- One pre- or post-surgical visit and one visit for the surgical procedure; and
- One visit for each allergic condition.

If you require preoperative testing and surgery more than 100 miles from your home, food and lodging expenses outside of the Hospital are covered during the preoperative testing period, but only if you receive preauthorization. Please see the preauthorization procedures below.

Payment of Transportation Benefits

The Plan will pay the following benefits for emergency and preauthorized non-emergency travel expenses:

- Ambulance costs within the United States. This includes transportation to the nearest Hospital by professional ambulance. A professional

ambulance is a land or air vehicle specially equipped to transport injured or sick people to a destination capable of caring for them upon arrival. Specially equipped means that the vehicle contains the appropriate stretcher, oxygen and other medical equipment necessary for patient care en route. A medical technician trained in lifesaving services accompanies the transported patients.

- Round-trip transportation, not exceeding the cost of coach class commercial air transportation, from the site of the illness or injury to the nearest professional treatment. If you use ground transportation and the one-way distance exceeds 100 miles, the Plan pays your documented travel expenses while en route for fares, mileage, food and lodging for the most direct route. If you obtain services in a location other than the site of the nearest professional treatment, the maximum Allowable Expense will be the cost of travel to the site of the nearest professional treatment, as determined by the Plan.
- The maximum Allowable Expense for food and lodging is \$120 per day, or \$50 per day without overnight lodging. If a parent or legal guardian accompanies a child under age 18, the Plan will pay up to an additional \$50 per day. Allowable Expenses for mileage are calculated at the current IRS allowance for mileage.

If the patient is a child under 18 years of age or an incapacitated adult, a parent, legal guardian or other attendant's transportation charges are allowed, but must be preauthorized as described above. When authorized by the claim payor, transportation charges for a Physician or registered nurse are also covered.

Procedures for Preauthorization of Transportation Benefits

All non-emergency travel **must** be preauthorized. No Plan benefits can be paid without prior travel authorization. Contact Zenith Administrators for more information about travel preauthorization and to obtain a travel preauthorization form. The Plan may need to obtain additional information from your Physician. Once a decision has been made regarding coverage of your travel expenses, you will receive written confirmation. Travel benefits are subject to all Plan provisions, limitations and exclusions.

SERVICES OBTAINED OUTSIDE THE US

The Plan provides coverage for treatment of an emergency medical condition while traveling outside the US.

Coverage for non-emergency services obtained outside the US shall be limited to a maximum lifetime benefit of \$150,000. Should the treatment obtained outside the US result in complications, benefits for treatment of

those complications, whether incurred within or outside the US, will also be included in the \$150,000 lifetime maximum. The Trust shall determine whether a service or supply is considered treatment of a complication which should be included in the \$150,000 lifetime benefit maximum.

All other plan provisions continue to apply, including but not limited to Plan exclusions for experimental and investigational services and all internal benefit limitations.

ALCOHOLISM AND DRUG ABUSE BENEFITS

If you or your dependent, while covered under the Plan, incurs expense for Treatment of Alcoholism or Drug Abuse, benefits will be paid in the same manner as any other Sickness, but not to exceed the benefit maximums outlined in the Schedule of Benefits.

The maximum payable for any future benefits will be reduced by the amount of benefits that have been paid.

Alcoholism or Drug Abuse means an illness characterized by:

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

An approved treatment facility is one that is licensed by the state in which it is located, for treatment of Alcoholism or Drug Abuse.

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

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

Exceptions

Benefits will not be paid for:

- Any expense for which benefits are paid under any other provision of the Plan; or
- Anything excluded under the General Exclusions and Limitations starting on page B-49.

MENTAL AND NERVOUS DISORDERS

The Plan pays benefits for Mental and Nervous Disorders according to the Schedule of Benefits. The Plan covers both inpatient and outpatient treatment.

Benefits are not provided for adolescent behavior problems; learning disabilities; marital, family, sexual, or other counseling or training; Custodial Care; services after a court-ordered admission; or services which are not Medically Necessary.

Exception

The expense incurred for outpatient Mental and Nervous will not be used to satisfy the Out-of-Pocket Limit and will not be paid at 100% after the Out-of-Pocket Limit is reached.

TREATMENT OF SPINAL DISORDERS

This benefit applies to specific services to diagnose and treat:

- Misalignment or dislocation of the spine; and
- Strained muscles or ligaments related to the spinal disorder.

The services subject to the limit shown in the Schedule of Benefits are:

- Office visits;
- Examinations;
- Consultations; and
- Regional manipulations.

The limit applies regardless of whether the services are performed by an MD, chiropractor, osteopath or other provider.

The limit does not apply if you are confined as an inpatient in a Hospital.

MEDICAL TREATMENT OF MOUTH, JAWS AND TEETH

The plan covers medical conditions of the teeth, jaw and jaw joints as well as supporting tissues including bones, muscles and nerves. Medical services include:

- Hospital care to perform dental services if required due to an underlying medical condition;
- Surgery needed to treat wounds, cysts or tumors or to alter the jaw, jaw joint or bite relationships when appliance therapy alone cannot provide functional improvement;

- Nonsurgical treatment of infections or diseases not related to the teeth, supporting bones or gums;
- Dental implants if necessary due to disease or accident but only if dentures or bridges are inappropriate or ineffective. (False teeth for use with the implants are covered only under the Dental Plan as a Class III Prosthetic Service.);
- Services needed to treat accidental fractures or dislocations of the jaw or Injury to natural teeth. The teeth must have been damaged or lost other than in the course of biting or chewing and must have been free of decay or in good repair. Benefits will be first provided under the Dental Plan and then under the Medical Plan;
- Diagnosis, appliance therapy, nonsurgical treatment, and surgery by a cutting procedure which alters the jaw joints or bite relationship for temporomandibular joint disorder or similar disorder of the joint.

Myofunctional therapy is not covered. This includes muscle training or in-mouth appliances to correct or control harmful habits.

PHENYLKETONURIA (PKU) TREATMENT BENEFITS

If you or your dependent requires formulas necessary for the treatment of phenylketonuria (PKU), the Plan will pay the Allowable Expense incurred in the same manner and subject to the same conditions and limitations as for any other covered service.

ROUTINE WELLNESS BENEFITS

(For Participants age 5 years or older)

The maximum benefit is shown in the Schedule of Benefits. Services do not have to be incurred at one time, but may be spread throughout the period to which the maximum benefit is applied.

Physical Exams

If you have a routine physical exam in:

- A Hospital outpatient department; or
- A Physician's office or clinic;

the Plan will pay according to the Schedule of Benefits.

Exceptions

The Plan will not pay for:

- A routine physical exam performed while the covered person is confined as a resident patient in a Hospital;

- Any expense which is paid under any other provision of the Plan; or
- Anything excluded under the General Exclusions and Limitations, starting on page B-49.

Diabetes Education

The Plan will cover diabetes education under the Wellness Benefit.

ROUTINE MAMMOGRAPHY BENEFITS

If a covered person age 35 or older incurs expenses for a routine Mammogram, the Plan will pay the same as any other covered x-ray or laboratory service, but not to exceed one Mammogram each calendar year. Benefits will be payable without regard to age or any calendar year limit if:

- The covered person, the covered person's mother or the covered person's sister has a history of breast cancer; and
- The Mammogram is recommended by the covered person's Physician.

ROUTINE PAP SMEAR BENEFIT

The Plan covers one pap smear per year, and will pay the Allowable Expenses the same as any other covered x-ray or laboratory service. You must ask your Physician to isolate the pap smear charge from the total for the physical examination or routine office visit. Charges for the office visit or other incidental lab procedures in connection with a pap test are covered, subject to limitations under the Routine Wellness benefit.

ROUTINE PROSTATE SPECIFIC ANTIGEN (PSA) TESTING

Allowable Expenses for Prostate Specific Antigen (PSA) testing will be paid the same as any other covered x-ray or laboratory service.

AUDIO SERVICES

The Plan pays the Allowable Expenses according to the Schedule of Benefits.

The Plan covers:

- An ontological (ear) examination by a Physician or surgeon;
- An audiological (hearing) examination and evaluation by a certified or licensed audiologist, including a follow-up consultation;
- A hearing aid (monaural or binaural) prescribed as a result of the examination. This includes ear molds, hearing aid instrument, initial batteries, cords, and other necessary supplementary equipment as

well as warranty and follow-up consultation within 30 days following delivery of the hearing aid; and

- Repairs, servicing or alteration of hearing aid equipment.

