APEA-AFT Health & Welfare Trust

Employee Benefit Plan

Juneau Education Support Staff

Effective Date: March 1, 2006
Restatement Date: July 1, 2007

RBMS, LLC dba
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PREFACE

Introduction and Purpose
The Plan Sponsor has established the Plan for the benefit of eligible Employees, on the terms and conditions described herein. With the exception of large medical claims, for which the Plan Sponsor is protected by excess loss insurance, Plan benefits are paid by the APEA-AFT Health & Welfare Trust (the "Trust") and supplemented by the contributions you make to participate. The Participating Employers and the Trust are independent of all health care providers and are not themselves providers of health care.

The Plan Sponsor's purpose in establishing the Plan is to help to offset, for eligible Employees, the economic effects arising from a non-occupational Injury or Illness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent. Through careful use of the Plan, you, as a consumer of health care, can have a direct impact on the cost of the Plan. This will benefit you by allowing the Plan to continue to provide this high quality level of benefits.

This Plan Document is both the Plan Document and the "Summary Plan Description" or "SPD." The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for Hospital, medical, or dental charges. The Plan Document is maintained by the Plan Sponsor and may be inspected at any time during normal working hours by any Covered Person.

Certain terms used in this SPD have been capitalized, indicating that they are defined. The meaning for these defined terms may be found in the section, "Definitions", or, where appropriate, certain terms are defined within a related section of the SPD. Please contact the Claims Administrator for assistance in understanding any defined term.

Legal Entity; Service of Process
The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract
This Plan Document and any Amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Participating Employer and any Covered Person or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Participating Employer or to interfere with the right of the Participating Employer to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Participating Employer with the bargaining representatives of any Employees.

General Benefit Information
In order to receive benefits under the Plan:

1. You must be covered under the Plan;
2. You must Incur an expense for which a benefit is payable;
3. The expense must be Incurred during the period of time and under the conditions specified by this Plan; and
4. A claim must be filed within the specified time period.

The Plan Administrator has hired a claims administration organization, RBMS, to perform certain administrative functions for the Plan and uses Medical Rehabilitation Consultants for Utilization Review (UR). If you have questions regarding your coverage or how benefits have been paid, contact RBMS at 907-561-3740 or 800-770-3740.

Please read this Summary Plan Description thoroughly and become familiar with the provisions of the Plan. If you have questions regarding your Plan's benefits or the procedures necessary to receive these benefits, please call RBMS at the above telephone numbers.

Customer Service
RBMS, as the Claims Administrator, is available to provide telephonic customer service assistance to help answer questions about eligibility and benefits as a service and convenience for Covered Persons. RBMS cannot anticipate all of the specific Plan information that may apply to your question. The Schedule of Benefits in this Summary Plan Description contains important benefit payment information including Deductible, Benefit Percentage and Out-of-Pocket Expense Maximum information, along with any lifetime and plan year maximums that apply to certain services. Important information is also contained in the sections for "Major Medical Benefits" and "Exclusions and Limitations." In addition, the Plan has other requirements and provisions that may affect benefits, such as "Cost Containment Provisions," and it is strongly recommended that you read the entire Summary Plan Description to ensure a complete understanding of the Plan provisions.

Customer service assistance provided by RBMS is not a guarantee of eligibility, coverage or benefits. RBMS relies upon the information provided by the Plan Administrator and will provide assistance to Covered Persons on that basis. This information is subject to changes which may not be available to RBMS at the time of the inquiry. All benefit determinations will be based upon the provisions of this Plan and the decision of the Plan Administrator in its sole discretion.

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ESTABLISHMENT OF THE PLAN;
ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION (the "Summary Plan Description"), made by APEA-AFT Health & Welfare Trust (the "Plan Sponsor") as of July 1, 2007, hereby amends and restates the APEA-AFT Health & Welfare Trust Employee Benefit Plan (the "Plan"), which was originally adopted by the Plan Sponsor, effective March 1, 2006.

Effective Date
The Summary Plan Description is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, or on such other date as specified in an applicable collective bargaining agreement with respect to the employees covered by such agreement.

Adoption of the Summary Plan Description
The Plan Sponsor, as the settlor of the Plan, hereby adopts this Summary Plan Description as the written description of the Plan. This Summary Plan Description represents both the plan document and the summary plan description. This Summary Plan Description amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

This Plan is maintained pursuant to an agreement between the Participating Employers, and the Juneau Education Support Staff Local 6096 (the "Union"). A copy of the agreement between the Participating Employers and the Union may be obtained upon written request to the Plan Administrator and is available for examination at the Plan Sponsor's principal office, and at each establishment of the Participating Employers in which at least 50 employees are customarily working. In the case of employees who do not usually work at, or report to, a single establishment of the Participating Employers, a copy of the agreement is available for examination at the meeting hall or office of Local 6096 of said Union in which there are at least 50 employees.

The association, committee, joint board of trustees, parent or most significant employer of a group of employers, all of which contribute to the Plan, or other similar representative of the parties who established or maintain the Plan, is APEA-AFT Health & Welfare Trust. Covered Persons may receive from the Plan Administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Plan, and if so, the sponsor's address.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Summary Plan Description to be executed.

APEA-AFT Health & Welfare Trust

By: 

Name: Dennis Geary

Title: Chairman

Date: 10/22/07

SCHEDULE OF BENEFITS

Major Medical Benefits

- **Deductibles, Out-of-Pocket Maximum Expense and Lifetime and Calendar Year Maximums**

Deductible, per Calendar Year	PPO and Non-PPO (Combined)
Individual	$500
Family	$1,500

Deductible, per Occurrence	PPO and Non-PPO (Combined)
Hospital Emergency Room	$50
The Hospital emergency room deductible will be waived if the Covered Person is admitted to the Hospital. Non-Emergency services provided in the emergency room will not be covered under the Plan.	

Out-of-Pocket Maximum Expense (excluding Deductibles), per Calendar Year	PPO and Non-PPO (Combined)
Individual	$1,000
Family	$3,000

Lifetime Maximums	PPO and Non-PPO (Combined)
Full Plan	$2,000,000
Substance Abuse	$28,985*
***Effective January 1, 2008, the Substance Abuse Lifetime Maximum will be:**	**$32,750**
Transplants – Organ & Tissue (includes donor's expenses)	$250,000

Calendar Year Maximums	PPO and Non-PPO (Combined)
Acupuncture	12 visits
Durable Medical Equipment	$5,000
Hearing Aid Expense	$800
Home Health Care	130 visits
Hospice Care • Inpatient • Outpatient	 10 days 6 months
Mental or Nervous Disorders • Inpatient • Outpatient	 30 days 50 visits
Private Duty Nursing	70 visits
Rehabilitation Therapy • Massage Therapy • Physical Therapy • Occupational Therapy	 (combined) 45 visits
Skilled Nursing/Convalescent Care Facility	120 days
Smoking Cessation Aids	$250

Substance Abuse Treatment	$14,495*
***Effective January 1, 2008, the Substance Abuse Calendar Year Maximum will be:**	**$16,380**

Per Occurrence Maximums	**PPO and Non-PPO (Combined)**
Transplant-Related Travel and Lodging – Per Transplant Benefit Period	$10,000
Transplant-Related Lodging Expense – Per Night (included in Travel and Lodging Maximum stated above)	$50

- **Benefit Percentages**

	PPO and Non-PPO Benefit Percentage
Acupuncture	70%
Ambulance	70%
Anesthesia	70%
Routine Cancer Screening	70%
Chiropractic Care	70%
Contraceptive Expenses	70%
Diagnostic X-ray and Laboratory	70%
Durable Medical Equipment	70%
Emergency Room Hospital Expenses – Calendar Year Deductible Waived	70%
Hearing Examination	80%
Hearing Aid Expense	70%
Home Health Care	70%
Hospice Care • PPO Facility • Out of Area Facility • Non-PPO Facility	 70% 70% 50%
Hospital Charges • PPO Facility • Out of Area Facility • Non-PPO Facility	 70% 70% 50%
For an Emergency admission to a non-PPO Hospital, Covered Expenses for the non-PPO Hospital will be reimbursed at 70%. Please refer to the section, "Cost Containment Provisions," for additional information.	
Mammograms	70%

Mental or Nervous Conditions
• Inpatient
  ○ PPO Facility
  ○ Out of Area Facility
  ○ Non-PPO Facility
• Outpatient
	
	70%
	70%
	50%
	70%

Neurodevelopmental Therapy	70%
Physician's Services – Medical and Surgical	70%

	PPO and Non-PPO Benefit Percentage
Preventive Care Exams – Includes Physical Exam, X-rays and Lab Tests, and Immunizations	
• Children, Birth to Age 1Year; limited to 6 exams per Calendar Year.	70%
• Children, Age 1 Year to Age 2 Years; limited to 2 exams per Calendar Year.	70%
• Children, Age 2 and older; limited to 1 exam per Calendar Year.	70%
• Adults, limited to 1 exam per Calendar Year.	70%
Private Duty Nursing	70%
Radiation and Chemotherapy	70%
Rehabilitation Therapy	
• Massage Therapy	70%
• Physical Therapy	70%
• Occupational Therapy	70%
Second Surgical Opinion	70%
Skilled Nursing/Convalescent Care Facility	
• PPO Facility	70%
• Out of Area Facility	70%
• Non-PPO Facility	50%
Substance Abuse Treatment	
• Inpatient	
○ PPO Facility	70%
○ Out of Area Facility	70%
○ Non-PPO Facility	50%
• Outpatient	70%
Transplants – Organ and Tissue	70%
All Other Covered Services	70%

Prescription Drug Benefits

Covered Prescription Drug Expenses:	Copayment Amount
Retail Pharmacy Option – *up to a 30-day supply*:*	
For generic drugs, per prescription or refill	$15
For preferred brand name drugs, per prescription or refill	$25
For non-preferred brand name drugs, per prescription or refill	$40
Mail Order Option – *up to a 90-day supply:*	
For generic drugs, per prescription or refill	$30
For brand name drugs, per prescription or refill	$50
For non-preferred brand name drugs, per prescription or refill	$80
* One copay for each 30 day supply of Retail Pharmacy Prescriptions; up to a 90-day supply maximum.	

Dental Benefits

Annual Deductible Amount	
Individual	$50
Family	$150

Benefit Percentages	
Type I – Diagnostic & Preventive (Not subject to Deductible)	100%
Type II – Restorative	80%
Type III – Reconstructive	50%

Maximum Benefits	
Calendar Year Maximum – Types I, II & III combined	$1,500

PREFERRED PROVIDER ORGANIZATIONS (PPOs)

The Plan has negotiated discounts for Covered Persons through Preferred Provider Organizations ("PPOs"). Benefits and out-of-pocket requirements vary if covered services are obtained from a PPO Preferred Provider versus a non-Preferred Provider or an out-of-area provider.

Participating Providers
Allowable charges will be reimbursed according to the Schedule of Benefits for Medically Necessary Covered Expenses. For providers who participate in the PPO, the allowable charge is the discounted fee that the providers have agreed to accept under our agreements with them. PPO Providers will seek payment from the Plan when they provide services to you. You will be responsible for any applicable Deductibles, copayments, Benefit Percentage balances, charges in excess of stated benefit maximums and charges for services or supplies not covered under the Plan. These amounts will be reflected on the "Explanation of Benefits" sent to you.

A "Participating Provider" or "Preferred Provider" is a provider in any state that has an agreement in effect with Providence Alaska Preferred, First Health or TAPPN, at the time services are rendered. The Plan has chosen Providence Alaska Medical Center as its participating acute-care Hospital in Anchorage. To determine if a particular provider is a Participating Provider, call the Claims Administrator at 907-561-3740 or 800-770-3740.

You have a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. You, together with your Physician, are ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The PPO Providers are independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any PPO Provider.

Non-participating Providers
When you use a non-Participating Provider, allowable charges will be paid at the Usual, Customary and Reasonable level and no discount will be given. You are also responsible for any applicable Deductibles, copayments, Benefit Percentage balances, charges in excess of the stated benefit maximums and charges for services or supplies not covered under the Plan. These amounts will be reflected on the "Explanation of Benefits" sent to you.

Exceptions will be made under the following circumstances:

1. If you must be taken to the nearest facility available for an Accident or Emergency; or
2. If a participating acute-care facility refers you to a non-participating facility.

Covered Persons Who Live Out-of-Area
If you live more than 25 miles outside the PPO service area, you are considered "out-of-area." This means that the Plan does not have agreements with Participating Providers in your area. You may come into the PPO service area for services and receive benefits at the Participating Provider level. If you come into the PPO service area for services and use a non-PPO Provider, your benefits will be paid at the non-PPO Provider level.

Covered Expenses for services received from an out-of-area acute-care Hospital will be reimbursed at the Out-of-Area Benefit Percentage.

Acute Care Facilities
The highest possible benefits are available when you use one of the Participating Providers listed below:

1. **Providence Alaska Preferred & TAPPN & First Health – Anchorage, Fairbanks, Kodiak, Palmer, Seward & Valdez**

    a. Fairbanks Memorial Hospital;
    b. Providence Alaska Medical Center;
    c. Providence Kodiak Island Medical Center;
    d. Providence Seward Medical Center;
    e. Providence Valdez Hospital. or
    f. Mat-Su Regional Medical Center.

2. **First Health - Outside Alaska**
    First Health has a listing of Participating Providers in all 50 states. If you are outside Alaska and require medical services, call First Health for a listing of Participating Providers at 888-685-7774, or RBMS at 800-770-3740 or 907-561-3740. You can also view First Health's listing of Participating Providers by accessing their web page at www.myfirsthealth.com.

3. **TAPPN**
    TAPPN has a listing of participating providers in Alaska. If you require medical services in Alaska, call RBMS at 800-770-3740 or 907-561-3740. You can also view the TAPPN providers at www.tappn.com.

Please note: Preferred Providers are subject to change. Please verify a providers' participation before obtaining services.

COST CONTAINMENT PROVISIONS

The Utilization Review ("UR") Program administrator is:

Medical Rehabilitation Consultants (MRC)
800-827-5058

Medical Rehabilitation Consultants has trained medical staff, Physicians and specialists who review and certify, in advance, hospitalizations and surgeries. Think of them as your medical consumer advocates.

UR is designed to help you make informed decisions about your medical care. It also helps you to use your group health benefits in the most cost-effective manner possible. By pointing out the alternatives that may be available to you, the program can help you to avoid unnecessary or more expensive medical procedures.

To benefit from UR, certification from Medical Rehabilitation Consultants must be obtained before you receive certain treatments or services listed below. Participation in the UR program is your responsibility. All it takes to start the certification process is a telephone call to Medical Rehabilitation Consultants at 800-827-5058. Whenever possible, notify Medical Rehabilitation Consultants ahead of time for medical care that requires certification under this program. You may call Medical Rehabilitation Consultants yourself or have your doctor, a relative, friend, or any other person call for you; however, it is your responsibility to make sure that the call is made.

Note: Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The UR program administrator will not interfere with your course of treatment or the Physician-patient relationship. All decisions regarding treatment and use of facilities will be yours and should be made independently of this program.

Pre-certification and post-certification are not a guarantee of eligibility or payment of benefits. It only means that the Plan or its authorized representative has confirmed that your Hospital admission meets Inpatient Hospital admission criteria for a given number of days. Payment of benefits is based on the provisions of this Plan and your eligibility for coverage at the time the expense is Incurred.

Utilization Review Requirements
The following is an explanation of the services that require certification:

- **Hospital Admissions**

Notify Medical Rehabilitation Consultants at least ten business days, or as soon as possible, before non-Emergency Hospitalization to obtain certification of Medical Necessity for the admission, including the number of days of Hospital Confinement.

- **Emergency Admissions**

When you are admitted to any Hospital on an Emergency basis, notify Medical Rehabilitation Consultants within two business days after admission (or as soon as possible after admission) to obtain certification, including the number of days of Hospital Confinement. In any event, notify Medical Rehabilitation Consultants before discharge.

Do not delay seeking medical care for any Covered Person who has a serious condition that may jeopardize his life or health because of the requirements of this program. For urgent, Emergency admissions, follow your Physician's instructions carefully, and contact Medical Rehabilitation Consultants within the time limit specified above. No penalty will be applied to your benefits if contact is made within this time period.

Since the Plan does not require you or a covered Dependent to obtain approval of a medical service prior to getting treatment for an urgent care or Emergency situation, there are no "Pre-service Urgent Care Claims" under the Plan. In an urgent care or Emergency situation, you or a covered Dependent simply follow the Plan's procedures following the treatment and file the claim as a "Post-service Claim."

- **Additional Hospital Days**

If your doctor believes that it is necessary for you to stay in the Hospital longer than the number of days that were originally certified, notify Medical Rehabilitation Consultants again to obtain certification for additional days.

- **Additional Services Requiring Certification**

Notify Medical Rehabilitation Consultants at least ten business days, or as soon as possible, before non-Emergency receipt of services or purchase of supplies listed below. If you require any of the following services on an Emergency basis, notify Medical Rehabilitation Consultants within two business days following the receipt of services or supplies, or as soon thereafter as possible.

