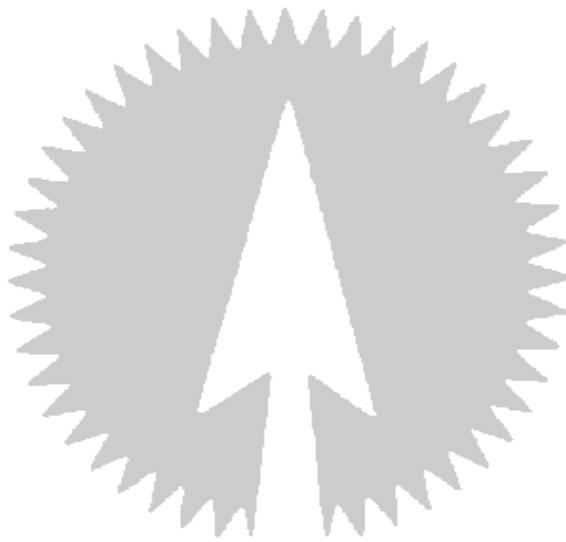


Tongass Timber Trust



Summary Plan Description

April 1, 2017

Alaska Forest Association, Inc.

***Maintaining Healthy Forests
for Today and Tomorrow***

Quick Contact Information

If You Have a Question

If you have questions, please contact Tongass Timber Trust as follows:

Address: 111 Stedman, Suite 200
Ketchikan, AK 99901

Telephone: (907) 225-6114

Email: claims@akforest.org

To Preauthorize Inpatient Hospitalization

Please call First Choice Health Network at (800) 808-0450.

To receive the maximum benefit, it's important to "preauthorize" all inpatient hospital stays ahead of time. In an emergency, you must call to preauthorize by the next business day or within 48 hours after an emergency admission.

See "Care Coordination and Preauthorization Requirements" on page 19 for more information about preauthorization.

Where to Submit Claims

Please submit all claims to:

Tongass Timber Trust
111 Stedman Street, Suite 200
Ketchikan, Alaska 99901

See the section called "How to File a Claim" beginning on page 47 for more information.

For More Information

Also, see our website at www.akforest.org for applicable forms and additional information.

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Introduction

This booklet contains important information for participants and dependents eligible for benefits under the Tongass Timber Trust Health Plan. Please read this booklet carefully and keep it for future reference.

If you have any questions after reading this booklet, please contact Tongass Timber Trust as follows:

- Telephone: (907) 225-6114
- Fax: (907) 225-5920
- Email: claims@akforest.org

The information here is intended to explain your benefits in a way that is easy to read and understand. Every effort has been made to ensure accuracy. Some of your benefits are provided through insured arrangements and may be governed by separate insurance contracts. If any interpretation or accuracy issues arise, legal terms of the appropriate insurance contracts or other official plan documents will govern. The summary plan description in this booklet is not a legal contract or a guarantee of payment. Tongass Timber Trust reserves the right to modify, amend or terminate the plan at any time for any reason.

Please note, the coverage described in this booklet is issued under a self-funded multiple employer welfare arrangement. The coverage and benefits provided under a self-funded multiple employer welfare arrangement is not protected by the Alaska Life and Health Insurance Guaranty Association. In addition, if the self-funded multiple employer welfare arrangement does not pay expenses that are eligible for payment under the plan for any reason, the employer or employee covered by the plan may be responsible for payment of those expenses.

A Message from the Trustees

On behalf of your employer and all members of the Alaska Forest Association, Inc., we are pleased to provide this program to you.

Tongass Timber Trust is a Multiple Employer Welfare Arrangement (MEWA) employee health and welfare plan established by the Alaska Forest Association, Inc. in order to provide group health and welfare benefits for workers employed by member firms. The Plan is governed by a Board consisting of six Trustees and administered through the Alaska Forest Association office. The Trustees are appointed by the Board of Directors of the Alaska Forest Association, and serve without pay. The Trustees are responsible for determining eligibility rules and benefits, selecting insurance companies, overseeing investments of reserves and all other administrative matters. You can obtain a list of participating employers in the yearly roster published by the Alaska Forest Association, Inc.

Why the Plan Was Established

Many employers offer employee benefits for their workers. However, our industry faces two distinct challenges in offering benefits:

- First, because of frequent winter layoffs due to weather and because of the somewhat migratory nature of our work, it is impossible for a single employer to provide the continuity of health care coverage that is so essential to employees in the logging and forest products industry.
- Second, many of our member firms hire only a few employees. Member firms include logging, road construction, tow boating, equipment suppliers and mill operators. Some firms provide year-round employment that stabilizes funding for the Trust. As the number of employees covered by a group health plan increases, the “per participant” operating costs of the Plan go down.

Tongass Timber Trust was formed in response to these challenges. Our goals? By *concentrating our buying power* in one plan, the Trust helps participants obtain maximum protection at minimum cost.

Your Contributions

The Trustees of Tongass Timber Trust establish premium rates based on claim experience and the cost of administration of the Plan.

Employees may be required to contribute a portion of their own and their dependents' premium, and this contribution may vary from employer to employer. However, the contribution cannot exceed the premium rate set by the Trustees. Information about your specific premium is available from your employer.

Very truly yours,

THE BOARD OF TRUSTEES

I. Eligibility

Employee Eligibility

If you are a new hire, you will be covered under this Plan on the first day of the month following two consecutive months in which you work 130 or more hours per month for a participating employer in the Tongass Timber Trust and for which the employer makes appropriate contributions on your behalf.

After you satisfy the waiting period described above, your coverage is continuous as long as you work 130 or more hours per month or you are compensated for 130 hours per month by your employer and the appropriate contributions are made on your behalf.

Some employers have elected to include an optional look-back period for determining eligibility. Please check with your employer to determine whether they have made this election.

If your employer has elected the optional look-back period, and you do not meet the minimum 130 hours worked for the previous month as described above, you can maintain eligibility if you have worked an average of 130 hours per month for the previous six months.

A person the Plan Administrator determines is not an employee will not be eligible to participate in the Plan regardless of whether a court or tax or regulatory authority determines that the person is an employee.

Dependent Eligibility

Eligible dependents you may enroll in the Plan are:

- Your legal spouse as defined under federal law. The Plan can request legal proof of marital status, such as a marriage certificate.
- Your child who is under age 26, regardless of the child's student or marital status, and whether or not the child lives with you or you provide any of the child's support.
- A child born to your covered dependent child who is under age 26.

No Double Coverage

This Plan does not allow double coverage (coverage as both an employee and dependent or as a dependent of more than one employee). Earned coverage as an employee always has precedence over coverage as a dependent. However, if a person's coverage as an employee or dependent ends, eligible coverage as another employee's dependent may begin with no break in coverage if that employee has previously designated the dependent on his or her enrollment form.

Coverage for your dependents will begin on the date your coverage becomes effective if you have completed, signed and returned the employee information enrollment form listing the eligible dependents you want to cover under the Plan by the deadline for initial enrollment. See the section called "Enrolling Your Dependents" for more information.

Eligible Children

For eligibility purposes, "**child**" is defined as your:

- Natural child;
- Stepchild;
- Legally adopted child;
- A newborn grandchild of the employee, if the newborn's mother or father is an enrolled dependent and if the grandchild is enrolled at birth.
 - Natural newborn grandchildren born on or after the employee's effective date to a covered dependent child will be covered from their date of birth. The grandchild's parent must remain covered under the plan in order for the grandchild to be covered.
 - A newborn not properly enrolled at the time of birth may not be enrolled at a later date, including during Open Enrollment or Special Enrollment periods, even if the grandchild's parent is a covered dependent child under this plan.
- Child who is "placed for adoption"; and
- Child for whom you are appointed as legal guardian who is chiefly dependent on you for support and maintenance.

"Placed for adoption" means you assume and retain a legal obligation for total or partial support of such child in anticipation of adoption of such child. Coverage for the child will continue until the earlier of:

- The termination of your legal obligation, or
- The day coverage would otherwise end under the Plan.

Ineligible Children

A child who has been legally adopted by another person is not eligible. Coverage under this Plan ends on the date custody is assumed by the adoptive parents.

Medical, Dental and Vision Benefits for a Developmentally Disabled Child

Medical, dental and vision benefits for your developmentally disabled child will not be terminated because the child reaches the maximum age for a dependent child as long as the child continues to be developmentally disabled and your coverage does not terminate for any other reason.

You must submit a statement of responsibility form requesting continued coverage for your developmentally disabled child prior to his or her reaching the maximum age for a dependent child.

Your child will be considered developmentally disabled only if he or she is unable to earn his or her own living because he or she is mentally incapacitated or physically disabled and he or she depends chiefly on you for support and maintenance. Proof of disability must be furnished to the Trustees periodically.

Court-Ordered Dependent Coverage

If You Have a Qualified Medical Child Support Order

The Plan may be required to cover your child due to a qualified medical child support order (QMCSO) even if you have not enrolled the child. See the section called

For More Information on QMCSOs

See the section called "Procedures for Determining if a Medical Child Support Order is Qualified" for more information.

“Procedures for Determining if a Medical Child Support Order is Qualified” for more information.

You are required to provide proof of your dependents’ eligibility upon request. False or misrepresented eligibility information will cause both your coverage and your dependents’ coverage to be irrevocably terminated (retroactively to the extent permitted by law). Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation.

Enrolling Your Dependents

When you become employed with a participating employer, you will receive an employee information enrollment form to fill out. To enroll your eligible dependents, you must complete the employee information enrollment form, indicating which eligible dependents you wish to cover, sign it and return your form to your employer at least one day before your coverage is due to take effect. For example, if you are hired on March 20 and you work at least 130 hours in each of the next two months (April and May), your coverage becomes effective on June 1 (the first day of the month following two consecutive months in which you work 130 hours). Your deadline for enrolling your dependents would be May 31.

Only the eligible dependents that you name on the employee information enrollment form will be covered as dependents. The enrollment form with the most recent date will replace all former forms.

If You Do Not Enroll Your Dependents When They Are First Eligible

If you do not enroll your dependents when they are first eligible for coverage under this Plan, for example, because your spouse has other group health coverage through his or her employer, you must generally wait until the next annual Open Enrollment period unless you have one of the “qualifying events” listed below.

When You Can Add Dependent Coverage

Open enrollment is generally the only time you may add dependents to your coverage. Open enrollment takes place yearly every December 1 through December 31.

To add your dependents during Open Enrollment, complete a new employee enrollment information form indicating the changes you are requesting to your dependents’ coverage and return it to your employer no later than December 31. The effective date of changes you make during Open Enrollment is January 1. If you’re covered under COBRA and add a dependent during Open Enrollment, coverage is effective January 1.

There are certain qualifying events that allow you to add dependent coverage at times other than during Open Enrollment. These include:

- Your spouse/dependent loses other health coverage. If you did not enroll your dependents for coverage under this Plan because they had other health plan coverage (for example, from your spouse's employment), you may add your eligible dependents to this Plan when that other coverage ends as a result of loss of eligibility for coverage or termination of employer contributions toward that coverage. (For this purpose, loss of eligibility for coverage does not include a loss due to your or your dependent's failure to make timely premium payments or termination of coverage for cause, such as fraud). You must request enrollment by completing, signing and returning a new employee information form to your employer no later than 60 days after the date the other coverage ends. If you satisfy these conditions, and you report the change within 60 days, coverage for your eligible dependent begins on the date the change took place.
- **You gain a dependent as a result of marriage, birth, adoption, placement for adoption or acquisition of a stepchild or child for whom you have legal guardianship.** You may enroll your dependents in this Plan if they become eligible dependents and you request enrollment by completing, signing and returning a new employee information form to your employer within 60 days after the date of the marriage, birth, adoption, placement for adoption or acquisition.
- The Plan allows a special enrollment for employees and dependents who are eligible but not enrolled if they lose Medicaid or CHIP coverage because they are no longer eligible, or they become eligible for a state's premium assistance program. Employees have 60 days from the date of the Medicaid/CHIP event to request enrollment under the Plan. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

To request special enrollment or obtain more information, contact Tongass Timber Trust, Alaska Forest Association, 111 Stedman Street, Suite 200, Ketchikan, AK 99901
Phone: (907) 225-6114

When Coverage Starts for New Dependents

If you acquire a new dependent as a result of one of the qualifying events listed above, effective dates of coverage are as follows:

- Coverage for your new spouse will begin on the date of marriage, if you report the change within 60 days, coverage for your eligible dependent begins on the date the change took place.
- Coverage for a newborn child (or a child who is newly adopted or placed for adoption in your home) begins on the date of birth, adoption or placement for adoption — **but only if you actually enroll your dependent no later than 60 days after the date of birth, adoption or placement.** Medical, dental and vision coverage begins as of the date of the child's acquisition as a stepchild or foster child as long as you enroll by completing, signing and returning a new employee information form to your employer within 60 days and pay applicable premiums in a timely manner.

There may be other qualifying events that allow you to add dependent coverage at times other than during Open Enrollment. Contact Tongass Timber Trust if you have questions about adding or dropping dependents.

Please note, you may be required to provide documentation (for example, a marriage certificate for adding a new spouse) or sign an affidavit in order to add your dependents due to a qualifying event.

When Coverage Ends

If you are terminated or quit, you cease to be an eligible employee and all coverage for you and your dependents ends on the date of your separation from employment.

In addition, your coverage under this Plan will end at midnight on the earliest of the following dates:

- Generally, the day on which you are no longer an eligible employee under the Plan (see below for exceptions, for example, if you are laid off)
- The day the premium for your coverage is due and unpaid
- The day the Plan or any coverage is terminated by Tongass Timber Trust.

When Dependent Coverage Ends

Your dependents' coverage will end at the earlier of any one of the following events:

- The day your employee coverage ends
- The date your dependent no longer meets the Plan's definition of eligible dependent
- If your dependent's premium is not timely paid, the last day of the month for which the premium was paid on time
- The date your dependent becomes covered under this Plan as an employee
- When coverage for all dependents under the Plan is discontinued by Tongass Timber Trust.

If Your Participating Employer Withdraws

If your coverage under this Plan ends due to the withdrawal of your participating employer, the following limitations will apply:

- Your coverage and the coverage of all your eligible dependents will automatically end on the date of such withdrawal
- The waiver of premium under the Extension of Benefits provision of this Plan (see the section called "Options for Continuing Coverage After Termination" for more information) will not be extended beyond the date of such withdrawal, and
- Prescription drugs will not be covered for more than a 30-day supply beyond the withdrawal date.

If You Are Rehired

If your coverage ends because you are terminated or quit and you are rehired 30 or more days later, you must requalify to establish coverage as if you were a new hire (see “Employee Eligibility” on page 7) whether or not you elected COBRA continuation coverage. You must also re-enroll your dependents if you want to reinstate dependent coverage, just as if you were a new hire.

If you are rehired by the same employer within 30 days after termination, you must step back into the same election you had prior to termination.

If You Take a Leave of Absence

Non-FMLA Leaves

If you take an authorized leave of absence (other than an FMLA leave), your coverage ends on the last day of the month following the month in which you worked a minimum of 130 hours or you were compensated for a minimum of 130 hours by your employer or the optional look-back period, whichever applies

Your employer, at its election, may continue to make contributions for you and thereby continue your coverage under the Plan for up to three calendar months after your coverage would otherwise cease.

Extension of Benefits if You Are Disabled

If you are disabled while you are an active employee, you may qualify for a six-month extension of health care benefits at no cost to you. See the section called “Options for Continuing Coverage After Termination” for more information.

You also may be able to continue medical, dental and vision benefits for yourself and your covered dependents under COBRA continuation coverage; see the section called “Continuing Your Health Care Coverage Through COBRA” for more information.

Special rules apply if you take an authorized family or medical leave under the Family and Medical Leave Act (FMLA) as described below.

Family and Medical Leave Act (FMLA) Leaves

If you take an authorized family or medical leave of absence under the Family and Medical Leave Act of 1993 (FMLA), as amended, all benefits (see the section called “Options for Continuing Coverage After Termination” for more information) will be continued on the same basis as if you were actively at work during the period of leave authorized by the FMLA. This means that if you were covered by the Plan on the day before you went on FMLA leave, all benefits will continue, with your employer continuing to pay the premium on your behalf and you paying any applicable premium for your covered dependents. Contact your employer for information regarding your payment of premium during FMLA.

If you do not pay a required premium (for dependent coverage, for example) during your FMLA leave, coverage that the premium would have purchased will not be continued during the leave. That coverage will resume on the day you return to work, subject to

any changes that may have occurred in the Plan during the time you were not covered, as long as you:

- Return to work immediately at the end of your FMLA leave, and
- Pay any required premiums on time.

You and your dependents are subject to all conditions and limitations of the Plan during your leave; however, any provision of the Plan that conflicts with the FMLA shall be administered in accordance with the FMLA.

You or your employer may be required to submit proof that your leave is in accordance with FMLA.

This continuation of coverage under FMLA leave is not concurrent with COBRA continuation (of medical, dental and vision benefits) if applicable or extension of benefits due to permanent or temporary disability. See the section called “Options for Continuing Coverage After Termination” for more information about extension of coverage while you’re disabled and for more information on COBRA continuation.

Contact your employer for additional information regarding FMLA.

If You Are Laid Off

If you are laid off, you cease to be an eligible employee and all coverage for you and your dependents ends on the later of:

- The last day of the month in which you were laid off, or
- The last day of the month following the month in which you were laid off if you worked or were compensated by your employer, for at least 130 hours in the month in which you were laid off, and your employer makes the appropriate contribution on your behalf.

You may continue medical, dental and vision benefits for yourself and covered dependents on a self-pay basis by electing COBRA continuation coverage. For more information about COBRA coverage, see the section called “Options for Continuing Coverage After Termination”.

Requalifying for Coverage after a Reduction in hours, Layoff, Sickness or Industrial Injury

If you have a reduction in hours or are laid off and later return to work for any participating employer, you will be covered under this Plan on the first day of the month following the first month in which you work 130 or more hours if **all four** of the following conditions are satisfied:

- You have a reduction in hours or are laid off due to lack of work, sickness or industrial injury
- You elect and pay COBRA continuation coverage during the layoff period if needed to prevent a break in coverage

- The month in which you work 130 or more hours for your employer begins no later than six months after the last day of employer paid coverage, and
- Your employer makes the appropriate contributions on your behalf.

If the four conditions above are not satisfied, you must requalify to establish coverage as if you were a new hire.

II. Medical Benefits

The Plan provides medical benefits to help you pay the major costs of **medically necessary** care for you and your eligible dependents. After you satisfy an annual deductible each year, you will pay a portion of most covered medical expenses until you reach an annual “out-of-pocket” coinsurance maximum.

For definitions of terms used in this section, please refer to the section called “Definitions”.

Medical Benefit Highlights

Major features of your medical benefits are listed in the chart below. However, these are only highlights; the details are covered in the rest of this section. It’s important to read this section carefully and understand the specifics of your coverage — and your share of the costs — **before** you seek medical care.