You must provide written certification from the examining Physician, which explains you are suffering from a hearing loss that may be lessened by the use of a hearing aid.

Non-Covered Audio Services

The Plan does not pay for:

- Replacement of a hearing aid, for any reason, more than once in a 3-year period;
- Batteries or other supplementary equipment other than those obtained upon purchase of a hearing aid;
- A hearing aid exceeding the specifications prescribed for correction of hearing loss;
- Expenses incurred after coverage ends, unless you order a hearing aid before the termination of coverage and receive it within 90 days of the coverage end date; and
- Audio related services otherwise covered under the Medical Plan.

NON-COVERED MEDICAL EXPENSES

GENERAL EXCLUSIONS AND LIMITATIONS

The Plan will not cover:

- Any Injury or Sickness which arises out of or in the course of any employment with any employer or for which the covered person is entitled to benefits under any workers' compensation or occupational disease law, or receives any settlement from a workers' compensation carrier;
- Any expense which is in excess of the Allowable Expense;
- Services or supplies which are not Medically Necessary;
- Any expense incurred after coverage ends (except as specifically provided under any extended benefits provision of the Plan);
- Any loss, expense or charge in excess of \$25,000 which results, whether the covered person is sane or insane, from:
 - An intentionally self-inflicted Injury or Sickness; or
 - Suicide or attempted suicide.
- Any loss, expense or charge resulting from the covered person's participation in a riot or in the commission of a felony;
- Any expense or charge which the covered person does not have to pay;
- Custodial Care or Developmental Care;
- Cosmetic or Reconstructive Surgery, except for:
 - Expenses resulting from Injury;
 - reconstructive breast surgery necessary because of a mastectomy, including all states of one reconstructive breast reduction on the nondiseased breast to make it equal in size with the diseased breast following reconstructive surgery on the diseased breast;
 - for congenital anomalies when the patient has been covered under the Plan since birth;
- Adolescent behavior problems; learning disabilities; marital, family, sexual or other counseling or training; Custodial Care; services after a court-ordered admission;
- Appetite control, food addictions, eating disorders (except for documented cases of bulimia or anorexia that meet standard

diagnostic criteria as determined by the Plan, and present significant symptomatic medical problems) or any treatment of obesity (except for surgery to treat morbid obesity);

- Dental work, dental surgery or Oral Surgery (unless specifically provided; see page B-45), including:
 - Treatment or replacement of any tooth or tooth structure, alveolar process, abscess or disease of the periodontal or gingival tissue; or
 - Surgery or splinting to adjust dental occlusion;
- Treatment of jaw joint disorders (unless specifically provided);
- Sex transformation or any treatment related to sexual dysfunction;
- Promotion of fertility including, but not limited to:
 - Fertility tests;
 - Reversal of surgical sterilization; and
 - Any attempt to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization, and embryo transfer or any similar treatment or method;
- Chelation therapy except for acute arsenic, gold, mercury or lead poisoning;
- Services or supplies not provided in accord with generally accepted professional standards on a national basis;
- Services or supplies which:
 - Are considered Experimental or Investigational drugs, devices, treatments or procedures; or
 - Result from or relate to the application of such Experimental or Investigational drugs, devices, treatments or procedures;
- Any expense or charge which is primarily for the covered person's education, training or development of skills needed to cope with any Injury or Sickness;
- Acupuncture treatment, except when used in lieu of an anesthetic agent for covered surgery;
- Services or supplies which are provided or paid for by the federal government or its agencies, except for:
 - The Veterans Administration, when services are provided to a veteran for a disability which is not service-connected;

- Military Hospital or facility, when services are provided to a retiree (or dependent of a retiree) from the armed services;
- A group health plan established by a government for its own civilian employees and their dependents; or
- Medicaid, if required by a Medicaid assignment of benefits;
- Any loss, expense or charge which results from an act of declared or undeclared war or armed aggression;
- Any loss, expense, or charge:
 - Which is incurred while the covered person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country; and
 - For which any governmental body or its agencies are liable;
- Treatment of mental, neuropsychiatric and personality disorders, except as provided in the “Mental and Nervous Disorders” section;
- Eye refractions/visual analysis therapy or training relating to muscular imbalance of the eye (orthoptics) or the fitting of eye glasses;
- The fitting of hearing aids, except as described under the “Audio Benefits” section;
- Services or supplies not specifically listed as a covered benefit under the Plan; and
- Any expense or charge which is primarily for the covered person’s convenience or comfort or that of the covered person’s family, caretaker, Physician, or other medical provider.

DENTAL BENEFITS

The Plan provides benefits for preventive dental services and treatment of dental conditions. See the Schedule of Benefits for information about the Plan's deductibles, reimbursement percentages and benefit maximums.

COVERED DENTAL SERVICES

Class I Services – Preventive

The Dental Plan covers the following Class I services rendered by a Dentist (DDS or DMD):

- Oral examinations;
- Dental x-rays required for the diagnosis of a specific condition;
- Routine dental x-rays, but not more than one full mouth or series per year;
- Topical fluoride application (painting the surface of the teeth with a fluoride solution);
- Prophylaxis, including cleaning, scaling, and polishing, but not more than twice in a calendar year; and
- Dental sealants applied to the first and second molars, but only:
 - For your dependent who is less than age 19; and
 - When the teeth have not been treated with sealants for at least 4 years.

Class II – Restorative

The Dental Plan covers the following Class II services:

- Fillings of silver amalgam, silicate and plastic restoration;
- Repair of dentures and bridges;
- Palliative (alleviation of pain) emergency treatment;
- Extractions (removal of teeth);
- Endodontics (treatment of disease of the tooth pulp) including pulpotomy, pulp capping and root canal treatment;
- Space maintainers;
- Oral Surgery, including surgical extractions;
- Apicoectomy (surgical removal of a root tip); and
- Periodontic services (treatment of the supporting tooth structures).

Class III – Prosthetic

The Dental Plan covers the following Class III services:

- Inlays and onlays;
- Crowns;
- Bridges, fixed and removable; and
- Dentures, full and partial.

Class IV Services – Orthodontic

The Dental Plan pays for Orthodontic care, treatment, services and supplies according to the Schedule of Benefits. The Plan will not pay for orthodontia performed exclusively on primary teeth.

NON-COVERED DENTAL SERVICES

The Dental Plan does not provide benefits for:

- Services for congenital deformities or for purposes of improving personal appearance;
- Services that the Dentist is not licensed to perform;
- Charges that are higher than would have been charged if there were no Dental Plan;
- Service for dentures, bridges, crowns or other devices started before the effective date of coverage;
- Charges made after your coverage ends, unless they are for prosthetic devices fitted and ordered while you were covered and arriving within 90 days of the coverage end date;
- Services rendered after the end of coverage, even if you are in the course of an approved treatment plan;
- Charges of more than one Dentist for the same services in the same visit;
- Appliances or restorations necessary to increase vertical dimensions or restore or correct occlusions;
- Orthodontic care, treatment, services and supplies, except as provided under Class IV services;
- A denture replacement made less than 5 years after the last one was obtained, whether or not it was covered under this Plan;
- Replacement costs of a lost or stolen denture if this benefit has been used within the last 5 years;

- Special techniques or personalized restoration for the construction of a denture beyond the standard procedure charges;
- Services or techniques that are in excess of the alternate course of treatment guidelines; and
- Anything excluded under the Non-Covered Medical Expenses.

The Plan may, at its discretion, make benefit payments directly to either the Dentist or other provider furnishing the service, the employee, or both.

To determine whether dental needs and treatment are within Plan limitations and exclusions, the Plan reserves the right to review your dental records, including x-rays, photographs and models. With respect to your dental services, the Plan, at its expense, also has the right to request that you obtain an oral examination by a Dentist of its choice.

ADVANCE CLAIM REVIEW

Before beginning treatment for which charges are expected to exceed \$500, ask your Dentist to file a description of the proposed course of treatment and expected charges with the claim payor. The claim payor reviews the proposal and advises you and your Dentist of the estimated benefits payable.

A course of treatment is a planned program of one or more services or supplies. It may be rendered by one or more providers for the treatment of a condition diagnosed by the attending Physician or Dentist as a result of an examination. It commences on the day the provider first renders the services to correct or treat such a condition.