- Outpatient Surgeries
- Home Health Nursing, including the associated Physical Therapy and Occupational Therapy
- Hyperbaric Oxygen Treatments
- Diagnostic radiology (excluding x-rays) CT, MRI, MRA and PET scans
- Skilled Nursing Facility Services
- Travel

CAUTION: Failure to comply with the UR pre-certification requirement may reduce the benefits otherwise available under the Plan.

Other Features

- **Alternate Course of Treatment**

The Plan Administrator may, at the recommendation of the case manager, determine that a service or supply, not otherwise listed for coverage under this Plan, be included for coverage, if the service or supply is deemed appropriate and necessary, and is in lieu of a more expensive, listed covered service or supply.

If a Covered Person, in cooperation with his or her provider, elects a course of treatment that is deemed by the Plan Administrator, in conjunction with the case manager, to be more extensive or costly than is necessary to satisfactorily treat the Illness or Injury, this Plan will allow coverage for the reasonable and appropriate value of the less costly or extensive course of treatment.

- **Individual Case Management**

Individual Case Management is a program to assist patients who suffer a long-term Illness or Injury. The Medical Rehabilitation Consultants case managers follow cases that require extended Hospital stays or on-going medical attention. Their goal is to work with the medical providers to help assure that all necessary services are provided while the patient's health benefit dollars are used as efficiently as possible.

Through early notification from utilization review nurses, case management can promptly become involved in potentially catastrophic cases and serve as a vehicle to significantly reduce the cost of catastrophic claims. The Medical Rehabilitation Consultants case manager becomes the patient's advocate. Patients and their families are often confused by the complexities of medical treatment and the variety of providers. This is a time when a patient whose Illness or Injury requires long-term or costly medical care needs a case manager who can provide emotional support and help coordinate services such as home health care or a Hospice Care Program.

Each of the Medical Rehabilitation Consultants case managers is a Registered Nurse. When requested to provide medical case management services, the Medical Rehabilitation Consultants case managers help to coordinate the attending Physician's plan of care, including the services of Physicians, nurses, Hospital social workers and Home Health Care Agencies. Most people prefer to recuperate at home rather than in a Hospital setting and, if medical care can be provided in the home rather than the Hospital, the Medical Rehabilitation Consultants case manager works with the Hospital's discharge planner and the patient's Physician to make the necessary arrangements for the home care. They help to arrange for such services as Physical Therapy, home nursing care, medical equipment or medication/drug treatment. The Medical Rehabilitation Consultants case managers also help obtain discounts on drugs, equipment and other services. They work with the patients and families to lessen the emotional trauma of serious Illness by addressing questions or concerns as they arise.

Medical Rehabilitation Consultants case managers also have access to the Medical Rehabilitation Consultants network of Physician advisors. These Physicians are board certified in various medical specialty areas. They serve as a valuable medical resource and are available for discussion with the case management nurses as well as the treating Physicians.

ELIGIBILITY AND ENROLLMENT; COMMENCEMENT AND TERMINATION OF COVERAGE

Eligibility for Individual Coverage
Each Employee will become eligible to enroll as a Covered Person on the first day of the month coinciding with or next following 31 days of Active Employment. A person who is an eligible Employee of more than one Participating Employer shall be covered as the Employee of only one employer. *Please see the definition of "Employee."* An Employee must actually begin work for the Participating Employer in order to be eligible.

Eligibility for Dependent Coverage
Each Employee will become eligible to enroll for coverage under this Plan for his or her Dependents on the latest of the following dates:

1. His or her date of eligibility for coverage of a Dependent as a Covered Person;
2. The date coverage for his or her Dependents first becomes available under the Plan; and
3. The first date upon which he or she or she acquires a Dependent.

An Employee may enroll his or her Dependents for coverage under the Plan only if he or she is a Covered Person. *Please see the definition of "Dependent."*

Effective Date of Employee Coverage
If completed enrollment forms are received by the Plan Administrator within 31 days of the date of eligibility, the Employee's coverage shall become effective at 12:01 A.M. on the date of eligibility. If an Employee fails to enroll within 31 days of eligibility, enrollment can occur only under the conditions specified under the sections entitled "Special Enrollment" or "Open Enrollment"**.**

If an eligible Employee is not Actively at Work due to a reason other than a medical condition on the date his or her coverage would otherwise become effective, coverage shall become effective on the day he or she returns to Active Employment.

Effective Date of Dependent Coverage
Coverage for Dependents will be effective at 12:01 A.M. on the earliest of the following dates:

1. On the Employee's effective date, if application is made at the same time as the Employee's initial enrollment;
2. From the moment of birth for the first 31 days for a Newborn Dependent Child, or a Child who is adopted or placed for adoption, and no Pre-existing Condition limitation will apply. If an Employee wishes to continue coverage beyond this 31-day period, written application for coverage and agreement to any required contribution must be made **during the first 31-day period from birth**; or
3. On the first day of eligibility, if application is made within 31 days of the date the Dependents become eligible for coverage.

If an Employee fails to enroll a Dependent within 31 days of eligibility, enrollment can occur only under the conditions specified under the sections entitled "Special Enrollment" or "Open Enrollment"**.**

A Dependent's effective date may not be prior to the Employee's effective date of coverage.

Special Enrollment

- **Special Enrollment for Individuals Losing Other Coverage**

An Employee is entitled to enroll in the Plan during a Special Enrollment Period if he or she meets all of the following requirements:

1. The Employee is eligible for coverage under the Plan but is not currently covered under the Plan;
2. The Employee previously declined to enroll in the Plan because of the existence of alternative group or other health coverage; and
3. The Employee was covered under such alternative group or other health coverage at the time he or she signed the waiver, and such coverage is no longer available, for any of the reasons set forth below.

A Dependent is entitled to enroll in the Plan during a Special Enrollment Period if he or she meets all of the following requirements:

1. The Dependent is eligible for coverage under the Plan but is not currently covered under the Plan;
2. The Employee, Dependent or another appropriate person previously declined, on the Dependent's behalf, to enroll in the Plan because of the existence of alternative group or other health coverage; and
3. The Dependent was covered under such alternative group or other health coverage at the time he or she signed the waiver, and such coverage is no longer available, for any of the reasons set forth below.

If a Dependent loses eligibility for other coverage, an Employee who is already enrolled in the Plan may be eligible to change the current benefit election if the loss of coverage triggers a special enrollment right under the Plan. The change must be consistent with the event. You must make written application for special enrollment and your new Plan election within 31 days of the date the other health coverage was lost. Documentation, satisfactory to the Plan Administrator, must be provided regarding the loss of eligibility for other coverage. A Certificate of Creditable Coverage from the alternative health plan will be considered satisfactory documentation. If you are unable to obtain a Certificate of Creditable Coverage within the 31-day special enrollment period, you must notify the Plan Administrator or the Claims Administrator, and you must provide any available documentation in support of your enrollment due to loss of the alternative health coverage.

Coverage (other than COBRA continuation coverage) will be considered no longer available when it terminates because of Loss of Eligibility or termination of employer contributions toward the cost of such coverage. COBRA continuation coverage will be considered no longer available when the COBRA coverage is exhausted.

"Loss of Eligibility" shall mean loss of coverage resulting from legal separation, divorce, death, termination of employment, a reduction in the number of hours of employment, or any loss of eligibility after a period that is measured based on any of those events. Loss of Eligibility shall not mean loss of coverage resulting from an individual's failure to pay premiums on a timely basis or any termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of fact in connection with such coverage.)

- **Special Enrollment for New Dependents**

An Employee is entitled to enroll himself and/or his or her Dependents in the Plan during a Special Enrollment Period if all of the following requirements are met:

1. The Employee and/or his or her Dependent is eligible for coverage under the Plan but is not currently covered under the Plan;
2. The Employee previously declined this enrollment in the Plan; and
3. An individual became a Dependent of the Employee through marriage, birth, adoption or placement for adoption.

"Special Enrollment Period" shall mean, with respect to individuals losing coverage, the period which ends 31 days after:

1. The date on which the coverage is exhausted, if the coverage was COBRA continuation coverage; or
2. The date on which the coverage terminated because of Loss of Eligibility or termination of employer contributions toward the cost of such coverage, for other individual or group health coverage.

With respect to special enrollment for new Dependents, the period which ends 31 days after the date of one of the following, triggers the special enrollment rights:

1. Marriage;
2. Birth;
3. Adoption; or
4. Placement for adoption.

"Enrollment Date" shall mean the first day of coverage or, if there is a waiting period, the first day of the waiting period. The definition of "Enrollment Date" is very important because it determines when the Pre-Existing Condition look-back period begins and when the limitation period begins and ends. *Please see the section entitled "Special Restrictions for Pre-Existing Conditions."*

Open Enrollment
A period between August 15th and September 15th of each Calendar Year has been designated as an annual open enrollment period during which individuals who are currently eligible for this Plan may add or delete themselves and their Dependents to or from coverage. Any such changes will become effective at 12:01 A.M. on October 1st next following the open enrollment, unless the Employee has not satisfied any waiting period, in which event coverage for the Employee and his or her Dependents will become effective at 12:01 A.M. on the first day of the month following completion of the waiting period.

All individuals who are added to the Plan during an annual open enrollment period will be Late Enrollees, subject to the applicable provisions for Pre-Existing Conditions set forth in this Plan.

Qualified Medical Child Support Orders
The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a "Qualified Medical Child Support Order" ("QMCSO") if such an individual is not already covered by the Plan as an Eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

"Alternate Recipient" shall mean any Child of a Covered Person who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Covered Person's Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible Dependent,.

"Medical Child Support Order" shall mean any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Covered Person's Child or directs the Covered Person to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"National Medical Support Notice" or "NMSN" shall mean a notice that contains the following information:

1. Name of an issuing state agency;
2. Name and mailing address (if any) of an employee who is a Covered Person under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the Child or Children of the Covered person or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

"Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Covered Person or Eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Covered Person and the name and mailing address of each such Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

In addition, a National Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "National Medical Support Notice";

2. a. Identifies either the specific type of coverage or all available group health coverage. If the employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated; or
   b. Informs the Plan Administrator that, if a group health plan has multiple options and the participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the Child will be enrolled under the Plan's default option (if any); and

3. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Covered Persons and Eligible Beneficiaries without regard to this section, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator shall, as soon as administratively possible:

1. Notify the Covered Person and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and
2. Make an administrative determination if the order is a QMCSO and notify the Covered Person and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice, the plan Administrator shall:

1. Notify the state agency issuing the notice with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:

    a. Whether the Child is covered under the Plan; and
    b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and

2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator shall:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order; and
2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

When Coverage Ends
Coverage will end without notice at 11:59 P.M. on the earliest to occur of the following dates:

1. For an Employee and his or her Dependents, on the date of termination of the Plan;
2. For an Employee or his or her Dependents, on the date of the expiration of the last period for which a contribution was made, in the event of a failure to make a contribution when due;
3. For an Employee and his or her Dependents, on the last day of the month in which the Employee ceases to be eligible for coverage under the Plan;
4. For Dependents, on the last day of the month in which he or she ceases to be eligible for coverage under the Plan as a Dependent;
5. For Dependents, on the date of termination of Dependent Coverage under the Plan; and
6. For an Employee and his or her Dependents, immediately after an Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Please note: An Employee must notify the Claims Administrator or the Plan Administrator immediately when an enrolled Dependent is no longer eligible to be enrolled in the Plan. If notice is not provided, the Plan Administrator, in its sole discretion, will determine the date on which coverage terminated according to the provisions of this Plan. Any claims paid by the Plan that were Incurred after the termination date will be subject to reimbursement according the "Right of Recovery" provision.

Continuation during FMLA Leave
The Plan will at all times comply with FMLA. During any leave taken under FMLA, you may maintain coverage under this Plan on the same conditions as if you had been continuously employed during the entire leave period. To continue your coverage, you must comply with the terms of the Plan, including election during the Plan's open enrollment period, and pay your contributions, if any. Contact the Participating Employer for information concerning your eligibility for FMLA.

Continuation during USERRA Leave
If you are absent from employment because you are in the Uniformed Services, you may elect to continue your coverage under this Plan for up to 24 months. To continue coverage, you must comply with the terms of the Plan, including election during the Plan's annual enrollment period, and pay your contributions, if any. In addition, USERRA also requires that, regardless of whether you elected to continue your coverage under the Plan, your coverage and your dependents' coverage be reinstated immediately upon your return to employment, so long as you meet certain requirements contained in USERRA.

Continuation during Other Approved Leave of Absence
If you are absent from work due to a temporary lay-off, or through a non-FMLA leave of absence approved by your Participating Employer, you may continue your coverage under this Plan for up to 90 days. You and your Participating Employer must comply with the terms of the Plan, including election during the Plan's open enrollment period, and pay all required contributions.

Certificates of Coverage
The Plan generally will automatically provide a Certificate of Coverage to anyone who loses coverage in the Plan. In addition, a Certificate of Coverage will be provided upon request, at any time while the individual is covered under a plan and up to 24 months after the individual loses coverage under the Plan.

The Plan will make reasonable efforts to collect information applicable to any Dependents and to include that information on the Certificate of Coverage, but the Plan will not issue an automatic Certificate of Coverage for Dependents until the Plan has reason to know that a Dependent is or has been covered under the Plan.

SPECIAL RESTRICTIONS ON PRE-EXISTING CONDITIONS

Special Restrictions for Pre-Existing Conditions
A Pre-Existing Condition limitation will apply for all Employees and Dependents entering or reentering the Plan on and after the effective date of the Plan, except as required under federal or state insurance law. No coverage is provided for expenses in connection with a Pre-Existing Condition.

A **"Pre-Existing Condition"** is any Sickness, Illness or Injury (other than Pregnancy), regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received, by or from a health care provider or practitioner duly licensed to provide such care under applicable state law and operating within the scope of practice authorized by such state law, during the six months immediately prior to the date an Employee's service waiting period commences, or, for a Late Enrollee, the first date of coverage under the Plan (the "Enrollment Date").

Coverage will be available for such condition on the day immediately following the expiration of 12 months after the Enrollment Date. A Covered Person has the right to demonstrate any Creditable Coverage, and the applicable period shall be reduced by the accumulated length of any prior periods of Creditable Coverage; however, any periods of Creditable Coverage that occurred before a Significant Break in Coverage (90 days or more) will not count to reduce the Pre-Existing Condition limitation period.

"Late Enrollee" shall mean a participant who enrolls in the Plan other than:

1. On the earliest date on which coverage can become effective for the individual under the terms of the Plan; or
2. Through special enrollment.

- **Proof of Creditable Coverage**

A Covered Person may prove Creditable Coverage by either of two methods:

1. For Creditable Coverage effective on or after July 1, 1996, the Covered Person may present a written Certificate of Coverage from the source or entity that provided the coverage showing:

    a. The date the Certificate was issued;
    b. The name of the group health plan that provided the coverage;
    c. The name of the Covered Person or Dependent to whom the Certificate applies;
    d. The name, address, and telephone number of the Plan Administrator or issuer providing the Certificate;
    e. A telephone number for further information (if different);
    f. Either:

        (1) A statement that the Covered Person or Dependent has at least 12 months (365 days) of Creditable Coverage, not counting days of coverage before a Significant Break in Coverage; or
        (2) The date any waiting period (and affiliation period, if applicable) began and the date Creditable Coverage began; and

    g. The date Creditable Coverage ended, unless the Certificate indicates that coverage is continuing as of the date of the Certificate; or

2. If the Covered Person for any reason is unable to obtain a Certificate from another plan (including because the Creditable Coverage was effective prior to July 1, 1996), he or she may demonstrate Creditable Coverage by other evidence, including but not limited to documents, records, third-party statements, or telephone calls by this Plan to a third-party provider of medical services. This Plan will treat a Covered Person as having provided a Certificate if that individual:

    a. Attests to the period of Creditable Coverage;
    b. Presents relevant corroborating evidence of some Creditable Coverage during the period; and
    c. Cooperates with the Plan Administrator's efforts to verify his or her status.

A Covered Person has the right to request a Certificate from his or her current or prior health plan, and the Plan Administrator will help the Covered Person in obtaining the Certificate.

Proof of Indian Health Service (IHS) eligibility will satisfy the requirement of a certificate of Creditable Coverage.

- **Notice of Pre-Existing Condition Exclusion**

If, within a reasonable time after receiving the information about Creditable Coverage described in the section entitled "Proof of Creditable Coverage," the Plan Administrator determines that an exclusion for Pre-Existing Conditions applies, it will notify the Covered Person of that conclusion and will specify the source of any information on which it relied in reaching the determination. Such notification will also explain the Plan's appeals procedures and give the Covered Person a reasonable opportunity to present additional evidence.

If the Plan Administrator later determines that an individual did not have the claimed Creditable Coverage, the Plan Administrator may modify its initial determination to the contrary. In that case, the individual will be notified of the reconsideration; however, until a final determination is reached, the Plan Administrator will act in accordance with its initial determination in favor of the Covered Person for the purpose of approving medical services.