ACTIVE EMPLOYEE PLAN

Feature	Buy-Up Plan	Base Plan
Annual Deductible <i>Amount you pay each calendar year before the Plan begins paying benefits; applies to medical expenses only.</i>	\$750 per person; maximum of \$2,250 per family	\$2,000 per person; maximum of \$4,000 per family
Coinsurance <i>Percentage the Plan pays (after you meet the deductible) for most covered services; you pay the remaining costs. Please note, not all services are paid at this coinsurance rate — exceptions are noted.</i>	80%*	80%*
Annual Out-of-Pocket Maximum <i>After your out-of-pocket expenses for covered services payable at the regular 80%* coinsurance rate reach this amount in one calendar year, covered services are considered at 100%* for the rest of the calendar year; this provides you important protection against catastrophic financial losses. The maximum out of pocket applies to medical expenses.</i>	\$5,750 per person; maximum of \$12,250 per family	\$6,350 per person; maximum of \$12,700 per family
Lifetime Maximum Benefit	Unlimited	Unlimited
Annual Maximum Benefit	Unlimited	Unlimited
Emergency Room	\$100 copay per visit in addition to deductible and coinsurance	Deductible and coinsurance
Prescription Drugs <i>Percentage the Plan pays for covered prescriptions, after you meet the deductible; out-of-pocket expenses for prescription drugs do apply to the annual coinsurance maximum and the Plan will pay 100% for prescription drugs once you meet the out-of-pocket maximum.</i>	Generic drugs: Plan pays 80% Brand-name drugs: Plan pays 60%	
Preventive Care The plan pays the following preventive care benefits: <ul style="list-style-type: none"> • Well child care and immunizations • Adult physical exams and related tests 	Plan pays 100%*, with no deductible Plan pays 100%*, with no deductible	

*Plan pays this percentage of eligible services up to Usual, Customary and Reasonable (UCR) limits. See page 93.

Retiree Eligibility

Upon your retirement from a participating Tongass Timber Trust employer, you are eligible for medical, dental and vision benefits if all of the following are true:

- You are at least 62 years of age,
- You have been insured under this Plan for at least five consecutive years with no break in coverage immediately prior to retirement,
- You choose to continue this Plan at the time you retire, and
- You pay the appropriate premiums on a monthly or quarterly basis to Tongass Timber Trust.

Your spouse and/or dependent children are eligible for medical, dental and vision benefits while you are eligible. If you die while enrolled in the Retiree Plan, coverage for your spouse and dependent children may be extended up to an additional 24 months

RETIREE PLAN

Feature	Retiree Plan
Annual Deductible <i>Amount you pay each calendar year before the Plan begins paying benefits; applies to medical expenses only.</i>	\$750 per person; maximum of \$2,250 per family
Coinsurance <i>Percentage the Plan pays (after you meet the deductible) for most covered services; you pay the remaining costs. Please note, not all services are paid at this coinsurance rate — exceptions are noted.</i>	80%*
Annual Out-of-Pocket Maximum <i>After your out-of-pocket expenses for covered services payable at the regular 80%* coinsurance rate reach this amount in one calendar year, covered services are considered at 100%* for the rest of the calendar year; this provides you important protection against catastrophic financial losses. The maximum applies to all medical expenses.</i>	\$1,900 per person, maximum of \$4,550 per family
Lifetime Maximum Benefit	Unlimited
Annual Maximum Benefit <i>This is the maximum amount that will be payable under the Plan for any individual during a calendar year.</i>	Unlimited
Prescription Drugs <i>Percentage the Plan pays for covered prescriptions, after you meet the deductible; out-of-pocket expenses for prescription drugs do apply to the annual coinsurance maximum and the Plan will pay 100% for prescription drugs once you meet the out-of-pocket maximum.</i>	Generic drugs: Plan pays 80% Brand-name drugs: Plan pays 60%
Preventive Care The plan pays the following preventive care benefits: <ul style="list-style-type: none"> • Well child care and immunizations • Adult physical exams and related tests 	Plan pays 100%*, with no deductible Plan pays 100%*, with no deductible

*Plan pays this percentage of eligible services up to Usual, Customary and Reasonable (UCR) limits. See page 93.

Using Preferred Providers to Save Money

The Plan allows you to receive medical services from any licensed medical provider in the United States. But you can also choose to save money by receiving medical and mental health/chemical dependency services from preferred providers.

Preferred provider services are available to all Plan participants through the networks listed below. These networks cover both hospital and physician services throughout all 50 states. Preferred providers agree to charge negotiated fees, usually at significant cost savings for you and the Plan.

To find out if your physician is a preferred provider for this Plan or to request the names of preferred providers, please call the applicable telephone number from the table below:

Preferred Provider Network Information	
Medical — Alaska, Washington, Oregon, Idaho and Montana	First Choice Health Network (800) 808-0450
Medical — All other states	Zelis Network Solutions (404) 459-7201
Mental Health/Chemical Dependency	First Choice Health Employee Assistance Program (800) 640-7682

Please note: First Choice Health Network (FCHN) has a network of qualified professionals to provide services for the treatment of mental health conditions or chemical dependency. FCHN can assist you in obtaining services by a physician, licensed/certified mental health or chemical dependency professional or other provider who is working within the scope of their license.

A Closer Look at Important Medical Plan Features

Deductible — This is the amount you must pay each calendar year for covered medical and dental services before benefits are payable under this Plan. A separate deductible applies to you and each of your dependents. Once the family deductible limit is met, additional family members do not need to satisfy an individual deductible.

What's Covered? What's Not?

See the sections called "Covered Medical Services" and "Medical Exclusions" for information on what specific medical services are covered, limited or excluded from coverage under this Plan.

Base Plan: The individual annual deductible is \$2,000 per person, with an annual maximum deductible of \$4,000 per family.

Buy-Up Plan: The individual annual deductible is \$750 per person, with an annual maximum deductible of \$2,250 per family.

Lifetime maximum benefits — the maximum lifetime amount payable under the Plan for **medical** benefits for any individual while insured is unlimited.

Annual Maximum Benefit — the maximum annual amount payable under the Plan for **medical** benefits for any individual while insured is unlimited.

Other medical maximums — For most covered services, this Plan pays 80% of the Usual, Customary and Reasonable charges after an annual deductible is met. However, some services have separate benefit maximums, as follows:

Hospice care lifetime maximum..... 6 months

Home health care annual maximum..... 60 visits

Private hospital room: The private room limit will be the average semi-private room charge of the hospital where the participant is confined.

Spinal treatment (non-surgical), Chiropractic Care.....10 annual visits*

Well child care and immunizations annual maximum Based on American Academy of Pediatrics and the Center for Disease Control recommendations.

* 10 annual visit limit waived if part of formal rehabilitation plan prescribed by a physician.

Coinsurance — Coinsurance is the percentage paid by the Plan for covered services after you meet the deductible, subject to Usual, Customary and Reasonable (UCR) limits (for more information, refer to the section called "Definitions") as well as applicable maximums above. The coinsurance rate for medical coverage, unless specified otherwise, is 80%.

For covered prescriptions, the coinsurance is 80% for generic drugs and 60% for brand-name drugs after the deductible is met. To receive benefits, you pay the full cost of the prescription at the pharmacy, and then submit a claim and your prescription receipt slip from the pharmacy (the part that shows your prescription information, not the cash register receipt) to the Plan for reimbursement up to the applicable coinsurance levels.

Out-of-pocket maximums — After your out-of-pocket expenses for most covered medical services payable at the regular 80% coinsurance rate reach the maximum amounts specified below in one calendar year, the coinsurance percentage the Plan pays for most covered services for the rest of the calendar year are considered at 100% (subject to Usual, Customary and Reasonable limits and other Plan maximums). Out-of-pocket expenses for prescription drugs do apply to the out-of-pocket maximum and the Plan will pay 100% for prescription drugs once you meet this maximum.

Base Plan Active Employees:

Individual annual out-of-pocket maximum..... \$ 6,350.00
Family annual out-of-pocket maximum \$12,700.00

Buy-up Plan Active Employees:

Individual annual out-of-pocket maximum..... \$ 5,750.00
Family annual out-of-pocket maximum \$12,250.00

Care Coordination and Preauthorization Requirements

In order to ensure you receive the most medically effective and cost-efficient medical and mental health/chemical dependency care in the most appropriate setting, the Plan has contracted with First Choice Health Network (FCHN) to perform case management, hospitalization review and other care coordination and utilization review services.

In order to receive the highest level of benefits — and to ensure you’re getting medically necessary, effective care — the Plan requires you to coordinate certain types of care through FCHN (such as preauthorizing any hospital admissions), as described below. However, the Plan will make final payment decisions on all claims.

Please note, FCHN cannot certify eligibility for or determine coverage for health care services obtained. Tongass Timber Trust should be contacted at 907-225-6114 for these issues.

Hospital Preauthorization and Utilization Review Program

This program is designed to ensure that you are hospitalized only when it is medically necessary and for the appropriate length of stay. To receive maximum benefits, preauthorization from First Choice Health Network is required for all inpatient hospital stays.

Preauthorization Requirements

To receive maximum benefits, all non-emergency hospital admissions must be preauthorized by First Choice Health Network before you or an eligible dependent is admitted to the hospital. You or your physician should call as soon as possible but at least 24 hours before admission or treatment (see below for emergency procedures):

- **Hospital admission preauthorization (Medical only):** Call FCHN at (800) 808-0450.

- If Medicare or another plan is primary coverage for the patient, preauthorization of the hospital stay through Tongass Timber Trust is **not** required.

Failure to contact First Choice Health Network prior to hospital admission for medical treatment will result in an additional \$200 deductible for each hospital admission.

Preauthorizing Emergency or Maternity Hospital Admissions

If the admission is due to an emergency or is maternity related, First Choice Health Network must be notified no later than:

- 48 hours after admission, or
- The first business day following a weekend or holiday admission.

Failure to comply will result in an additional \$200 deductible for the admission.

Second Surgical Opinion

A second surgical opinion is not required, but First Choice Health Network or the Plan may occasionally suggest seeking a second opinion on cases that are questionable. Coverage is the same as for the original opinion.

Concurrent Review

After you're admitted to the hospital, a Utilization Management Nurse will continue to evaluate your care program through concurrent review to monitor the length of your stay. If the Utilization Management Nurse disagrees with the length of treatment recommended by the doctor or if FCHN determines that continued hospitalization is no longer necessary, you and your doctor will be advised accordingly, and benefits **will not be payable** for continued hospitalization. Please note that, regardless of whether the Plan pays benefits or not, you and your physician make the final decisions, in all cases, regarding your hospitalization and medical treatment. Coverage of charges related to hospital confinement will be subject to all other terms and conditions of the Plan.

Hospital Discharge Planning

Discharge planning is beneficial when continued medical care is required, but may be provided in a less intensive setting than a hospital. Utilization management nurses will work with you, your physician and the hospital staff to develop a discharge plan that allows for a safe release from the hospital. First Choice Health Network can arrange alternate care, such as home health care, skilled nursing facilities and hospice care.

For approval of these types of services, call:

- **First Choice Health Network:** (800) 808-0450 (*medical only*)

Case Management Services

Under special circumstances, medical case managers at First Choice Health Network act as patient advocates and develop individualized treatment plans to

meet the needs of patients with catastrophic or chronic illness. They work with patients and their families to help them through the sometimes confusing maze of health care to make sure that the most appropriate care, in the most appropriate setting, is received at the most appropriate price. Registered nurses and doctors work together with medical professionals to identify long-term, high-cost illnesses and injuries. Most often these cases are identified during the utilization review process when the clinical staff confers with the patient's care givers to determine the patient's health care needs. Through case management, individualized plans of treatment are developed and coordinated to assure cost effective quality health care.

Mental Health and Chemical Dependency Benefits

Mental health and chemical dependency benefits are covered after you satisfy the annual medical deductible. Mental Health and Chemical Dependency Benefits must meet the following requirements to be covered by the Plan:

- Care must be medically necessary and provided at the least restrictive level of care

Covered Medical Services

Covered medical services are the services and supplies listed in this section. The service or supply must be medically necessary to diagnose or treat a sickness, pregnancy or injury.

- **Acupressure and acupuncture**
- **Ambulance service** provided by a professional ambulance service to transport an individual from the place where he or she is injured or stricken by disease to the nearest hospital qualified to provide treatment for such injury or sickness; ambulance transportation must be medically necessary and not for personal or convenience reasons.
- **Air ambulance service coverage** is limited to the billed amount up to a total of a maximum Load Fee of \$13,000 and a maximum Rate per Mile fee of \$80 per mile. The maximum load fee and the rate per mile fee apply separately. This fee-schedule does not include ground ambulance charges.
- **Air ambulance services** is limited to one transport during a 12 month period, if provided by a regularly scheduled commercial airline, air taxi service, helicopter, medi-flight or air ambulance for air transportation services:

Within the United States and Canada

For confinement in the nearest legally operated hospital equipped to furnish medically necessary care for the treatment of that injury or sickness

The patient is totally disabled due to the injury or illness, and the disability is life endangering and requires immediate medical attention, and

The disabled person is admitted immediately as a registered bed patient and stays at least 24 hours after transport.

However, if the above conditions are met but the first hospital is not equipped to handle the emergency, air travel involving transfer from the first hospital to another hospital with the required facilities is covered, when necessary and recommended by the attending physician. In addition, the charges for a registered graduate nurse or physician (other than one who resides in your home or who is a member of your or your spouse's family) acting as an attendant during the flight will be covered when recommended by a physician.

Only the initial trip for injury or sickness is covered

No further air ambulance benefit will be provided for 12 consecutive months.

- **Anesthesia**

The services of a physician in administering general or regional anesthesia, including customary preoperative and postoperative care, are covered when a Surgical Services Benefit is payable under the Plan. Coverage is determined as follows:

The Plan will pay 80% of the basic value unit plus modify unit (if any) plus actual minutes (described below) based on Usual, Customary and Reasonable charges generally incurred for cases of comparable nature and severity in the particular geographic area. If the operating physician or his or her assistant administers the anesthesia, the maximum benefit is 20% of the amount otherwise payable.

All anesthesia values are determined by adding a basic value, which is related to the complexity of the service, plus modifying units (if any), plus the number of minutes that elapse between the administration of the anesthesia and the time the patient can safely be placed under postoperative care.

Assistant anesthesiologist charges will be considered for benefits at 20% of usual and customary charges of the primary anesthesiologist.

- **Artificial limbs and artificial eyes**

- **Colonoscopy: Routine Screening Colonoscopies** are covered at 100% after age 50 or earlier if recommended by a physician due to risk factors (per American Cancer Society standards). When ordered by a physician for diagnostic purposes, colonoscopies are considered for payment as any normal medical procedure.

- **Dental work, oral surgery** — Services performed by a physician or duly licensed dentist for dental work and oral surgery may be included as covered medical services if they are for the prompt repair of natural teeth or other body tissue required as a result of an injury. The only other such services that may be included as covered medical services are for the following:

The surgical removal of teeth not completely erupted

The surgical excision of a tooth root without extraction of the entire tooth, but not including root canal therapy, or

Other surgical incision or excision procedures on the gums and tissues of the mouth when not performed in connection with tooth repair or extraction, but not including dental cleaning, root scaling, planing or other scraping procedures.

See the “Dental Benefits” section for services covered under the dental plan.

- **Diabetic supplies and equipment** are covered as follows:

Expenses for equipment and supplies for diabetes treatment are paid in the same manner and subject to the same conditions and limitations as any other covered service

Expenses for medication for diabetes treatment are paid in the same manner and subject to the same conditions and limitations as any outpatient prescription drugs.

Expenses for outpatient diabetes self-management training, education or medical nutrition therapy prescribed by a physician are paid in the same manner and subject to the same conditions and limitations as any other covered service as long as it is provided by a licensed health care provider with training in the treatment of diabetes.

- **Durable medical or surgical equipment** is medical equipment that can withstand repeated use, is not disposable, is used to serve a medically therapeutic purpose, is generally not useful to a person in the absence of sickness or injury and is appropriate for use in the home. Benefits will be provided for the purchase or rental (not to exceed the purchase price) of durable medical equipment when it is medically necessary and prescribed by a physician for therapeutic use in direct treatment of a covered illness or injury. Repair of covered medically necessary equipment due to normal use, change in physical condition, or growth of a child is eligible for coverage. Duplicate items are not covered. Purchase vs. rental is at the discretion of the Plan.

Examples of non-covered durable medical equipment can include, but are not limited to:

- Commodes
- Bath stool or chair
- Blood pressure monitors

Examples of covered durable medical equipment can include, but are not limited to:

- Walkers
- Crutches
- Standard manual wheelchairs

- Standard manual hospital beds
- Oxygen and equipment for administering oxygen.

Durable medical equipment **must** be preauthorized by the Plan if the purchase cost is more than \$1,000 or the rental cost is more than \$250 per month.

- **Hearing Aids:**

Benefit Maximum – The hearing benefit will be covered at 100% up to an \$800 maximum every 3 years per individual.

Hearing Aids – Hearing aids are included under the hearing benefit, subject to the benefit maximum. This includes ear mold(s), hearing aid instrument, initial batteries, cords, and other necessary supplementary equipment as well as warranty, and follow-up consultation within 30 days following delivery of the hearing aid; repairs, servicing or alteration of hearing aid equipment. You must provide the Trust with written certification from the examining physician explaining that you are suffering a hearing loss that may be lessened by the use of a hearing aid.

- **Home health care/skilled care** — skilled care services are services that must be delivered or supervised by licensed professional medical personnel in order to obtain the specified medical outcome. Skilled care services in your home are covered after you meet the annual deductible, up to a maximum of 60 visits per calendar year.

Eligible home health care expenses are defined as the reasonable and customary charges made by a home health agency, for the following necessary services or supplies furnished in the home in accordance with a home health care plan.

- Part time or intermittent skilled nursing care by or under the supervision of a registered professional nurse
- Physical, occupational or speech therapy provided by the home health service agency
- Medical supplies and equipment, drugs and medications prescribed by a physician
- Laboratory services by or on behalf of a hospital or physician.

For determining the number of visits with respect to the first two services above, each visit by a representative of a home health service agency is considered one home health care visit.

- **Hospice care** — Hospice care services are covered for up to six months if the covered person is terminally ill, as follows:

The daily benefit payable for inpatient hospice care services will not exceed the semi-private room rate of any hospital, skilled nursing facility

or convalescent rest home or nursing care with which the hospice is associated.

Payment of hospice care benefits is not in lieu of hospital or medical benefits under the Plan, but the Plan will not pay duplicate benefits for the same services and supplies or the same days of confinement.

When a terminally ill participant receives hospice care benefits as described, the Plan will also pay up to a combined maximum of \$500 for all family members (with no deductible) the expense incurred for:

Counseling of the participant's immediate family

Bereavement counseling of the participant's immediate family.

If a participant is receiving hospice care services when coverage under this Plan terminates, hospice care benefits will continue to be paid under the Extension of Benefits provision of the Plan, but not to exceed the Hospice Care maximum of six months.