Emergency treatments, oral examinations, prophylaxis, and dental x-rays are considered part of a course of treatment, but you may seek these services without advance claim review.

The Plan pays for the least expensive, professionally adequate service. By receiving an advance review, you will reduce the possibility of unexpected claim denials.

As part of advance claim review and proof of loss for any claim, the Plan, at its expense, has the right to require you to obtain an oral examination. You must furnish to the Plan all diagnostic and evaluative material required to establish your right to benefits. Evaluative material includes dental x-rays, models, charts and written reports.

In many cases, alternative services or supplies may be used to treat a dental condition. If so, benefit coverage is limited to the services and supplies customarily employed to treat the disease or Injury and recognized by the dental profession to be appropriate according to

broadly accepted national standards of practice. The Plan takes into account your total oral condition.

Following are examples of coverage limited to customary services and supplies:

- Restorative:
 - Gold, baked porcelain restoration, crowns and jackets – If a tooth can be restored with amalgam or like material and you and your Dentist select another type of restoration, your benefits are limited to the appropriate charges for amalgam or similar material; and
 - Reconstruction – Covered expenses only include charges for procedures necessary to eliminate oral disease and replace missing teeth. Appliances or restorations to increase vertical dimension or restore the occlusion are considered optional and are not covered.
- Prosthodontics:
 - Partial dentures – If cast chrome or acrylic partial dentures will restore a dental arch satisfactorily and you and your Dentist choose a more elaborate precision appliance, Allowable Expenses are limited to the appropriate charges for cast chrome or acrylic;
 - Complete dentures – If, in the provision of complete denture services, you and your Dentist decide on personalized restorations or specialized techniques, as opposed to standard procedures, covered expenses are limited to appropriate charges for the standard procedures; and
 - Replacement of existing dentures – Charges for existing denture replacements are covered only if the existing dentures are not or cannot be made serviceable; otherwise, covered expenses are limited to appropriate charges for services necessary to make appliances serviceable.

PAYMENT OF CLAIMS

HOW TO FILE CLAIMS

Before benefits are paid, the Plan must be given written documentation of incurred expenses.

Your provider may file a claim on your behalf. If you wish to file your own claim, please complete and sign a claim form. Attach the provider's itemized bill to the claim form and submit the form to Zenith Administrators.

Timely Claim Filing

All claims must be submitted:

- Within 90 days after the loss occurs; or
- As soon as reasonably possible, but not later than one year after the loss occurs unless the claimant is not legally capable.

Examination

The Plan may require that a claimant be examined by a Physician of the Plan's choice. The Plan will not require more than a reasonable number of examinations. Where not prohibited by law, the Plan may also require an autopsy, at the Plan's expense.

WHEN CLAIMS ARE PAID

All Plan benefits will be paid as soon as the Plan receives acceptable documentation.

Direct Payments

Any benefits for Hospital, medical, surgical or dental services which you have assigned will be paid to the Hospital or the provider of the services. If you have not assigned the benefits, the Plan, at its option, will pay you or the Hospital or the provider of service.

Any other benefits will be paid to you except for any benefits unpaid at your death, which may be paid, at the Plan's option, to:

- Your beneficiary; or
- Your estate.

If your beneficiary is unable to give a valid release or if benefits unpaid at your death are not more than \$1,000, we may pay up to \$1,000 to any relative of yours who the Plan finds is entitled to the benefit.

Any payment made in good faith will fully discharge the Plan to the extent of the payment.

CLAIM DENIAL

If a claim is denied or partly denied, you will be notified in writing and given an opportunity for a review. The written denial will give:

- The specific reasons for denial;
- A reference to the specific Plan provisions on which the denial is based;
- A description of any additional material or information necessary to process the claim and the reason why such material or information is needed; and
- An explanation of the Claims Review Procedure.

If you think a decision about a claim is incorrect, call or write Zenith Administrators and ask that your claim be reviewed. Your "Explanation of Benefits" explains the reasons why your claim has been denied in whole or in part. It is important that you understand these reasons before you decide if you want to appeal further and if you need more information. If you are not satisfied with the response you receive from Zenith Administrators, contact the Trust Administrative Office.

CLAIMS REVIEW PROCEDURE

When a claim has been denied or partly denied, you may appeal the denial and have a review. **You must follow Steps 1, 2 and 3, in order and in the time periods designated or you will lose your right to appeal the claim denial.**

Step 1

Within 90 days of the date on the written notice from Zenith Administrators that your claim has been partially or wholly denied, you or your representative may make a written request for review to Zenith Administrators. You or your representative may review pertinent documents relating to the denial and you may submit pertinent issues and comments in writing.

Zenith Administrators will make its decision promptly and not later than 60 days after receipt of your request for review. The decision on review will be in writing and will include specific reasons for the decision.

Step 2

If you are dissatisfied with Zenith Administrator's decision, and wish to pursue your appeal further, you must request a hearing before the Board of Trustees within 60 days of the date on Zenith Administrator's written notification of their decision.

Your request for a hearing must be made in writing and must be directed to the Public Employees Local 71 Board of Trustees at 2510 Arctic Boulevard, Anchorage, Alaska 99503. Your written appeal should state the reasons you believe you are entitled to benefits. You may include supporting documentation that you would like the Trustees to consider. The Trustees will consider the appeal at their next regularly scheduled appeals meeting, provided your appeal request and all the supporting documentation is received no later than ten business days prior to the next regularly scheduled appeals meeting. Appeals submitted after the ten business day cutoff will not be heard at the next appeals meeting, but will be considered at the subsequent scheduled appeals meeting of the Board of Trustees. You may appear before the Board of Trustees to present your appeal in person or telephonically, if you wish. You may also be represented by an attorney or by any other representative of your choosing.

After the hearing, the Trust will issue a written decision regarding your appeal within 30 days of the hearing. The 30 day period may be extended if the Trustees require additional time or documentation to make their decision.

Step 3

If you disagree with the Trustees' decision, and you wish to seek further review of your denied claim, you must request that the matter be submitted to arbitration, in accordance with the Employee Benefit Plan Claim Arbitration Rules of the American Arbitration Association, provided that you submit a written demand for arbitration to the American Arbitration Association, together with the required filing fee, within 60 days of the date on the written decision by the Board of Trustees. If an appeal to arbitration is requested, the Trustees shall submit to the arbitrator a complete copy of the record upon which the Trustees' decision was made.

The question for the arbitrator shall be (1) whether the Trustees were in error upon an issue of law, (2) whether they acted arbitrarily, capriciously, or in bad faith in the exercise of their discretion, or (3) whether their findings of fact were supported by substantial evidence. The review by the arbitrator of the final decision or action of the Trustees shall be based only on such evidence presented to or considered by the Board of Trustees at the time it made the decision or took the action which is the subject of the review. New evidence is not admissible in the arbitration.

The decision of the arbitrator shall be final and binding upon the Trustees, upon the appealing party, and upon all other parties whose interests are affected thereby.

The expenses of arbitration shall be shared by the appealing party and by the Trust Fund pursuant to the American Arbitration Association Employee Benefit Plan Claims Rules, unless otherwise ordered by the arbitrator.

The Trust will provide you with a copy of the American Arbitration Association Employee Benefit Plan Claim Arbitration Rules, at your request, or they may be obtained at www.adr.org.

HOW TO CONTINUE HEALTH COVERAGE

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise cease. This section of the booklet generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. COBRA, and the description of COBRA coverage contained in this section, applies only to the group health plan benefits offered under the Plan, and not to any other benefits offered under the Plan or by your employer (such as life insurance, disability, or accidental death and dismemberment benefits).

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. For additional information about your rights or obligations under the Plan and under federal law, you should contact the Trust Administrative Office. With the exception of a special provision for participants who lose coverage because of temporary layoff (including layoff as a seasonal worker) or leave of absence without pay, the Plan provides no greater COBRA rights than what COBRA requires – nothing in this section is intended to expand your rights beyond COBRA's requirements.

What is COBRA coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event occurs and any required notice of that event is properly provided to the Plan's Administrator, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternative recipients under a Qualified Medical Child Support Order may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.) Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

Who is entitled to elect COBRA?

If you are an employee of an employer who participates in the Plan offered through the Public Employees Local 71 Trust, you will be entitled to elect COBRA coverage if you lose your group health coverage under the Plan because one of the following qualifying events occurs:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events occurs:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced or legally separated from your spouse.