CONTINUATION OF COVERAGE UNDER COBRA

Introduction
The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to Covered Persons when they otherwise would lose their group health coverage. It also can become available to other members of the Covered Persons family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the person. Coverage will end in certain instances, including if the Covered Person or their covered dependents fail to make timely payment of premiums. Covered Persons should check with their employer to see if COBRA applies to them and their covered dependents.

COBRA Continuation Coverage
"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of the employer's plan) are not considered for continuation under COBRA.

Qualifying Events
Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." The Employee, the Employee's spouse, and the Employee's dependent Children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event.

A covered Employee (meaning an employee covered under the Plan) will become a Qualified Beneficiary if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events happens:

1. The hours of employment are reduced; or
2. The employment ends for any reason other than gross misconduct.

The spouse of a covered Employee will become a Qualified Beneficiary if he or she loses his or her coverage under the Plan because any of the following Qualifying Events happens:

1. The spouse dies;
2. The spouse's hours of employment are reduced;
3. The spouse's employment ends for any reason other than his or her gross misconduct;
4. The spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. The spouse becomes divorced or legally separated from his or her spouse.

Dependent Children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-covered Employee dies;
2. The parent-covered Employee's hours of employment are reduced;
3. The parent-covered Employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The Child stops being eligible for coverage under the plan as a "Dependent Child."

Employer Notice of Qualifying Events
When the Qualifying Event is the end of employment, reduction of hours of employment, death of the covered Employee, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the Qualifying Event.

Employee Notice of Qualifying Events
Each covered Employee or Qualified Beneficiary is responsible for providing the Plan Administrator with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

1. Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee (or former employee) from his or her spouse;
2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan;
3. Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;
4. Notice that a Qualified Beneficiary entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of Continuation Coverage; and
5. Notice that a Qualified Beneficiary, with respect to whom a notice described in paragraph (4) above has been provided, has subsequently been determined by the SSA to no longer be disabled.

The Plan Administrator is:

APEA-AFT Health & Welfare Trust
c/o RBMS, LLC
PO Box 241569
Anchorage, AK 99524-1569
Phone 907-561-3740
Fax 907-563-7763

A form of notice is available, free of charge, from the Plan Administrator and must be used when providing the notice.

- **Deadline for providing the notice**

For Qualifying Events described in (1), (2) or (3) above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date on which the relevant Qualifying Event occurs;
2. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
3. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

For the disability determination described in (4) above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date of the disability determination by the SSA;
2. The date on which a Qualifying Event occurs;

3. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
4. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

For a change in disability status described under (5) in the section, "Employee Notice of Qualifying Events", above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled; or
2. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must be postmarked (if mailed), or received by the Plan Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if the person is electing COBRA Continuation Coverage, his or her coverage under the Plan will terminate on the last date for which he or she is eligible under the terms of the Plan, or if the person is extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

- **Who Can Provide the Notice**

Any individual who is the covered Employee (or former employee), a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee (or former employee) or Qualified Beneficiary, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

- **Required Contents of the Notice**

The notice must contain the following information:

1. Name and address of the covered Employee or former employee;
2. Identification of the initial Qualifying Event and its date of occurrence, if the person is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period;
3. A description of the Qualifying Event (for example, divorce, legal separation, cessation of dependent status, entitlement to Medicare by the covered Employee or former employee, death of the covered Employee or former employee, disability of a Qualified Beneficiary or loss of disability status);
4. In the case of a Qualifying Event that is divorce or legal separation, name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan, date of divorce or legal separation, and a copy of the decree of divorce or legal separation;
5. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former employee, date of entitlement, and name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan;
6. In the case of a Qualifying Event that is a Dependent Child's cessation of dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age, lost student status, married or other);

7. In the case of a Qualifying Event that is the death of the covered Employee or former employee, the date of death, and name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan;
8. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;
9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
10. A certification that the information is true and correct, a signature and date.

If a copy of the decree of divorce or legal separation or the SSA's determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or legal separation or the SSA's determination within 30 days after the deadline. The notice will be timely if done so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or legal separation or the SSA's determination is provided.

If the notice does not contain all of the required information, the Plan Administrator may request additional information. If the individual fails to provide such information within the time period specified by the Plan Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the covered Employee (or former employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Electing COBRA Continuation Coverage
Complete instructions on how to elect COBRA Continuation Coverage will be provided by the Plan Administrator within 14 days of receiving the notice of the Qualifying Event. The individual then has 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates and the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their spouses, and parents may elect COBRA Continuation Coverage on behalf of their Children.

In the event that the Plan Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the Plan Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

Duration of COBRA Continuation Coverage
COBRA Continuation Coverage will be available up to the maximum time period shown below. Generally, multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event; however, if the first Qualifying Event is the covered Employee's entitlement to Medicare benefits, followed by termination or reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

1. 36 months after the date the covered Employee became entitled to Medicare benefits; and
2. 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours.

For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the covered Employee (or former employee), the covered Employee's (or former employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce or legal separation, or a Dependent Child's losing eligibility as a Dependent Child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the covered Employee's hours of employment, and the covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA Continuation Coverage for his spouse and Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

- **Disability Extension of COBRA Continuation Coverage**

If an Employee or anyone in an Employee's family covered under the Plan is determined by the SSA to be disabled and the Employee notifies the Plan Administrator as set forth above, the Employee and his or her entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee will be charged for this extended COBRA Continuation Coverage.

- **Second Qualifying Event Extension of COBRA Continuation Coverage**

If an Employee's family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the spouse and Dependent Children in the family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event properly is given to the Plan as set forth above. This extension may be available to the spouse and any Dependent Children receiving COBRA Continuation Coverage if the covered Employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, 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.

Shorter Duration of COBRA Continuation Coverage

COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

1. The date the employer ceases to provide a group health plan to any employee;
2. The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
3. The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first). However, a Qualified Beneficiary who becomes covered under a group health plan which has a pre-existing condition limit must be allowed to continue COBRA Continuation Coverage for the length of a pre-existing condition or to the COBRA maximum time period, if less; or
4. The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Premium Requirements
Once COBRA Continuation Coverage is elected, the individual must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Additional Information
Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator, who is:

APEA-AFT Health & Welfare Trust
c/o RBMS, LLC
PO Box 241569
Anchorage, AK 99524-1569
Phone 907-561-3740
Fax 907-563-7763

Current Addresses
In order to protect the rights of the Employee's family, the Employee should keep the Plan Administrator (who is identified above) informed of any changes in the addresses of family members.

The Trade Act of 2002
Two provisions under the Trade Act of 2002 (the "Trade Act") affect the benefits received under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 65% tax credit for premiums paid for certain types of health insurance, including COBRA premiums. Second, eligible individuals under the Trade Act who do not elect COBRA continuation within the election period will be allowed an additional 60-day period to elect COBRA continuation coverage. If the qualified beneficiary elects continuation during this second election period, the coverage period will run from the beginning date of the second election period. You should consult the Plan Administrator if you believe the Trade Act applies to you.

Multiple Qualifying Events
A second qualifying event could occur during the initial period of COBRA coverage due to the death of the former Employee, or the spouse if he elected separately and covered eligible Dependents, divorce, or other loss of eligibility such as a Dependent reaching the limiting age. When such a qualifying event occurs, the requirements specified in the sections entitled "Notice and Election Requirements" and "Premium

Requirements" will apply. The maximum time period for continuation following the second qualifying event will be combined with the preceding period of coverage under COBRA so that the total period of coverage will not exceed 36 months from date of the original qualifying event. Coverage may cease before the end of the maximum period as described in the section entitled "Maximum Time Periods."

MAJOR MEDICAL BENEFITS

Deductibles
A Deductible is a specified dollar amount of Covered Expenses you must Incur during a Calendar Year before any other Covered Expenses can be considered for payment at the Benefit Percentages stated in the Schedule of Benefits of this Plan. The amount credited toward a Deductible will not exceed the allowable charge for the covered service or supply.

Covered Expenses that are Incurred during the last three months of a Calendar Year which are applied to an individual's Deductible for that Calendar Year will also be allowed as credit toward the Deductible amount in the next Calendar Year.

Covered Expenses
Covered medical expenses are the Usual, Customary and Reasonable expenses Incurred by or on behalf of a Covered Person for the Hospital or other medical services listed below which are:

1. Ordered by a Physician;
2. Medically Necessary for the treatment of the Illness or Injury; and
3. Eligible for payment under the Plan.

Benefit Percentage
The Benefit Percentage is the percentage of Covered Expenses, in excess of the Deductible amount, which the Plan pays. The Benefit Percentage is listed in the Schedule of Benefits.

Lifetime and Calendar Year Maximums
The Lifetime Maximum, which is shown in the Schedule of Benefits, is the maximum amount the Plan will pay for Covered Expenses for each Covered Person during his or her lifetime, whether or not he or she has been continuously covered. Certain Calendar Year Maximums, which are the maximum amounts the Plan will pay for certain Covered Expenses for a Covered Person during a Calendar Year, are shown in the Schedule of Benefits. These Calendar Year maximums are part of, and not in addition to, the Lifetime Maximum.

Covered Major Medical Benefits
Subject to the Plan's provisions, limitations and exclusions, the following are covered major medical benefits:

1. **Acupuncture.** Charges for acupuncture services performed by a Physician as a form of anesthesia for a covered surgical procedure, or for treatment of chronic pain.

   For the purposes of acupuncture services, a Physician will include an acupuncturist certified by the American Association of Acupuncture and Oriental Medicine, who is practicing within the scope of both his certification and the laws of the jurisdiction where treatment is given.

2. **Ambulance.** Charges for transportation by professional ambulance, including approved available air and train transportation (excluding chartered air flights), to a local Hospital or transfer to the nearest facility having the capability to treat the condition.

3. **Anesthesia.** Charges for the cost and administration of an anesthetic.

4. **Birthing Center**. Charges for the services of a Birthing Center for Medically Necessary care provided within the scope of its license.

5. **Blood.** Charges for processing and administration of blood or blood components, excluding the cost of the actual blood or blood components if replaced.

6. **Cancer Screening.** Charges, including an associated office visit, for:

   a. An annual prostate cancer screening test for a Covered Person who is:

      (1) At least 35 years of age but less than 40 years of age and the person is in a high risk group. For purposes of this provision, "high risk" means a person who is an African-American or who has a family history of prostate cancer; or

      (2) 40 or more years of age.

   b. An annual Pap smear cancer screening test for a Covered Person who is 18 or more years of age.

   In this section, "prostate cancer screening tests" includes a prostate antigen blood test or another test that is equivalent or better in cancer detection.

7. **Chemotherapy.** Charges for chemotherapy and radiation therapy.

8. **Chiropractic Care.** Charges for spinal adjustment and manipulation, X-rays for manipulation and adjustment and other modalities performed by a Physician or other licensed practitioner, as limited in the Schedule of Benefits.

9. **Contraception Expenses.** Charges for contraceptive drugs (not covered elsewhere under the Plan) and devices which require a Physician's prescription and which are approved by the FDA. Examples include injectables (such as Depo-Provera), implants (such as Norplant), and Intrauterine Devices (IUDs). Covered Expenses include consultations, exams, procedures and other related medical services and supplies.

10. **Dental.** Charges for dental services rendered by a Physician or Dentist for the treatment of an Injury to the jaw or to the natural teeth, including the initial replacement of these teeth, and any necessary dental X-rays for the Injury, providing treatment is rendered during the Calendar Year in which the Accident occurred, or the next following Calendar Year. Treatment not rendered within this time period will not be covered under this benefit. Charges for anesthesia and facilities associated with dental services are covered if such services are required because of the Covered Person's condition.

11. **Diabetes Education.** Charges in connection with an outpatient self-management training or education program for diabetes, and medical nutrition therapy, if diabetes treatment is prescribed by a health care Provider. Coverage for the cost of diabetes outpatient self-management training or education and for the cost of medical nutrition therapy is only allowed if provided by a health care Provider with training in the treatment of diabetes. "Diabetes" includes insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes.

12. **Diagnostic Tests; Examinations.** Charges for X-rays, microscopic tests, laboratory tests, esophagoscopy, gastroscopy, proctosigmoidoscopy, colonoscopy and other diagnostic tests and procedures to diagnose a symptomatic Illness or Injury.

13. **Durable Medical Equipment.** Charges for rental, up to the purchase price, of Durable Medical Equipment, including glucose home monitors for insulin-Dependent diabetics. DME includes associated supplies for the necessary function of any equipment. At its option, and with its advance written approval, the Plan may cover the purchase of such items when it is less costly and more practical than rental. The Plan does not pay for:

    a. Repairs;
    b. Replacements for equipment still under warranty; or
    c. The rental or purchase of items which do not fully meet the definition of "Durable Medical Equipment."

14. **Hearing Aids and Hearing Examinations.** Charges for a routine hearing exam performed by a Physician, or an audiologist who is certified in audiology and is supervised by a Physician, and charges for a non-disposable electronic hearing device (including mold) and installation, in accordance with a written prescription by a Physician, subject to the limits stated in the Schedule of Benefits.

15. **Hemodialysis.** Charges for hemodialysis.

16. **Home Health Care.** Charges by a Home Health Care Agency for:

    a. Registered Nurses or Licensed Practical Nurses;
    b. Certified home health aides under the direct supervision of a Registered Nurse;
    c. Registered therapist performing physical, occupational or Speech Therapy;
    d. Physician calls in the home; and
    e. Services, drugs and medical supplies which are Medically Necessary for the treatment of the Covered Person that would have been provided in the Hospital, but not including Custodial Care.

    Each visit will count toward the Calendar Year visit maximum as listed on the Schedule of Benefits.

    Please Note: Transportation services are not covered under this benefit.

17. **Hospice Care.** Charges relating to Hospice Care provided the Covered Person has a life expectancy of 6 months or less, subject to the maximums, if any, stated in the Schedule of Benefits. Covered Hospice expenses are limited to:

    a. Room and Board for Confinement in a Hospice;
    b. Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Sickness;
    c. Medical supplies, drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition;
    d. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.);
    e. Home health aide services;
    f. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide;
    g. Medical social services by licensed or trained social workers, Psychologists or counselors;
    h. Nutrition services provided by a licensed dietitian;
    i. Respite care; and

j. Bereavement counseling, which is a supportive service provided by the Hospice team to Covered Persons in the deceased's Family after the death of the Terminally Ill person, to assist the Covered Persons in adjusting to the death. Benefits will be payable up to 15 visits per Family if the following requirements are met:

(1) On the date immediately before his or her death, the Terminally Ill person was in a Hospice Care Program and a Covered Person under the Plan; and
(2) Charges for such services are Incurred by the Covered Persons within 6 months of the Terminally Ill person's death.

18. **Hospital.** Charges made by a Hospital for:

a. Inpatient Treatment

(1) Daily Semi-Private Room and Board charges;
(2) Intensive Care Unit (ICU) and Cardiac Care Unit (CCU) Room and Board charges;
(3) General nursing services; and
(4) Medically Necessary services and supplies furnished by the Hospital, other than Room and Board.

b. Outpatient Treatment

(1) Emergency room;
(2) Treatment for chronic conditions;
(3) Physical Therapy treatments;
(4) Hemodialysis; and
(5) X-ray, laboratory and linear therapy.

19. **Hospital Audit and Case Management Fees.** Charges for an independent audit of Hospital records to determine Medical Necessity, for an independent audit of Hospital billing accuracy, and for UR case management services that have been approved by the Plan Administrator, in its sole discretion, as being reasonable and necessary to the determination of coverage under the Plan. Such charges may include the reasonable cost by a Provider for photocopies of medical records requested by the Plan for the purpose of the independent audit or case management services.

20. **Mammograms.** Charges in connection with mammograms will be covered as follows:

a. One baseline mammogram for a Covered Person who is at least 35 years of age but less than 40 years of age;
b. One mammogram every two years for a Covered Person who is at least 40 years of age but less than 50 years of age;
c. An annual mammogram for a Covered Person who is at least 50 years of age; and
d. A mammogram at any age for a Covered Person with a history of breast cancer or whose parent or sibling has a history of breast cancer, upon referral by a Physician.

21. **Massage Therapy**. Charges for massage are covered only when provided by or under the direct supervision of a Physician, up to the Rehabilitation Therapy maximum shown on the Schedule of Benefits.

22. **Mastectomy.** Charges in connection with a mastectomy will include the following:

a. Reconstruction of the breast on which the mastectomy has been performed;
b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
c. Prostheses and physical complications from all stages of mastectomy, including lymphademas;

in a manner determined in consultation with the attending Physician and the patient.

23. **Maternity Inpatient Stays**. Charges in connection with Hospital Inpatient expenses related to the Pregnancy of a Covered Person. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

24. **Medical Supplies.** Charges for dressings, casts, splints, trusses, braces and other Medically Necessary medical supplies, with the exception of dental braces or corrective shoes, but including syringes for diabetic and allergy diagnosis, and lancets and chemstrips for diabetics.