- **Hospital services** including room and board and other services and supplies the hospital furnishes including charges for emergency room or other facilities to treat a medical emergency. Room and board charges include all hospital charges for services, such as general nursing care, made in connection with room occupancy (not included, however, is any charge for daily room and board in a private room over the private room limit shown on the schedule of benefits).
- **Laboratory tests and X-rays** for diagnostic purposes.
- **Mammography** — See Well Woman Care in this section.
- **Maternity care**, including childbirth, pregnancy and complications of pregnancy.
- **Medical travel assistance**

With prior application and approval, the plan will reimburse travel expenses for select procedures with an experienced provider demonstrating high quality outcomes and delivering the procedure at a lower cost inclusive of the maximum medical travel assistance benefit is selected in accordance with this notice.

In those situations, the Trust will provide up to \$1,000 to reimburse a participant for medically necessary travel expenses for a colonoscopy and up to \$2,000 to reimburse a participant for medically necessary travel expenses for hip replacement surgery, knee replacement surgery and back surgery at medical facilities that are listed on an addendum (see below). Other procedures and facilities may be approved by prior application to the Trustees.

The following limitations also apply:

- This benefit applies only to conditions covered under the medical plan and is limited to the services listed below.

- ❑ Transportation is for the member incurring the covered medical service and the maximum is the highest level of coverage for a single service even if multiple services are delivered during a trip.
- ❑ Companion travel is a valid expense for these covered services and covered under the benefit provision of the member incurring the service.
- ❑ Transportation must be primarily for and essential to the medical care.
- ❑ Eligible air transportation expenses are round-trip commercial coach fare.
- ❑ This benefit must be preauthorized and travel receipts must be provided along with the Tongass Medical Travel Request Form. For air transportation, a copy of the ticket with the passenger name(s), dates, total cost of travel and origination and final destination points must accompany the request.
- ❑ Your claim must include a statement or letter from your physician attesting to the medical necessity of the services you received that required the air travel.

Addendum:

Procedures

Hip replacement
 Knee replacement
 Back surgery
 Colonoscopy

Medical Facilities

Harborview Hospital
 Swedish Hospital
 Virginia Mason Hospital
 Overlake Hospital
 University of Washington Hospital

- **Newborn care** — covered the same as any other covered medical service for charges made by a physician.
- **Nursing services, including registered graduate nurse (RN) services** (not provided by a nurse who resides in your home or who is a member of your or your spouse’s family) and **private duty nursing services** (covered only to the extent they are medically necessary). Payment is not made for services that are custodial or for services that do not require the skill level of a registered nurse.
- **Pap smear** — See Well Woman Care in this section.
- **Phenylketonuria (PKU) treatment** — if you or your dependent requires formulas necessary for the treatment of phenylketonuria (PKU), the Plan will pay the expense incurred in the same manner and subject to the same conditions and limitations as for any other covered medical service.
- **Physical exams, routine** —routine physical exams are covered at 100% with no deductible.

- **Physician services** provided by a physician who does not reside in your home or who is not a member of your or your spouse's family.
- **Plastic and reconstructive services** — Plastic and reconstructive services and procedures are covered only when preauthorized for the following conditions. The services are subject to the same limitations as for any other covered medical service.
 - To correct a functional deficit resulting from a congenital disease or anomaly.
 - To correct a functional physical disorder resulting from disease.
 - To correct a functional physical disorder resulting from a prior surgery provided the prior surgery would be eligible for coverage under this plan.

In connection with reconstructive surgery following a mastectomy, see the section called "Women's Health and Cancer Rights Act".

Coverage does **not** include:

- Cosmetic services, supplies or surgery to repair, modify or reshape a functioning body structure for the improvement of the patient's appearance or self-esteem
- Complications resulting from non-covered services
- Orthognathic surgery for adults, regardless of origin or cause
- Dermabrasion, chemical peels and/or skin procedures used to improve appearance or to remove scars or tattoos.
- **Prescription drugs** — The Plan covers generic and brand-name drugs that are approved by the FDA and which by law require a physician's prescription, up to a 90-day supply at one time.
- **Preventive care (routine)** — See routine physical exams, prostate cancer screening, well child care, and well woman care.
- **Prostate cancer screening** — Routine prostate screening tests (a prostate antigen blood test or another test that is equivalent or better in cancer detection, if recommended by a physician) are covered at 100% with no deductible imposed, provided that:
 - The participant is age 40 or older, or
 - The participant is at least 35 and is considered to be at high risk (for example, someone who has a family history of prostate cancer).
- **Spinal treatment (non-surgical)/chiropractic care** — Non-surgical spinal treatment is covered the same as any other condition when services are provided by a physician up to 10 visits annually. Manipulation of the spine is covered when furnished by a chiropractor for the medically necessary treatment of a covered illness or condition when such services are reasonably expected to result in self-

sustaining functional improvement. Services provided by a licensed physical therapist are excluded. Benefits for X-rays received in connection with non-surgical spinal treatment are payable in the same manner as they are for other covered X-rays. See Spinal Treatment in the Other Medical Maximums section.

- **Surgical services and surgical assistance services** — covered the same as any other service, after the deductible and is subject to Usual, Customary and Reasonable limits and other Plan maximums. In the event of multiple surgeries or multiple surgeons in attendance during one surgery, or supplies for which data is unavailable, “Usual, Customary and Reasonable” will be determined by the charges generally incurred for cases of comparable nature and severity in the particular geographic area concerned.
- **Surgical Assistant charges-** will be considered for benefits at 20% of the usual and customary charges of the primary surgeon charges.
- **Well child care** — Covered at 100% with no deductible. Includes well child exams and immunizations.
- **Well woman care** — Women’s health care providers include any generally recognized medical specialty of licensed practitioners who provide women’s health care services within their lawful scope of practice. They include, but are not limited to:
 - An allopathic physician (M.D.) or osteopathic physician (D.O.) who is a family or general practitioner, internist, obstetrician or gynecologist
 - A licensed physician assistant
 - An advanced registered nurse practitioner (A.R.N.P) who specializes in women’s health, family practice or midwifery, or
 - A certified nurse midwife (C.N.M.).

For the purposes of this section, “well woman care” includes maternity care, reproductive health services, gynecological care, general examination and preventive care as medically appropriate, including follow-up visits. Also included are services provided by a women’s health care provider for other health problems discovered and treated during the scope of a visit for women’s health care services and which is within the practitioner’s scope of practice. The deductible does not apply to women’s health care service.

Pap smears are covered at one per 12 month period.

Mammography is covered for participants 35 years and over of age up to a limit of one mammogram per 12 month period. However, mammograms are covered without regard to age and do not have a yearly limit if one of the following is true:

- The participant or participant’s mother or sister has a history of breast cancer,
- or
- The participant’s physician recommends the mammogram.

The plan will cover the following women's preventive services with no cost sharing:

- All FDA-approved contraceptive methods, sterilization procedures, patient education and counseling for all women with reproductive capacity
- Lactation support and counseling
- HPV and HIV testing
- Domestic violence screening and counseling
- Counseling on sexually transmitted infections
- Screening for gestational diabetes.

Medical Exclusions

Treatment, services and supplies in connection with any of the following are excluded from medical coverage and will not be paid:

- **Alcoholics Anonymous** or other similar chemical dependency programs or support groups
- **Adventure based and wilderness programs** that focus mainly on education, socialization or delinquency
- **Any treatment, service or supply not shown as a covered service**, except in instances where the treatment, service or supply is recommended by a physician, is medically necessary and is reasonably expected to reduce the total cost of treatment
- **Any treatment, service or supply not addressed in this booklet**, unless it is determined to be medically necessary and is not excluded as a covered service
- **Anything excluded** under the general exclusions and limitations
- **Biofeedback or stress reduction classes.** Some instances of pain management is covered
- **Chelation therapy**, except for acute arsenic, gold, mercury or lead poisoning
- **Clinical Trials** – costs incurred due to the participation in a phase I, II, III or IV clinical trial, including but not limited to:
 - the costs of the investigative item, device or service;
 - the costs of items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis;
 - the cost for a service that is inconsistent with commonly accepted and established standards of care for the diagnosis.However, routine medical expenses associated with a clinical trial (phase I, II, III or IV) will be covered under the Plan if medically necessary or to the extent legally required.
- **Cosmetic services (surgical and non-surgical)** except for:
 - Repair of defects which result from surgery for which the participant was paid benefits under the Plan

- The reconstructive (not cosmetic) repair of a congenital defect for a dependent child which materially corrects a bodily malfunction
- **Court ordered treatments** or treatments related to deferral of prosecution, deferral of sentencing or suspended sentencing or treatments serving as a condition of retaining driving rights when no medical necessity exists
- **Custodial Care**, including housing that is not integral to a medically necessary level of care or care solely to comply with a court order, to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite
- **Dental services**, dental surgery or oral surgery (unless specifically provided) including:
 - Treatment involving any tooth structure, alveolar process, abscess or disease of the periodontal or gingival tissue
 - Surgery or splinting to adjust dental occlusion
- **Eating disorders** including any loss, expense or charge that results from appetite control, food addictions or eating disorders (except for documented cases of bulimia or anorexia that meet standard diagnostic criteria as determined by the Plan, which present significant symptomatic medical problems)
- **Hearing aids**
 - Replacement of a hearing aid, for any reason, more than once in a three benefit year period
 - Batteries or other supplementary equipment other than those obtained upon purchase of the hearing aid
 - A hearing aid exceeding the specifications prescribed for correction of hearing loss
 - Expenses incurred after coverage ends, unless you order a hearing aid before your termination and receive it within 90 days of your termination date
- **Home health services** for:
 - Services that consist primarily of the duties of a housekeeper, companion or sitter
 - Services and supplies not included in the home health care plan
 - Services of a person who is part of your family or lives with you in your home
 - Expense for which benefits are paid under any other provision of this Plan
 - Estate planning, drafting of wills or other legal services
 - Funeral arrangements or services

- **Hospice care services** for:

Transportation services

Any expense paid under any other provision of this Plan

Anything excluded under the general exclusions and limitations; except any requirement that the care be part of an active plan of medical treatment which is reasonably expected to reduce the disability will not apply

Any exclusion concerning a Worker's Compensation or occupational disease law will not apply.

- **Infertility treatment** including (but not limited to) any attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization and embryo transfer or any similar treatment or method

- **Message therapy**

- **Non-Emergent Care** provided outside of the United States

- **Obesity surgery**, except for surgery to treat morbid obesity

- **Orthognathic surgery** except for dependent children

- **Orthopedic** shoes, orthotics or other supportive devices for the feet, including related diagnosis, treatment and fittings

- **Prescriptions for:**

- Drugs or medicines that can be lawfully obtained without a physician's prescriptions

- Drugs available or received without charge under any local, state or federal program

- Prescription refills in excess of the frequency and amount specified by the physician while insured under this Plan

- Drugs or medications dispensed more than one year after the date of prescription

- Experimental/investigational drugs or medicines

- Fertility drugs or medicines

- Dietary supplements

- Drugs or medicines used for cosmetic purposes or beauty aids

- Vitamins, except pre-natal when the participant is or expected to be pregnant

Vision hardware — However, this may be covered by your vision benefits; see "Vision Coverage" on page 40

III. Dental Benefits

Dental benefits provided by the Plan help you pay a portion of the cost of your dental care. Before the Plan pays most dental benefits, you must first satisfy the annual dental deductible. After you satisfy the deductible, most services are covered at 80% or 50%, depending on the type of service, up to an annual maximum dental benefit of \$1,500 per adult participant. Dental care for dependent children to age 19 is unlimited. The dental deductible does not apply to covered orthodontia.

The chart below highlights major features of your dental coverage. Please note, these are just the highlights and they don't include every detail. You should read this entire section carefully before you seek dental care to be sure you understand all the details of your coverage.

Highlights of Your Dental Benefits

Feature	Benefit
Annual Deductible <i>Amount you pay each calendar year before the Plan begins paying benefits; applies to dental expenses only.</i>	\$50 per person
Annual Maximum Dental Benefit <i>The annual maximum dental benefit is the most the Plan will pay for covered dental services in a calendar year.</i>	Maximum of \$1,500 per adult per calendar year Dental care for dependent children to age 19 is unlimited
Basic Dental Services <i>Eligible Basic services are listed beginning on page 34; they include diagnostic, preventive and routine dental service.</i>	Plan pays 80%*
Major Dental Services <i>Eligible Major dental services are listed beginning on page 36, and include crowns and bridges.</i>	Plan pays 50%*
Orthodontia — <i>Eligible orthodontia services are listed on page 36.</i>	Plan pays 50% , up to a lifetime maximum of \$1,500 per adult. Plan pays 50% , up to a lifetime maximum of one set of braces/orthodontia for children up to age 19.

*Plan pays this percentage of eligible services up to Usual, Customary and Reasonable (UCR) limits. See page 93.

Advance Claim Review

Advance claim review offers you and your dentist an opportunity to find out how a specific dental treatment or service will be paid before you incur the expenses — so there are no surprises. It's strongly recommended that you seek advance claim review before beginning a course of treatment for which dentists' charges are expected to be \$500 or more.

To obtain an advance claim review, your dentist should submit a pre-treatment estimate claim form to the Plan Administrator, along with a description of the proposed course of treatment, copies of X-rays showing the condition for which treatment is needed and the proposed charges.

The Plan will then determine the estimated benefits payable for covered dental services expected to be incurred and advise you and the dentist before treatment begins. As part of claim review and proof of loss for any claim, the Plan may require an oral examination of the treated individual at the Plan's expense.

A Closer Look at Important Dental Plan Provisions

Deductible — This is the amount you must pay each calendar year for covered dental services before benefits are payable under this Plan. A separate deductible applies to you and each of your dependents. The individual annual deductible is \$50 per person, Orthodontia benefits are not subject to the deductible.

Coinsurance— The percentage paid by the Plan for covered services after you meet the deductible, subject to Usual, Customary and Reasonable limits as well as applicable maximums.

Calendar year maximum dental benefit — No more than the calendar year maximum benefit of \$1,500 per adult participant is payable for all dental services incurred by an individual in a calendar year, regardless of any interruption in coverage. There is no annual maximum benefit for dependent children up to age 19.

Lifetime maximum orthodontia benefit for adults — There is a \$1,500 per adult lifetime maximum benefit for covered orthodontia services. This means that the plan will pay no more than \$1,500 for all orthodontia services incurred by one adult participant. There will be no dollar limit on medically necessary orthodontia for children up to age 19, although benefits are limited to once per lifetime.

Covered Dental Benefits

After you satisfy the deductible, the Plan covers eligible dental services at either 80% or 50% (depending on the dental service received) of Usual, Customary and Reasonable levels, up to applicable maximums.

In order to be covered, all dentists' charges must meet both of the following tests:

- They are necessary and customarily employed nationwide for the treatment of the dental condition
- They are appropriate and meet professionally recognized national standards of quality.

Basic Dental Benefits

After you meet the deductible, the Basic dental services listed in the "Covered Benefits" section below are covered and considered for payment at 80%, subject to Usual, Customary and Reasonable limits and applicable Plan maximums.

Covered Benefits

- Routine examinations are covered once in a six-month period
- Complete mouth or panoramic X-rays are covered once every five years
- Four supplementary bitewing X-rays are covered once every 12 months
- Emergency examination and examination by a specialist in an American Dental Association recognized specialty
- Prophylaxis (cleaning) is covered once in a six-month period
- Periodontal maintenance procedures are covered in lieu of a prophylaxis, if the patient has completed active periodontal treatment and six months have elapsed since the last prophylaxis
- Sealants on permanent molar teeth are covered only for children 14 and younger
- Topical application of fluorides is covered once in a six month period only for children age 14 and younger, when performed in conjunction with a prophylaxis
- Space maintainers when used to maintain space for eruption of permanent teeth only for children age 17 and younger
- Amalgam restorations, synthetic porcelain (silicate) restorations and plastic restorations for treatment of visible destruction of hard tooth structure resulting from dental decay
- Stainless steel crowns are covered once every two years
- Major and minor oral surgery that includes the following general categories:
 - Removal of teeth (extractions)
 - Preprosthetic surgery
 - Treatment of pathological conditions
 - Traumatic facial injuries

- General anesthesia - general anesthesia and/or IV sedation is a covered procedure only when administered by a dentist that meets the educational and legal requirements of the state in which he or she is licensed to practice dentistry, and only in conjunction with a covered oral surgery procedure; please note that dentists licensed and practicing in Alaska have specific educational and legal requirements for administration of general anesthetic and IV sedation
- Surgical and non-surgical procedures for treatment of the tissues supporting the teeth, including root planning, sub-gingival curettage and gingivectomy; root planning or subgingival curettage (but not both) are covered once every 12 months
- Minor occlusal adjustment when used for relief of traumatic occlusions (eight teeth or less) such as smoothing teeth or reducing cusps (i.e., discing, odontoplasty or enamoplasty) is covered once every 12 months
- Procedures for pulp and root canal therapy, including
 - Pulp exposure treatment
 - Pulpotomy
 - Apicoectomy
 Root canal treatment on the same tooth is covered once every two years.

For the following three covered services, only replacements and additions that meet the “Prosthesis Replacement Rule” (see next section) will be covered. Payment for full or partial dentures will be made according to the seat date.

- Repair or re-cementing of crowns, bridgework or dentures
- Initial installation of partial or full removable dentures (excluding adjustments for the six-month period following installation) to replace one or more natural teeth extracted while the individual is covered by the Plan
- Replacement of an existing partial or full removable denture or fixed bridgework by a new partial or full removable denture

Note: See the “General Dental Exclusions” section for a list of services that are not covered under Basic Dental Benefits.

Prosthesis Replacement Rule

This rule specifies that replacements or additions to existing dentures, crowns or bridgework will be covered only if evidence satisfactory to Tongass Timber Trust is furnished that one of the following applies:

- The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridge work was installed
- The existing denture, crown or bridge work cannot be made serviceable and was installed at least five years prior to its replacement.

Major Dental Benefits

After you meet the deductible, eligible Major Dental Services described below are covered and considered for payment at 50%, subject to Usual, Customary and Reasonable limits and applicable Plan maximums. Please see the additional “Major Dental Services Limitations and Exclusions” following the list of covered benefits.

Covered Benefits

- Fixed prosthodontics such as crowns (except stainless steel) and onlays (gold, porcelain, plastic, gold substitute castings or combinations of these materials), covered once every five years for the same tooth. Note – stainless steel crowns are considered for payment at 80%
- Fixed bridgework for treatment of carious lesions (visible destruction of hard tooth structure resulting from tooth decay)
- Baked porcelain laminates are a covered benefit if the tooth is broken down sufficiently to justify the placement of a crown.

Note: Payment for crowns and bridgework will be made when the crown or bridgework is seated.

Note: See the General Dental Exclusions section for a list of services not covered under Basic Dental Benefits.