A person enrolled as the employee's dependent child will be entitled to elect COBRA if he or she loses group health coverage under the Plan because any of the following qualifying events occurs:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct; or
- The child ceases being eligible for coverage under the Plan as a "dependent child" under the definition provided by the Plan.

When is COBRA coverage available?

When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify the Public Employees Local 71 Trust Administrator of any of these three qualifying events. However, for other qualifying events, you must provide notice to the Public Employees Local 71 Trust Administrator. The events that require such notice are divorce or legal separation of the employee and spouse, or a dependent ceasing to be eligible for coverage under the Plan as a dependent child. Where notice of the qualifying event is required, a COBRA election will be available to you only if you notify the Public Employees Local 71 Trust Administrator in writing within sixty (60) calendar

days after the later of (1) the date of the qualifying event or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. In providing this notice, you must use the form entitled "Notice of Qualifying Event (Form & Notice Procedures)," and you must follow the Notice Procedures for Notice of Qualifying Event that appear at the end of the form. If these procedures are not followed, or if the notice is not provided in writing to the Public Employees Local 71 Trust Administrator within the 60-day notice period, you will lose your right to elect COBRA continuation coverage. A copy of the Notice of Qualifying Event (Form & Notice Procedures) can also be obtained from the Public Employees Local 71 Trust Administrator.

Electing COBRA

Each qualifying beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their dependent children. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice will lose his or her right to elect COBRA continuation coverage.

Qualified beneficiaries may be enrolled in one or more group health components of the Plan at the time of a qualifying event. If a qualified beneficiary is entitled to a COBRA election as a result of a qualifying event, he or she may elect COBRA under the group health component under which he or she was participating on the day before the qualifying event occurred. If you lose coverage because of temporary layoff (including layoff as a seasonal worker) or leave of absence without pay, you may continue your health coverage or you can elect a low option medical plan.

Qualifying beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied).

Open Enrollment Rights and HIPAA Special Enrollment Rights

Qualified beneficiaries who have elected COBRA will be given the same opportunity available to similarly-situated active employees to change their coverage options or to add or eliminate coverage for dependents at

open enrollment. In addition, HIPAA's special enrollment rights will apply to those who have elected COBRA.

How long does COBRA last?

COBRA coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the covered employee's divorce or legal separation, or dependent child's losing eligibility as a dependent child, COBRA coverage can last for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for the qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last up to 36 months after the date of the Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage under the Plan for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months. When the qualifying event is temporary layoff (including layoff as a seasonal worker) or leave of absence without pay, the Plan has extended the period of COBRA coverage from 18 months up to a total of 24 months.

The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage period described in this notice for several reasons:

- The Plan no longer provides group health coverage;
- The premium for the qualified beneficiary's COBRA coverage is not timely paid;
- After electing COBRA, you (employee, spouse, or dependent child) become covered under another group health plan (as an employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the other plan has applicable exclusions or limitations, then your COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12-

month preexisting condition waiting period expires.) This rule applies only to the qualified beneficiary who becomes covered by another group health plan. (Note that under HIPAA, an exclusion or limitation of the other group health plan might not apply to the qualified beneficiary, depending on the length of his or her creditable coverage prior to enrolling in the other group health plan.);

- After electing COBRA, you (employee, spouse or dependent child) become entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare;
- You (employee, spouse, or dependent child) became entitled to a 29-month maximum coverage period due to disability of a qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however continuation coverage will not end until the month that begins more than 30 days after the determination.);
- Occurrence of any event (e.g. submission of a fraudulent benefit claim) that permits termination of coverage for cause with respect to covered employees or their spouses or dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of federal law.

Extension of COBRA Coverage

There are two ways in which the period of COBRA coverage resulting from a termination of employment or reduction of hours of employment can be extended.

Disability extension

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the Public Employee Local 71 Trust Administrator in writing and in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours of employment. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours of employment resulting in the loss of coverage and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months as described above). The disability extension is available only if you notify the Public Employees Local 71 Trust Administrator in writing of the Social

Security Administration's determination of disability within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction of hours of employment; and
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination or reduction of hours of employment.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours of employment in order to be entitled to a disability extension.

In providing this notice, you must use the form entitled "Notice of Disability (Form & Notice Procedures)," and you must follow the Notice Procedures for Notice of Disability that appear at the end of the form. If these procedures are not followed, or if the notice is not provided in writing to the Public Employees Local 71 Trust Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours of employment, then there will be no disability extension of COBRA coverage. A copy of the Notice of Disability (Form & Notice Procedures) can be obtained from the Public Employees Local 71 Trust Administrator.

Second qualifying event extension

If your family experiences another qualifying event while receiving COBRA coverage because of the covered employee's termination of employment or reduction in hours of employment (including COBRA coverage during a disability extension period described above), the spouse and dependent children receiving COBRA coverage can get up to an additional 18 months of COBRA coverage, for a maximum of 36 months, if notice of the second qualifying event is given in writing and timely to the Public Employees Local 71 Trust Administrator. This extension may be available to the spouse and any dependent children receiving COBRA coverage if the employee or former employee dies or gets divorced or legally separated, or if the dependent child ceases to be eligible as a dependent under the terms of 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. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare.)

This extension due to a second qualifying event is available only if you notify the Public Employees Local 71 Trust Administrator in writing of the

second qualifying event within 60 days after the later of (1) the date of the second qualifying event or (2) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan). In providing this notice, you must use the form entitled "Notice of Second Qualifying Event (Form & Notice Procedures)," and you must follow the Notice Procedures for Notice of Second Qualifying Event that appear at the end of the form. If these procedures are not followed or if the notice is not provided in writing to the Public Employees Local 71 Trust Administrator during the 60-day notice period, then there will be no extension of COBRA coverage due to a second qualifying event. A copy of the Notice of Second Qualifying Event (Form & Notice Procedures) can be obtained from the Public Employees Local 71 Trust Administrator.

More Information about Individuals Who May be Qualified Beneficiaries

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate Recipients

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by the Public Employees Local 71 Trust Administrator during the covered employee's period of employment with an employer who is contributing to the Public Employees Local 71 Trust, is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

If You Have Questions

Questions concerning your Plan or your COBRA rights should be addressed to the contact or contacts identified below. For more information about your rights under COBRA, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefit Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Note that this Plan is a non-federal governmental plan, which is exempt from ERISA; however, COBRA does apply to this Plan and the information on the DOL website is instructive, but there may be

some distinctions between the provisions of COBRA applicable to governmental plans and those offered to private-sector ERISA plans.

Keep Your Plan Informed of Address Changes and Changes in Your Family Information

To protect your family's rights, you should keep the Public Employees Local 71 Trust Administrator informed of any changes in the addresses of family members. In addition, you have the obligation to report to the Public Employees Local 71 Trust Administrator any changes in your family eligibility information. You should also keep, for your records, a copy of any notices you send to the Public Employees Local 71 Trust Administrator and proof of mailing of such notices.

Plan Contact Information

You may obtain information about the Plan and COBRA coverage on request from:

Public Employees Local 71 Trust Administrator
2510 Arctic Boulevard
Anchorage AK 99503-2516
Telephone (800) 446-3671 or 276-7611 in Anchorage

Contact information for the Plan may change from time to time.

DISABLED EMPLOYEES OR DISABLED DEPENDENTS

Disabled employees or Disabled dependents who lose coverage may be entitled to an extension of their health benefits if Totally Disabled due to Injury, illness, or pregnancy when coverage terminates. Extended benefits for Total Disability are provided for the number of months you have been covered under the plan, to a maximum of 12 months. In such a case, only the condition which caused the Disability is covered. Coverage is provided only while the Total Disability continues.

FAMILY AND MEDICAL LEAVE- as Federally Mandated

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

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

In the event you and your spouse are both covered as members of the Plan, the continued coverage under (1) may not exceed a combined total of 12 weeks. In addition, if the leave is taken to care for a parent with a serious health condition, the continued coverage may not exceed a combined total of 12 weeks.

CONDITIONS:

1. If, on the day your coverage is to begin, you are already on an FMLA leave of absence, you will be considered actively at work. Coverage for you and any eligible dependents will begin in accordance with the terms of the Plan. However, if your leave of absence is due to your own or any eligible dependent's serious health condition, benefits for that condition will not be payable to the extent benefits are payable under any prior group plan.
2. You are eligible to continue coverage under FMLA if:
 - a. you have worked for your employer for at least one year;
 - b. you have worked at least 1,250 hours over the previous 12 months;
 - c. your employer employs at least 50 employees within 75 miles from your work-site; and
 - d. you continue to pay any required premium for yourself and any eligible dependents in a manner determined by your employer.
3. In the event you choose not to pay any required premium during your leave, your coverage will not be continued during the leave.