25. **Mental or Nervous Conditions.** Charges in connection with treatment of Mental or Nervous Conditions for:

    a. Inpatient and Outpatient treatment, including treatment of eating disorders (such as anorexia nervosa, bulimia, or any similar condition), when furnished by a Hospital, Qualified Treatment Facility, Physician, Psychologist, psychological associate, licensed marital family therapist, licensed professional counselor, or a licensed clinical social worker, up to the limits shown in the Schedule of Benefits;
    b. Individual and group counseling;
    c. Individual and group psychotherapy;
    d. Psychological testing; and
    e. Family counseling for Family members who are Covered Persons. Such treatment must be necessary and consistent with the condition of the Covered Person, whether rendered while confined in a Hospital or Qualified Treatment Facility, or on an Outpatient basis.
    f. Services rendered by a Residential Treatment Facility are not covered.

26. **Neurodevelopmental Therapy**. Charges for services in connection with neurodevelopmental therapy. Neurodevelopmental therapy consists of speech, physical or occupational therapy given to restore or improve a speech or body function, or develop a speech or body function delayed by a neurological disease; or maintain a speech or body function, if, without therapy, a neurological disease would cause significant deterioration in the Covered Person's condition.

    Not included are charges for any services unless they are prescribed by a Physician in accordance with a specific treatment plan that details the treatment to be rendered and the frequency and duration of the treatment and provides for on-going reviews and is renewed only if therapy is still Medically Necessary**.**

27. **Newborn Care.** Charges for Hospital and Physician nursery care for Newborns who are natural Children of the Employee during the first 31-day period from birth. Benefits will be provided under

the Child's coverage and the Child's own Deductible and Benefit Percentage provisions will apply. Covered Expenses include:

a. Hospital routine care for a Newborn during the Child's initial Hospital Confinement at birth; and
b. The following Physician services for well-baby care during the Newborn's initial Hospital Confinement at birth:

   (1) The initial Newborn examination and a second examination performed prior to discharge from the Hospital; and
   (2) Circumcision.

The Plan will cover a routine hearing exam during the first 30-day period from birth for a covered Dependent Child. A second exam will be covered if necessary to diagnose a condition identified during the initial hearing exam.

Benefits are also provided for Hospital and Physician nursery care for an Injury or Illness of Newborn as any other medical condition.

Please note: Coverage following the first 31-day period from birth will be available **only if the Newborn is properly enrolled in the Plan during the first 31-day period following birth.**

28. **Nursing Services.** Charges for services of a Registered Nurse or Licensed Practical Nurse.

29. **Obstetrical.** Physician's charges for obstetrical services are considered on the same basis as for an Illness, including the Covered Person's prenatal care; obstetrical and gynecological care rendered by a Nurse or Nurse Midwife.

30. **Occupational Therapy.** Charges for treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing Outpatient facility, up to the Rehabilitation Therapy maximum shown on the Schedule of Benefits.

31. **Oral Surgery.** Charges for Oral Surgery, limited to excision of neoplasms including benign, malignant and pre-malignant lesions, tumors or cysts, incision and drainage of cellulitis, surgical procedures involving accessory sinus, salivary glands and ducts.

32. **Oxygen.** Charges for oxygen and the rental of equipment for its own administration.

33. **Phenylketonuria (PKU).** Charges for the formulas necessary for the treatment of phenylketonuria.

34. **Physical Therapy.** Charges for treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing duly licensed Outpatient therapy facility, up to the Rehabilitation Therapy maximum shown on the Schedule of Benefits.

35. **Physician Services.** Charges for services of a Physician for Medically Necessary care, including office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care and surgical opinion consultations.

36. **Preventive Care* – Adults.** Charges for routine preventive care exams for covered Employees and covered spouses, including physical examination, routine x-ray and laboratory tests, and immunizations, limited to one exam per Calendar year.

37. **Preventive Care* – Dependent Children.** Charges for routine preventive care exams for covered Dependent Children, including physical examination, routine x-ray and laboratory tests, and immunizations, as follows:

    a. Birth to Age 1, limited to 6 exams per Calendar Year;
    b. Age 1 Year to Age 2, limited to 2 exams per Calendar Year; and
    c. Ages 2 and older, limited to one exam per Calendar Year.

    *All preventive care services must be provided in keeping with prevailing medical standards, be furnished or supervised by a Physician and comply with all other Plan provisions. Vision and hearing exams are not covered under this provision.

38. **Prosthetics.** Charges for the initial placement of prosthetic devices.

39. **Radiation Therapy.** Charges for radiation therapy and treatment.

40. **Second Surgical Opinions.** Charges for second opinions for proposed surgical procedures that are covered under the Plan.

41. **Skilled Nursing.** Charges made by a Skilled Nursing Facility or a Convalescent Care Facility, up to the limits set forth in the Schedule of Benefits, in connection with convalescence from an Illness or Injury (excluding drug addiction, chronic brain syndrome, alcoholism, senility, mental retardation or other Mental or Nervous Disorders) for which the Covered Person is confined, including:

    a. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis, such as general nursing services. If private room accommodations are used, the daily Room and Board charges allowed will not exceed the facility's average Semi-Private charges or an average Semi-Private rate made by a representative cross-section of similar institutions in the area;
    b. Medical services customarily provided by the facility, with the exception of the charges of medical providers that are separately billed, including private duty or special nursing services and Physician's services; and
    c. Drugs, biologicals, solutions, dressings and casts, furnished for use during the Convalescent Period, but no other supplies.

    Your Physician must certify that 24-hour nursing service is Medically Necessary. Separate stays due to related causes will be treated as one if your stays are separated by less than three months.

42. **Speech Therapy.** Charges for Speech Therapy, by a Physician or qualified speech therapist, when needed due to an Illness or Injury (other than a functional nervous disorder) or due to surgery performed as the result of a Illness or Injury, excluding speech therapy services that are educational in any part or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders. If the speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy.

43. **Substance Abuse.** Charges in connection with Substance Abuse for:

    a. Services rendered by a psychiatrist, Psychologist or a licensed clinical social worker who is under the direct supervision of a Physician;
    b. Inpatient charges up to the limits shown in the Schedule of Benefits for Substance Abuse made by a Hospital, Qualified Treatment Facility, Physician and for drugs and medicines which must be obtained only on the written prescription of a Physician;
    c. Charges for drugs and medicines which must be obtained only on the written prescription of a Physician and used other than while a registered bed patient in a Hospital;
    d. Individual and group counseling;
    e. Individual and group psychotherapy;
    f. Psychological testing; and
    g. Family counseling for Family members who are Covered Persons. Such treatment must be necessary and consistent with the condition of the Covered Person, whether rendered while confined in a Hospital or Qualified Treatment Facility, or on an Outpatient basis.

    No benefits are payable under this provision for treatment of nicotine habit or addiction.

44. **Surgery.** Charges for surgical operations and procedures, unless otherwise specifically excluded under the Plan, and limited as follows:

    a. Multiple procedures adding significant time or complexity will be allowed at:

        (1) 100% (full Usual, Customary and Reasonable value) for the first or major procedure; and

        (2) 50% for the second and subsequent procedures.

    b. Bilateral procedures which add significant time or complexity, which are provided at the same operative session, will be allowed at 100% of the Usual, Customary and Reasonable allowance for the major procedure, and 50% for the secondary or lesser procedure.

    c. Charges made for services rendered by an assistant surgeon will be allowed at 25% of the Usual, Customary and Reasonable allowance for the primary procedure for the type of surgery performed.

45. **TMJ Syndrome**. Charges in connection with temperomandibular joint (TMJ) syndrome or dysfunction.

46. **Voluntary Sterilization**. Charges for services and supplies in connection with tubal ligation and vasectomy.

Coverage for Organ and/or Tissue Transplants

The Plan Administrator strongly recommends that any covered person who is a candidate for any transplant procedure contact Utilization Review program administrator for a pre-authorization review before making arrangements for the procedure. This communication may identify certain types of procedures, or expenses associated with the procedures, which will not be covered under the Plan, before the actual services are rendered.

The benefits under this Plan are available only when the transplant recipient is a Covered Person.

- **Participating Transplant Centers**

As a result of the pre-authorization review, the Covered Person may be offered information about obtaining transplant services at a Participating Transplant Center. The term "Participating Transplant Center" means a licensed health care facility which has entered into a participation agreement with the Plan for certain fee arrangements to provide health services to Covered Persons in the Plan. The Participating Transplant Center's goal is to perform necessary transplants in the most appropriate setting for the procedure with consideration for and enhancement of the quality of patient care.

There is no obligation for the patient to use a Participating Transplant Center. However, benefits for the transplant and its related expenses may vary depending on whether services are provided in or out of the Participating Transplant Center. The Covered Person is free to decide whether or not to receive treatment, services or supplies provided by a Participating Transplant Center without regard to any benefits under this Plan.

- **Covered Transplant Expenses**

The term "Covered Expenses" with respect to transplants includes the Usual, Customary and Reasonable expenses for services and supplies which are covered under this Plan (or which are specifically identified as covered only under this provision) and which are Medically Necessary and appropriate to the transplant:

1. The type of transplant must not be experimental or investigative, based on the criteria stated in the definition of "Experimental Treatment." The type of transplants that meet our criteria for coverage are:

    a. Heart;
    b. Lung;
    c. Heart/lung;
    d. Liver;
    e. Kidney;
    f. Pancreas;
    g. Kidney/pancreas; and
    h. Certain autologous and allogeneic bone marrow transplants, including hematopoietic stem cell harvesting and infusion, whether harvested from bone marrow, peripheral blood or any other source.

2. Charges Incurred in the evaluation, screening and candidacy determination process.
3. Charges Incurred for organ transplantation
4. Charges for organ procurement, including donor expenses not covered under the donor's plan of benefits, as follows:

    a. Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ.
    b. Coverage for organ procurement from a living donor will be provided for the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant, as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow-up care.
    c. If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or donated marrow (allogeneic). Coverage will also be provided for search charges to identify an unrelated match, treatment and storage costs of the marrow, up to the time of re-infusion.
    d. Charges Incurred for follow-up care, including immunosuppressant therapy.

e. Charges for transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual. In addition, all covered lodging expenses are limited to a maximum per night as shown in the Schedule of Benefits. All reasonable and necessary transportation, lodging and meal expenses Incurred in connection with one procedure or treatment type will be limited to the Per Occurrence Maximum for a Transplant Benefit Period, as shown in the Schedule of Benefits.

- **Transplant Benefit Period**

Covered transplant-related travel and lodging expenses will accumulate during a Transplant Benefit Period, and will be charged toward the transplant Per Occurrence Maximums shown in the Schedule of Benefits. The term "Transplant Benefit Period" means the period that begins on the date of the initial evaluation and ends on the date that is twelve consecutive months following the date of the transplant. If the transplant is a bone marrow transplant, the date the marrow is re-infused is considered the date of the transplant.

- **Donor Expenses**

Medical expenses of the donor will be covered under this provision to the extent that they are not covered elsewhere under this Plan or any other benefit plan covering the donor. No coverage is provided for donor expenses when the transplant recipient is not a Covered Person under this Plan.

GENERAL EXCLUSIONS AND LIMITATIONS

This section applies to all benefits provided under any section of this Plan. No benefits are available for the following:

1. **Abortion**. Charges in connection with abortion, unless life-threatening to the mother or the result of incest or rape.

2. **Armed Forces; War**. Charges Incurred as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country; charges for services or supplies rendered or furnished to a Covered Person while he or she is in the active military service of any country. This exclusion does not apply to any Covered Person who is not a member of the armed forces.

3. **Billing**. For unbundled charges, to the extent multiple fees are billed which should have been included in a global fee or surgical suite rate. For fees which are upcoded or exploded, to the extent higher payment is requested than the procedures performed justify. For other billing activity outside the standard of medical or traditional billing practice.

4. **Cosmetic**. Charges for Cosmetic Procedures (including liposuction) and services or supplies for cosmetic purposes, except for the correction of defects incurred through traumatic injuries, services rendered to a Newborn that are necessary for treatment, or correction of a congenital defect, as the result of an Illness or the surgical procedure to treat an Illness or Injury, or as otherwise specifically included.

5. **Counseling.** Charges for counseling in connection with marriage, family, child, career, social adjustment, pastoral or financial issues, except as specifically included.

6. **Custodial Care**. Charges Incurred in connection with Custodial Care.

7. **Dental**. Anesthesia and facility charges associated with dental services and charges incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or a molar process and any other dental, orthodontic or oral surgical charges, **except as specifically included**.

8. **Education and Training.** Charges for education or training. This exclusion does not apply to an outpatient self-management training or education program for diabetes, as specifically included for coverage.

9. **Employment**. Charges arising out of or in the course of any employment or occupation for wage or profit, or for which the Covered Person is entitled to benefits under any Workers' Compensation or occupational disease law, or any such similar law.

10. **Excess Charges**. Charges in excess of the Usual, Customary and Reasonable allowance for the services or supplies, or in excess of any maximum or limits considered for benefits under the Plan.

11. **Exercise Programs**. Charges for exercise programs for treatment of any condition, except Physician-supervised, Medically Necessary cardiac rehabilitation or Occupational Therapy or Physical Therapy which is specifically included.

12. **Experimental**. Charges for Experimental Treatment.

13. **Foot Care**. Charges for routine foot care.

14. **Government**. Charges for care, treatment or supplies furnished by a program or agency funded by any government, except for Medicaid or when otherwise prohibited by law.

15. **Hair Loss**. Charges for care and treatment for hair loss, including wigs, hair transplants and any drug that promises hair growth, unless prescribed by a Physician. Please refer to the Schedule of Benefits for any limits associated with this benefit.

16. **Hospital Admissions**. Charges for Hospital admissions when such Confinement is for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations or tests not connected with the actual Illness or Injury, unless the tests could not have been performed on an Outpatient basis without adversely affecting the patient's physical condition or the quality of medical care rendered.

17. **Hospital Employees**. Charges for professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and who is paid by that Hospital or Facility for their services.

18. **Illegal Acts**. Charges related to, resulting from or occurring during the commission of a felony by the Covered Person, including without limitation, engaging in an illegal occupation or act, but excluding minor traffic violations.

19. **Immediate Family**. Charges for services rendered by a member of the Covered Person's immediate family or by a person who normally resides in the Covered Person's household. For purposes of this exclusion, "immediate family" means a spouse, Child, brother, sister, brother-in-law, sister-in-law, parent, parents-in-law or grandparent.

20. **Infertility.** Charges Incurred in connection with surrogacy, in-vitro fertilization, embryo transfer procedure, G.I.F.T. (Gamete Intrafallopian Transfer), artificial insemination, or any type of artificial impregnation procedure, whether or not such procedure is successful.

21. **Jaw Surgery**. Charges for jaw augmentation or reduction (orthognathic surgery), regardless of the origin of the condition that makes the procedure necessary.

22. **Medicare**. Charges to the extent they exceed the Medicare limiting charge, for Covered Persons for whom this Plan pays its benefits secondary to Medicare.

23. **Miscellaneous**. Charges Incurred for education or training other than as specifically provided in the Plan, hypnosis, standby Physician services, completion of forms, mailing and shipping expenses, missed appointments, telephone calls, or chelation therapy (except to treat heavy metal poisoning.

24. **No Coverage**. Charges for services or supplies which are Incurred at a time when no coverage is in force for that person.

25. **No Obligation**. Charges for which the Covered Person is not legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.

26. **Not Medically Necessary**. Charges for services or supplies which are not Medically Necessary for the diagnosis or treatment of an Illness or Injury.

27. **Not Recommended**. Charges for services or supplies not recommended by a qualified Physician, nutritional supplements and drugs, medicines or medical supplies that do not require a written prescription to purchase, services not performed according to accepted standards of medical practice, or services performed outside the scope of the provider's license.

28. **Orthotics**. Charges for Orthotic Appliances.

29. **Other Plan Provisions**. Charges for services and supplies that are specifically limited or excluded in other parts of this Plan or not specified as covered under the Plan.

30. **Other Types of Medicine**. Charges for homeopathy; naturopathy; primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; vision perception training; carbon dioxide therapy, and charges Incurred for holistic, environmental or ecologic health care, including drugs and ecologicals.

31. **Outside USA**. Charges Incurred outside the United States if the Covered Person traveled to such a location for the primary purpose of obtaining medical services, drugs or supplies.

32. **Personal Comfort**. Charges for services or supplies for personal comfort (for example, the difference between a private room charge and the Semi-Private allowance), beautification items and television or telephone use.

33. **Pre-Existing Conditions**. Charges for services and supplies for treatment of Pre-Existing Conditions, except as specifically included.

34. **Prosthetics**. Charges for replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

35. **Refusal to Comply**. For charges which cannot be evaluated for possible coverage under the Plan because the Employee or Covered Person refuses to comply with release of or requests for information.

36. **Self-Help**. Charges for biofeedback.

37. **Sexual**. Charges Incurred in connection with the reversal of surgical sterilizations, sexual dysfunctions or inadequacies, penile prosthetic implants, impotency drugs such as Viagra™, or sex transformations.

38. **Speech Therapy**. Charges in connection with Speech Therapy, except as specifically included.

39. **Subrogation**. Charges for or in connection with any Injury or Sickness subject to the "Third Party Recovery, Subrogation and Reimbursement" provision of this Plan, unless and until the requirements of that provision have been met to the satisfaction of the Plan Administrator in its sole discretion.