Orthodontia Benefits

Adults: The orthodontia services listed below are covered with no deductible and considered for payment at 50% up to a lifetime maximum benefit of \$1,500.

Dependent Children up to age 19: The orthodontia services listed below are covered with no deductible and considered for payment at 50% up to a lifetime maximum of one set of braces/ orthodontia.

Covered Orthodontia Services

- Diagnosis (including models and photographs)
- Initial appliance insertion
- Ongoing treatment and adjustments.

To be covered, costs for orthodontia treatment must:

- Be incurred by a participant or dependent while covered for orthodontia. (For treatment up to and including initial insertion of bands or appliances, treatment is considered incurred on the insertion date. Subsequent treatment is considered to be incurred on the date the treatment is performed, if completed on the same date, or the date the treatment is completed.)
- Not be excluded by any other dental, medical or general exclusion.

General Dental Limitations

While the Plan covers a number of dental services, the following examples illustrate some of the limitations.

- **Restorations** — Restorations on the same surface(s) of the same tooth are covered once every two years.
- **Posterior amalgam** — If a composite or plastic restoration is placed on a posterior tooth, an amalgam allowance will be made for such a procedure.
- **Gold, baked porcelain restorations, crowns and jackets** — If a tooth can be restored with a material such as amalgam and you and the dentist select another type of restoration, the covered dental expenses for the procedure actually performed will be limited to the reasonable charges appropriate to the procedure using amalgam or similar material.
- **Reconstruction** — Covered dental expenses will include only charges for those procedures necessary to eliminate oral disease and to replace missing teeth. Appliances or restorations necessary to increase vertical dimension are considered optional and are not covered.
- **Partial dentures** — If a cast chrome or acrylic partial denture will restore a dental arch satisfactorily and you and the dentist select a more elaborate or precision appliance, the covered dental expenses for the procedure performed will be limited to the reasonable charges appropriate to a cast chrome or acrylic partial denture.
- **Complete dentures** — If, in the provision of complete denture services, you and the dentist decide on personalized restorations or specialized techniques as opposed to the standard procedure, the covered dental expenses for the procedure actually performed will be limited to the reasonable charges appropriate to the standard procedure.
- **Replacement of existing dentures** — Charges for replacement of an existing denture can be included as a covered dental expense only if the existing denture is not serviceable and cannot be made serviceable, provided the existing denture was installed at least five years prior to its replacement. Otherwise, the covered dental expenses for the replacement will be limited to the reasonable charge appropriate for those services that would be necessary to render such appliances serviceable.
- **Denture adjustments and relines** — Denture adjustments and relines done more than six months after the initial placement are covered. Subsequent relines and jump rebases (but not both) will be covered once every 12 months.
- **Implants** — Implants are not a covered benefit. Alternate benefits apply: the Plan will allow the appropriate amount for a crown or a full or partial denture toward the cost of appliances constructed on implants. Surgical replacement or removal of implants or attachments to implants is not covered.

- **Abutments** —A crown used as an abutment to a partial denture is not a covered benefit unless the tooth is decayed to the extent that a crown would be required to restore the tooth, whether or not a partial denture is required.
- **Over dentures** — Root canal therapy performed in conjunction with over dentures is limited to two teeth, and is covered at 80%.

General Dental Exclusions

In addition to the exclusions listed earlier in this section, the following services are excluded from dental coverage under this Plan:

- Consultations
- Study models
- Charges for the review of a proposed treatment plan
- Plaque control programs
- Oral hygiene instruction
- Dietary instruction
- Caries susceptibility tests
- Home fluoride kits
- Charges for broken appointments
- Charges for completing claim forms
- Charges for patient management problems
- Hospitalization charges and any additional fees charged by the dentist for hospital treatment
- Night guards and habit-breaking appliances
- Application of desensitizing medications
- Analgesics (such as nitrous oxide or I.V. sedation) or other euphoric drugs, injections or prescription drugs
- Periodontal splinting and/or crown and bridgework in conjunction with periodontal splinting
- Occlusal splints
- Periodontal appliances
- Extraoral grafts (grafting of tissues from outside of the mouth or use of artificial materials)
- Duplicate dentures
- Cleaning of prosthetic appliances

More Exclusions

The exclusions listed in this section apply to dental benefits only.

See the section called "General Exclusions and Limitations" for information about additional exclusions that apply to all Plan benefits, including dental benefits.

- Charges for the replacement of a lost, missing or stolen prosthetic device
- Tooth implants
- Removal of implants, crowns and copings in conjunction with over dentures
- Charges for the laboratory examination of a tissue specimen (please note: these services may be covered under the medical plan)
- Dentistry for cosmetic reasons; cosmetic services include, but are not limited to, laminates or bleaching of teeth (*exception: baked porcelain laminates are a covered benefit if the tooth is broken down sufficiently to justify the placement of a crown*)
- Charges for treatment by someone other than a dentist except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision and guidance of the dentist
- Experimental services and supplies (and related complications), the use of which are not generally recognized by the American Dental Association as tested and accepted dental practice; this also applies to items requiring approval by the Food and Drug Administration or other governmental agency if such approval was not granted at the time the service or supply was ordered
- Services for injuries or conditions which are covered under Worker's Compensation or Employers' Liability Laws
- Services which are provided to the eligible person by a federal, state or provincial government agency or provided without cost to the eligible person by any municipality, county or other political subdivision
- Charges for any dental services and supplies that are covered expenses in whole or in part under any other part of this Plan, or under any other plan of group benefits provided by your employer
- All other services not specifically included in this program under covered dental benefits.

If Coverage Ends While You Are Receiving Services

Expenses for dentures, fixed bridgework and crowns that are incurred after termination of the individual's dental coverage will be considered to be expenses **incurred when ordered** (and may therefore be eligible to be covered), but only if the item is finally installed or delivered no later than 30 days after termination of coverage.

For this purpose, "ordered" means:

- For dentures, that impressions have been taken from which the denture will be fabricated
- For fixed bridgework or crowns that the teeth serving as retainers or support or which are being restored have been fully prepared to receive the item, and impressions have been taken from which it will be fabricated.

This section applies only if an individual's coverage terminates while the individual is not "totally disabled" as defined in the Definitions section.

For information about continuing your dental coverage after termination under COBRA rules, see the section called "Continuing Your Health Care Coverage Through COBRA".

IV. Vision Benefits

Active employees, retired employees and COBRA participants and their covered dependents are eligible to receive vision benefits described in this section.

Vision Coverage

There is no deductible for vision benefits. Benefits for most covered vision services and supplies are limited to once every 12 consecutive months; the Frame Benefit is limited to no more than once every 24 consecutive months. Coverage is as described below.

- **Adult** – The vision benefit will be subject to an annual **\$350** maximum per person
 - **Vision Exams** – A complete eye examination (which must include a refraction) is covered up to **90%**, subject to the annual benefit maximum, once every 12 consecutive months
 - **Lenses** – Up to two single vision, bifocal, trifocal or lenticular lenses are covered once every 12 consecutive months, subject to the annual benefit maximum
 - **Frames** – One set of frames are covered up to **\$90** per person, subject to the annual benefit maximum, once every 24 consecutive months
 - **Contacts** – Contacts are covered up to **\$170** per person, subject to the annual benefit maximum, once every 12 consecutive months
- **Dependent up to age 19** – The vision benefit has no annual dollar limit, but is subject to the percentage and frequency limits as listed below:
 - **Vision Exams** – A complete eye examination (which must include a refraction) is covered up to **90%**, once every 12 consecutive months
 - **Lenses** – Up to two single vision, bifocal, trifocal or lenticular lenses are covered once every 12 consecutive months
 - **Frames** – One set of frames are covered once every 24 consecutive months
 - **Contacts** – A year's supply of contacts are covered once every 12 consecutive months

The Plan pays the actual charge up to the limits specified above.

Important Vision Benefit Provisions

This Plan only covers vision care services or supplies that are:

- Furnished by a legally-qualified ophthalmologist or optometrist, or
- Prescribed for a participant by a legally-qualified ophthalmologist or optometrist.

Vision Benefit Exclusions

No benefits are payable for:

- Charges for an eye examination that does not include refraction
- Lenses that are not purchased within 12 months of the date of the eye examination
- Anti-reflective coatings
- Charges for tinting lenses or for light sensitive lenses
- Replacement of lost, stolen or broken lenses or frames
- Duplicate or spare eyeglasses
- Special procedures, such as orthoptics or vision training or for special supplies such as non-prescription sunglasses and subnormal vision aids
- Any eye examination required by an employer as a condition of employment, or which an employer is required to provide under a labor agreement, or which are required by any law of a government
- Any vision care services or supplies that are covered expenses in whole or in part under any other part of this Plan, or under any other plan of group benefits provided by your employer
- Services or supplies received while the individual is not covered or charges for lenses and frames that are furnished or ordered as a result of an eye examination that occurred prior to the date the individual becomes covered under this Plan.

More Exclusions

The exclusions listed in this section apply to vision benefits only.

See the section called "General Exclusions and Limitations" for information about additional exclusions that apply to all Plan benefits, including vision benefits.

If Coverage Ends While You Are Receiving Services

Expenses incurred for lenses and frames within 30 days of termination of the individual's coverage under this benefit section will be considered to be covered vision care expenses, but only if a complete eye examination, including refraction, was performed during the 30 day period immediately preceding the termination of coverage and the examination resulted in lenses being prescribed for the first time or new lenses required because of a change in prescription.

This section applies only if an individual's coverage terminates while the individual is not "totally disabled" as defined on page 93.

For information about continuing your vision coverage after termination under COBRA rules, see the section called “Continuing Your Health Care Coverage Through COBRA” on page 56.

V. Coordination of Benefits - if You Have Coverage through More Than One Plan

Coordination of benefits (COB) rules applies whenever you have coverage through more than one health plan. COB rules determine how benefits are paid or coordinated between your plans.

If you are covered by another plan or plans, the benefits under this Plan and the other plan will be coordinated. This means the primary plan pays its full benefits first, then the other plan pays.

The primary plan first pays the benefits that would be payable under its terms in the absence of the provision. The secondary plan then pays benefits according to its COB rules.

Please note: different COB rules apply if you are covered under Medicare. Go to the section called “Medicare Coordination of Benefits” for more information.

Definition of “Plan”

For the purposes of Coordination of Benefits rules described in this section, “plan” means any of the following coverages, including Plan coverage and any coverage that is declared to be “excess” to all other coverage and provides benefit payments or services to a participant for hospital, medical, surgical, dental, prescription drug or vision care:

- Group, blanket or franchise insurance (except student accident insurance)
- Group health plans, including HMOs (Health Maintenance Organizations)
- Coverage under a labor management plan, a union welfare plan, an employer organization plan or an employee benefit plan
- Coverage under government programs, other than Medicare or Medicaid, and any other coverage required by law
- Other arrangements of insured or self-insured group coverage.

If any of the above coverage includes group and group-type hospital indemnity coverage, “plan” also means indemnity benefits above \$100 per day.

Determining Which Plan Is Primary

When the other plan does not have a COB provision, that plan is primary and must determine benefits first.

When the other plan does have a COB provision, the first of the following rules to apply governs.

- If a plan covers the claimant as an employee, member or non-dependent, then that plan will be primary.
- If the claimant is a dependent child whose parents are not divorced or separated, then the plan of the parent whose birthday is earlier in the calendar year will be primary, except:
 - If both parents' birthdays are on the same day, the rule below starting with "If none of the above rules apply" will apply
 - If another plan does not include this COB rule based on the parents' birthdays, but instead has a rule based on the gender of the parent, then that plan's COB rule will determine the order of benefits.
- If the claimant is a dependent child whose parents are divorced or separated, then the following rules apply:
 - A plan that covers a child as a dependent of a parent who by court decree must provide health coverage will pay first
 - When there is no court decree which requires a parent to provide health coverage to a dependent child, the following rules will apply:
 - When the parent who has custody of the child has not remarried, that parent's plan will be primary
 - When the parent who has custody of the child has remarried, that parent's plan will be primary, the stepparent's plan secondary and the plan of the parent without custody will pay benefits third.
- If a dependent is married, the spouse's plan will be primary over the dependent's parent's plan.
- In the case of a dependent grandchild, either parent's plan will be primary over either grandparent's plan.
- If none of the above rules apply, the plan that has covered the claimant for the longer period of time will be primary, except when:
 - One plan covers the claimant as a laid off or retired employee (or a dependent of such an employee), and
 - The other plan includes this COB rule for laid off or retired employees (or is issued in a state which requires this COB rule by law). Then the plan that covers the claimant as other than a laid off or retired employee (or a dependent of such an employee) will be primary.

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

How the Plan Pays Benefits Using Coordination of Benefits

When This Plan Is Primary

When this Plan is primary, benefits will be paid first, at normal Plan coverage levels.

When This Plan Is Secondary

If this Plan is secondary, first the other plan's benefits are determined and paid. Then this Plan's benefits are paid; for services payable under both plans, the combined benefits from both plans will not exceed 100% of the expense incurred.

For example, let's say you incur a medical expense of \$100 and the primary plan pays \$80. Assuming the expense is a covered service under this Plan, the Plan would pay the remaining \$20.

Credit Savings

Where the Plan does not have to pay its full benefits because of COB, the savings will be credited to the claimant for the remainder of that calendar year. These savings will be applied to any unpaid covered expense during the year. In the above example, TTT could have paid \$80, but only paid \$20, the difference, \$60, would be applied to your credit savings.

How COB Affects Benefit Limits

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

Right to Collect and Release Needed Information

In order to calculate and receive benefits, the claimant must give the plan any information that is needed to coordinate benefits. With the claimant's consent, the plan may release to or collect from any person or organization any needed information about the claimant subject to HIPAA privacy regulations.

Facility of Payment

If benefits this Plan should have paid are instead paid by another plan, this Plan may reimburse the participant or the provider. Amounts reimbursed are Plan benefits and are treated like other Plan benefits in satisfying Plan provisions.

Right of Recovery

If this Plan pays more for a covered expense than is required by this provision, the excess payment may be recovered from:

- The claimant
- Any person to whom the payment was made, or
- Any insurance company, service plan or other organization which should have made payment.

Medicare Coordination of Benefits

This Medicare COB provision applies when the eligible person has health coverage under this Plan, and is eligible for coverage under Medicare, Parts A and B (whether or not the participant has applied or is enrolled in Medicare). It applies before any other COB provision of this Plan.

Effect on Benefits

If, in accord with the following rules, this Plan has primary responsibility for the covered person's claims, then this Plan pays benefits first.

If, in accord with the following rules, this Plan has secondary responsibility for the covered person's claims, first Medicare benefits are determined and paid, and then this Plan's benefits are paid. However, for services payable under both plans, the combined Medicare benefits and Plan benefits will not exceed 100% of the expense incurred.

Rules for Determining Order of Benefits

For You

This Plan has primary responsibility for your claims if you are:

- Covered under this Plan because of your current active employment status with an ADEA (Age Discrimination in Employment Act) Employer, and you are eligible for Medicare benefits because of age, or
- Covered under this Plan because of your current active employment status and you are eligible for Medicare benefits because of disability.

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

For Your Dependent

This Plan has primary responsibility for your dependent's claims if you are covered under this Plan because of your current active employment status with an ADEA Employer, and your dependent spouse is eligible for Medicare because of age,

This Plan has secondary responsibility for your dependent's claims if your dependent is eligible for Medicare benefits and the above conditions do not apply.

For these purposes, "ADEA Employer" means an employer subject to the federal Age Discrimination in Employment Act (ADEA) with 20 or more employees each working in 20 or more calendar weeks during the current or preceding calendar year.

Exception for End Stage Renal Disease

If Medicare does not already have primary responsibility when you or your dependent becomes eligible for Medicare benefits because of end stage renal disease:

- This Plan has primary responsibility for yours or your dependent's claims for up to 30 months beginning with the month in which you or your dependent is first eligible for Medicare benefits because of end stage renal disease, and
- This Plan has secondary responsibility after the end of this 30-month period.

IX. General Exclusions and Limitations

The Plan does not pay under the health benefit provisions for:

- Any injury or sickness for which the participant is entitled to benefits under a Worker's compensation or occupational disease law, or any other work related illness or injury (but this exclusion does not apply to accidental death and dismemberment benefits)
- Any expense in excess of the Usual, Customary and Reasonable charges
- Any expense or charge for services or supplies not medically necessary or not recommended by a physician
- Any expense incurred after coverage ends (except as specifically provided under any extended benefits provisions in the Plan)
- Any loss, expense or charge resulting from the participant's participation in a riot or in the commission of a felony
- Any expense or charge that the participant does not have to pay
- Any expense or charge for custodial care, developmental care or domiciliary care
- Any loss, expense or charge that results from cosmetic or reconstructive surgery, except for:
 - The reconstructive (not cosmetic) repair of a congenital defect for a dependent child which materially corrects a bodily malfunction
 - The reconstruction of a breast after a mastectomy, including all stages of any reconstructive breast reduction performed on the non-diseased breast to make it equal in size with the reconstructed diseased breast, or
 - Repair of defects that result from surgery for which the covered person was paid benefits under the Plan
- Any expense or charge for services or supplies that are:
 - Not provided in accord with generally accepted professional medical standards
 - For experimental treatment
 - Investigative, and not proven safe and effective
- Any expense or charge for services or supplies provided or paid for by federal government or its agencies, except for:
 - The Veterans Administration, when services are provided to a veteran for a disability which is not service connected
 - A military hospital or facility, when services are provided to a retiree (or dependent of a retiree) from the armed forces

- A group health plan established by a government for its own civilian employees and their dependents
- Medicaid if required by a Medicaid assignment of benefits
- Any loss, expense or charge that results from an act of declared or undeclared war or armed aggression
- Any loss, expense or charge:
 - Incurred while the participant is on active duty or training in the Armed Forces, National Guard or Reserves of any state or
 - For which any governmental body or its agencies are liable
- Any expense or charge primarily for the participant's convenience or comfort or that of the participant's family, caretaker, physician or other medical provider.

X. How to File a Claim

Medical, Dental, and Vision Claims

In order to receive prompt payment for your claims, please follow the procedures outlined below:

1. If at all possible, have your provider submit a claim for you. Most providers are willing to do so, but if they will not, you can submit the claim yourself as long as you provide the Plan Administrator with all the necessary information to process the claim. Please be sure the following information is included in the documentation that you submit:

- Name of the covered employee
- Name of the patient
- Name, address, and tax ID number of the provider
- Date(s) of service
- Services provided (CPT codes)
- Diagnosis code(s)
- Fees for services.

If You Have Questions About a Claim

If you have questions regarding claims, covered benefits or eligibility, contact the Plan Administrator's office at (907) 225-6114, email claims@akaforest.org or write to:
Tongass Timber Trust
111 Stedman, Suite 200
Ketchikan, AK 99901

Please note: balance due statements from providers cannot be processed. An itemized billing showing the above information is needed before your claim can be processed.