You will be able to reinstate your coverage on the day you return to work, subject to any changes that may have occurred in the Plan during the time you were not covered. You and any covered dependents will not be subject to any evidence of good health requirement provided under the Plan. Any partially-satisfied waiting periods, including any limitations for a preexisting condition, which are interrupted during the period of time premium was not paid will continue to be applied once coverage is reinstated.

4. You and your dependents are subject to all conditions and limitations of the Plan during your leave, except that anything in conflict with the provisions of FMLA will be construed in accordance with the FMLA.
5. If requested by us, you or your employer must submit proof acceptable to us that your leave is in accordance with FMLA.
6. This FMLA continuation is concurrent with any other continuation option except for COBRA, if applicable. You may be eligible to elect any COBRA continuation available under the Plan following the day your FMLA continuation ends.
7. FMLA continuation ends on the earliest of:
 - a. the day you return to work;
 - b. the day you notify your employer that you are not returning to work;
 - c. the day your coverage would otherwise end under the policy; or
 - d. the day coverage has been continued for 12 weeks.

DEFINITIONS FOR TERMS IN THIS SECTION

Prior group plan means the group plan providing similar benefits (whether insured or self-insured including HMO's and other prepayment plans provided by the Policyholder) in effect immediately prior to the effective date of this Plan.

COBRA means the Consolidated Omnibus Budget Reconciliation Act, as amended.

Serious Health Condition is defined as stated in the FMLA.

IMPORTANT NOTICE

Contact your employer for additional information regarding FMLA.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS - as Federally Mandated

What is USERRA?

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) was signed into law on October 13, 1994, and clarifies and strengthens the Veterans' Reemployment Rights (VRR) Statute. USERRA's purpose is to minimize the disadvantages that may occur if you need to leave civilian employment to serve in the country's uniformed services. USERRA covers virtually every individual in the country who serves in or has served in the uniformed services, and applies to all employers in the public and private sectors, including state, local, and federal government.

As of December 10, 2004, the Veterans Benefits Improvement Act of 2004 amended USERRA, extending the period for continued health benefits coverage from 18 months to 24 months. The Trust has adopted procedures that it will follow when administering USERRA elections for continuation of health benefits coverage. (These procedures are similar to those used for COBRA continuation coverage elections.) The Trust has also adopted procedures for immediate reinstatement in the Trust's Benefit Plans for employees who return to work after uniformed service. This notice describes the new procedures.

What is Uniformed Service under USERRA?

Protection under USERRA is provided to anyone who is (or has been) in the "uniformed services," which is defined very broadly by the law. USERRA defines "uniformed service" as active or reserve service in the Army, Air Force, Navy, Marine Corps, and Coast Guard; service in the National Guard, Air Guard, and the Public Health Service; and any other category designated by the President during time of war.

Who May Elect USERRA Continuation Coverage?

To have a right under USERRA to continued health benefits coverage under the Trust's Benefit Plans, you must:

1. Be a participant in the Plan immediately prior to leaving for uniformed service;
2. Enter uniformed service as defined by USERRA;
3. Provide advance notice of the uniformed service, unless you are prevented from doing so by military necessity or it is otherwise impossible or unreasonable under the circumstances;

4. Timely complete and return the USERRA Continuation Coverage Election Form and pay the appropriate premium to the Trust Administrator; and
5. Be absent from employment for performance of uniformed service for the entire period of coverage.

How do You Notify the Trust of Your Uniformed Service?

If you are going to be absent from work due to uniformed service, you (or an appropriate officer of your branch of the uniformed service) must give advance notice to the Trust Administrator, unless notice is precluded by military necessity. You can contact the Administrator either orally or in writing. When the Administrator receives your notice of duty, that office will determine your entitlement to USERRA health benefits continuation coverage and send either a USERRA Continuation Coverage Election Form or an explanation of why you are not entitled to USERRA continuation coverage. If needed, the Administrator may request appropriate records documenting the uniformed service for later evaluation of your eligibility for USERRA continuation coverage or of your rights to reemployment and restoration of benefits.

How do You Obtain a USERRA Continuation Coverage Election Form?

As mentioned above, if you promptly notify the Trust Administrator of your plan to enter uniformed service, you will automatically receive a USERRA Continuation Coverage Election Form if the Trust Administrator determines that you are eligible to elect continuation coverage. Also, you can contact the Trust Administrator at your convenience to request a USERRA Continuation Coverage Election Form.

When are the USERRA Election and Payment Deadlines?

You have 60 days after reporting for uniformed service to complete and return the USERRA Continuation Coverage Election Form provided by the Trust Administrator (currently Zenith Administrators, Inc.). The Administrator's receipt of your Election Form will be determined by the postmark or hand-delivery date,

After electing USERRA continuation coverage, you have 45 days to pay the initial premium to the Trust Administrator. The date a premium payment is made is determined by the date it is postmarked or hand delivered. All premiums for subsequent months are due on the 1st day of the month to which the premium applies. If your payment is not made by the first of the month, the Administrator will send notice that you have 30 days from the premium due date to pay the premium or your coverage will terminate effective with the last month for which you paid a premium. Any claims submitted during the 30-day grace period will be held until the

premium is received, and any claims incurred during the grace period will be denied if the premium is not paid by the end of the grace period. If you miss the deadline for completing and return the USERRA Continuation Coverage Election Form, or the deadline for paying any premium, you will lose your right to USERRA continuation coverage under the Plan.

Who Pays the USERRA Continuation Coverage Premium?

Leave for Fewer than 31 Days: If your uniformed service is for fewer than 31 days, your employer will pay the cost of coverage on the same basis as it did prior to the your absence for uniformed service, and you must self-pay your portion of the premium for coverage.

Leave for More than 31 Days: If your uniformed service is for more than 31 days, you must pay the full premium by the deadline described above. The premium for coverage for leave lasting more than 31 days will be 102% of the premium charged for active participants.

How does USERRA Continuation Coverage Coordinate with COBRA?

If you elect to continue coverage under USERRA, the Plan will continue coverage for 24 months beginning on the date your uniformed service begins, or the date after you fail to apply for reemployment within the time limits described below, whichever is less. Unlike COBRA continuation coverage, your entitlement to USERRA continuation coverage is not affected by your entitlement to coverage another group health plan or Medicare. If a second Qualifying Event occurs while you are in uniformed service (for example, if you die or divorce), then your spouse and/or children may be entitled to an extension of coverage under COBRA for up to a total of 36 months of continuation coverage, between your USERRA election and a subsequent COBRA election.

How do You Get Regular Health Plan Coverage Reinstated?

To have a right to reinstated health benefits coverage from the Trust's Benefit Plan following your absence from work for uniformed service, you must:

1. Have been on leave from a full-time, temporary, part-time, probationary, or seasonal position subject to the collective bargaining agreement between Public Employees Local 71 and a participating Employer;
2. Have been in "uniformed service" as defined by USERRA;
3. Have provided advance notice of the absence, unless military necessity prevented you from doing so or it was otherwise impossible or unreasonable under the circumstances;

4. Have not received a dishonorable or bad-conduct discharge, a discharge under other than honorable conditions, or any other disqualifying discharge;
 5. Have no more than five years of cumulative uniformed service (although some limited exceptions apply)
 6. Report back for work (or apply to return to work) promptly. If your uniformed service was:
 - **Less than 31 days of service**--you must report by the next workday after returning from service (allowing for 8 hours sleep and reasonable time to get home).
 - **From 31 to 180 days of service**--you must apply for reemployment within 14 days after returning from service.
 - **More than 180 days of service**--you must apply for reemployment within 90 days after returning from service.
- Note: These time limits may be extended up to 2 years if you are hospitalized or incapacitated by a service-related injury or illness.
7. If your military leave was for more than 30 days, you must provide any available documents requested by the Plan to establish that you are entitled to the protections of USERRA; and
 8. Be reemployed in covered employment.

If these requirements are met, then health benefits coverage for you and your eligible spouse and/or dependents will be reinstated immediately. However, an exception applies to disabilities that the Secretary of Veteran's Affairs (the VA) determines to be connected to military service.