40. **Transplants**. Charges for transplants, except as provided in the transplant benefit provision. Non-human organs, Experimental or Investigational transplant services and supplies, and any transplant expenses which are eligible to be paid under any private or public research fund, government program or other funding program, are not covered.

41. **Travel**. Charges Incurred for travel, except as specifically included.

42. **Vision**. Charges Incurred in connection with eye refractions; the purchase or fitting of eyeglasses or contact lenses, except the initial purchase of eyeglasses or contact lenses following cataract surgery; radial keratotomy or other refractive surgery for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error.

43. **Weight**. Charges for care and treatment of obesity, including morbid obesity, weight loss or dietary control whether or not it is, in any case, part of the treatment plan for another Illness.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

PRESCRIPTION DRUG BENEFITS

"Participating Pharmacies" are pharmacies that have contracted with the Plan to charge reduced fees for covered drugs. Covered Persons will be issued an identification card to use at the Participating Pharmacy at time of purchase. A purchase directly from a Participating Pharmacy using the Plan identification card is called the "Retail Network Pharmacy Option". Covered Persons may not use a Plan identification card to purchase drugs at any time coverage is not in effect, and will be held fully responsible for the consequences of any such use.

An option is also available to order Maintenance Drugs through the mail (the "Mail Order Option"). "Maintenance Drugs" are medications prescribed for chronic, long-term Illnesses or Injuries which are required on a regular, recurring basis. Examples of chronic conditions that may require maintenance drugs are: asthma, heart disease, high blood pressure, high cholesterol, epilepsy and diabetes. Because of volume buying, Express Scripts, the mail order pharmacy, is able to offer the Plan significant savings on their prescriptions for Maintenance Drugs.

To obtain a list of Participating Pharmacies, or to arrange for purchase under the Mail Order Option, please contact:

Express Scripts
Attn: Claims Department
PO Box 66773
St. Louis, MO 63166-6773
888-201-5853
www.express-scripts.com

When you use either option, your claim for benefits will automatically be filed for you with the Claims Administrator.

If you fail to show your Plan identification card at the pharmacy, or if you use a non-Participating Pharmacy, you must pay for the cost of the drug and file your claim for reimbursement directly with Express Scripts at the address shown above. Your reimbursement will be determined based upon the amount that the Plan would have paid if you had used a Participating Pharmacy.

The copayment is applied as shown on the Schedule of Benefits. The copayment amount is not counted toward any Out-Of-Pocket Maximum Expense under the Plan.

Covered Expenses
The following are covered under the Plan:

1. All drugs prescribed by a Physician that require a prescription (including oral and non-injectable contraceptives) either by federal or state law, except the drugs excluded below;
2. All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity; and
3. Insulin, insulin syringes and needles, and insulin-related chemical strips, when prescribed by a Physician for the treatment of diabetes.

Limitations
The benefits set forth in this section will be limited to:

1. The cost of a generic drug if a generic drug is available. However, the brand name drug will be considered a covered expense if a generic drug is not available. If the Covered Person requests a brand name drug when a generic drug is available, even if the Physician has written DAW on the prescription, then, in addition to the generic drug copay, the Covered Person must pay the difference between the cost of the generic drug and the brand name drug.
2. Tretinoin agents used in the treatment of acne and/or for cosmetic purposes (ex. Retin-A) are covered through age 25 only.
3. Refills only up to the number of times specified by a Physician;
4. Refills up to one year from the date of order by a Physician;
5. With respect to the Retail Network Pharmacy Option, any one prescription is limited to a 30-day supply; and
6. With respect to the Mail Order Option, any one prescription is limited to a 90-day supply.

Exclusions
The following exclusions and limitations are in addition to those set forth in the section entitled "General Exclusions and Limitations." No benefits will be paid for the following:

1. **Devices.** Devices or appliances, support garments and other non-medicinal substances, regardless of their intended use, except as specifically included.
2. **Dispensing Limits.** For the Retail Network Pharmacy Option - More than a 30-day supply in any one prescription or refill. Through the Mail Order Option - more than a 90-day supply (or the amount otherwise limited by state law), when dispensed in any one prescription or refill. Through either method - Any prescription refill in excess of the number specified by the Physician or allowed by law, or any refill dispensed after one year from the order of the Physician or the maximum time allowed by law if less than one year.
3. **Experimental.** Drugs labeled "Caution - limited by federal law to Investigational use," or Experimental Treatment drugs, even though a charge is made to the individual.
4. **Government**. Prescriptions which an eligible person is entitled to receive without charge from any governmental program.
5. **Injection**. Charges for the administration or injection of any medication.
6. **Inpatient**. Medication which is taken or administered, in whole or part, while the person is confined in a Hospital or other health care facility
7. **Job-Related**. Prescriptions which an eligible person is entitled to receive without charge under any workers' compensation or similar law.
8. **Legend Drugs**. Anorexiants (weight-loss drugs) and anti-obesity drugs; fertility drugs; erectile dysfunction drugs; nutritional supplements; Rogaine; and smoking deterrent products.
9. **Lost Medication**. Replacement of lost or stolen medication.
10. **OTC**. Over-the-counter drugs, except for insulin, even if prescribed.
11. **Other Injectables**. Immunization agents, vaccines, blood, or blood plasma.

Prescription Drug Coordination of Benefits
You may also be covered under another prescription benefit program. This Plan includes a "coordination of benefits" feature to handle such situations. If the other program pays benefits first, you can submit your pharmacy receipts to Express Scripts for reimbursement. The amount of your reimbursement will be the amount you paid to the pharmacy for your prescription, less this Plan's applicable copayment amount. Please refer to the Schedule of Benefits for a listing of copayment amounts.

CuraScript Pharmacy
The CuraScript Pharmacy is available to service specialty medication prescription needs. Specialty medications tend to be more complex to administer and monitor than traditional medications. These

medications treat chronic conditions such as rheumatoid arthritis, multiple sclerosis, cancer, hepatitis, psoriasis, growth hormone, hemophilia and HIV/AIDS.

CuraScript is highly regarded for its series of CARE*Logic* programs, which are based on solid clinical management and patient adherence to prescribed therapies. The program also includes topics such as self-injection techniques and therapy-education during the new-patient enrollment process.

When you have filled a specialty medication for the first time at a retail pharmacy, you will receive information in the mail from Express Scripts informing you that you will need to contact CuraScript for your next refill. When you call the toll-free number, an Admission Coordinator will set-up the delivery of your next refill, and assign you to a dedicated Patient Care Coordinator. The Patient Care Coordinator will coordinate ongoing medication delivery, perform ongoing adherence and compliance monitoring, and provide medication refill reminders.

DENTAL BENEFITS

Type I: Diagnostic and Preventive Services
In accordance with the Schedule of Benefits, the Plan will pay for the following diagnostic and preventive services:

1. Routine oral examinations, limited to two examinations in any 12-month period, and problem-focused examinations limited to two examinations in any 12-month period.

2. Diagnostic services, including diagnostic x-rays, as follows:

    a. Full mouth series including bitewings, if needed, and panoramic film (limited to once in any 36 consecutive months);
    b. Bitewing films; and
    c. Vertical bitewing x-rays.

3. Topical fluoride application for Covered Persons under age 20, limited to two treatments in any 12-month period.

4. Prophylaxis, limited to two in any 12-month period.

5. Sealants for Covered Persons under age 14.

6. Space maintainers when needed to preserve space resulting from the premature loss of deciduous teeth, including all adjustments in the first six months after installation.

Type II: Restorative Services
In accordance with the Schedule of Benefits, the Plan will pay for the following restorative services:

1. Emergency palliative treatment.

2. Diagnostic x-rays, including:

    (a) Intraoral periapical or occlusal x-rays-single films; and
    (b) Extraoral superior or inferior maxillary film.

3. Extractions.

4. Amalgam, silicate, acrylic, synthetic, porcelain and composite filling restoration to restore diseased or accidentally broken teeth

5. Oral Surgery performed on the teeth or gums.

6. Transplantation of tooth or tooth bud.

7. General anesthetics and IV sedation administered in the Dentist's office in connection with covered oral or dental surgery.

8. Treatment of periodontal and other diseases of the gums and tissue of the mouth.

9. Injection of antibiotic drugs by an attending Dentist.

10. Endodontics, including root canal therapy.

11. Crowns (when tooth cannot be restored with a filling material):

    a. Prefabricated stainless steel; and
    b. Prefabricated resin crown (excluding temporary crowns).

12. Repair or re-cementing of crowns, inlays, and bridgework, and repair of dentures.

Type III: Reconstructive Services
In accordance with the Schedule of Benefits, the Plan will pay for the following reconstructive services:

1. Inlays, onlays, gold fillings and crown restorations (including post and core) to restore diseased or accidentally broken teeth, but only when the tooth, as a result of extensive cavities or fractures, cannot be restored by amalgam, silicate, acrylic, synthetic, porcelain or composite filling restoration.

2. Labial veneers, resin and porcelain laminate.

3. Initial installation of fixed bridgework, including inlays and crowns as abutments.

4. Initial installation of partial or full removable dentures, including precision attachments and any adjustments during the six-month period following installation.

5. Replacement of an existing partial or full removable denture, new bridgework or the addition of teeth to an existing partial or full removable denture or bridgework, except that only replacements and additions that meet the "Prosthesis Replacement Rule" below will be covered.

6. Relining or rebasing of dentures more than 6 months after initial placement or replacement of dentures.

7. Occlusal guard (for bruxism only) limited to one in any Calendar Year.

Prosthesis Replacement Rule
The "Prosthesis Replacement Rule" requires that replacements or additions to existing dentures or bridgework will be covered only if satisfactory evidence is furnished that one of the following applies:

1. The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture was installed;

2. The existing denture or bridgework cannot be made serviceable and was installed at least five years prior to its replacement; or

3. The existing denture is an immediate temporary denture that cannot be made permanent and replacement by a permanent denture is required and takes place within twelve months from the date of initial installation of the immediate temporary denture.

Dental Treatment Plan
If a Covered Person's proposed course of treatment reasonably can be expected to involve dental charges of $450 or more, a description of the procedures to be performed and an estimate of the charges may be filed with the Plan Administrator or Claims Administrator prior to the commencement of the course of treatment. **However, approval is not required prior to treatment.** Any pre-determination of dental benefits is provided only as a convenience to the Covered Person.

If requested, the Plan Administrator or Claims Administrator will notify the Covered Person, and the Dentist or Physician, of the pre-determination based upon such proposed course of treatment. In determining the amount of benefits available, consideration will be given to alternate procedures, services, supplies and courses of treatment which may be performed to accomplish the required result. **The pre-determination is not a guarantee of payment or approval of a benefit.** After treatment is received, a claim must be filed as a post-service claim, which will be subject to all applicable Plan provisions.

Dental Exclusions and Limitations
The following exclusions and limitations are in addition to those set forth in the section entitled "General Exclusions and Limitations." No benefits will be paid for the following:

1. Charges for Cosmetic Procedures, including, but not limited to, personalization or characterization of complete or partial denture restoration.

2. Charges for oral hygiene instructions, plaque control or dietary planning.

3. Charges for replacement of dentures and removable or fixed prosthesis due to theft, misplacement or loss.

4. Charges for appliances or restorations used solely to increase vertical dimensions, restore occlusion (orthodontia), to correct temporomandibular joint dysfunction (TMJ) or pain syndrome, or to correct attrition, abrasion or erosion.

5. Charges for space maintainers, except as specifically included.

6. Charges for general anesthesia and intravenous sedation in connection with a non-covered service.

7. Charges for services not provided by a Physician or Dentist, except cleaning and scaling of teeth and topical application of fluoride may be performed by a Licensed Dental Hygienist under the supervision of a Physician or Dentist.

8. Charges for any services or supplies which are eligible for coverage under any other part of the Plan.

9. Charges for fixed bridgework, or a crown or a gold restoration if involving a replacement or modification of a denture, bridgework, crown or gold restoration which was installed during the five years immediately preceding such replacement or modification.

10. Charges for any portion of a dental procedure Incurred before the effective date or after the termination of the individual's coverage.

    An expense will be considered Incurred as defined in the section, "Definitions," or as follows:

a. For an appliance or modification of an appliance, the date the impression was taken;
b. For crowns, bridge work or gold restorations, the date the tooth was seated; and
c. For root canal therapy, the date the pulp chamber was opened.

If the procedure is completed within 90 days after termination of coverage and the individual is not otherwise entitled to payment under any other like dental coverage of any type or source, the charge will be considered as Incurred prior to the date of termination.

11. Charges for temporary restorations.

12. Dental care that does not have ADA endorsement.

13. Customized dental procedures.

14. Charges for facility and anesthesiologist are specifically excluded, unless performed in a Dentist's office.

The Covered Person is responsible for payment of any charges that exceed any stated benefit limits or maximums and for any services and supplies not covered under this Plan. Charges for dental services in excess of the benefits available under this section are not covered under other sections of this Plan and do not accumulate toward the Out-of-Pocket Maximum Expense.

PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of RBMS, LLC to provide certain claims processing and other technical services.

Plan Administrator
The Plan is administered by the Plan Administrator. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is dissolved, is otherwise unable to perform, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies and care are Experimental Treatments), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Covered Person is entitled to them.

Duties of the Plan Administrator
The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Covered Person's rights;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a claims administration organization to pay claims;
9. To perform all necessary reporting;
10. To establish and communicate procedures to determine whether a medical child support order is a QMCSO;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan
The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust Agreement (if any).

Any such Amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which shall be acted upon as provided in the Plan Sponsor's Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable federal and state law. Notice shall be provided as required by applicable federal and state law. In the event that the Plan Sponsor is a different type of entity, then such Amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents.

If the Plan is terminated, the rights of the Covered Persons are limited to expenses Incurred before termination. Benefits under this Plan shall not vest. All Amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

CLAIM PROCEDURES; PAYMENT OF CLAIMS

This section applies to Medical, Dental and Prescription Drug claims

You will receive Plan identification (ID) card, which will contain important information, including claim filing directions and contact information. Your ID card will show your PPO network, and your Cost Containment Program administrator.

At the time you receive treatment, show your ID card to your provider of service. In most cases, your provider will file your claim for you. You may file the claim yourself by submitting the required information to:

RBMS, LLC
P.O. Box 241569
Anchorage, AK 99524-1569
907-561-3740
800-770-3740

Most claims under the Plan will be *"*Post Service Claims*."* A *"*Post Service Claim*"* is a claim for a benefit under the Plan after the services have been rendered. Post Service Claims must include the following information in order to be considered filed with the Plan:

A Form HCFA or Form UB92 completed by the provider of service, including:

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges (including PPO network repricing information);
6. The name of the Plan;
7. The name of the covered Employee; and
8. The name of the patient.

A call from a provider who wants to know if an individual is covered under the Plan, or if a certain procedure or treatment is a Covered Expense before the treatment is rendered, is not a "claim" since an actual claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

Under the Plan, there are three types of claims: Pre-service (Non-urgent), Concurrent Care and Post-service.

1. Pre-service Claims. A "Pre-service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

   A "Pre-service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the Covered

Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

It is important to remember that, if a Covered Person needs medical care for a condition which would seriously jeopardize his life, there is no need to contact the Plan for prior approval. The Covered Person should obtain such care without delay.

Further, if the Plan does not require the Covered Person to obtain approval of a specific medical service prior to getting treatment, then there is no Pre-service Claim. The Covered Person simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

2. Concurrent Claims. A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

   a. The Plan Administrator determines that the course of treatment should be reduced or terminated; or
   b. The Covered Person requests extension of the course of treatment beyond that which the Plan Administrator has approved.

   Since the Plan does not require the Covered Person to obtain approval of a medical service in an emergency or urgent care situation prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment in an urgent care situation. The Covered Person simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

3. Post-service Claims. A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

- **When Health Claims Must Be Filed**

Health claims must be filed with the Claims Administrator within 365 days of the date charges for the service were Incurred. Benefits are based upon the Plan's provisions at the time the charges were Incurred. **Claims filed later than that date shall be denied.**

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Claims Administrator in accordance with the Plan's procedures. However, a Post-service Claim is considered to be filed when the following information is received by the Claims Administrator, together with a Form HCFA or Form UB92:

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges (including repricing information);
6. The name of the Plan;
7. The name of the covered Employee; and
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within 45 days from receipt by the Covered Person of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

- **Timing of Claim Decisions**

The Plan Administrator shall notify the Covered Person, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Non-urgent Care Claims:

    a. If the Covered Person has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
    b. If the Covered Person has not provided all of the information needed to process the claim, then the Covered Person will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Covered Person will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Covered Person (if additional information was requested during the extension period).

2. Concurrent Claims:

    a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Covered Person of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Covered Person will be notified sufficiently in advance of the reduction or termination to allow the Covered Person to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
    b. Request by Covered Person Involving Non-urgent Care. If the Plan Administrator receives a request from the Covered Person to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a Post-service Claim).

3. Post-service Claims:

    a. If the Covered Person has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
    b. If the Covered Person has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Covered Person will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Covered Person will be notified of the determination by a date agreed to by the Plan Administrator and the Covered Person.

4. Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

5. Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

6. Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

- **Notification of an Adverse Benefit Determination**

The Plan Administrator shall provide a Covered Person with a notice, either in writing or electronically, containing the following information:

1. A reference to the specific portion(s) of the summary plan description upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary;
4. A statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Covered Person's claim for benefits;
5. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
6. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Covered Person, free of charge, upon request); and
7. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental Treatment), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, or a statement that such explanation will be provided to the Covered Person, free of charge, upon request.

Appeals of Adverse Benefit Determinations

- **Full and Fair Review of All Claims**

The provisions and timelines of the Appeal of Adverse Benefit Determinations noted below must be followed specifically or the Covered Person will lose their right to further review of the benefit claim determination. In cases where a claim for benefits is denied, in whole or in part, and the Covered Person believes the claim has been denied wrongly, the Covered Person may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Covered Person with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. Covered persons at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination and 60 days to appeal a second adverse benefit determination;
2. Covered persons the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
4. For a review that takes into account all comments, documents, records, and other information submitted by the Covered Person relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
5. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and
7. That a Covered Person will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim for benefits in possession of the Plan Administrator or the Claims Administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances.

First Appeal Level

- **Requirements for First Appeal**

The Covered Person must file the first appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, the Covered Person's appeal must be addressed as follows and mailed as follows:

RBMS, LLC
Claims Department
P.O. Box 241569
Anchorage, Alaska 99524-1569
Attention: Appeals Manager

It shall be the responsibility of the Covered Person to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Covered Person;
2. The Employee/Covered Person's social security number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Covered Person will lose the right to raise factual arguments and theories which support this claim if the Covered Person fails to include them in the appeal**;

5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Covered Person has which indicates that the Covered Person is entitled to benefits under the Plan.

If the Covered Person provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

- **Timing of Notification of Benefit Determination on First Appeal**

The Plan Administrator shall notify the Covered Person of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.

2. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – Pre-service Non-urgent or Post-service.

3. Post-service Claims: Within a reasonable period of time, but not later than 30 days after receipt of the appeal.

4. Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

- **Manner and Content of Notification of Adverse Benefit Determination on First Appeal**

The Plan Administrator shall provide a Covered Person with notification, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Summary Plan Description on which the denial is based;
3. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. A statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim for benefits;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Covered Person upon request;
6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, will be provided free of charge upon request;
7. A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary; and
8. A description of the Plan's review procedures and the time limits applicable to the procedures.

- **Furnishing Documents in the Event of an Adverse Determination**

In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as appropriate.

Second Appeal Level

- **Adverse Decision on First Appeal; Requirements for Second Appeal**

Upon receipt of notice of the Plan's adverse decision regarding the first appeal, the Covered Person has 60 days to file a second appeal of the denial of benefits. The Covered Person again is entitled to a "full and fair review" of any denial made at the first appeal, which means the Covered Person has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the Covered Person's second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal."

- **Timing of Notification of Benefit Determination on Second Appeal**

The Plan Administrator shall notify the Covered Person of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second appeal.

2. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – Pre-service Non-urgent or Post-service.

3. Post-service Claims: Within a reasonable period of time, but not later than 30 days after receipt of the second appeal.

4. Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

- **Manner and Content of Notification of Adverse Benefit Determination on Second Appeal**

The same information must be included in the Plan's response to a second appeal as a first appeal, except for:

1. A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is needed; and
2. A description of the Plan's review procedures and the time limits applicable to the procedures. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

- **Furnishing Documents in the Event of an Adverse Determination**

In the case of an adverse benefit determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.

- **Decision on Second Appeal**

If, for any reason, the Covered Person does not receive a written response to the appeal within the appropriate time period set forth above, the Covered Person may assume that the appeal has been denied.

Appeal to Arbitration

If the Covered Person is dissatisfied with the written decision of the Plan on the Second Appeal, the Covered Person may appeal the matter to arbitration in accordance with the Employee Benefit Plan Claim Arbitration Rules of the American Arbitration Association, provided that the Covered Person submit a written request for arbitration to the American Arbitration Association, together with the required filing fee, within 60 days of the date of the written decision of the Plan on the Second Appeal. Arbitration is the sole and exclusive remedy for challenging the decision of the Plan on the Second Appeal. If an appeal to arbitration is requested, the Plan shall submit to the arbitrator a complete copy of the record upon which the Plan made its decision to deny the benefit claim in both the First and Second Appeals, and the hearing before the Plan Administrator.

The question for the arbitrator shall be (1) whether the Plan Administrator was in error upon an issue of law, (2) whether the Plan Administrator acted arbitrarily, capriciously, or in bad faith in the exercise of its discretion, or (3) whether the findings of the Plan Administrator were supported by substantial evidence. The review by the arbitrator of the final decision or action of the Plan Administrator shall be based only on such evidence presented to the or considered by the Plan Administrator at the time that it made the decision or took the action which is the subject of the review.

The decision of the arbitrator shall be final and binding upon the Plan, upon the Covered Person, and upon all other parties whose interests are affected thereby.

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

The Plan will provide a copy of the American Arbitration Association Benefit Plan Claim Arbitration Rules to the Covered Person, or their designated representative, upon request, or those rules may be found online at www.adr.org.

Appointment of Authorized Representative

A Covered Person is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan Administrator, in writing, to the contrary.

Physical Examinations

The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose condition, Illness or Injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the

pendency of a claim. The Covered Person must comply with this requirement as a necessary condition to coverage.

Autopsy
The Plan reserves the right to have an autopsy performed upon any deceased Covered Person whose condition, Illness, or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

Payment of Benefits
All benefits under this Plan are payable, in U.S. Dollars, to the covered Employee whose Illness or Injury, or whose covered Dependent's Illness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered Employee and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, the Plan Administrator may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of this Plan, is or was providing the care and support of such Employee.

- **Assignments**

Benefits for expenses covered under this Plan may be assigned by a Covered Person to the provider; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

Hospitals must agree to submit itemized bills, chart notes and other medical records that are necessary and appropriate for any audit required at the discretion of Plan Administrator, and must agree to cooperate with the Plan's designated auditor free of charge in order for the Plan to honor any assignment of benefits by the Covered Person to the Hospital. Details are contained in the section, "Right to Audit".

- **Right to Audit**

At the sole discretion of the Plan Administrator, Hospital bills will be professionally audited for compliance with nationally-accepted billing and coding standards. In accordance with the guidelines described in the most current edition of the HOSPITAL CHARGEMASTER GUIDE published by Ingenix, and/or other appropriate, widely-accepted billing protocols as determined by the Plan Administrator, coverage for any undocumented or unbundled codes for services and supplies will be denied. Otherwise eligible charges by the Hospital must satisfy the Usual, Customary and Reasonable Fee definition in order to be Covered Expenses.

In order for the Plan to honor any assignment of benefits by the Covered Person to the Hospital:

- **The Hospital must agree to submit itemized bills, chart notes and other medical records that are necessary and appropriate for such an audit;**
- **The Hospital must agree to fully cooperate with the Plan's designated auditor; and**
- **The Hospital must comply with the audit and the Plan's designated auditor free of charge.**

Covered Person Responsibilities:

- **The Covered Person will be responsible for any amount owed to the Hospital due to its failure to comply with this provision.**

- **The Covered Person will be responsible for any amount owed to the Hospital for charges that are found to be in excess of the Usual, Customary and Reasonable Fee. Any such amounts will not be considered Covered Expenses under the Plan.**

Each Covered Person has a free choice of any provider, and the Covered Person, together with his provider, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

- **Non-U.S. Providers**

Medical expenses for care, supplies, or services which are rendered by a provider whose principal place of business or address for payment is located outside the United States (a "Non-U.S. Provider") are payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:

1. Benefits may not be assigned to a Non-U.S. Provider;
2. The Covered Person is responsible for making all payments to Non-U.S. Providers, and submitting receipts to the Plan for reimbursement;
3. Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred date;
4. The Non-U.S. Provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
5. Claims for benefits must be submitted to the Plan in English.

- **Recovery of Payments**

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, or are not paid according to the Plan's terms, conditions, limitations or exclusions. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the Covered Person or dependent on whose behalf such payment was made.

A Covered Person, Dependent, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan, in consideration of such payments, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in

strict accordance with their state's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, provider or other person or entity to enforce the provisions of this section, then that Covered Person, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

- **Medicaid Coverage**

A Covered Person's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Covered Person. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as required by the state Medicaid program; and the Plan will honor any subrogation rights the state may have with respect to benefits which are payable under the Plan.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent duplication of benefits. It applies when the Employee or any of his or her Dependents who are covered by the Plan are also covered by one or more Other Plans. When more than one coverage exists, one Plan normally pays its benefits in full and the other Plans pay a reduced benefit. This Plan will always pay either its benefits in full or a reduced amount that, when added to the benefits payable by the Other Plan(s), will not exceed 100% of Allowable Expenses. Only the amount paid by this Plan will be charged against the Plan benefit maximums.

"Allowable Expenses" means any Medically Necessary, reasonable and customary item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be the benefit.

Please note: This Plan contains an exclusion which provides that no benefits are available for charges Incurred for which the Covered Person is entitled to receive benefits during an extension period of his or her previous health plan. Allowable Expenses will exclude any such charges.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Further, when an HMO is primary and the Covered Person does not use an HMO provider, this Plan will not consider as Allowable Expenses any charge that would have been covered by the HMO had the Covered Person used the services of an HMO provider

It is important that you fulfill any requirements of Other Plan(s) for payment of benefits. If you fail to properly file for, and receive payment by, any Other Plan(s), this Plan will estimate the benefits that would otherwise have been payable and apply that amount, as though actually paid, to the "Payment" calculation explained in this section.

The Claims Administrator may release to and obtain from any other insurer, Other Plan or party, any information that it deems necessary for purposes of this provision. A covered Employee shall cooperate in obtaining such information and shall furnish all information necessary to implement this provision. Failure to do so may result in the denial of benefits under this Plan.

Other Plans
The term "Other Plan," as used in this provision to refer to a plan other than this Plan, means any plan, policy or coverage providing benefits or services for or by reason of health, medical, vision or dental care or treatment. Such plans may include, without limitation:

1. Group insurance or any other arrangement for coverage for Covered Persons in a group whether on an insured or uninsured basis, including but not limited to:

    a. Hospital indemnity benefits; and
    b. Hospital reimbursement-type plans;

2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans;

3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;

4. A licensed Health Maintenance Organization (HMO);

5. Any coverage for students that is sponsored by, or provided through a school or other educational institution;

6. Any coverage under a Government program, and any coverage required or provided by any statute;

7. Group automobile insurance;

8. Individual automobile insurance coverage on an automobile leased or owned by the employer;

9. Individual automobile insurance coverage based upon the principles of "No Fault" coverage;

10. Any plans or policies funded in whole or in part by an employer or deductions made by an employer from a person's compensation or retirement benefits;

11. Labor/management trustees, union welfare, employer organization or Employee benefit organization plans;

12. Individual homeowner's insurance coverage;

13. Individual renter's insurance coverage; or

14. Individual boat owner's insurance coverage.

Claim Determination Period
The term "Claim Determination Period" means a Calendar Year, or that portion of a Calendar Year during which the Covered Person for whom a claim is made has been covered under this Plan.

Coordination Procedures
Unless determined to be primary, benefits paid under this Plan will be reduced, so that the sum of benefits paid under this Plan and benefits paid by any Other Plans for Covered Expenses do not exceed Allowable Expenses. A plan which is primary will pay before a plan which is secondary or subsequent.

Payments
This Plan will determine benefits according to the following rules:

1. If a plan contains no provision for Coordination of Benefits or states that its coverage is primary, then it pays before all other plans; or

2. If the plan that covers the claimant directly is through COBRA, and the other plan that covers the claimant, either as a dependent or directly, is through active status, then the active status plan is primary payer. Otherwise, the plan that covers the claimant directly (other than as a dependent) is primary payer. For purposes of this determination rule, "claimant" means the employee (or former employee) or spouse upon whose expenses the claim is based;

3. If the claimant is a Dependent Child, then the plan of the parent whose birthday falls first (omitting year of birth) in the Calendar Year is primary. However, if his or her parents are divorced or separated (whether or not ever legally married) then:

a. The plan of the parent with custody will be primary, unless a court order or decree specifies the other parent has financial responsibility, in which case that parent's plan would be primary; or
b. If the parent with custody has remarried, the plan of the parent with custody will be considered primary. The plan of the stepparent that covers the Child as a Dependent will be considered secondary. The plan of the parent without custody will be considered last. or

4. A "no fault" automobile policy not described in sub-paragraph (1) above will be primary; or

5. If the order set out in 1, 2, 3, or 4 above does not apply in a particular case, then the plan that has covered the claimant for the longest period of time will be primary.

The Plan Administrator has the right:

1. To obtain or share information with an insurance company or other organization regarding Coordination of Benefits without the claimant's consent;

2. To require that the claimant provide the Plan Administrator with information on such Other Plans so that this provision may be implemented;

3. To pay the benefits available under this Plan to an insurer or other organization if, in the opinion of the Plan Administrator, in its sole discretion, the insurer or other organization is entitled to them. Such benefits shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability; and

4. To recover payments whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount in excess of the maximum amount of payment necessary to satisfy the intent of this provision, in accordance with the Plan's Recovery of Payments" provision.

MEDICARE

Applicable to Active Employees and Their Spouses Ages 65 and Over
An active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

Applicable to All Other Covered Persons Eligible for Medicare Benefits
To the extent required by federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be permitted to pay its benefits first. In these cases, benefits under this Plan will be calculated as secondary payer. The Covered Person will be assumed to have full Medicare coverage (that is, both Part A & B) whether or not the Covered Person has enrolled for the full coverage. If the provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare-approved expenses.

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Beneficiaries Who Are Covered Under This Plan
If any Covered Person is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Benefits Subject to this Provision
This provision shall apply to all benefits provided under any section of this Plan.

When this Provision Applies
A Covered Person may incur medical or other charges related to Injuries or Illness caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the Injuries or Illness. If so, the Covered Person may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be subrogated to all rights the Covered Person may have against that other person or Another Party and will be entitled to Reimbursement. In addition, the Plan shall have the first lien against any Recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supersedes any right that the Covered Person may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Covered Person procures or may be entitled to procure regardless of whether the Covered Person has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. As a condition to receiving benefits under the Plan, the Covered Person agrees that acceptance of benefits is constructive notice of this provision.

The Covered Person must:

1. Execute and deliver a Subrogation and Reimbursement agreement;

2. Authorize the Plan to sue, compromise and settle in the Covered Person's name to the extent of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Covered Person's rights to Recovery when this provision applies;

3. Immediately reimburse the Plan, out of any Recovery made from Another Party, 100% of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);

4. Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and

5. Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

When a right of Recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other Illnesses or Injuries), the Covered Person will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, <u>before</u> any medical or other benefits will be paid by the Plan for the Injuries or Illness. The Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other benefits for the Injuries or Illness before these papers are signed and things are done (for example, to obtain a prompt payment discount); however, in that event,

the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Covered Person will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines. A Covered Person who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Covered Person who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because the Covered Person is not the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed.

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary.

Amount Subject to Subrogation or Reimbursement

Any amounts recovered will be subject to Subrogation or Reimbursement. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his charges and expenses.

When Recovery Includes the Cost of Past or Future Expenses

In certain circumstances, a Covered Person may receive a Recovery that includes amounts intended to be compensation for past and/or future expenses for treatment of the illness or injury that is the subject of the Recovery. This Plan will not cover any expenses for which compensation was provided through a previous Recovery. This exclusion will apply to the full extent of such Recovery or the amount of the expenses submitted to the Plan for payment, whichever is less. The Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

It is the responsibility of the Covered Person to inform the Plan Administrator when expenses are related to an Illness or Injury for which a Recovery has been made. Acceptance of benefits under this Plan for which the Covered Person has received a Recovery will be considered fraud, and the Covered Person will be subject to any sanctions determined by the Plan Administrator, in its sole discretion, to be appropriate. The Covered Person is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses that exceed the Recovery.

"Another Party"

"Another party" shall mean any individual or entity, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person's Injuries or Illness.

"Another party" shall include the party or parties who caused the Injuries or Illness; the insurer, guarantor or other indemnifier of the party or parties who caused the Injuries or Illness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or entity that is liable or legally responsible for payment in connection with the Injuries or Illness.

"Recovery"

"Recovery" shall mean any and all monies paid to the Covered Person by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the Injuries or Illness. Any Recovery shall be deemed to apply, first, for Reimbursement.

"Subrogation"
"Subrogation" shall mean the Plan's right to pursue the Covered Person's claims for medical or other charges paid by the Plan against Another Party.

"Reimbursement"
"Reimbursement" shall mean repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the injury or illness and for the expenses incurred by the Plan in collecting this benefit amount.