2. Benefits will be made payable to you unless you have assigned your benefits to the provider.

3. **Send all claims to:** **Tongass Timber Trust**
111 Stedman, Suite 200
Ketchikan, Alaska 99901

4. Most providers prefer to photocopy your health plan member card for reference. If you do not have one please contact your employer or the Plan Administrator's office.

Prescription Reimbursements

We do not have agreements with any pharmacies for prescription claims submission. Instead, we ask you to pay the pharmacy for your prescriptions and then submit a claim to us for reimbursement. Your claim should include the pharmacy slip. Please note that a number of the slips are two-part; you need to submit the part that states:

- Name of the person for whom the prescription is prescribed
- Name and cost of the prescription
- Date the prescription is filled, as well as quantity issued
- Name and address of the pharmacy

- Name of the doctor who wrote the prescription.

Please note: we will cover up to a 90 day supply of a prescription at one time.

Forms for submitting your prescriptions for reimbursement are available from the Plan Administrator and on our website at www.akforest.org. Whether or not you use the form, processing will be expedited if you note for what condition you are taking each particular drug.

Deadline for Filing a Claim

All claims should be reported promptly. Failure to submit claims in a timely manner will result in denial of benefits. The deadline for benefits is 12 months after the date of service.

Deadline for Legal Action

No legal action can be brought to recover under any benefit after three years from the deadline for filing claims.

Payment of Claims

You may assign the payment of health care benefits to a hospital or doctor by signing the authorization on the claim form. Claim forms received from providers that do not have a signature but indicate “signature on file” will have benefits paid directly to the provider.

All other benefits are payable to you. However, Tongass Timber Trust has the right to pay any medical benefits directly to an institution or person providing services covered under this Plan unless you have specified otherwise by the time you file the claim.

Claim Review and Appeal Procedures

This section provides general information about the claims and appeals procedure applicable to the Plan under ERISA. Note that state insurance laws may provide additional protection to claimants under insured arrangements and if so, those rules will apply.

For medical benefits, the Plan will comply with additional claim and appeal rules required under Health Care Reform. You will be notified if any of these new rules impact your claim. These rules would not apply to stand alone dental or vision claims.

As used in this section, the following definitions apply:

- A “claim” is broadly defined to include any request for Plan benefits made in accordance with the Plan’s reasonable claims filing procedure
- An “adverse benefit determination” is a denial, reduction, termination of or a failure to provide or make payment (in whole or in part) for a benefit. An adverse benefit determination for medical claims includes a rescission of coverage (generally a retroactive cancellation of coverage) under the Plan, whether or not in connection with the rescission there is an adverse effect on any particular benefit at that time.

How Claims Are Processed

In order to receive prompt payment for your claims you must follow the claim filing procedures described beginning with “How to File a Claim”. If you file a claim that does not follow the Plan’s claim filing procedures, you will be notified within ten days (or 24 hours in the case of an urgent care claim) of the failure, and of the proper procedures to be followed in filing the claim.

Claims that are properly filed will be processed in accordance with the following guidelines:

Post-Service Health Claims

Post-Service Health Claims are properly filed claims for medical, dental or vision benefits that are not an urgent care or pre-service health claim as defined below. Under normal circumstances, you will be notified of the benefit determination for a post-service health claim within 30 days of receipt of the claim. If additional information is needed to process the claim, you will be notified within 30 days of receipt of the claim, and will be advised of the specific information required. You will then have 45 days from receipt of the notice to provide the additional information. A benefit determination will be made no later than 15 days after the earlier of (1) the date the requested information is received or, (2) 45 days have passed since the request for additional information was made.

Pre-Service Health Claims

Pre-Service Health Claims are properly filed claims that must be preauthorized to receive full benefits from the Trust. Currently, inpatient hospital admissions, including those for mental health and chemical dependency diagnoses services must be preauthorized. Dental pre-determinations are suggested, but not mandatory. Under normal circumstances you will be notified of the benefit determination for a pre-service claim within 15 days of receipt of the claim. If additional information is needed to process the claim you will be notified within 15 days, and will be advised of the specific information required. You will then have 45 days from receipt of the notice to provide the additional information. A benefit determination will be made no later than 15 days after the earlier of (1) the date the requested information is received, or (2) 45 days have passed since the request for additional information was made.

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

Urgent Care Health Claims

Urgent care claims are claims or requests for services that must be decided more quickly because using the normal time frames for benefit determinations and appeals could seriously jeopardize the health of the individual or expose him or her to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims may be filed orally or in writing by you, your beneficiary or a health care provider with knowledge of the individual’s medical condition.

Under normal circumstances you will be notified of the benefit determination for an urgent care claim as soon as possible but no later than 72 hours of receipt of the claim. If additional information is needed to process the claim you will be notified within 24 hours, and will be advised of the specific information required. A benefit determination will then be made no later than 48 hours after the earlier of (1) the date the Trust receives the additional information, or (2) 48 hours have passed since the request for additional information was made.

The Plan will treat a claim as urgent if any physician with knowledge of the patient's medical condition deems the claim to involve urgent care. The medical plan must defer to an attending provider to determine if a claim is urgent.

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

Concurrent Care Health Claims

Concurrent care claims are those involving a decision to reduce or terminate an ongoing course of treatment, as well as decisions regarding requests by you to extend a course of treatment beyond what has been approved. You will be notified of any reduction or termination of a previously approved course of treatment prior to the date of the reduction or termination, allowing you sufficient time to appeal and obtain a determination on the appeal before the decision is to take effect.

If an urgent care claim is involved, any request by you to extend the course of treatment beyond the period of time or number of treatments previously approved shall be decided as soon as reasonably possible. In any case you will be notified of the determination within 24 hours of receipt of the request.

Any appeal of a decision involving a concurrent care claim will be treated as either a Pre-Service, Urgent Care or Post-Service claim appeal, as appropriate under the circumstances.

Notice of Adverse Benefit Determination

For all types of claims, a notice of adverse benefit determination will provide the following information:

- The specific reason for the adverse determination
- A reference to the specific plan provision on which the determination is based
- A description of any additional material or information needed to perfect the claim together with an explanation of why that material or information is necessary
- If an internal rule, guideline or protocol was relied on in denying the claim, a statement that such a rule, guideline or protocol was relied on and that a copy will be provided without charge upon request

- If the decision is based upon a medical necessity determination, the service or supply being experimental or investigational in nature or an equivalent exclusion, an explanation of the medical judgment applying the terms of the Plan to the claimant's circumstances
- An explanation of the Trust's internal appeal procedures, including applicable time limits
- For medical claims incurred on or after January 1, 2012, the notice will include information sufficient to identify the claim involved. This includes:
 - the date of service;
 - the health care provider;
 - the claim amount (if applicable); and
 - the denial code.
- For medical claims incurred on or after January 1, 2012, the notice will also include:
 - a statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
 - a description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
 - in addition to the description of the Plan's internal appeal procedures, a description of the external review processes; and
 - the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

A notice of the adverse benefit determination will be mailed to you or your beneficiary at the last known address. For determinations involving urgent care, this information may be provided orally within the appropriate time frame.

How to Appeal an Adverse Benefit Determination

Medical coverage for you and your dependents will continue pending the outcome of an internal appeal. This means that the Plan will not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

If the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to your medical claim, you are deemed to have exhausted the internal claims and appeals process. In this case, you may seek an external review or pursue legal remedies (as discussed below) without waiting for further Plan action. However, this will not apply if the error was de minimus, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, you may resubmit your claim for internal review and you may ask the Plan to explain why the error is minor and why it meets this exception. Additionally, if your claim is an Urgent Care Claim or a claim requiring an ongoing course of treatment, you may begin an expedited external review before the Plan's internal appeals process has been completed.

If a claim for benefits is denied in part or in whole, you have the right to appeal the claim. You will have 180 days from receipt of an adverse benefit determination to

appeal a health claim decision. An appeal must be submitted by you, your beneficiary or an authorized representative. All appeals must be made in writing, except that urgent care appeals may be submitted orally. Appeals must be submitted to the proper address for the Trust's administrative office. An appeal must identify the benefit determination involved, set forth the reasons for the appeal and provide any information you or your authorized representative believes is pertinent. Except for urgent care claims, appeals will be accepted from an authorized representative only if accompanied by a written statement signed by you (or parent or legal guardian where appropriate) which identifies the representative and authorizes him or her to seek benefits for the claimant. An assignment of benefits is not sufficient to make a provider an authorized representative.

Failure to file a claim appeal within the applicable time frame will serve as a bar to any claim for benefits or for any other form of relief from the Trust.

The following procedures shall be the exclusive procedures available to you or your beneficiary who is dissatisfied with an eligibility determination, benefit denial or partial benefit award or any other adverse benefit determination by the Trust or its authorized claims payers. Except as described above, these procedures must be exhausted before you or your beneficiary may file suit under Section 502(a) of ERISA.

Information to Be Provided Upon Request

You and/or your authorized representative may, upon request and free of charge, have reasonable access to all documents relevant to the claim for benefits. Relevant documents shall include information relied upon, submitted, considered or generated in making the benefit determination. They will also include internal guidelines, procedures or protocols concerning the denied treatment option without regard to whether such document or advice was relied on in making the benefit determination.

If a decision is based upon a medical necessity determination, an explanation of that determination and its application to the individual's medical circumstances will also be available upon request.

With respect to medical claims, you will be able to review your file and present evidence as part of the claim appeal. In addition, prior to making an appeal determination, the Trust must provide you with any new or additional evidence considered, relied upon, or generated by the medical plan (or at the direction of the medical plan) in connection with the claim. This evidence will be provided at no cost to you, and will be given before the determination in order to give you a reasonable opportunity to respond.

Prior to issuing a final internal adverse benefit determination on appeal based on a new or additional rationale, the rationale will be provided at no cost to you. It will be given before the determination in order to give you a reasonable opportunity to respond.

Review of Appeal by Trustees

Claim appeals will be reviewed by the Board of Trustees, or a Committee of Trustees, and a decision made within the following time limits:

- Post-Service Claim — within 60 days of receipt of appeal Pre-Service Claim — within 30 days of receipt of appeal.
- Urgent Care — within 72 hours of receipt of appeal.

The Trustees will review the administrative file that consists of all documents relevant to the claim. They will also review all additional information submitted by or on you or your beneficiary's behalf. The review will be conducted without deference to the initial benefit determination.

If the benefit determination is based on medical judgment, the Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional consulted will not be the individual who made the initial benefit determination nor a subordinate of that individual. Upon request by the claimant, the Trustees will identify by name any individuals consulted for medical or vocational advice. In all cases, the claimant will be notified of the Trustee's decision as soon as reasonably possible and within the relevant time limit. Under no circumstances will the claimant be notified later than five days after the decision is made.

For medical claims, the Trustees will ensure that all claims and appeals are adjudicated in a manner designed to ensure there is no conflict of interest with regard to the individual making the decision. The Trustees will ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. The Trustees will ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, rather than based on the professional's qualifications.

Contents of Decision

A denial of appeal will provide the following information:

- A reference to the specific Plan provision(s) on which the decision was based
- A notice that all information relevant to the claim is available without charge upon request
- If the Trustees relied on an internal rule, guideline or protocol, its decision will identify the rule, guideline or protocol involved and explain that a copy will be provided without charge upon request
- If the Trustee's decision was based on a medical judgment, its decision will explain the medical judgment applying the terms of the Plan to the claimant's circumstances
- A notice of the claimant's rights under section 502(a) of ERISA
- In the case of an Urgent Care appeal, information will be provided to you or your authorized representative via telephone, facsimile or other expedited method, provided that a written or electronic verification is furnished not more than 72 hours later.
- For Medical claim adverse benefit determinations, the notice will include information sufficient to identify the claim involved. This includes:

- The date of service;
 - The health care provider;
 - The claim amount (if applicable); and
 - The denial code.
- For Medical claims, the notice will also include:
 - a statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
 - a description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
 - in addition to the description of the Plan's internal appeal procedures, a description of the external review processes; and
 - the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review processes.

The Trust provides for no voluntary alternative dispute resolution procedures. If you or your beneficiary remain dissatisfied with the Trust's determination after exhausting the claim appeal procedures, you have the right to pursue a civil action under 29 U.S.C. §1132(a) (i.e., section 502(a) of ERISA).

Tongass Timber Trust Follows the HHS-Administered External Review Process

For claims involving medical judgment, as determined by the external reviewer, or a coverage rescission, you are entitled to request an independent, external review of the decision. You must request the external review within four (4) months of the date you receive an adverse benefit determination. If your claim relates to a need for urgent care or receipt of an on-going course of treatment, you may start an expedited external review while the Plan's appeals process is underway. If your request for an external review is determined eligible for such a review, an independent organization will review the Trustee's decision and provide you with a written determination, generally within 45 days.

The external review decision is binding on you and the Plan, except to the extent other remedies are available under federal law.

The external review process does not apply to an adverse benefit determination or final internal adverse benefit determination that relates to a participant's or beneficiary's failure to meet the requirements for eligibility under the terms of a group health plan (for example, worker classification and similar issues) or that is not related to medical judgment or coverage rescission.

XI. Options for Continuing Coverage After Termination

This section describes options for continuing certain Plan coverages on a self-pay basis after your participation in the Plan terminates.

Extended Health Care Benefits if You Are Disabled

If you are an active employee and you become totally or temporarily disabled, your medical, dental and vision benefits will be extended for a period of up to six months or through the last day of the month in which you are released to come back to work, whichever is earlier. If you return to employment with a participating employer and work 130 or more hours in the month following your release for work, extension of benefits will continue through the end of that month.

This disability extension is provided for you by the Trust and no contribution is required from either you or your employer. The extension of benefits applies only to you, the employee, and is not available for dependents.

The six-month extension begins on the first of the month following the last month for which your employer paid coverage. If you take medical leave under FMLA (see the section called “If You Take a Leave of Absence”) because of your disability, this disability extension begins after your FMLA leave ends. Disability extension benefits run concurrently with any COBRA continuation coverage you elect (see the section called “Continuing Your Health Care Coverage Through COBRA” for information about COBRA).

Disability extension benefits are available only for covered services and supplies rendered and received before the end of the six-month extension period.

Disability extension benefits do not include dependent health care coverage — but dependents may be eligible to continue their health care coverage on a self-pay basis through COBRA rules, (see the section called “Continuing Your Health Care Coverage Through COBRA”). Retirees are not eligible for disability extension benefits.

Continuing Your Health Care Coverage Through COBRA

Introduction

The following information about your right to continue your health care coverage in the Plan is important. Please read it very carefully.

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. The following paragraphs generally explain COBRA coverage, when it may become

available to you and your family, and what you need to do to protect the right to receive it.

COBRA (and the description of COBRA coverage contained in this booklet) applies only to the **medical, dental and vision benefits** offered under the Plan. The Plan provides no greater COBRA rights than what COBRA requires—nothing in this booklet is intended to expand your rights beyond COBRA's requirements.

For additional information about your rights and obligations under the Plan and under federal law, contact the Plan Administrator, Tongass Timber Trust, using the contact information under the section called "Plan Administrator Contact Information" on page 67.

What Is COBRA Coverage?

COBRA coverage is available to "qualified beneficiaries"

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below in the section called "Who Is Entitled to Elect COBRA?".

COBRA coverage is the same as coverage available to other participants or beneficiaries under the Plan

After the Plan Administrator is properly notified of a qualifying event, COBRA coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

We use the pronoun "you" in the following paragraphs to refer to each person in your family who is or may become a qualified beneficiary.

COBRA coverage is the same coverage that the Plan gives to other employees or dependents under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other employees or dependents covered under the Plan, including open enrollment and special enrollment rights. Qualified beneficiaries who elect COBRA must pay for COBRA coverage.

Additional information about the Medical, Dental, and Vision Benefits is available in other portions of this booklet.

Who Is Entitled to Elect COBRA?

Qualifying Events for Covered Employee

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

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

Qualifying Events for Covered spouse

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

- Your spouse (the employee) dies
- Your spouse's (the employee's) hours of employment are reduced
- Your spouse's (the employee's) employment ends for any reason other than his or her gross misconduct, or
- You become divorced from your spouse (the employee). Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce, and the divorce later occurs, then the divorce may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce.

Qualifying Events for Dependent Child

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

- The employee dies
- The employee's hours of employment are reduced
- The employee's employment ends for any reason other than his or her gross misconduct
- The employee becomes divorced from his or her spouse, or
- The child stops being eligible for coverage under the Plan as a "dependent child" (for example, your child exceeds the maximum age for dependent child status).

Electing COBRA after Leave under the Family and Medical Leave Act (FMLA)

If an employee takes FMLA leave and does not return to work at the end of the leave, the employee (and the employee's spouse and dependent children, if any) will be entitled to elect COBRA if:

- They were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave), and
- They will lose Plan coverage because of the employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave.) COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period

(subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours. (See the section called “Length of COBRA Coverage” on page 61.)

When is COBRA Coverage Available?

The Plan will offer COBRA coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, or the death of the employee, your employer must notify the Plan Administrator of the qualifying event.

When You Must Notify the Plan Administrator about Certain Qualifying Events

You must notify the Plan Administrator about certain qualifying events. For these qualifying events (divorce of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify the Plan Administrator within 60 days after the latest of (1) the date of the qualifying event and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

No COBRA election will be available unless you follow the Plan’s notice procedures and meet notice deadline.

In providing this notice, you must follow the procedures specified in the section called “Notice Procedures” on page 67. If these procedures are not followed or if the notice is not provided to the Plan Administrator during the 60-day notice period, **you will lose your right to elect COBRA.**

Electing COBRA Coverage

To elect COBRA by Mail, Personal Delivery, FAX or E-Mail

To elect COBRA, you must complete the Election Form that is part of the Plan’s COBRA election notice and submit it to the Plan Administrator. (The Plan Administrator provides an election notice, including the Election Form, to qualified beneficiaries after it receives notice of a qualifying event. You may also obtain a copy of the Election Form from the Plan Administrator.)

Mail, fax, hand-deliver or e-mail the completed Election Form to the Plan Administrator at:

Tongass Timber Trust
111 Stedman, Suite 200
Ketchikan, Alaska 99901

Attention: COBRA Election
Fax: (907) 225-5920

E-mail: afa@akforest.org

You must attach a copy of the completed and signed Election Form, to the email.

To Elect COBRA by Telephone

You may also elect COBRA by completing the Election Form by telephone. After you receive your COBRA Election Form, call the Tongass Timber Trust COBRA processor at (907) 225-6114 and provide the COBRA processor the information required by the Election Form. The COBRA processor will complete the Election Form on your behalf and will send you an initial statement of COBRA premiums, indicating the coverage you elected. You must review the statement and notify the COBRA processor immediately of any errors.

Deadline for COBRA Election

You must complete the Election Form in writing and mail, hand-deliver, fax or e-mail it to the Plan Administrator at the address, fax number or e-mail address specified above.