COORDINATION OF BENEFITS (COB)

DEFINITIONS FOR TERMS IN THIS SECTION

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, prescription drug or vision care:

- Group, blanket or franchise insurance (except student accident insurance);
- Group health care programs issued by insurers, health care services contractors, and health maintenance organizations;
- Coverage under a labor-management trustees plan, a union welfare plan, an employer organization plan or an employee benefits plan;
- Coverage under governmental programs, including Medicare or Medicaid, and any other coverage required or provided by law; and
- Other arrangements of insured or self-insured group coverage.

If any of the above coverages include group and group-type hospital indemnity coverage, Plan also means that amount of indemnity benefits which exceeds \$100 a day.

Claimant means the covered person for whom the claim is made.

Claim Period means part or all of a calendar year during which the claimant is covered under the Plan.

A **Covered Expense** means any expense which is covered by at least one Plan during a Claim Period; however, any expense which is not payable by the Primary Plan because of the claimant's failure to comply with cost containment requirements (such as second surgical opinions, preadmission testing, preadmission review of Hospital Confinement, mandatory outpatient surgery, etc.) will not be considered a Covered Expense by the Secondary Plan. Where a Plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service during a Claim period will also be considered a Covered Expense.

COORDINATION OF BENEFITS (COB)

If the claimant is covered by another Plan or Plans, the benefits under this Plan and the other Plan(s) will be coordinated. This means one Plan pays its full benefits first, then the other Plan(s) pay(s).

The Primary Plan (which is the Plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.

The Secondary Plan (which is the Plan that pays benefits after the Primary Plan) will limit the benefits it pays so that the sum of its benefit and all other benefits paid by the Primary Plan will not exceed the greater of:

- 100% of total Covered Expense; or
- The amount of benefits it would have paid had it been the Primary Plan.

The "Order of Benefit Determination" section below explains the order in which Plans must pay.

This COB provision will not apply to a claim when the Covered Expense for a Claim Period is \$50 or less, but if:

- Additional expense is incurred during the Claim Period; and
- The total Covered Expense exceeds \$50

then this COB provision will apply to the total amount of the claim.

ORDER OF BENEFIT DETERMINATION

When another Plan does not have a COB provision, that plan must determine benefits first.

When another Plan does have a COB provision, the first of the following rules which applies govern:

- (a) If a Plan covers the claimant as an employee, member or nondependent, then that Plan will pay its benefits first.
- (b) If the claimant is a dependent child whose parents are not divorced or separated then the Plan of the parent whose birthday anniversary is earlier in the calendar year will pay first, except:
 - (1) If both parents' birthdays are on the same day, rule (d) will apply.
 - (2) If another Plan does not include this COB rule based on the parents' birthdays, but instead has a rule based on the gender of the parent, then that Plan's COB rule will determine the order of benefits.
- (c) If the claimant is a dependent child whose parents are divorced or separated, then the following rules apply:

- (1) A Plan which covers a child as a dependent of a parent who by court decree must provide health coverage must pay first.
- (2) When there is no court decree which requires a parent to provide health coverage to a dependent child, the following rules will apply:
 - a. When the parent who has custody of the child has not remarried, that parent's Plan will pay first.
 - b. When the parent who has custody of the child has remarried, then benefits will be determined by that parent's Plan first, by the stepparent's Plan second, and by the Plan of the parent without custody third.
- (d) If none of the above rules apply, the Plan which has covered the claimant for the longer period of time will pay its benefits first, except when:
 - (1) One Plan covers the claimant as a laid-off or retired employee (or a dependent of such an employee); and
 - (2) The other Plan includes this COB rule for laid-off or retired employees (or is issued in a state which requires this COB rule by law);then the Plan which covers the claimant as other than a laid-off or retired employee (or a dependent of such an employee) will pay first.

Where part of a Plan coordinates benefits and a part does not, each part will be treated like a separate Plan.

CREDIT SAVINGS

Where the Plan does not have to pay its full benefits because of COB, the savings will be credited to the claimant for the Claim Period. These savings would be applied to any unpaid Covered Expense during the Claim Period.

HOW COB AFFECTS BENEFIT LIMITS

If COB reduced the benefits payable under more than one Plan provision, each benefit will be reduced proportionately. Only the reduced amount will be charged against any benefit limit in those Plan provisions.

RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

In order to receive benefits, the claimant must give the Plan any information which is needed to coordinate benefits. With the claimant's

consent, the claim payor may release to or collect from any person or organization any needed information about the claimant.

FACILITY OF PAYMENT

If benefits which this Plan should have paid are instead paid by another Plan, this Plan may reimburse the other Plan. Amounts reimbursed are Plan benefits and are treated like other Plan benefits in satisfying Plan liability.

RIGHT OF RECOVERY

If payments are made under this Plan for any treatment or service or loss of income because of Injury to, or Sickness of, a covered individual caused by the act or omission of a third party, who has a lawful claim, demand or right against a third party or parties (including an insurance carrier) for indemnification, damages or other payment with respect to such Injury or Sickness, then:

- The Trust shall have the Right of Recovery to the extent of the payments made under this Plan, to have the rights of the covered individual to receive or claim such indemnification, damages or other payment. The covered individual shall execute or secure the execution of such instruments as the Trust may require to enforce its rights hereunder;
- Any individual who shall receive payment from any such third party or parties because of Injury to, or Sickness of, a covered individual shall reimburse the Trust from such payment so received (but not in excess of the amount of benefits paid).

What this means is that if you receive a benefit payment from the Plan and a liability claim is made against a third party, benefits payable by the Plan must be included in the claim and when the claim is settled the Trust must be reimbursed for the benefits provided.

CONTRACT LIABILITY

The full extent of liability under this Plan and benefits conferred, including recovery under any claim of breach, will be limited to the actual cost of hospital and medical services as described here and will specifically exclude any claim for general damages that includes alleged "pain, suffering or mental anguish."

MEDICARE COORDINATION OF BENEFITS

This Medicare COB provision applies when the covered person:

- (a) Has health coverage under the Plan; and
- (b) Is eligible for insurance under Medicare, Parts A and B, whether or not the covered person has applied or is enrolled in Medicare.

The Medicare COB provision applies before any other COB provision of the Plan.

EFFECT ON BENEFITS

1. If, in accord with the following rules, the Plan has primary responsibility for the covered person's claims, then the Plan pays benefits first.
2. If, in accord with the following rules, the Plan has secondary responsibility for the covered person's claims:
 - (a) First Medicare benefits are determined or paid; and
 - (b) Then Plan benefits are paid;

but for services payable under both plan, the combined Medicare Benefits and Plan benefits will not exceed 100% of the expense incurred.

RULES FOR DETERMINING ORDER OF BENEFITS

1. For You. The Plan has primary responsibility for your claims if:
 - (a) You are covered under the Plan because of your current active employment status with an ADEA Employer, and you are eligible for Medicare Benefits because of age; or
 - (b) The Plan is part of a Large Group Plan, and you are covered under the Plan because of your current active employment status, and you are eligible for Medicare Benefits because of disability.

The Plan has secondary responsibility for your claims if you are eligible for Medicare Benefits and the above conditions do not apply.

2. For Your Dependent. The Plan has primary responsibility for your dependent's claims if:
 - (a) You are covered under the Plan because of your current active employment status with an ADEA Employer, and your dependent spouse is eligible for Medicare because of age; or

(b)The Plan is part of a Large Group Plan, and you are covered under the Plan because of your current active employment status, and your dependent is eligible for Medicare Benefits because of disability.

The Plan has secondary responsibility for your claims if your dependent is eligible for Medicare Benefits and the above conditions do not apply.

3. Exception for End Stage Renal Disease. If Medicare does not already have primary responsibility when you or your dependent becomes eligible for Medicare Benefits because of end stage renal disease:

(a)The Plan has primary responsibility for you or your dependent's claims for up to 30 months beginning with the month in which you or your dependent is first eligible for Medicare Benefits because of end stage renal disease; and

(b)The Plan has secondary responsibility after the end of this 30-month period.

DEFINITIONS FOR TERMS IN THIS SECTION

Medicare Benefits means service and supplies which the covered person receives or is eligible for under Medicare, whether or not the covered person has applied for or is enrolled in Medicare.

ADEA Employer means an employer which:

(a)Is subject to the federal Age Discrimination in Employment Act (ADEA); and

(b)Has 20 or more employees each working day in 20 or more calendar weeks during the current or preceding calendar year.