When a Covered Person retains an Attorney
If the Covered Person retains an attorney, that attorney must sign the Subrogation and Reimbursement agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other illnesses or injuries. Additionally, the Covered Person's attorney must recognize and consent to the fact that the Plan precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his pursuit of Recovery. The Plan will not pay the Covered Person's attorneys' fees and costs associated with the Recovery of funds, nor will it reduce its Reimbursement pro rata for the payment of the Covered Person's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

An attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Covered Person's attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because neither the Covered Person nor his attorney is the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed.

When the Covered Person is a Minor or is Deceased
The provisions of this section apply to the parents, trustee, guardian or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the representative has access or control of the Recovery.

When a Covered Person Does Not Comply
When a Covered Person does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Covered Person to enforce the provisions of this section, then that Covered Person agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

GENERAL PROVISIONS

Clerical Error
Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made, unless the error or delay is discovered more than six months after the effective date of coverage, in which event no adjustment will be made.

Conformity with Applicable Laws
This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Summary Plan Description. It is intended that the Plan will conform to the requirements of any applicable law.

Interpretation
The use of masculine pronouns in this Summary Plan Description shall apply to persons of both sexes unless the context clearly indicates otherwise.

The use of the words, "you" and "your" throughout this Summary Plan Description applies to eligible or covered Employees and, where appropriate in context, their covered Dependents.

Headings
The headings used in this Summary Plan Description are used for convenience of reference only. Covered Persons are advised not to rely on any provision because of the heading.

Payment of Plan Costs
The Plan Sponsor is responsible for funding the Plan and will do so as required by law. To the extent permitted by law, the Plan Sponsor is free to determine the manner and means of funding the Plan. The amount of the Covered Person's contribution (if any) will be determined from time to time by the Plan Sponsor, in its sole discretion.

Protection Against Creditors
No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Covered Person, the Plan Administrator in its sole discretion may terminate the interest of such Covered Person or former Covered Person, his or her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Covered Person or former Covered Person, as the Plan Administrator may determine, any such application shall be a complete discharge of all liability with respect to such benefit payment.

Right to Receive and Release Necessary Information
For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information

necessary to determine the acceptability of any applicant or Covered Person for benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action; however the Plan Administrator at all times will comply with the Privacy Standards. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Statements; Fraud
The following actions by any Covered Person, or a Covered Person's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire Family of which the Covered Person is a member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Person in the Plan;
2. Attempting to file a claim for a Covered Person for services which were not rendered or drugs or other items which were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

Waiver
No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Workers' Compensation
This Plan excludes coverage for any Injury or Illness that is eligible for coverage under any workers' compensation policy or law regardless of the date of onset of such Injury or Illness. However, if benefits are paid by the Plan and it is later determined that a Covered Person received or is eligible to receive workers' compensation coverage for the same Injury or Illness, the Plan is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the Injury or Illness regardless of the amount or terms of any settlement the Covered Person receives from workers' compensation. The Plan will exercise its right to recover against the Covered Person. The Plan reserves its right to exercise its rights under this section and the section entitled "Recovery of Payment" even though:

1. The workers' compensation benefits are in dispute or are made by means of settlement or compromise;
2. No final determination is made that the injury or illness was sustained in the course of or resulted from your employment;
3. The amount of workers' compensation benefits due specifically to health care expense is not agreed upon or defined by the Covered Person or the workers' compensation carrier; or
4. The health care expense is specifically excluded from the workers' compensation settlement or compromise.

You are required to notify the Plan Administrator immediately when a claim is filed for coverage under workers' compensation if a claim for the same Injury or Illness is or has been filed with this Plan. Failure to do so, or to reimburse the Plan for any expenses it has paid for which coverage is available through workers' compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the Plan for recovery and disciplinary action.

Not a Contract

This Summary Plan Description and any amendments constitute the terms and provisions of coverage under this Plan. The Summary Plan Description shall not be deemed to constitute a contract of any type between the Participating Employer and any Covered Person or to be consideration for, or an inducement or condition of, the employment of any employee. Nothing in this Summary Plan Description shall be deemed to give any employee the right to be retained in the service of the Participating Employer or to interfere with the right of the Participating Employer to discharge any employee at any time.

DEFINITIONS

The following words and phrases shall have the following meanings when used in the Summary Plan Description. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of the Summary Plan Description for that information.**

Accident
"Accident" shall mean an event that is sudden, unexpected, unintended and over which the Covered Person has no control and that is caused by a non-infectious source external to the body.

Actively at Work or Active Employment
"Actively at Work" or "Active Employment" shall mean performance by the Employee of all the regular duties of his occupation at an established business location of the Participating Employer, or at another location to which he may be required to travel to perform the duties of his employment. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor. In no event will an Employee be considered Actively at Work if he has effectively terminated employment.

Ambulatory Surgical Center
"Ambulatory Surgical Center" shall mean any public or private establishment with an organized medical staff of Physicians, permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, continuous Physician services and registered professional nursing services, whenever a patient is in the facility, and which does not provide services or other accommodations for patients to stay overnight.

Benefit Period
"Benefit Period" shall mean a time period of one year commencing with the effective date of this Plan or the Plan anniversary. This Benefit Period will terminate on the earliest of the following date:

1. The last day of the one-year period;
2. The day the Plan benefit maximum applicable to the Covered Person becomes payable; or
3. The day the Covered Person ceases to be covered for benefits under this Plan.

Benefit Percentage
"Benefit Percentage" shall mean that percentage of Covered Expenses in excess of the Deductible amount, which the Plan pays. It is the basis used to determine any Out-of-Pocket Expenses in excess of the annual Deductible which are to be paid by the Employee.

Birthing Center
"Birthing Center" shall mean a facility that meets the following requirements:

1. Is licensed by the department responsible for the licensing of such facilities in the geographical area in which it is located;
2. Has permanent facilities which are equipped and operated mainly for childbirth; and
3. Provides continuous service by Physicians, registered nurses or midwife nurse practitioners when a patient is in the center.

Calendar Year
"Calendar Year" shall mean January 1 through December 31 of the same year.

Certificate of Coverage
"Certificate of Coverage" shall mean a written certification provided by any source that offers medical care coverage, including the Plan, for the purpose of confirming the duration and type of an individual's previous coverage.

Child or Children
"Child" or "Children" shall mean, in addition to the Employee's own blood descendant of the first degree or lawfully adopted child, a child placed with the Employee in anticipation of adoption, a child for whom coverage is an alternate recipient required under a QMCSO as required by the federal Omnibus Budget Reconciliation Act of 1993, any stepchild or any other child for whom the Employee has obtained legal guardianship. In order for a child to meet the Plan's definition of a dependent, the child must qualify as a dependent pursuant to IRS Code § 152 or AS Sec. 21.36.095.

Claims Administrator
"Claims Administrator" shall mean RBMS, LLC, PO Box 241569, Anchorage, AK 99524-1569.

COBRA
"COBRA" shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended.

Complications of Pregnancy
"Complications of Pregnancy" shall mean:

1. Conditions whose diagnoses are distinct from Pregnancy but adversely affected by Pregnancy or caused by Pregnancy. Such conditions include:

    a. Acute nephritis;
    b. Nephrosis;
    c. Cardiac decompensation;
    d. Hyperemesis gravidarum;
    e. Puerperal infection;
    f. Toxemia;
    g. Eclampsia;
    h. Missed abortions;
    i. Gestational diabetes; and
    j. Postpartum depression or psychosis.

2. A non-elective cesarean section surgical procedure;
3. Terminated ectopic Pregnancy; or
4. Spontaneous termination of Pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy do not mean:

1. False labor;
2. Occasional spotting;
3. Prescribed rest during the period of Pregnancy;
4. Similar conditions associated with the management of a difficult Pregnancy not constituting a distinct complication of Pregnancy; or
5. Thrombophlebitis.

Confinement
"Confinement" shall mean being a resident patient in a Hospital for at least 15 consecutive hours per day.

Successive Confinements are considered one Confinement unless:

1. It is due to a different or unrelated Injury or Illness causing the prior Confinement;
2. It is separated by 30 consecutive days when the Covered Person is not confined.

Convalescent Nursing Facility
"Convalescent Nursing Facility" shall mean a lawfully operated institution or that part of such an institution that meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an Inpatient basis, for a person convalescing from Injury or Illness, professional nursing services rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a Registered Nurse and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily activities;
2. Its services are provided for compensation from its patients and under the full-time supervision of a Physician or Registered Nurse;
3. It maintains a complete medical record on each patient;
4. It has an effective utilization review plan; and
5. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, custodial or educational care, or care of Mental or Nervous Disorders.

The term shall also apply to expenses Incurred in an institution referring to itself as a Skilled Nursing Facility, extended care facility, convalescent nursing home or any other similar designation.

Convalescent Period
"Convalescent Period" shall mean a period of time commencing with the date of Confinement by the Covered Person to a Convalescent Nursing Facility. Such Confinement must meet both of the following conditions:

1. The Confinement must have been for a period of not less than three consecutive days; and
2. The convalescent Confinement must commence within 14 days after the Covered Person is discharged from a Hospital and both the Hospital and convalescent Confinements must have been for the care and treatment of the same Illness or Injury. The convalescent Confinement must be as an alternative to Hospitalization. The Plan may require that a Physician certify that the convalescent care is rendered as an alternative to Hospitalization.

Cosmetic or Cosmetic Procedure
"Cosmetic or Cosmetic Procedure" shall mean any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an Injury

Covered Expenses
"Covered Expenses" shall mean Usual, Customary and Reasonable expenses Incurred by a Covered Person for any Medically Necessary treatments, services or supplies listed for coverage and not specifically excluded from coverage elsewhere in this Plan.

Covered Person
"Covered Person" shall mean a covered Employee and his or her covered Dependents who are eligible for benefits under the Plan.

Creditable Coverage
"Creditable Coverage" shall mean coverage of an individual under any of the following: a group health plan, health insurance coverage, Medicare, Medicaid (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines), medical and dental care for members and certain former members of the Uniformed Services and their dependents, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under Section 5(e) of the Peace Corps Act, or Title XXI of the Social Security Act (State Children's Health Insurance Program). To the extent that further clarification is needed with respect to the sources of Creditable Coverage listed in the prior sentence, please see the complete definition of Creditable Coverage that is set forth in 45 C.F.R. § 146.113(a).

Custodial Care
"Custodial Care" shall mean that type of care or service, wherever furnished and by whatever name called, that is designed primarily to assist a Covered Person, whether or not Totally Disabled, in the activities of daily living. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such activities include, but are not limited to, bathing, dressing, feeding, preparation of meals or special diets, housekeeping, assistance in walking or in getting in and out of bed, and supervision over medication that can normally be self-administered.

Deductible
"Deductible" shall mean a specified dollar amount of Covered Expenses that must be Incurred during a Calendar Year and paid by the Covered Person before any additional Covered Expenses can be considered for payment at the Benefit Percentages stated in the Schedule of Benefits of this Plan.

Dental Hygienist
"Dental Hygienist" shall mean an individual who works under the supervision of a Dentist and is currently licensed to practice dental hygiene by a governmental authority that has jurisdiction over the licensure and practice of dental hygiene.

Dental Treatment Plan
"Dental Treatment Plan" shall mean the attending Dentist's written report of recommended treatment for a Period of Dental Treatment, on a form satisfactory to the Plan, which:

1. Itemizes the dental procedures required for the necessary care of the individual;
2. Shows the charges for each procedure; and
3. Is accompanied by any appropriate diagnostic material as may be required by the Plan.

Dentist
"Dentist" shall mean a licensed Dentist, dental surgeon or oral dental surgeon.

Dependent
"Dependent" shall mean:

1. The Employee's legal spouse, who is a resident of the same country in which the Employee resides. Such spouse must have met all requirements of a valid marriage contract or common law certification in the state of marriage of such parties.
2. The Employee's Child who meets all of the following conditions:

a. Is a resident of the same country in which the Employee resides;
b. Is unmarried;
c. Is considered a "dependent" of the Employee for tax exemption purposes under Section 152 of the Internal Revenue Code of 1986, as amended. This requirement is waived if the Employee is obligated to provide medical care coverage for the Child under an order or judgment of a court of competent jurisdiction;
d. Is less than 25 years of age. This requirement is waived for any mentally retarded or physically handicapped Child who is incapable of self-sustaining employment and is chiefly dependent upon the Employee for support and maintenance, provided the Child suffered such incapacity prior to attaining 25 years of age. Proof of incapacity must be furnished to the Plan, and additional proof may be requested from time to time.

3. Any Child born to an Employee or an Employee's spouse while such Employee or Employee's spouse is covered under this Plan shall also be considered an eligible Dependent under this Plan. The Newborn Child is covered from the moment of birth for the first 31 days. If an Employee wishes to continue coverage beyond this 31-day period, written application for coverage and agreement to any required contribution must be made **during the first 31-day period from birth**. The Newborn must rely on the Employee for support.

A covered Dependent Child who attains the limiting age while covered under the Plan shall remain eligible for medical benefits if ALL of the following exist at the same time:

1. He or she is mentally or physically handicapped;
2. He or she is incapable of self-sustaining employment;
3. He or she is dependent on the covered Employee for at least 50% of his or her support and maintenance; and
4. He or she is unmarried.

The Employee must furnish satisfactory proof to the Plan Administrator that the above conditions continuously exist on and after the date the limiting age is reached. The Plan Administrator may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to the Plan Administrator, the Child's coverage shall cease on the date such proof is due.

The term Dependent excludes these situations:

1. A spouse who is legally separated or divorced from the Employee. Such spouse must have met all requirements of a valid separation agreement or divorce decree in the state granting such separation or divorce; or
2. Any person on active military duty.

Dependent Coverage
"Dependent Coverage" shall mean coverage under the Plan for benefits payable as a consequence of an Illness or Injury of a Dependent.

Durable Medical Equipment
"Durable Medical Equipment" shall mean equipment that is:

1. Able to withstand repeated use;
2. Primarily and customarily used to serve a medical purpose; and

3. Not generally useful for a person in the absence of Illness or Injury.

Emergency
"Emergency" shall mean a situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An emergency includes poisoning, shock, hemorrhage, severe chest pain, difficulty in breathing, sudden onset of weakness or paralysis of a body part, severe burns, unconsciousness, partial or complete severing of a limb, and convulsions.

Other emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, that an Emergency did exist.

Employee
"Employee" shall mean a person who is a regular employee of the Participating Employer, regularly scheduled to work 37 ½ hours per week, or at least 7 ½ hours per day, for the Participating Employer in an employer-employee relationship, and who meets the eligibility requirements of this Plan.

Experimental or Experimental Treatment
"Experimental" or "Experimental Treatment" shall mean services and supplies that are rendered on a research basis as determined by:

1. The Alaska State Medical Association;
2. The AMA's Council on Medical Specialty Societies;
3. The American Medical Association;
4. The Surgeon General;
5. The Food and Drug Administration; or
6. The Health Care Financing Administration.

All phases of clinical trials shall be considered experimental, except phase II, III, or IV qualified clinical trials (funded by NCI, DOD, FDA) for cancer drugs and drugs approved by the FDA for general use.

Family
"Family" shall mean a covered Employee and his or her covered Dependents.

FMLA
"FMLA" shall mean the Family and Medical Leave Act of 1993, as amended.

FMLA Leave
"FMLA Leave" shall mean a leave of absence, which the Participating Employer is required to extend to an employee under the provisions of the FMLA.

Full-Time Employment
"Full-Time Employment" shall mean a basis whereby an Employee is employed, and is compensated for services, by the Participating Employer for at least the number of hours per week or per day as stated in the definition for "Employee". The work may occur either at the usual place of business of the Participating Employer or at a location to which the business of the Participating Employer requires the Employee to travel.

HIPAA
"HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Care Agency
"Home Health Care Agency" shall mean a public or private agency or organization that specializes in providing medical care and treatment in the home. It must meet all of the following conditions:

1. It is primarily engaged in providing skilled nursing and other therapeutic services and is duly licensed, if required, by the appropriate licensing authority;
2. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one Physician and at least one Registered Nurse to govern the services provided and it must provide for full-time supervision of such services by a Physician or Registered Nurse;
3. It maintains a complete medical record on each individual; and
4. It has a full-time administrator.

Hospice
"Hospice" shall mean a health care program providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons who are Terminally Ill.

Hospice Benefit Period
"Hospice Benefit Period" shall mean a specified amount of time during which the Covered Person undergoes treatment by a Hospice. Such time period begins on the date the attending Physician of a Covered Person certifies a prognosis of Terminally Ill, and the Covered Person is accepted into a Hospice program. The period shall end the earliest of six months from this date or at the death of the Covered Person. A new Hospice Benefit Period may begin if the attending Physician certifies that the patient is still Terminally Ill; however, the Plan Administrator may require additional proof before a new Hospice Benefit Period can begin.

Hospice Care
"Hospice Care" shall mean care rendered as part of a Hospice Care Program to a Terminally Ill Covered Person by or under arrangements with a Hospice Care Agency.

Hospice Care Agency
"Hospice Care Agency" shall mean an agency or organization that meets all of the following tests:

1. Has Hospice Care available 24 hours a day;
2. Is licensed as such by the jurisdiction it is in;
3. Provides:

    a. Skilled nursing services;
    b. Medical social services;
    c. Psychological and dietary counseling; and

4. Provides or arranges for other services which will include:

    a. Services of a Physician;
    b. Physical or Occupational Therapy;
    c. Part-time or home health aide services consisting of primarily caring for a Terminally Ill family member; and
    d. Inpatient care in a facility when needed for pain control and other acute and chronic symptom management.