If mailed, your election must be postmarked (and if hand-delivered, faxed or e-mailed, your election must be received by the Plan Administrator) no later than 60 days after the date the COBRA election notice was provided by the Plan Administrator. **If you do not submit a completed election form by this due date, you will lose your right to elect COBRA.**

If you elect COBRA by telephone, you must call the COBRA Processor during normal business hours no later than 60 days after the date the COBRA election notice was provided by the Plan Administrator. You must speak directly with the COBRA Processor. Do not leave a recorded phone message. **If you do not call and speak with the COBRA processor and provide the information required by the Election Form by this due date, you will lose your right to elect COBRA.**

May I elect COBRA if I have other plan coverage or Medicare?

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage automatically terminates if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage

Independent Election Rights

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

Notify the Plan Administrator if a Qualified Beneficiary is Entitled to Medicare before Electing COBRA

When you complete the Election Form, you must notify the Plan Administrator if any qualified beneficiary has become entitled to Medicare (Part A, Part B, or both) and, if so, the date of Medicare entitlement. If you become entitled to Medicare (or first learn that you are entitled to Medicare) after submitting the Election Form, you must immediately notify the Plan Administrator of the date of your Medicare entitlement at the address, fax number, e-mail address or telephone number for electing COBRA shown above.

Special Considerations in Deciding Whether to Elect COBRA

Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it is important that you choose carefully between COBRA continuation coverage and other coverage options, because once you have made your choice, it can be difficult or impossible to switch to another coverage option.

You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

Length of COBRA Coverage

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the section called "Termination of COBRA Coverage before the End of the Maximum Coverage Period" on page 63.

When the Qualifying Event is Death, Divorce or Child's Loss of Dependent Status

When Plan coverage is lost due to the death of the employee, the covered employee's divorce, or a dependent child's losing eligibility as a dependent child, COBRA coverage can last for up to a total of 36 months.

When the Covered Employee Becomes Entitled to Medicare Within 18 Months of Termination or Reduction of Hours

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

When the Qualifying Event is Termination or Reduction of Hours

When Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for up to a total of 18 months.

Extension of Maximum Coverage Period

If you elect COBRA, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Plan Administrator of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage.

Disability Extension of COBRA Coverage

If the Social Security Administration determines a qualified beneficiary to be disabled and you notify the Plan Administrator in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 60th day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). The extension of coverage is available for all qualified beneficiaries in the family who are receiving COBRA coverage, not just the disabled individual. ***No disability extension will be available unless you follow the Plan's notice procedures and meet notice deadline.***

Deadline for Notifying the Plan Administrator About a Qualified Beneficiary's Disability

The disability extension is available only if you notify the Plan Administrator of the Social Security Administration's determination of disability within 60 days after the latest of:

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

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

In providing this notice, you must follow the procedures specified in the section called "Notice Procedures for Notice of Disability" on page 70. If these procedures are not followed or if the notice is not provided to the Plan Administrator during the 60-day notice period and within 18 months after the covered employee's termination of

employment or reduction of hours, then there will be no disability extension of COBRA coverage.

Second Qualifying Event Extension of COBRA Coverage

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare.)

Deadline for Notifying the Plan Administrator of a Second Qualifying Event

The extension due to a second qualifying event is available only if you notify the Plan Administrator of the second qualifying event within 60 days after the latest of (1) the date of the second qualifying event and (2) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan).

In providing this notice, you must follow the procedures specified in the section called "Notice Procedures for Notice of Second Qualifying Event" on page 72. If these procedures are not followed or if the notice is not provided to the Plan Administrator during the 60-day notice period, **there will be no extension of COBRA coverage due to a second qualifying event.**

Termination of COBRA Coverage Before the End of the Maximum Coverage Period

COBRA coverage will automatically terminate before the end of the maximum period if:

- Any required premium is not paid in full on time
- A qualified beneficiary becomes covered, after electing COBRA coverage, under another group health plan
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA coverage
- The employer ceases to provide any group health plan for its employees, or
- During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. For more information about the disability extension period, see the section called "Extension of Maximum Coverage Period" on page 62.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage, such as fraud.

When a Qualified Beneficiary Becomes Entitled to Medicare or Obtains Other Coverage After Electing COBRA

You must notify the Plan Administrator within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage. You may provide this notice on the monthly payment notice that you return to the Plan Administrator with your COBRA premium payment. Alternatively, you may notify the Plan Administrator by written notice mailed, delivered, faxed or emailed to the Plan Administrator or by telephone notice to the COBRA Processor of the Plan Administrator at the address, fax number email address or telephone number described above under the section called “ COBRA Coverage”.

Termination of COBRA Coverage Due to Medicare Entitlement or Other Coverage

COBRA coverage will terminate (retroactively if applicable) on the day Medicare entitlement occurs or on the day other group health coverage is acquired. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date, regardless whether or when you provide notice of Medicare entitlement or other group health plan coverage.

If a Qualified Beneficiary Ceases to be Disabled

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Plan Administrator of that fact within 30 days after the Social Security Administration’s determination. You must follow the notice procedures specified beginning on page 74.

Termination of COBRA Coverage When A Qualified Beneficiary Ceases to be Disabled

If the Social Security Administration’s determination that the qualified beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration’s determination that the qualified beneficiary is no longer disabled. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date, regardless whether or when you provide notice that the disabled qualified beneficiary is no longer disabled. (For more information about the disability extension period, see the section called “Extension of Maximum Coverage Period” on page 62.)

Premiums For COBRA Coverage

Each qualified beneficiary must pay a premium for COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

Making COBRA Premium Payments

How Premium Payments Must be Made

If you pay your COBRA premium by mail, you must pay by check. Do not send cash. You may pay the premium in cash in-person at the address below.

Your first payment and all monthly payments for COBRA coverage should be mailed or paid in-person to:

Tongass Timber Trust
111 Stedman, Suite 200
Ketchikan, Alaska 99901

First Payment for COBRA Coverage

If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date the Election Notice is postmarked, if mailed, and the date the Election Notice is received, if hand-delivered, faxed, or e-mailed.)

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. If your first payment does not cover the entire period through the month before you make your first payment, then your COBRA coverage ends on the last day of the last month for which you made full payment.

Example:

Assume your coverage under the Plan terminates on August 31 and you elect COBRA coverage on the following October 31.

You must make your first payment no later than December 15.

If you make the first payment on December 6, the payment must include the premiums for the months of September, October and November. (The payment for December is due December 1, subject to a grace period described below.)

If your first payment covers only September (and no further payment is made by December 15), your COBRA coverage ends on September 30.

You are responsible for making sure that the amount of your first payment is correct. Contact the Plan Administrator to confirm the correct amount of your first payment. Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it. **If you do not make your first payment for COBRA coverage within 45 days after the date of your election, you will lose all COBRA rights under the Plan.**

Monthly Payments for COBRA Coverage

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due

for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event. Each monthly payment for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break.

As a courtesy, the Plan Administrator will send you a payment reminder each month for COBRA coverage. It is your responsibility to pay your COBRA premiums on time even if you do not receive this payment reminder.

Grace Periods for Monthly Payments

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. **If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.**

More Information About Individuals Who May Be Qualified Beneficiaries

Children Born to or Placed for Adoption with the Covered Employee During COBRA Period

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

Alternate Recipients Under QMCSOs

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

If You Have Questions

Questions concerning your Plan or your COBRA rights should be addressed to the Plan Administrator. For more information about your rights under the Employee Retirement

Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assistant in your area who you can talk to about the different options, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Administrator Contact Information

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

Tongass Timber Trust
111 Stedman, Suite 200
Ketchikan, Alaska 99901

Attention: COBRA

Telephone: (907) 225-6114 (ask for the "COBRA Processor")

Fax: (907) 225-5920 (include the words "Attention: COBRA")

E-mail: afa@akforest.org

Notice Procedures

These Notice Procedures tell you how to satisfy your obligation to provide the following notices to the Plan Administrator:

- Notice of qualifying event
- Notice of disability
- Notice of second qualifying event, and
- Notice of cessation of disability.

Address, Fax, E-mail and Telephone Numbers for Notices to the Plan Administrator

As described below, you may provide these Notices by mail, personal delivery, fax, e-mail or telephone. All Notices must be in writing, except Notice by telephone.

If you provide Notice by mail or personal delivery, address or deliver it to:

Tongass Timber Trust
111 Stedman, Suite 200
Ketchikan, Alaska 99901

Attention: COBRA

If you provide Notice by fax, fax it to:

Tongass Timber Trust

Fax: (907) 225-5920

(Include the words “Attention: [Insert the name of the Notice]” in the fax cover sheet)

If you provide the Notice by e-mail, send it to:

afa@akforest.org

(Include the name of the Notice in the subject line. You must attach a copy of the completed and signed Notice — for example, a copy in PDF format — to the email.)

If you provide Notice by telephone, call:

(907) 225-6114, and ask for the “COBRA Processor”

(You must speak with the COBRA processor and provide the necessary information for your Notice to be valid. Do not leave a voice mail message. You must call during normal business hours.)

Notice Procedures for Notice of Qualifying Event

These Notice Procedures for Notice of Qualifying Event tell you how to satisfy your obligation to notify the Plan Administrator when any of these qualifying events occur: a divorce or a child’s loss of dependent status. (See “When Dependent Coverage Ends”.)

Deadline for Notice of Qualifying Event

The deadline for providing this notice is 60 days after the latest of (1) the qualifying event and (2) the date on which the covered spouse or dependent child would lose coverage under the terms of the Plan as a result of the qualifying event. Your notice is “provided” on the date of the postmark (if mailed), on the date the Plan Administrator receives it (if personally delivered, faxed, or e-mailed), or on the date you call and provide all required information to the COBRA Processor.

Required Information for Notice of Qualifying Event

Your notice must contain the following information:

- The name of the Plan (Tongass Timber Trust)
- The name and address of the employee or former employee who is or was covered under the Plan
- The name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the qualifying event (divorce or child’s loss of dependent status)

- The qualifying event (divorce or child's loss of dependent status), and
- The date that the divorce or child's loss of dependent status happened, and
- The signature, name, and contact information of the individual sending the notice.

If your coverage is reduced or eliminated and later a divorce occurs, and you are notifying the Plan Administrator that your Plan coverage was reduced or eliminated in anticipation of the divorce, you must provide notice within 60 days of the divorce in accordance with these Notice Procedures for Notice of Qualifying Event and must in addition provide evidence satisfactory to the Plan Administrator that your coverage was reduced or eliminated in anticipation of the divorce.

You May Use the Plan's Notice of Qualifying Event Form

To provide written Notice of Qualifying Event, you may use the Plan's Notice of Qualifying Event form. A copy of the Plan's Notice of Qualifying Event form is included in the last section of this booklet. You may also obtain a copy of the Plan's Notice of Qualifying Event from the website for Tongass Timber Trust at www.akforest.org.

Incomplete Notice of Qualifying Event

If you provide a notice that does not contain all of the information and documentation required by these Notice Procedures for Notice of Qualifying Event, such a notice will nevertheless be considered timely **if all of the following conditions are met:**

- The notice is provided in the manner specified in the section called "Address, Fax, E-mail and Telephone Numbers for Notices to the Plan Administrator" on page 67.
- The notice is provided by the deadline described above
- From the notice provided, the Plan Administrator is able to determine that the notice relates to the Plan (Tongass Timber Trust)
- From the notice provided, the Plan Administrator is able to identify the covered employee and qualified beneficiary(ies), the qualifying event (the divorce or child's loss of dependent status), and the date on which the qualifying event occurred, and
- The notice is supplemented in writing with the additional information necessary to meet the Plan's requirements (as described in these Notice Procedures for Notice of Qualifying Event) within 15 business days after a written or oral request by the Plan Administrator for more information (or, if later, by the deadline for the Notice of Qualifying Event described above).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA will not be offered. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

Who may Provide Notice of Qualifying Event

The covered employee (the employee or former employee who is or was covered under the Plan), a qualified beneficiary with respect to the qualifying event, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

Additional Evidence of Date of Divorce or Child's Loss of Dependent Status may be Required

If the Plan Administrator requests, you must provide documentation of the date of the divorce or child's loss of dependent status that is satisfactory to the Plan Administrator (for example, a divorce decree to establish the date of divorce, a birth certificate to establish the date that a child reached the limiting age, so that the Plan Administrator can determine if you gave timely notice of the qualifying event and were consequently entitled to elect COBRA. If you are unable to provide satisfactory evidence that the divorce occurred or the child ceased to be a dependent on the date specified in your Notice of Qualifying Event within 15 business days after a written or oral request from the Plan Administrator, the former spouse's or dependent child's COBRA coverage may be terminated (retroactively if applicable) as of the date that COBRA coverage would have started. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date.

Notice Procedures for Notice of Disability

These Notice Procedures for Notice of Disability tell you how to satisfy your obligation to notify the Plan Administrator that a qualified beneficiary's disability started at some time before the 60th day after the covered employee's termination of employment or reduction of hours.

Deadline for Notice of Disability

The deadline for providing this notice is 60 days after the latest of (1) the date of the Social Security Administration's disability determination, (2) the date of the covered employee's termination of employment or reduction of hours, and (3) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the termination of employment or reduction of hours. Your Notice of Disability must also be provided within 18 months after the covered employee's termination of employment or reduction of hours. Your notice is "provided" on the date of the postmark (if mailed), on the date the Plan Administrator receives it (if personally delivered, faxed, or e-mailed), or on the date you call and provide all required information to the COBRA Processor.

Required Information for Notice of Disability

Your notice must contain the following information:

- The name of the Plan (Tongass Timber Trust)
- The name and address of the employee or former employee who is or was covered under the Plan

- The initial qualifying event that started your COBRA coverage (the covered employee's termination of employment or reduction of hours)
- The date that the covered employee's termination of employment or reduction of hours happened
- The name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving COBRA coverage at the time of the notice
- The name and address of the disabled qualified beneficiary
- The date that the qualified beneficiary became disabled
- The date that the Social Security Administration made its determination of disability
- A statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled, and
- The signature, name, and contact information of the individual sending the notice.

Your Notice of Disability must include a copy of the Social Security Administration's determination of disability.

You May Use the Plan's Notice of Disability Form

To provide written Notice of Disability, you may use the Plan's Notice of Disability form. A copy of the Plan's Notice of Disability is reproduced in the last section of this booklet. You may also obtain a copy of the Plan's Notice of Disability from the website for Tongass Timber Trust at www.akforest.org.

Incomplete Notice of Disability

If you provide a notice to the Plan Administrator that does not contain all of the information and documentation required by these Notice Procedures for Notice of Disability, such a notice will nevertheless be considered timely **if all of the following conditions are met:**

- The notice is provided in the manner specified in the section called "Address, Fax, E-mail and Telephone Numbers for Notices to the Plan Administrator".
- The notice is provided by the deadline described above
- From the written notice provided, the Plan Administrator is able to determine that the notice relates to the Plan and a qualified beneficiary's disability
- From the written notice provided, the Plan Administrator is able to identify the covered employee and qualified beneficiary(ies) and the date on which the covered employee's termination of employment or reduction of hours occurred, and
- The notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these Notice Procedures for Notice of Disability) within 15 business days after a written or

oral request from the Plan Administrator for more information (or, if later, by the deadline for the Notice of Disability described above).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

Who May Provide Notice of Disability

The covered employee (the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the covered employee's termination or reduction of hours and is still receiving COBRA coverage, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA coverage period due to the disability reported in the notice.

Notice Procedures for Notice of Second Qualifying Event

These Notice Procedures for Notice of Second Qualifying Event tell you how to satisfy your obligation to notify the Plan Administrator that a second qualifying event (such as a divorce, the covered employee's death, or a child's loss of dependent status) has occurred in order to extend COBRA coverage beyond the initial 18- or 29-month maximum coverage period.

Deadline for Notice of Second Qualifying Event

The deadline for providing this notice is 60 days after the latest of (1) the date of the second qualifying event and (2) the date on which the covered spouse or dependent child would lose coverage under the terms of the Plan as a result of the second qualifying event (if this event had occurred while the qualified beneficiary was still covered under the Plan). Your notice is "provided" on the date of the postmark (if mailed), on the date the Plan Administrator receives it (if personally delivered, faxed, or e-mailed), or on the date you call and provide all required information to the COBRA Processor.

Required Information for Notice of Second Qualifying Event

Your notice must contain the following information:

- The name of the Plan (Tongass Timber Trust);
- The name and address of the employee or former employee who is or was covered under the Plan
- The initial qualifying event that started your COBRA coverage (the covered employee's termination of employment or reduction of hours)
- The date that the covered employee's termination of employment or reduction of hours happened

- The name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving COBRA coverage at the time of the notice
- The second qualifying event (a divorce, the covered employee's death, or a child's loss of dependent status)
- The date that the divorce, the covered employee's death, or a child's loss of dependent status happened, and
- The signature, name, and contact information of the individual sending the notice.

You May Use the Plan's Notice of Qualifying Event Form

To provide written Notice of Second Qualifying Event, you may use the Plan's Notice of Second Qualifying Event form. A copy of the Plan's Notice of Second Qualifying Event form is included in the back of this booklet. You may also obtain a copy of the Plan's Notice of Second Qualifying Event from the website for Tongass Timber Trust at www.akforest.org.

Incomplete Notice of Second Qualifying Event

If you provide a written notice to the Plan Administrator that does not contain all of the information and documentation required by these Notice Procedures for Notice of Second Qualifying Event, such a notice will nevertheless be considered timely **if all of the following conditions are met:**

- The notice is provided in a manner specified in the section called "Address, Fax, E-mail and Telephone Numbers for Notices to the Plan Administrator".
- The notice is provided by the deadline described above
- From the written notice provided, the Plan Administrator is able to determine that the notice relates to the Plan
- From the written notice provided, the Plan Administrator is able to identify the covered employee and qualified beneficiary(ies), the first qualifying event (the covered employee's termination of employment or reduction of hours), the date on which the first qualifying event occurred, the second qualifying event, and the date on which the second qualifying event occurred, and
- The notice is supplemented in writing with the additional information necessary to meet the Plan's requirements (as described in these Notice Procedures for Notice of Second Qualifying Event) within fifteen (15) business days after a written or oral request from the Plan Administrator for more information (or, if later, by the deadline for this Notice of Second Qualifying Event described above).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

Who may provide Notice of Second Qualifying Event

The covered employee (the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the covered employee's termination or reduction of hours and is still receiving COBRA coverage, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA coverage period due to the second qualifying event reported in the notice.

Additional Evidence of Date of Divorce or Child's Loss of Dependent Status may be Required

If the Plan Administrator requests, you must provide documentation of the date of the divorce or child's loss of dependent status that is satisfactory to the Plan Administrator (for example, a divorce decree to establish the date of divorce, a birth certificate to establish the date that a child reached the limiting age, so that the Plan Administrator can determine if you gave timely notice of the second qualifying event and were consequently entitled to an extension of COBRA coverage. If you are unable to provide satisfactory evidence that the divorce occurred or the child ceased to be a dependent on the date specified in your Notice of Second Qualifying Event within 15 business days after a written or oral request from the Plan Administrator, the qualified beneficiary's COBRA coverage may be terminated (retroactively if applicable) as of the date that COBRA coverage would have ended without an extension due to the divorce or loss of dependent status. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date.