Large Group Plan means a plan which covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year.

IMPORTANT INFORMATION ABOUT MEDICARE

Medicare may affect Plan benefits, therefore, you may want to contact your local Social Security office for information about Medicare. This should be done before you or your spouse's 65th birthday.

THIRD PARTY REIMBURSEMENT AND/OR SUBROGATION

This provision applies if you or your dependent is injured or sick as a result of the act or omission of a third party. The Plan does not provide benefits for an injury, accident or illness for which there is a right of recovery against a third party. However, if you or your dependent has medical expenses as a result of an injury, accident or illness for which a third party is, or may be held responsible, the Plan, as a convenience to you or your dependent, will advance payment of such expenses on the condition that you or your dependent (if applicable) sign and return a Subrogation Agreement. The Subrogation Agreement constitutes an enforceable contract which creates a reimbursement right for the Plan and obligates you (or your dependent, as applicable) to reimburse the Plan for the full value of the benefits paid by the Plan, on a first-dollar basis, from any recovery, settlement or judgment received by you, your dependent, or legal representative from the liable third party and/or their insurer. The Subrogation Agreement also creates an assignment of any recovery, settlement or judgment in favor of the Plan up to the amount of the benefits paid by the Plan.

DEFINITIONS FOR TERMS IN THIS SECTION

Reimbursement Rights means the Plan's right to be reimbursed if:

- The Plan pays Plan benefits for you or your dependent because of an Injury or Sickness caused by a third party's act or omission; and
- You, your dependent or the legal representative recovers an amount from the third party, the third party's insurer, an uninsured motorist insurer or anyone else by reason of the third party's act or omission. This recovery may be the result of a lawsuit, a settlement or some other act. The Plan is entitled to be paid first out of any recovery, up to the amount of the Plan benefits paid.

Subrogation Rights, as used in this provision, means the Plan's right to enforce the Plan's recovery of any Plan benefits paid for you or your dependent because of an Injury or Sickness caused by a third party's act or omission. The Plan is entitled to be paid first out of any recovery, up to the amount of benefits paid by the Plan.

Third Party means another person or organization.

REIMBURSEMENT AND SUBROGATION RIGHTS

If you or your dependent has an Injury or Sickness caused by a third party's act or omission:

1. The Plan will pay Plan benefits for that Injury or Sickness subject to the Plan's Reimbursement and Subrogation Rights on the condition that you or your dependent, or your legal representative execute a Subrogation Agreement and the condition that you (or your dependent, as applicable):
 - (a) Will not take any action which would prejudice the Plan's Reimbursement or Subrogation rights; and
 - (b) Will cooperate in doing what is reasonably necessary to assist the Plan in enforcing the Plan's Reimbursement or Subrogation Rights, including signing an assignment, a reimbursement agreement or other document upon the Plan's written request.
2. The Plan's Reimbursement or Subrogation Rights will not be reduced because the recovery is not described as being related to medical costs or loss of income.
3. The Plan may enforce the Plan's Reimbursement or Subrogation Rights by filing a lien with the third party, the third party's insurer or another insurer, a court having jurisdiction in this matter or any other appropriate party.
4. The Plan may elect to charge any reimbursement due the Plan under this provision against any future benefits payments for you or your dependent under this Plan. This will not reduce the Plan's right to be paid first out of any recovery up to the amount of Plan benefits not yet reimbursed.
5. After reimbursement from benefits paid by the Plan, the Plan may be relieved from any obligation to pay further benefits to you or your dependents for such injuries up to the entire net amount of the balance of the settlement judgment recovered by you or your dependent for hospital, medical, dental or surgical benefits.
6. The Board of Trustees will review a request for a waiver of Subrogation Rights, in part or in whole, in the event you or your dependent is not fully compensated due to a lack of insurance or recoverable funds. The Board of Trustees has the sole and exclusive discretion as to what circumstances would justify a waiver of any part of the Plan's Subrogation Rights.

DEFINITIONS

Acupuncture means the practice of insertion of needles into specific exterior body locations to relieve pain, to induce surgical anesthesia, or for therapeutic reasons.

Allowable Expense means the actual costs (billed amount) charged for Medically Necessary services to the extent that such charges are Usual, Customary and Reasonable (UCR) for the area and the type of service. For Non-PPO inpatient Hospital services within the Municipality of Anchorage, the Allowable Expense will be limited to the Contracted Rate at the preferred provider Hospital. The Allowable Expense for outpatient facility charges at a non-PPO provider within the Municipality of Anchorage will be limited to 50% of the billed charges or the case rate, if any. The Allowable Expense for physical therapy services within the Municipality of Anchorage will be limited to the Contracted Rate at the preferred provider physical therapist.

Charges in excess of the Allowable Expense as determined by the Plan will not be paid by the Plan, and will not apply to your deductible or Out-of-Pocket Limit.

Contracted Rate means the rate negotiated with PPO providers for covered services.

Cosmetic or Reconstructive Surgery means any surgical procedure performed primarily:

- To improve physical appearance or to change or restore bodily form without materially correcting a bodily malfunction; or
- To prevent or treat a Mental or Nervous Disorder through a change in bodily form.

Custodial Care means services or supplies, regardless of where or by whom they are provided which:

- A person without medical skills or background could provide or could be trained to provide; or
- Are provided mainly to help the covered person with daily living activities, including, but not limited to:
 - Walking, getting in and/or out of bed, exercising and moving the covered person;
 - Bathing, using the toilet, administering enemas, dressing and assisting with any other physical or oral hygiene needs;
 - Assistance with eating by utensil, tube or gastronomy;

- Homemaking, such as preparation of meals or special diets, and house cleaning;
- Acting as a companion or sitter; or
- Supervising the administration of medications which can usually be self-administered, including reminders of when to take such medications; or
- Provide a protective environment;
- Are part of a maintenance treatment plan or are not part of an active treatment plan intended to or reasonably expected to improve the covered person's Sickness, Injury or functional ability; or
- Are provided for the convenience of the covered person or the caregiver or are provided because the covered person's own home arrangement is not appropriate or adequate.

The Plan determines what services or supplies are Custodial Care. When a confinement in a facility or a visit to a Physician is found to be mainly for Custodial Care, some services (such as prescription drugs, x-rays and lab tests) may still be covered if Medically Necessary and otherwise covered by the Plan. All bills should be routinely submitted for consideration.

Dentist means a licensed dentist who performs a dental service which is payable under the Plan. A Dentist 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).

Developmental Care means services or supplies, regardless of where or by whom they are provided, which:

- Are provided to a covered person who has not previously reached the level of development expected for the covered person's age in the following areas of major life activity:
 - Intellectual;
 - Physical;
 - Receptive and expressive language;
 - Learning;
 - Mobility;
 - Self-direction;
 - Capacity for independent living; or

- Economic self-sufficiency; or
- Are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to Injury or Sickness); or
- Are educational in nature.

The Plan will determine what services or supplies are Developmental Care. When a confinement in a facility or a visit to a Physician is found to be mainly for Developmental Care, some services (such as prescription drugs, x-rays and lab tests) may still be covered if Medically Necessary and otherwise covered by the Plan. All bills should be routinely submitted for consideration.

Experimental or Investigational means that:

- The drug or device cannot be lawfully marketed without the approval of the US Food and Drug Administration and approval for marketing has not been given for regular nonexperimental or noninvestigational purposes at the time the drug or device is furnished;
- The drug, device, medical treatment, or procedure has been determined to be an Experimental or Investigational procedure by the treating facility's Institutional Review Board or other body servicing 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 the investigative program;
- Reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I, II, III or IV clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment or diagnosis; or
- Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment or diagnosis.

For purposes of this section, "reliable evidence" shall mean only published reports and articles in peer reviewed authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Home Health Care Agency is an organization:

- Providing skilled nursing and other therapeutic services in the patient's home;
- Associated with a professional policy-making group of at least one Physician and one RN supervising full-time;
- Keeping complete medical records on each patient;
- Staffed by a full-time administrator; and
- Meeting licensing standards.