Hospice Care Facility
"Hospice Care Facility" shall mean a facility, or a distinct part of a facility, such as a Hospital or Convalescent Nursing Facility, that meets all of the following tests:

1. Is established , equipped and operated mainly as a setting for providing Inpatient Hospice Care to Terminally Ill persons;
2. Charges for the services and supplies it provides;
3. Is licensed as such by the jurisdiction it is in;
4. Keeps medical records on each patient;
5. Provides an ongoing quality assurance program with reviews by M.D.s or D.O.s other than those who own or direct the facility;
6. Is run under the direction of a staff M.D. or D.O. At least one such Physician must be on call at all times;
7. Provides 24-hour-a-day skilled nursing services under the direction of Registered Nurses;
8. Has a full-time administrator; and
9. Has personnel which includes at least:

    a. One Physician;
    b. One Registered Nurse;
    c. One licensed or certified social worker (LSW/CSW) employed by the agency;
    d. One pastoral or other counselor; and

10. Has established policies governing the provisions of Hospice Care;
11. Assesses the patient's medical and social needs and develops a Hospice Care Program to meet those needs;
12. Permits all area medical personnel to utilize its services for their Terminally Ill patients; and
13. Utilizes volunteers trained in providing services to Terminally Ill patients to meet their non-medical needs.

Hospice Care Program
"Hospice Care Program" shall mean a written plan of Hospice Care, which:

1. Is established by and periodically reviewed by:

    a. A Physician attending the Covered Person; and
    b. Appropriate personnel of a Hospice Care Agency;

2. Is designed to provide palliative and supportive care to Terminally Ill persons; and
3. Includes an assessment of the medical and social needs, and a description of the care to be rendered to meet those needs.

Hospital
"Hospital" shall mean an institution that meets all of the following conditions:

1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an Inpatient basis at the patient's expense;
2. It is constituted, licensed and operated in accordance with the applicable laws of the jurisdiction in which it is located;
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an Illness or an Injury;

4. Such treatment is provided for compensation by and under the supervision of Physicians with continuous 24-hour nursing services by Registered Nurses;
5. It qualifies as a hospital or a Psychiatric Hospital and is licensed by the appropriate state authority; and
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics or a nursing home.

Illness or Sickness
"Illness" or "Sickness" shall mean a bodily disorder, disease, physical sickness, mental infirmity, functional nervous disorder, Pregnancy or Complications of Pregnancy of a Covered Person. A recurrent Illness will be considered one Illness.

Concurrent Illnesses will be considered one Illness unless the concurrent Illnesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one Illness.

Incurred
"Incurred" shall mean that a Covered Expense is incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Injury
"Injury" shall mean physical damage to the body, caused by an external force, and which is due directly and independently of all other causes, to an accident.

Inpatient
"Inpatient" shall mean the classification of a Covered Person when that person is admitted to a Hospital, Hospice or Convalescent Nursing Facility for treatment, and charges are made for Room and Board to the Covered Person as a result of such admission.

Intensive Care Unit
"Intensive Care Unit" shall mean a section, ward or wing within a Hospital, which is separated from other facilities, and:

1. Is operated exclusively for the purpose of providing professional medical treatment for critically ill patients;
2. Has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; and
3. Provides constant observation and treatment by Registered Nurses or other highly trained Hospital personnel.

Licensed Practical Nurse
"Licensed Practical Nurse" shall mean an individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

Medically Necessary
"Medically Necessary" shall mean any health care treatment, service or supply determined by the Plan Administrator to meet each of these requirements:

1. It is ordered by a Physician for the diagnosis or treatment of an Illness or Injury;
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use, and that omissions would adversely affect the person's medical condition; and
3. It is furnished by a provider with appropriate training, experience, staff and facilities to furnish that particular service or supply.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Covered Person is receiving or the severity of the Covered Person's condition, and that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

The Plan Administrator will determine whether these requirements have been met based upon published reports in authoritative medical and scientific literature; regulations, reports, publications or evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institute of Health, and the Food and Drug Administration (FDA); listings in the following compendia: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information and The United States Pharmacopoeia Dispensing Information; and other authoritative medical sources to the extent that the Plan Administrator, in its sole discretion, determines them to be necessary. The fact that any particular Physician may prescribe, order, recommend, or approve a service or supply does not in and of itself, make the service or supply Medically Necessary.

Medicare
"Medicare" shall mean the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

Mental or Nervous Disorder
"Mental or Nervous Disorder" shall mean any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Newborn
"Newborn" shall mean an infant from the date of birth until the initial Hospital discharge, or until the infant is 14 days old, whichever occurs first.

Nurse Midwife
"Nurse Midwife" shall mean a Registered Nurse who is licensed as a midwife by the state in which the services are provided.

Occupational Therapy
"Occupational Therapy" shall mean a program of care that focuses on the physical, cognitive and perceptual disabilities that influence the patient's ability to perform functional tasks. The therapist evaluates the patient's

ability to use his or her fingers and hands (fine motor skills), perceptual skills, cognitive functioning and eye-hand coordination. Therapy sessions may also involve physical movement exercises. Functional tasks also may be used. The therapist may also perform splinting of the patient's arms or hands and may provide the patient with special equipment. Therapy which is intended to address primarily vocational rehabilitation issues (i.e., return to work skills) will not be considered a Covered Expense under this Plan.

Optometrist
"Optometrist" shall mean a licensed optometrist.

Oral Surgery
"Oral Surgery" shall mean maxillofacial surgical procedures limited to:

1. Excision of neoplasms including benign, malignant and pre-malignant lesions, tumors and cysts;
2. Incision and drainage of abscess;
3. Surgical procedures involving accessory sinuses, salivary glands and ducts; and
4. Removal of impacted teeth.

Orthotic Appliance
"Orthotic Appliance" shall mean any device or appliance for the correction or prevention of musculoskeletal deformities or disorders involving joints, muscles and other supporting structures, such as ligaments and cartilage.

Out-of-Pocket Maximum Expense
"Out-of-Pocket Maximum Expense" shall mean the total dollar amount the Covered Person will be required to pay, **excluding** the Deductible and penalties, expenses in excess of stated maximums and limits, for Covered Expenses under the Plan.

Outpatient
"Outpatient" shall mean the classification of a Covered Person when that Covered Person receives medical care, treatment, services or supplies at a clinic, a Physician's office at a Hospital, if not a registered bed patient at that Hospital, an outpatient psychiatric facility or an Outpatient Substance Abuse Treatment Facility.

Outpatient Substance Abuse Treatment Facility
"Outpatient Substance Abuse Treatment Facility" shall mean an administratively distinct governmental, public, private or in dependent unit or part of such unit that provides Outpatient mental health services and which provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

Participating Employer
"Participating Employer" shall mean Juneau City and Borough School District.

Period of Dental Treatment
"Period of Dental Treatment" shall mean all treatment performed in the oral cavity during one or more sessions as the result of the same initial diagnosis, and shall include any complications arising during such treatment.

Physician
"Physician" shall mean a legally licensed medical or dental doctor or surgeon, chiropractor, osteopath, podiatrist, certified consulting Psychologist or psychiatrist to the extent that same, within the scope of their

license, are permitted to perform services provided in this Plan. The term "Physician" also includes a Nurse Midwife, a nurse practitioner, and a social worker with the degree "MSW".

Physical Therapy
"Physical Therapy" shall mean a plan of care provided to return a patient to the highest level of motor functioning possible. The physical therapist extensively evaluates the patient's muscle tone, movement, balance, endurance, ability to ambulate, ability to plan motor movements, strength and coordination. If the patient requires special equipment (such as a wheelchair, walker or splint), the therapist evaluates the patient's ability to use the equipment and determines the correct size and type of equipment for the specific patient. The therapist constructs a program of exercises and movements to maximize the patient's motor skills.

Plan
"Plan" shall mean the APEA-AFT Health & Welfare Trust Employee Benefit Plan.

Plan Administrator
"Plan Administrator" shall mean the APEA-AFT Board of Trustees.

Plan Fiduciary
Plan Fiduciary shall mean the APEA-AFT Board of Trustees.

Plan Sponsor
"Plan Sponsor" shall mean APEA-AFT.

Plan Year
"Plan Year" shall mean a period of time beginning with the Effective Date of this Plan or the anniversary of that date and ending on the day before the next anniversary of the Effective Date of this Plan.

Pregnancy
"Pregnancy" shall mean that physical state which results in childbirth, abortion or miscarriage.

Privacy Standards
"Privacy Standards" shall mean the standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

Provider
Provider shall means a state licensed Physician, Physician assistant, dentist, osteopath, Optometrist, chiropractor, Nurse Midwife, advanced nurse practitioner, naturopath, physical therapist, occupational therapist, marital and family therapist, Psychologist, Psychological associate, licensed clinical social worker, licensed acupuncturist, certified direct-entry midwife, licensed professional counselor (LPC) or other practitioner or facility defined or listed herein, or approved by the Plan Administrator.

Psychiatric Day Treatment Facility
"Psychiatric Day Treatment Facility" shall mean an accredited mental health facility that provides treatment for individuals suffering from acute Mental or Nervous Disorders, in a structured psychiatric program, utilizing individualized treatment plans with specific attainable goals and objectives appropriate to the program, and is clinically supervised by a certified psychiatrist. Treatment must be provided for not more that 8 hours in any 24-hour period.

Psychiatric Hospital
"Psychiatric Hospital**"** shall mean an institution constituted, licensed, and operated as set forth in the laws

that apply to hospitals, which meets all of the following requirements:

1. It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons either by, or under the supervision of, a physician;
2. It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided;
3. It is licensed as a psychiatric hospital;
4. It requires that every patient be under the care of a physician; and
5. It provides 24-hour-a-day nursing service.

It does not include an institution, or that part of an institution, used mainly for nursing care, rest care, convalescent care, care of the aged, custodial care or educational care.

Psychologist
"Psychologist" shall mean a licensed Psychologist or psychological associate.

Qualified Treatment Facility
"Qualified Treatment Facility" shall mean a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, residential treatment facility, Psychiatric Day Treatment Facility, Substance Abuse Facility, alternative Birthing Center, Home Health Care Agency, or any other such facility that the Plan approves.

Registered Nurse
"Registered Nurse" shall mean an individual who has received specialized nursing training, is authorized to use the designation of "R.N.," and is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

Rehabilitation Center
"Rehabilitation Center" shall mean a legally operating institution or facility providing a program of coordinated and integrated services, including evaluation and treatment with an emphasis on education and training of those who have severe disabling impairments of recent onset or recent progression, or those who have had prior exposure to rehabilitation and require an identifiable intensity of services. It must be under the supervision and direction of one or more Physicians with 24-hour nursing care provided by Registered Nurses. The institution or center may not be used as a place of rest, as a nursing home or a place for the aged.

Room and Board
"Room and Board" shall mean all charges by whatever name called which are made by a Hospital, Hospice, or Convalescent Nursing Facility as condition of occupancy. Such charges do not include the professional services of Physicians or intensive nursing care by whatever name called.

Semi-Private
"Semi-Private" shall mean a class of accommodations in a Hospital or Convalescent Nursing Facility in which at least two patient beds are available per room.

Significant Break in Coverage
"Significant Break in Coverage" shall mean a period of 90 consecutive days during each of which an individual does not have any Creditable Coverage. Periods of Creditable Coverage that are separated by less than 90 days will be aggregated for the purpose of reducing the Plan's Pre-existing Condition exclusion unless they occur prior to a Significant Break in Coverage.

Skilled Nursing Facility
"Skilled Nursing Facility" shall mean an institution or a distinct part of one that is operating pursuant to the law for such an institution. In addition the Plan requires that:

1. Its main purpose is to provide 24-hour-a-day accommodations and skilled nursing care for patients recovering from Sickness or Injury;
2. It is not used mainly as a place for the aged, drug addicts, alcoholics, the mentally ill, or a place for rest;
3. It is licensed by the appropriate state authority and/or approved by Medicare;
4. It is under the full-time supervision of a Physician or Registered Graduate Nurse;
5. The patient's plan of care is prescribed by a Physician and updated at least every 30 days;
6. It has an agreement to have Physician's services available when needed;
7. It maintains adequate medical records for all patients;
8. It has written transfer agreement with at least one Hospital; and
9. It is approved as such by Medicare.

Speech Therapy
"Speech Therapy" shall mean a program of care that evaluates the patient's motor-speech skills, expressive and receptive language skills and writing and reading skills, and determines if the patient requires an extensive hearing evaluation by an audiologist. The therapist also evaluates the patient's cognitive functioning, as well as his or her social interaction skills such as the ability to maintain eye contact and initiate conversation. Therapy may also involve developing the patient's speech, listening and conversational skills, and higher level cognitive skills such as understanding abstract thought, making decisions and sequencing. Therapy may be considered medically appropriate even for patients who do not have apparent speech problems, but who do have deficits in higher level language functioning as a result of trauma or identifiable organic disease process.

Substance Abuse
"Substance Abuse" shall mean a condition, certified by a Physician, to be primarily alcoholism or drug dependency; provided, however, that any addiction from the use of tobacco shall not be included.

Substance Abuse Facility
"Substance Abuse Facility" shall mean an institution, other than a Hospital or Convalescent Nursing Facility, established and lawfully operating for the care and treatment of Substance Abuse conditions and licensed by an appropriate state agency as a substance abuse facility. It shall include a Hospital or that portion of a Hospital appropriately licensed as a substance abuse facility.

Terminally Ill
"Terminally Ill" shall mean a medical prognosis of six months or less to live.

Total Disability or Totally Disabled
"Total Disability" or "Totally Disabled" shall mean, as to a Covered Person who is employed, that he or she is at all times prevented from engaging in any job or occupation for wage or profit.

For a covered spouse who is not employed and a covered Dependent Child, Total Disability means a condition preventing the person from engaging, and the person not engaging, in the usual and customary activities of a person in good health and of the same age and sex.

Uniformed Services

*"*Uniformed Services*"* shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

USERRA
*"*USERRA*"* shall mean The Uniformed Services Employment and Reemployment Rights Act, a federal law, effective October 13, 1994.

Usual, Customary and Reasonable
"Usual, Customary and Reasonable" shall mean actual fees for services and supplies which are reasonably necessary for the care and treatment of Illness or Injury, but only to the extent that such fees are reasonable. Determination that a fee is reasonable will be made by the Plan Administrator, taking into consideration:

1. The fee which the provider most frequently charges the majority of patients for the service or supply;
2. The prevailing range of fees charged in the same area by providers of similar training and experience for the service or supply; and
3. Unusual circumstances or complications requiring additional time, skill and experience in connection with the particular service or supply.

For purposes of this section, **"Area"** means a metropolitan area, county or such greater area as is necessary to obtain a representative cross-section of providers rendering such services or furnishing such supplies.

HIPAA PRIVACY PRACTICES

The following is a description of certain uses and disclosures that may be made by the Plan of your health information:

Disclosure of Summary Health Information to the Plan Sponsor
In accordance with HIPAA's Standards for Privacy of Individually Identifiable Health Information (the "privacy standards"), the Plan may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

1. Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
2. Modifying, amending or terminating the Plan.

"Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes
In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);

2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

3. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;

4. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

5. Make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);

6. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);

7. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);

8. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been

delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);

9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

10. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

    a. The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

       Trust Accountant

       Assistant Business Manager

    b. The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

    c. In the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

1. The Plan documents have been amended to incorporate the above provisions; and
2. The Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the privacy standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage
The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the third party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or

excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the privacy standards.

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and
4. Report to the Plan any security incident of which it becomes aware.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

GENERAL PLAN INFORMATION

Name of Plan:	APEA-AFT Health & Welfare Trust Employee Benefit Plan
Plan Sponsor:	APEA-AFT Board of Trustees 211 Fourth Street, Suite 306 Juneau, AK 99801 Phone (907) 586-2334 (Fax) (907) 463-4980
Plan Administrator: **(Named Fiduciary)**	APEA-AFT Board of Trustees 211 Fourth Street, Suite 306 Juneau, AK 99801 Phone (907) 586-2334 (Fax) (907) 463-4980
Plan Sponsor Tax ID No.:	52-7332235
Fiscal Plan Year:	July 1 through June 30
Plan Type:	Medical Dental Prescription Drug
Claims Administrator:	RBMS, LLC d/b/a/ Risk & Benefit Management Services P.O. Box 241569 Anchorage, AK 99524-1569 Phone: (907) 561-3740 or (800) 770-3740 Fax: (907) 561-8813 Internet: www.rbmsllc.com
Participating Employer(s):	Juneau City and Borough School District
Agent for Service of Legal Process:	APEA-AFT Health & Welfare Trust Plan Administrator 211 Fourth Street, Suite 306 Juneau, AK 99801 Phone (907) 586-2334 (Fax) (907) 463-4980

APPENDIX I – PLAN AMENDMENTS