Additional Evidence of Date of Covered Employee's Death may be Required

If your notice was regarding the death of the covered employee, you must, if the Plan Administrator requests it, provide documentation of the date of death that is satisfactory to the Plan Administrator (for example, a death certificate or published obituary), so that the Plan Administrator can determine if you gave timely notice of the second qualifying event and were consequently entitled to an extension of COBRA coverage. If you are unable to provide satisfactory evidence within 15 business days after a written or oral request from the Plan Administrator that the date of death was the date specified in your Notice of Second Qualifying Event, the COBRA coverage of all qualified beneficiaries receiving an extension of COBRA coverage as a result of the covered employee's death may be terminated (retroactively if applicable) as of the date that COBRA coverage would have ended without an extension due to the covered employee's death. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date.

Notice Procedures and Deadlines for Notice of Cessation of Disability

If you are providing a Notice of Cessation of Disability (a notice that a disabled qualified beneficiary whose disability resulted in an extended COBRA coverage period is determined by the Social Security Administration to be no longer disabled), the deadline for this notice is 30 days after the date of the Social Security Administration's determination.

Your notice must be provided no later than the deadline described above. Your notice is “provided” on the date of the postmark (if mailed), on the date the Plan Administrator receives it (if personally delivered, faxed, or e-mailed), or on the date you call and provide all required information to the COBRA Processor.

Your notice should contain the following information:

- The name of the Plan (Tongass Timber Trust)
- The name and address of the employee or former employee who is or was covered under the Plan
- The name(s) and address(es) of all qualified beneficiary(ies)
- The qualifying event that started your COBRA coverage
- The date that the qualifying event happened, and
- The signature, name, and contact information of the individual sending the notice.

Your notice must include the name and address of the disabled qualified beneficiary, the date of the Social Security Administration’s determination that he or she is no longer disabled, and a copy of the Social Security Administration’s determination.

Who May Provide Notice of Cessation of Disability

The covered employee (the employee or former employee who is or was covered under the Plan), a qualified beneficiary with respect to the qualifying event, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the other coverage, Medicare entitlement, or cessation of disability reported in the notice.

COBRA Coverage will Terminate Regardless Whether or When Notice of Cessation of Disability is Provided

If a disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled, COBRA coverage for all qualified beneficiaries whose COBRA coverage is extended due to the disability will terminate (retroactively if applicable) as described above in the section called “Termination of COBRA Coverage Before the End of the Maximum Coverage Period” on page 63, regardless whether or when a Notice of Cessation of Disability is provided.

XII. Important Plan Information

***Name of Plan:* Tongass Timber Trust**

Board of Trustees

Chairman:

Keaton Gildersleeve

Gildersleeve, Inc.
14750 SW Springhill Road
Gaston, OR 97119

Bob Byers

Tongass Cutting LLC
P.O. Box 1890
Petersburg, AK 99833

Linda Lewis

Phoenix Logging
P.O. Box 5758
Ketchikan, AK 99901

Jerry Larrabee

Larrabee Logging
P.O. Box 5233
Carefree, AZ 85377

Leo Gellings

Phoenix Logging
P.O. Box 5758
Ketchikan, AK 99901

George Baggen

Samson Tug & Barge
P.O. Box 559
Sitka, AK 99835

Plan Identification Number

Employer Identification Number: 92-0062073

Plan Number: 501

Type of Plan

This Plan is a welfare plan providing the following types of benefits:

- Medical
- Dental
- Vision

This Plan is administered by the Board of Trustees with the assistance of the Alaska Forest Association, Inc.

Plan Administrator

Board of Trustees—Tongass Timber Trust
Alaska Forest Association
111 Stedman Street, Suite 200
Ketchikan, AK 99901

Phone: (907) 225-6114

Fax: (907) 225-5920

Email: afa@akforest.org

Agent for Service of Legal Process

The agent for service of process is the Executive Director of the Alaska Forest Association, Inc. Service of legal process may be served upon the Executive Director or any of the Trustees listed above.

Participation, Eligibility and Benefits

The eligibility rules that determine which employees and beneficiaries are entitled to benefits are set forth in this booklet.

Circumstances That May Result in Ineligibility or Denial of Benefits

An employee or beneficiary who is eligible for benefits may become ineligible as a result of one or more of the following circumstances:

- The employee's failure to work the required hours to maintain eligibility (or failure to make a contribution or self-payment, where authorized); see eligibility rules in this booklet
- The failure of the employee's employer to report the hours and remit contributions on his or her behalf to the Trust Fund.

In the case of beneficiaries who are dependent on an eligible employee, they may become ineligible if:

- They are no longer dependent, or
- They have attained the disqualifying age.

See the rules under "Dependent Eligibility" on page 7.

An employee or beneficiary who is eligible may nonetheless be denied benefits as a result of one or more of the following circumstances:

- The failure of the employee or beneficiary to file a claim for benefits within one year of the date he or she incurred the expense for which benefits are payable
- The failure of the employee or beneficiary to file a complete and truthful benefit application
- The failure of the employee to meet the deductibles or copayments (when applicable) for medical or dental bills incurred by him or her and his or her family in each calendar year
- Failure of the employee to include all eligible dependents on the employee information enrollment form
- Where the employee or beneficiary has other group health coverage, it is possible that benefits payable under this Plan may be reduced or denied due to coordination of benefits between the two plans.

Source of Contributions

This Plan is funded through employer and employee contributions.

The employer contributions and the employee self-payments are received and held in trust by the Board of Trustees pending the payment of insurance premiums, claims and administrative expenses. The employer is responsible for notifying employees that claims will be withheld until delinquent contributions are received by the Plan Administrator.

The medical, dental, and vision benefits under this Plan are provided on a self-funded basis.

Plan Year

The Plan year begins January 1 and ends December 31 for all purposes of accounting and all reports to the United States Department of Labor and other regulatory bodies.

ERISA Rights

As a participant in the Tongass Timber Trust, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants be entitled to:

Receive Information About Your Plan and Benefits

- Examine without charge, at the Trust office, upon ten days advance written request, all Plan documents, including insurance contracts, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and an updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report.
- File suit in a federal court, if any materials requested are not received within 30 days of a participant's request, unless the materials were not sent because of matters beyond the control of the Plan Administrator. The court may require the Trustees to pay up to \$110 for each day's delay until the materials are received.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, your spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes obligations upon the persons who are responsible for the operation of this employee benefits plan. These persons are referred to as “fiduciaries” in the law. Fiduciaries must act solely in the interest of the Plan participants and they must exercise prudence in the performance of their Plan duties.

Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Plan.

In the event Plan fiduciaries misuse the assets of the Plan, you may request assistance from the U.S. Department of Labor or sue in federal court, which may award you costs of suit, including your attorney fees if you are successful.

Participating employers may not fire you or discriminate against you to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If you are improperly denied a welfare benefit, in full or in part, you have the right to a hearing before the Trustees at which you may present your position and any supporting evidence. You also have the right to be represented by an attorney or any other representative of your choosing. Further, if you are dissatisfied with the Trustees’ determination, you may appeal the Trustees’ decision by filing suit in federal or state court. If you have any questions about this statement or your rights under ERISA, you should contact the Trustees, their administrative agent or the nearest area office of the EBSA at the address below.

ERISA requires us to advise you of any modifications of your group health plan.

If you have any questions, contact your Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you may also contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, as listed in your telephone directory or the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA at (866) 444-EBSA.

Amendment or Termination of the Plan

The Trustees have the authority to amend the Plan, including amendments that expand, restrict or terminate all or part of the rules relating to eligibility for benefits, or the amount and nature of such benefits as they may determine. The Trustees also reserve right to amend the Plan to implement any cost control measures that it may deem advisable.

Amendments may be retroactive to the extent necessary to comply with applicable law. No amendment or termination shall reduce the amount of any benefit otherwise payable under the Plan for charges incurred prior to the effective date of such amendment or termination.

If a benefit is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to the Trust to the extent permitted under applicable law, unless otherwise stated in the applicable Plan document.

Amendment or Termination of the Trust Agreement

The Trustees may amend the Trust Agreement of the Tongass Timber Trust to any extent at any time, except the Trustees may not adopt an amendment that diverts the Trust Fund from the purpose of providing an entity to which employer and participating employee contributions are paid and administering employee welfare benefit plan(s) for participating employees and their beneficiaries.

The Alaska Forest Association, Inc. may terminate the Trust Agreement at any time. If the Trust were terminated, the monies and assets remaining after expenses would be used to continue benefits provided under the Plan until they were exhausted (unless Department of Labor regulations require a different disposition). If termination were a result of a merger, remaining money and assets after expenses would be transferred to the trust fund with which the merger had been negotiated.

Procedures for Determining if a Medical Child Support Order Is Qualified

The National Medical Support Notice (Notice) is a standardized medical child support order that is to be used by State child support enforcement agencies to enforce medical child support obligations. The Department of Labor and the Department of Health and Human Services adopted regulations on December 27, 2000, implementing the National Medical Support Notice provisions of the Child Support Performance and Incentive Act of 1998 (CSPIA). ERISA 609(a) (5) (C) 466(a) (19) of the Social Security Act.

The Notice is an exclusive document used by a child support enforcement agency to enforce the provision of health care coverage to children of non-custodial parents who are required to provide health care coverage through any employment-related group health plan pursuant to a child support order and for whom the employer is known to the agency.

When the Plan Administrator receives a Notice it must be reviewed and a determination made whether it is appropriately completed. The Plan Administrator must complete the Plan Administrator Response (included with Part B of the Notice), indicating whether the notice is a QMCSO and return it to the State agency that issued the Notice within 40 business days after the date of the Notice.

If the Plan Administrator determines that the Notice is appropriately completed, the Plan Administrator is required to treat the Notice as a QMCSO. The Plan Administrator must inform the State agency that issued the Notice when coverage under the plan of the child named in the Notice will begin and must provide the custodial parent of the child (or, in some cases, a named State official) with information about the child's coverage under the Plan, such as the Plan's summary plan description, any forms or documents necessary to make claims under the Plan, etc.

An appropriately completed Notice is a notice that includes the following information:

- The name of an issuing State child support enforcement agency;
- The name and mailing address of the employee, enrolled or eligible for enrollment, who is obligated by a State court or administrative order to provide medical support for each named child;

- The name and mailing address of each child covered by the Notice. The name and address of a State or local official may be substituted for the address of the child.

A Notice may be appropriately completed even if some items of information in the Notice are not included as long as the Notice includes the information listed above. In addition, if any of the necessary information described above has been omitted but is reasonably available to the Plan Administrator, the Notice should not fail to be appropriately completed solely because of such omission.

An appropriately completed Notice satisfies the informational requirements of the QMCSO provisions by:

- Providing the name and last known mailing address (if any) of the participant and the name and mailing address of each child covered by the order;
- Having the child support enforcement agency identify either the specific type of coverage or all available group health coverage;
- Instructing the Plan Administrator that if a Notice does not designate either specific type(s) of coverage or all available coverage, it should assume that all are designated, and further instructing the Plan Administrator that if a group health plan has multiple options and the participant is not enrolled, the agency will make a selection after the Notice is qualified and, if the agency does not respond within 20 business days, the child will be enrolled under the Plan's default option if there is one; and
- Specifying that the period of coverage may end for the named child only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of events specified in the Notice.

A Notice also requires the Plan to provide to a named child only those benefits that the Plan provides to any dependent of a participant who is enrolled in the Plan, and any other benefits that are necessary to meet the requirements of the State laws relating to medical child support:

- Require health plans to enroll a child under his or her parent's health coverage even if the child was born out of wedlock, does not reside with the covered parent or in the Plan's service area, or is not claimed as a dependent on the parent's Federal income tax return;
- Require a health plan to enroll a child pursuant to court or administrative order without regard to the Plan's open enrollment restrictions;
- Require employers and health plans to comply with court or administrative orders requiring the parent to provide health care coverage for a child; and
- Require health plans to permit a custodial parent to file claims on behalf of his or her child under the non-custodial parent's health coverage and to make benefit payments to the custodial parent or health care provider.

Military Service Under USERRA

Under the Uniformed Services Employment and Re-employment Rights Act of 1994, if you leave covered employment to perform certain United States military service, you and your covered dependents may have the right to continue group health benefits – including medical, dental, vision and prescription drug coverage.

You may elect to continue such health coverage for yourself and your eligible dependents until the earlier of:

- The end of the period during which you are eligible to apply for re-enrollment in accordance with USERRA, or
- 24 consecutive months after coverage ends.

To continue coverage, you or your dependent must pay the required premium (including your former employer's share and any retroactive premium) unless your service in the uniformed service is for fewer than 31 days, in which event you must pay your share, if any, of the premium. The Plan Administrator will inform you or your dependent of procedures to pay premiums.

A covered person's continued health coverage will end at midnight on the earliest of:

- The day your former employer ceases to provide any group health plan to all employees
- The day the premium is due and unpaid
- The day a covered person again becomes covered under the Plan
- The day health coverage has been continued for the applicable time period noted above (or any longer period provided in the Plan), or
- The day the Plan terminates.

Any health coverage for an eligible dependent will also end as provided in the "when dependents coverage ends" provision of the Plan.

In the event health coverage is continued under any other continuation provision of the Plan, the periods of continued coverage will run concurrently. If another continuation provision provides a shorter continuation period for which premium is paid in whole or in part by your employer, then the premium you are required to pay may increase for the remainder of the period provided above.

Following your discharge from qualified military service, you may be eligible to apply for re-employment with your former employer in accordance with USERRA. Such re-employment includes your right to elect re-instatement in any existing health coverage provided by your employer.

Your employer's leave of absence policy will determine your right to participate in any insurance.

After re-employment, credit will be given, if applicable, for the period of such service, if required to determine your benefit amounts, eligibility or costs.

Note: If a conflict between this provision and USERRA arises, the provisions of USERRA as interpreted by your employer or former employer will apply.

Definition of Uniformed Service

Uniformed service is the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full time National Guard duty and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty and a period for which a person is absent for employment for the purpose of performing certain funeral honor duty.

Uniformed service includes service in any of the following:

- United States Armed Forces
- Army National Guard
- Air National Guard, when engaged in active duty for training, inactive duty training, or full time National Guard duty
- Commissioned corps of the Public Health Service
- Any other category of persons designated by the President in time of war or emergency.

Third Party Reimbursement and/or Subrogation

When you or your covered dependent are injured or become ill because of the actions or inactions of a third party, the Plan may cover your eligible health care (medical, dental and vision) expenses. However, to receive coverage, you must notify the Plan that your illness or injury was caused by a third party, and you must follow special Plan rules. This section describes the Plan's procedures with respect to subrogation and right of recovery.

Subrogation means that if an injury or illness is someone else's fault, the Plan has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the Plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party related to the illness or injury.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that the Plan:

- Has an equitable lien on any and all monies paid (or payable) to you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;
- May appoint you as constructive trustee for any and all monies paid (or payable) to you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury; and

- May bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the sickness or injury.

If you (or your attorney or other representative) receive any payment from the sources listed later in this section – through a judgment, settlement or otherwise – when an illness or injury is a result of a third party, you agree to place the funds in a separate, identifiable account and that the plan has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the Plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must pay the Plan back first, in full, out of such funds for any health care expenses the Plan has paid related to such illness or injury. You must pay the Plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses. Furthermore, you must pay the Plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury. If any money is left over, you may keep it.

Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) you incur in obtaining the funds.

The Plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

- Money from a third party that you, your guardian or other representatives receive or are entitled to receive;
- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive;
- Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid; and
- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives.

As a Plan participant, you are required to:

- Cooperate with the Plan's efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan's subrogation or recovery rights outlined in this Summary.
- Notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.
- Provide all information requested by the Plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.

The Plan may terminate your Plan participation and/or offset your future benefits in the event that you fail to provide the information, authorizations, or to otherwise cooperate

in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan.

If the subrogation provisions in these "Acts of Third Party" provisions conflict with subrogation provisions in an insurance contract governing benefits at issue, the subrogation provisions in the insurance contract will govern. If the right of recovery provisions in these "Acts of Third Party" provisions conflict with right of recovery provisions in an insurance contract governing benefits at issue, the right of recovery provisions in the insurance contract will govern.

Recovery of Overpayment

Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this Plan, the Plan has the right to recover these expenses from any individual (including you, and the insurance company or any other organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefits until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered.

Non-assignment of Benefits

Plan participants cannot assign, pledge, borrow against, or otherwise promise any benefit payable under the Plan before receipt of that benefit. However, benefits will be provided to a participant's child if required by a Qualified Medical Child Support Order. In addition, subject to the written direction of a Plan participant, all or a portion of benefits provided by the Plan may, at the option of the Plan, and unless a participant requests otherwise in writing, be paid directly to the person rendering such service. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan to the extent of such payment.

Misstatement of Fact

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

Special Rights for Mothers and Newborn Children

For the mother or newborn child, the Plan will not restrict benefits for any hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery, or 96 hours following a Cesarean section. However, the mother's or newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours, as applicable) after the delivery. In any case, no authorization is required from the Plan or an insurance company for a length of stay that does not exceed 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

The Plan will provide certain coverage for benefits received in connection with a mastectomy, including reconstructive surgery following a mastectomy. This benefit applies to any covered employee or dependent, including you, your spouse, and your dependent child(ren).

If the covered person receives benefits under the Plan in connection with a mastectomy and elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the covered person. Coverage may apply to:

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

Benefits for breast reconstruction are subject to annual Plan deductibles and coinsurance provisions that apply to other medical and surgical benefits covered under the Plan.

XIII. Definitions

The following definitions explain terms used in this booklet. The term defined may or may not be a covered service under the Plan. Please refer to the medical exclusions and general exclusions section of this booklet.

When used in this booklet:

- **Chemical dependency condition** means a condition characterized by a physiological or psychological abuse/dependency on a controlled substances and/or alcohol that impairs or endangers the participant's or beneficiary's health. It must be listed on Axis I of the most current version of the Diagnostic and Statistics Manual of Mental Disorders, published by the American Psychiatric Associate. This does not apply to other conditions excluded or covered under other sections of the Plan.

The following conditions are not considered Chemical Dependency Conditions or are covered under other sections of the Plan (subject to all terms, limitations and exclusions):

- Conditions related to Mental Health (refer to Mental Health Condition definition)
- Nicotine and Caffeine Related Disorders

Chemical Dependency Rehabilitation Program: Provides 24-hour rehabilitation treatment, seven days a week for chemical dependency conditions. Services include group, individual and when indicated, family or multi-family group therapy. The facility must offer sufficient availability of medical and nursing services to manage ancillary detoxification needs.

Coinsurance — A feature of many medical and dental plans, “coinsurance” refers to an arrangement where the plan and the participant share costs on a percentage basis – for example, 80% and 20% would indicate the Plan pays 80% and the participant would pay 20%.