Hospital means any of the following facilities which are licensed by the proper authority in the area in which they are located:

- A place which is licensed as a general hospital by the proper authority of the area in which it is located;
- A place which:
 - (1) Is operated for the care and treatment of resident inpatients;
 - (2) Has a registered graduate nurse (RN) always on duty;
 - (3) Has a laboratory and x-ray facility; and
 - (4) Has a place where major surgical operations are performed;or
- A facility which is accredited by the Joint Commission on the Accreditation of Healthcare Organizations, American Osteopathic Association or the Commission on Accreditation of Rehabilitative Facilities if the function of such facility is primarily of a rehabilitative nature, provided such rehabilitation is specifically for treatment of a physical disability. Such facility need not have major surgical facilities.

When treatment is needed for Mental and Nervous Disorders, Alcohol and Drug Abuse and/or Substance Abuse, Hospital can also mean a place which meets these requirements:

- Has rooms for resident inpatients;
- Is equipped to treat mental and nervous disorders, alcohol and drug abuse, and/or substance abuse;
- Has a resident Physician on duty or on call at all times;
- As a regular practice, charges the patient for the expense of confinement; and
- Is licensed by the proper authority of the area in which it is located.

A Hospital does not include a hospital or institution or part of a hospital or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home, home for the aged, halfway house or board and care facilities.

Hospital Confinement means a Medically Necessary Hospital stay of 24 consecutive hours or more in any single or multiple departments or parts of a Hospital for the purpose of receiving any type of medical service. These requirements apply even if the Hospital does not charge for daily room and board. How the Hospital classified the stay is irrelevant.

Any Hospital Confinement satisfying this definition will be subject to all Plan provisions relating to inpatient Hospital services or admissions, including any applicable preadmission review requirements. Hospital stays or services not satisfying this definition will be considered under the Plan provisions for outpatient services.

Injury means an accidental bodily Injury which requires treatment by a Physician. It must result in loss independently of Sickness and other causes.

Mammogram means an x-ray examination of the breast.

Medical Emergency means a severe condition which the Plan determines:

- results from symptoms which occur suddenly and unexpectedly; and
- requires immediate Physician's care to prevent death or serious impairment of the covered person's health.

or

- poses an imminent serious threat to the covered person or to others.

Medically Necessary service or supply means one which is ordered by a Physician and which the Plan determines is:

- provided for the diagnosis or direct treatment of an Injury or Sickness;
- appropriate and consistent with the symptoms and findings or diagnosis and treatment of the covered person's Injury or Sickness;
- provided in accord with generally accepted medical practice on a national basis; and
- the most appropriate supply or level of service which can be provided on a cost effective basis (including but not limited to inpatient vs. outpatient care, electric vs. manual wheelchair, surgical vs. medical or other types of care).

The fact that the covered person's Physician prescribes services or supplies does not automatically mean such services or supplies are Medically Necessary and covered by the Plan.

Mental and Nervous Disorders / Alcohol and Drug Abuse means any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as a Mental Disorder. Not included in this definition are conditions or diseases specifically excluded from coverage.

Oral Surgery means excision of partially or completely unerupted or impacted teeth.

Physician means any of the following licensed practitioners who perform a service payable under the Plan:

- Doctor of medicine (MD), osteopathy (DO), podiatry (DPM), chiropractic (DC), or dentistry (DDS or DMD);
- Occupational therapist or physical therapist;
- Audiologist;
- Optometrist or ophthalmologist;
- Midwife;
- Naturopath;
- 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 marital and family therapist (LMFT);
- Christian Science Practitioner, authorized by the Mother Church, First Church of Christ Scientist, Boston, Massachusetts;
- Nurse practitioner, if licensed by the State in which is he/she is practicing, provided he/she is practicing within the scope of that license;
- Licensed physician's assistant (PA); or
- Where required to cover by law, any other licensed practitioner who:
 - (1) is acting within the scope of his/her license; and
 - (2) 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).

Sickness means a disease, disorder or condition which requires treatment by a Physician and includes childbirth, pregnancy or any related conditions.

Total Disability, Totally Disabled or Disabled means for health coverage, that because of an Injury or Sickness:

- you are completely and continuously unable to perform the material and substantial duties of your regular occupation and are not engaging in any work or occupation for wages or profit; or
- your dependent is:
 - whether physically or mentally unable to perform all of the usual and customary duties and activities (the “ normal activities”) of a person of the same age and gender who is in good health; and
 - not engaged in any work or occupation for wages or profit.

Usual, Customary and Reasonable (UCR) means the charge the Plan determines to be the prevailing rate charged in the geographic area in which the service is provided, or the provider’s usual charge, whichever is less.

The allowance for documented multiple surgical procedures, whether related or not, is 100% of the prevailing fee for the greater procedure and 50% for each lesser procedure during the same operative session. Exceptions:

- Fractures: when reduction (or treatment) of one or more separate and distinct fractures takes place (such as an arm and a leg) 100% of the prevailing fee is allowable for each fracture.
- More than one surgeon: When the skill of two or more surgeons is required and each performs separate operations, the allowance is 100% of the prevailing fee for each procedure, provided the doctors bill separately, even though the procedures are performed at the same operative session. The allowance for an assistant surgeon is 20% of the prevailing fee.

You, your means an employee or member who is covered under the Plan.

VISION BENEFITS

The vision benefits described in the following section are underwritten by Vision Service Plan (VSP) and are completely separate from the medical and dental plans described in the prior sections of this booklet.

You may choose to obtain lasik vision services in lieu of your vision allowance for one year. Claims should be submitted to the Trust Administrative Office. Contact the Trust Administrative Office for more information.

VISION SERVICE PLAN

The vision plan covers charges for eye care when provided or prescribed by an ophthalmologist or optometrist. The Plan covers only those expenses which are reasonable and customary for the services provided in the area where the expenses are incurred. The Plan requires a copayment for lenses and frames. No copayment is required for exams.

You and your dependents (if dependent coverage has been selected) may use the services of a Vision Service Plan (VSP) member doctor or any other licensed ophthalmologist or optometrist.

EXAM ONLY PLAN

This Plan covers one complete examination or vision survey per person during any 12 consecutive months, according to the Schedule of Benefits.

FULL PLAN

Exam

This Plan covers one complete examination or vision survey per person during any 12 consecutive months, according to the Schedule of Benefits.

Conventional Lenses

Prescription lenses will be covered once during any 12 consecutive months, if a visual analysis indicates new lenses are necessary. Lenses are covered according to the Schedule of Benefits.

Frames

New frames will be covered whenever necessary, but not more than once during any 24 consecutive months, and will be covered according to the Schedule of Benefits.

Contact Lenses – Elective

If contact lenses are elected instead of eyeglasses, this Plan will provide a benefit. This benefit will use up your lenses and frame benefit. For

example, you will not be eligible again for a frame until 24 months after the date you purchased your contacts.

Contact Lenses – Medically Necessary

Medically necessary contact lenses may be prescribed by a VSP doctor for certain conditions. A VSP doctor must receive prior approval from VSP for medically necessary contact lenses. Upon approval from VSP, the medically necessary contact lenses will be paid according to the Schedule of Benefits. When prescribed by a non-member doctor, the non-member doctor must get prior approval from VSP for this benefit to be paid.

A patient who has received contact lenses either Elective or Medically Necessary would again be eligible for vision benefits as follows:

- Examination and conventional lenses, after 12 months;
- Frames, after 24 months; and
- Contact lens replacement, after 12 months if a change in prescription so indicates.

SERVICES NOT PAID UNDER VISION BENEFITS

- Replacement of lost or broken lenses or frames which are furnished under the Plan, except at the normal intervals when services are otherwise covered;
- Glasses secured when no prescription change is warranted;
- Sunglasses, plain or prescription;
- Photosun lenses or tinted lenses, except pink shades No. 1 and 2;
- Pano (non-prescription) lenses;
- Two pairs of glasses in lieu of bifocals;
- Any excess charge for no-line bifocals (blended type), unless the doctor certifies that the no-line bifocal (blended type) is necessary and prior approval is obtained.
- Special procedures, such as orthoptics and visual training;
- Contact lenses and subnormal vision aids, except as described in this section;
- Medical or surgical treatment of the eyes. You will be notified if an examination indicates that this type of treatment is required and, if desired, a referral will be made. However, the Vision Benefit will not pay for medical or surgical treatment, whether or not a referral is

made. (See Medical Benefits section for medical and surgical coverage.);

- Services or materials which are payable under Workers' Compensation, employer liability or similar program;
- Services which are provided without cost through any government agency;
- Eye examinations required as a condition of employment, which the employer must provide by virtue of a labor agreement; and
- Eye examinations required by a government body.