Cosmetic or reconstructive surgery means any surgical procedure performed primarily:

- To improve physical appearance or change or restore bodily form without materially correcting a bodily malfunction, or
- To prevent or treat a mental or nervous disorder through a change in bodily form.

Custodial care means services or treatment that, regardless of where provided:

- Could be rendered safely by a person without medical skills
- Is designed mainly to help the patient with daily living activities, including but not limited to:
 - o Personal care such as help in walking and getting in and out of bed; help with bathing; help with eating by spoon, tube or gastrostomy; exercising; dressing; enema and using the toilet
 - o Homemaking, such as preparing meals or special diets
 - o Moving the patient
 - o Acting as companion or sitter
 - o Supervising medication that can usually be self-administered
 - o Oral hygiene
 - o Ordinary skin and nail care.

The Plan and/or an independent medical review panel determine what services are custodial care. When a confinement or visit is found to be mainly for custodial care, some services (such as prescription drugs, X-rays and lab tests) may still be covered. All bills should be routinely submitted for consideration.

Dentist means a licensed dentist who performs a service which is payable under the plan, not including a person who lives with you or is part of your family (you, your spouse, or a child, brother, sister or parent of you or your spouse).

Developmental care means services or supplies that, regardless of where or by whom they are provided:

- Are provided to a covered person who has not previously reached the level of intellectual, speech, motor or physical development normally expected for the covered person’s age

- Are primarily provided to assist in the development of those skills referred to above
- Are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to injury or sickness).

The Plan or a qualified party or entity selected by the Plan will determine what services or supplies is developmental care. When a confinement, visit or other service or supply is found to be primarily for developmental care, some services or supplies (such as prescription drugs, X-rays and lab tests) may still be covered if medically necessary and otherwise covered by the plan. All bills should be routinely submitted for consideration.

Domiciliary care means services or supplies that, regardless of where or by whom they are provided:

- Primarily provide a protective environment and assistance with basic personal needs for the participant
- Are primarily provided because the participant's own home arrangements are not appropriate or adequate
- Is not part of an active treatment plan intended to or reasonably expected to improve the participant's condition or functional ability.

The Plan or a qualified party or entity selected by the Plan will determine what services are domiciliary care. When a confinement, visit or other service or supply is found to be primarily for domiciliary care, some services or supplies (such as prescription drugs, X-rays and lab tests) may still be covered if they are medically necessary and otherwise covered by the Plan. All bills should be routinely submitted to us for consideration.

Durable medical or surgical equipment means equipment that:

- Replaces bodily function lost or impaired due to a sickness, injury or congenital abnormality
- Can stand repeated use
- Is suited for use in the home
- Is mainly and customarily used for a medical purpose
- Is not generally useful to a person in the absence of an injury or sickness.

ERISA means the Employee Retirement Income Security Act of 1974.

Experimental or investigational drug, device and treatment or procedure means:

- A drug or device that cannot be lawfully marketed without approval of the FDA and has not been so approved for marketing at the time the drug or device is furnished
- A drug, device, treatment or procedure that was reviewed and approved (or was required by federal law to be reviewed and approved) by the treating facility's

Institutional Review Board or other body serving a similar function, or a drug, device, treatment or procedure used with a patient's informed consent document that was reviewed and approved (or was required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function

- A drug, device, treatment or procedure that reliable evidence shows is the subject of ongoing phase I, II or III clinical trials or is under study to determine its maximum tolerated dose, or toxicity, safety, efficacy or efficacy as compared with a standard means of treatment or diagnosis
- A drug, device, treatment or procedure for which the prevailing opinion among experts, as shown by reliable evidence, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, or toxicity, safety, efficacy or efficacy as compared with a standard means of treatment or diagnosis.
- However, routine medical expenses associated with a clinical trial (phase I, II, III or IV) will be covered under the Plan if medically necessary or to the extent legally required.

Home health care agency means any institution that:

- Is licensed by state or local law and operated primarily for the purpose of providing skilled nursing care and therapeutic services in an individual's home
- Maintains clinical records on each patient
- Provides services under the supervision of a physician or a registered nurse
- Has operational policies established by a professional group, including at least one physician and one registered nurse, excluding any institution primarily involved in providing custodial care.

Home health care plan means a program for continued care and treatment of an individual, established and approved in writing by the individual's attending physician, for the same injury or sickness for which the individual was hospitalized, together with such physician's certification that the proper treatment of the injury or sickness would require continued confinement in a hospital in the absence of the services and supplies provided as a part of the home health care plan. No payment is made for:

- Services or supplies not included in the home health care plan
- Services by an individual who ordinarily resides in your home or is a member of your family
- Custodial care (services which are provided primarily to assist any individual in the activities of daily living, for example, meals and personal grooming)
- Transportation services other than medically necessary ambulance transport.

Hospice means a separate facility that provides a hospice care program and admits terminally ill people.

Hospice care services may be provided by:

- A hospice care program that is coordinated by an interdisciplinary program licensed or certified as such by the state where the services are rendered to meet the physical, psychological, spiritual and social needs of terminally ill persons and their families by providing palliative (pain controlling) and supportive medical, nursing and other health services through home or inpatient care during the sickness or bereavement, or
- A hospital or related institution, home health agency, hospice or other facility licensed by the state to operate the hospice.

Hospice caregivers may not be related to the patient.

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

- A place licensed as a general hospital,
- A place that is operated for the care and treatment of resident inpatients, has a registered graduate nurse (RN) always on duty, has a laboratory and X-ray facility and has a place where major surgical operations are performed, or
- A facility accredited by the Joint Commission on the Accreditation of Healthcare Facilities, American Osteopathic Association or the Commission on the Accreditation of Rehabilitative Facilities, if the function of such facility is primarily of a rehabilitative nature, provided such rehabilitation is specifically for treatment of a physical disability; such facility need not have major surgical facilities.

When treatment is needed for a mental disease or disorder, hospital can also mean a place that meets these requirements:

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

A hospital does not include a hospital or institution or part of a hospital or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged.

Hospital confinement means a medically necessary hospital stay of 24 consecutive hours or more in any single or multiple departments or parts of a hospital for the purpose of receiving any type of medical service. Any hospital confinement satisfying this definition will be subject to all Plan provisions relating to inpatient hospital services

or admissions, including any applicable pre-admission review requirements. Hospital stays or services not satisfying this definition will be considered under Plan provisions for outpatient services.

Intensive Outpatient Program: Provides services for Mental Health or Chemical Dependency Conditions on an outpatient basis through planned, structured services available at least two hours per day and three days per week. Services include group, individual and when indicated family or multi-family group therapy treatment. Medical monitoring, evaluation and adjunctive services are available.

Medical emergency means the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain that would lead a prudent person possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in:

- Placing his or her health in serious jeopardy
- A serious impairment to bodily functions, or
- A serious dysfunction of any bodily organ or part.

Medically necessary means a service or supply that is ordered by a physician and which the Plan, its medical staff or a qualified party or entity selected by the Plan determines is:

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

The fact that the participant's physician prescribes services or supplies does not automatically mean such services or supplies are medically necessary and covered by the plan.

Mental health condition means a mental disorder listed on Axis I of the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association. This does not apply to other conditions excluded or covered under other sections of the Plan.

The following conditions are not considered Mental Health Conditions and are covered under other sections of the Plan (subject to all terms, limitations and exclusions)

- Conditions related to Substance Abuse/Chemical Dependency Disorders (refer to Substance Abuse/Chemical Dependency definition)

- Developmental Delays/Learning Disorders
- V codes as primary diagnosis

Morbid obesity means a condition in which an adult has been 100 pounds over normal weight (by the Plan's underwriting standards) for at least five years despite documented unsuccessful attempts to reduce weight under a physician-monitored diet and exercise program.

Open Enrollment to add dependents is yearly from December 1 to December 31. Dependents enrolled during open enrollment will be eligible for coverage on the following January 1.

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

- A doctor of medicine (MD), osteopathy (DO), surgical chiropody, podiatry or chiropractic
- A licensed clinical psychologist, or

Where law requires, any other licensed practitioner who:

- Is acting within the scope of that license, and
- Performs a service payable under the Plan when performed by a MD.

A physician does not include a person who lives with you or is part of your family (you, your spouse, or a child, brother, sister or parent of you or your spouse).

Pregnancy, complications of means:

- Any condition resulting in hospital confinement, the diagnosis of which is distinct but is adversely affected or caused by pregnancy, or
- A non-elective cesarean section, an ectopic pregnancy that is terminated, a spontaneous termination of pregnancy when a viable birth is not possible, a puerperal infection, eclampsia and toxemia

False labor, occasional spotting, physician prescribed rest, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with a difficult pregnancy are not complications of pregnancy.

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

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

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature, the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, treatment or procedure, or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, treatment or procedure.

Residential Treatment Plan: Provides a 24-hour level of care 7 days a week for patients with long term or severe Mental Health or Chemical Dependency conditions. Care is medically monitored, with 24-hour medical and nursing staff availability. Services include treatment with a wide range of diagnostic and therapeutic behavioral health services that cannot be adequately provided through existing community programs. Residential care also includes family involvement in assessment, treatment and discharge planning, and offers training in the basic skills of living as determined necessary for each patient.

Spinal treatment means detection or correction (by manual or mechanical means) of a condition of the vertebral column including misalignment, distortion or subluxation in the body to remove nerve interference or its effects. The interference must be the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

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

Terminally ill means to have no reasonable prospect of cure and to have less than six months to live, as determined by a physician.

Third Party means another person or organization, other than the Plan or participant.

Total disability or totally disabled means:

- For medical benefits, that because of an injury or sickness:
 - You are completely and continuously unable to perform the material and substantial duties of your regular occupation and are not engaging in any work for profit, or
 - Your dependent is unable to perform the normal activities of a person of the same age and is not engaged in any work for profit.

Usual, Reasonable and Customary means the maximum amount the Plan will consider for reimbursement. The Plan measures and determines this amount by comparing the actual charge for the service or supply with prevailing regional charges.

IV. COBRA NOTICES

NOTICE OF DISABILITY Tongass Timber Trust

INSTRUCTIONS:

Use this form when the Social Security Administration (SSA) has determined that a qualified beneficiary was disabled on any day of the first 60 days following a COBRA qualifying event that was the covered employee's (a) termination of employment or (b) reduction of hours. (**Note:** If SSA made the disability determination before the termination of employment or reduction of hours, you may still use this Notice of Disability to report the earlier disability determination, so long as the qualified beneficiary remains disabled and you provide this Notice of Disability by the deadline described below.)

Complete, date, sign, mail, hand-deliver, fax or e-mail this Notice of Notice of Disability to Tongass Timber Trust at:

Tongass Timber Trust
111 Stedman Street, Suite 200
Ketchikan, Alaska 99901
Attention: Notice of Disability

Fax: 907-225-5920
(include the words "Attention: Notice of Disability" in the fax cover sheet)

E-mail: afa@akforest.org (Attach a copy of the completed, signed and dated original. Include the words "Notice of Disability" in the subject line)

You are not required to use this form of Notice of Disability.

Questions? Call Tongass Timber Trust at (907) 225-6114.

DEADLINE:

Complete and sign and mail, deliver, fax or email Notice within 60 days after the latest of (1) the date of SSA's disability determination, (2) the date of termination of employment or reduction of hours, or (3) the date on which the qualified beneficiary would lose coverage under the terms of the Trust plan as a result of the termination of employment or reduction of hours. Your Notice must also be mailed, delivered, faxed or emailed within 18 months after the termination of employment or reduction of hours. (If mailed, the postmark is the date of mailing.) If you fail to notify Tongass Timber Trust of a qualified beneficiary's disability within the 60-day period, all COBRA qualified beneficiaries lose their right to extend COBRA coverage beyond 18 months.

REQUIRED DOCUMENTATION:

You must include a copy of SSA's determination of disability with this Notice of Disability. If, however, you cannot provide a copy, complete, sign and mail, deliver, fax or email this Notice by the Deadline above. Tongass Timber Trust will contact you.

1. Identify the Employee

Print Name of Employee:

Address of Employee:

2. Identify Initial Qualifying Event

Initial Qualifying Event was: Termination of employment Reduction in hours

Date of Initial Qualifying Event

3. Identify Disabled Qualified Beneficiary

Name of Disabled Qualified Beneficiary

Address: Same as employee's address Different address (provide address)

3. Identify All Other Qualified Beneficiaries (Attach Sheet with Additional Names if Necessary)

Print Name of Qualified Beneficiary

Address: Same as employee's address Different address (provide address)

Print Name of Qualified Beneficiary

Address: Same as employee's address Different address (provide address)

4. Social Security Administration Disability Determination

Date of SSA Disability Determination:

Date Qualified Beneficiary Became Disabled (according to SSA determination):

Has SSA subsequently determined that the qualified beneficiary is no longer disabled? Yes No

Have you enclosed a copy of SSA's Disability Determination Yes No

5. Certification, Signature, Date and Telephone Number

I certify that the above information is true and correct.

I am the: Employee or Former Employee Disabled Qualified Beneficiary Other Qualified Beneficiary Other (explain):

Signature

Print Name

Date

Telephone Number

FOR OFFICE USE ONLY

Social Security Administration determination of disability enclosed? Yes No

Notice was Mailed Delivered Faxed Emailed

Kept with Notice Envelope Fax Cover Sheet Email

Date of Postmark, Delivery, Fax or Email: _____, 20_____

Was Notice timely? Yes No

NOTICE OF QUALIFYING EVENT

Tongass Timber Trust

INSTRUCTIONS:

Use this Notice of Qualifying Event when any of the following events occur:

- A spouse covered under the Plan has divorced from the covered employee.
- A spouse whose Plan coverage was eliminated or reduced in anticipation of divorce divorces the covered employee.
- A child covered under the Plan has ceased to be a dependent under the terms of the Plan.

Complete, date, sign, mail, fax, hand-deliver or e-mail this Notice of Qualifying Event to: Tongass Timber Trust at

Tongass Timber Trust
111 Stedman Street, Suite 200
Ketchikan, Alaska 99901
Attention: Notice of Qualifying
Event

Fax: 907-225-5920
(include the words "Attention:
Notice of Qualifying Event" in the
fax cover sheet)

E-mail: afa@akforest.org (Attach a copy of
the completed, signed and dated original.
Include the words "Notice of Qualifying
Event" in the subject line)

You are not required to use this form of Notice of Qualifying Event

Questions? Call Tongass Timber Trust at (907) 225-6114.

DEADLINE:

Mail, fax or email this Notice within 60 days after the later of (1) the date of Event you identify in Event Description below or (2) the date on which the covered spouse or dependent child would lose coverage under the terms of the Tongass Timber Trust plan as a result of the Event. (If mailed, the postmark is the date of mailing.) If you fail to mail, deliver, fax or email this Notice within the 60-day period, the spouse and dependent child(ren) lose their right to elect COBRA coverage.

1. Identify the Employee	
Print Name of Employee:	Address of Employee:
2. Event Description (Check Box A or B and complete)	
<input type="checkbox"/> A. Employee and spouse divorced	Date of divorce:
Print name of spouse:	Address of spouse:
<input type="checkbox"/> B. Employee's child ceased to be an eligible dependent under the Tongass Timber Trust plan	
Reason child ceased to be eligible dependent (check one): <input type="checkbox"/> Attained age _____ <input type="checkbox"/> Other (explain):	
Print name of child:	Date child ceased to be dependent (for example, date attained age):
Address of child: <input type="checkbox"/> Same as employee's address <input type="checkbox"/> Different address (provide address below)	
3. Certification, Signature, Date and Telephone Number	
I certify that the above information is true and correct.	
I am the (check one): <input type="checkbox"/> Employee <input type="checkbox"/> Spouse or former spouse <input type="checkbox"/> Former dependent child <input type="checkbox"/> Other (explain below)	
Signature	Print Name
Date	Telephone Number

FOR OFFICE USE ONLY

Notice was Mailed Delivered Faxed Emailed

Date of Postmark, Delivery, Fax or Email: _____, 20_____

Was Notice timely? Yes No

Kept with Notice Envelope Fax Cover Sheet Email

NOTICE OF SECOND QUALIFYING EVENT

Tongass Timber Trust

INSTRUCTIONS:

Use this Notice of Second Qualifying Event when (1) a spouse or dependent child is receiving COBRA coverage due to the covered employee's termination of employment or reduction in hours of employment AND (2) any of the following events (second qualifying events) occur during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours:

- A spouse who is receiving COBRA coverage becomes divorced from the covered employee;
- A child who is receiving COBRA coverage ceases to be a dependent under the terms of the Plan; or
- The covered employee dies while one or more qualified beneficiaries are receiving COBRA coverage.

Complete, date, sign, mail, fax, hand-deliver or e-mail this Notice of Second Qualifying Event to:

Tongass Timber Trust
111 Stedman Street, Suite 200
Ketchikan, Alaska 99901
Attention: Notice of Second
Qualifying Event

Fax: 907-225-5920
(include the words "Attention: Notice
of Second Qualifying Event" in the
fax cover sheet)

E-mail: afa@akforest.org (Attach a copy of
the completed, signed and dated original.
Include the words "Notice of Second
Qualifying Event" in the subject line)

You are not required to use this form of Notice of Second Qualifying Event

Questions? Call Tongass Timber Trust at (907) 225-6114.

DEADLINE:

Complete, sign, mail, fax or email this Notice of Second Qualifying Event within 60 days after the latest of (1) the date of the second qualifying event and (2) the date on which the covered spouse or dependent child would lose coverage under the terms of the Tongass Timber Trust Plan as a result of the second qualifying event (if this event had occurred while the qualified beneficiary was still covered under the Plan). (If mailed, the postmark is the date of mailing.) If you fail to mail, deliver, fax or email this Notice within the 60-day period, the spouse and dependent child(ren) lose their right to extend COBRA coverage.

1. Identify the Employee

Print Name of Employee:

Address of Employee:

2. Identify Initial Qualifying Event

Termination of Covered Employee's Employment Reduction in Hours of Covered Employee's Employment

3. Identify Second Qualifying Event (Check Box A, B or C and complete)

A. Employee and spouse divorced

Date of divorce:

Print name of spouse:

Address of spouse:

B. Employee's child ceased to be an eligible dependent under the Tongass Timber Trust plan

Reason child ceased to be eligible dependent (check one): Attained age Other (explain):

Print name of child:

Date child ceased to be dependent (for example, date attained age,):

Address of child: Same as employee's address Different address (provide address below)

C. Death of Employee

Date of employee's death

4. Certification, Signature and Date

I certify that the above information is true and correct.

I am the (check one): Employee Spouse or former spouse Former dependent child

Other (explain below)

Signature

Print Name

Date

FOR OFFICE USE ONLY

Notice was Mailed Delivered Faxed Emailed

Date of Postmark, Delivery, Fax or Email: _____, 20____ Was Notice timely? Yes No

Kept with Notice envelope fax cover sheet email