

**ASEA/AFSCME Local 52  
Health Benefits Plan  
Amended and Restated  
Effective February 19, 2020**

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# **ASEA/AFSCME Local 52 Health Benefits Plan**

## **PREAMBLE**

The Plan shall be entitled the ASEA/AFSCME Local 52 Health Benefits Plan. The Plan Document governing the Plan, originally adopted by the Board of Trustees for the ASEA/AFSCME Local 52 Health Benefits Trust effective July 1, 2001, is hereby amended and restated effective February 19, 2020.

This Plan is designed to provide participating Employees the opportunity to elect benefits from the various Benefit Plan options described herein, and to pay for those benefits with a combination of Employer contributions and Employee contributions (Pre-tax Contributions).

The Plan is intended to qualify as a cafeteria plan under Code § 125 and offers a variety of benefit coverage choices through a flexible benefit arrangement.

The Health Care Reimbursement Account Plan is included as part of the Code Section 125 Plan offered through the Trust and such Plan intended to qualify as a "self-insured medical reimbursement plan" under Code § 105 and medical care expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code § 105(b). Although incorporated herein by reference, the Health Care Reimbursement Account Plan is a separate plan for purposes of administration and COBRA and is operated under a separate plan document.

The Health Reimbursement Arrangement offered in conjunction with a Benefit Plan, Plan D election is intended to meet the definition in IRS Notice 2002-45 and medical care expenses reimbursed under the Health Reimbursement Arrangement are intended to be eligible for exclusion from participating Employees' gross income under Code Section 105(b). Although incorporated herein by reference, the Health Reimbursement Arrangement Plan is a separate plan for purposes of administration and COBRA and is operated under a separate plan document.

## ARTICLE I DEFINITIONS

**"Administrative Agent"** means the Third-Party Administrator for the ASEA/AFSCME Local 52 Health Benefits Trust and Plan(s), who is authorized by the Board of Trustees pursuant to a service agreement to perform the day-to-day administrative and business functions of the Trust.

**"Anniversary Date"** means the first day of any Plan Year.

**"Benefits Booklet"** means the current ASEA/AFSCME Local 52 Health Benefits Plan Booklet (which meets the requirements for a summary plan description). The Benefit Booklet describes in detail the separate Plan options available for election by Participants and the rules and conditions for the provision of benefits provided under the Plan. The Benefits Booklet is incorporated by reference into this Plan Document.

**"Benefit Plan(s)"** means those Qualified Benefits available to a Participant under this Plan (Plan Options A, B, C, or D). Plan D includes an election for the Health Reimbursement Arrangement.

**"Board of Trustees"** means the Board of Trustees of the ASEA/AFSCME Local 52 Health Benefits Trust.

**"Change in Status"** means any of the events described in Article III, Section 2, as well as any other events included under subsequent changes to Code § 125 or regulations issued under Code § 125 which the Plan Administrator (in its sole discretion) decides to recognize on a uniform and consistent basis as described in Article II, Section 2.

**"COBRA"** means the Consolidated Omnibus Budget Reconciliation Act.

**"Code"** means the Internal Revenue Code of 1986, as amended.

**"Collective Bargaining Agreement"** means the collective bargaining agreement negotiated between an Employer and a labor organization representing the Employer's Employees' providing for participation in the Trust and governing the Contribution requirements (Employer and Employee) that fund some or all of the Benefits provided by this Plan.

**"Compensation"** means the total W-2 compensation for Federal income tax withholding purposes paid by the Employer to the Employee for services performed, determined prior to any Salary Reduction election under this Plan, prior to any salary reduction election under any other Code § 125 cafeteria plan, and prior to any salary deferral election under any Code § 401(k), 403(b) or 408(k) arrangement.

**"Contributions"** means the payment required by the participating Employer, or of participating Employee, pursuant to the terms of a collective bargaining agreement, or special agreement for the purpose of providing employee welfare benefits to the Employees covered by said collective bargaining agreement or special agreement, and their Spouses and Dependents under this Plan; and the self-payment rules adopted by the Trustees.

**"Dependent"** means the Spouse (including persons legally separated, but not divorced) of the Employee, or a child of the Employee who is—

The Employee's natural child, adopted child or child placed for adoption, legally placed foster child, child for whom the Employee is the legal guardian, who meets one of the foregoing categories, up to the attainment of age 26.

A mentally or handicapped child who reaches age 19 while covered under the Plan may continue coverage beyond their 26<sup>th</sup> birthday, if the child is:

- Chiefly dependent upon the Employee for support;
- Is living with the Employee or an institution;
- Is not capable of self-sustaining employment; and
- Is claimed as a dependent on the Employee's Federal income tax return for the Plan Year.

Notwithstanding the foregoing, the Plan will provide benefits in accordance with the applicable requirements of any qualified medical child support order, as defined by the Public Health Service Act.

**"Election Form"** means the form provided by the Administrative Agent for the purpose of allowing an eligible Employee or new hire to elect, during an Open Enrollment, upon being hired, or as a result of a Change in Status, to participate in this Plan by electing benefits from the options (Plan A, B, C, or D) available through the Plan, and the Health Care Reimbursement Plan.

**"Employee"** means—

- an individual the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll and covered by a collective bargaining agreement executed between the Employer and the labor organization representing the Employee, or through a Special Agreement, requiring contribution payments to the Plan,
- an ASEA/AFSCME Local 52 member who is on leave without pay or who is a layoff Employee, or
- an Employee of an Employer participating in the Trust through a Special Participation Agreement.

**"Employer"** means the State of Alaska or other such Employer who is entitled to participate in the benefit plans provided through this Trust, pursuant to collective bargaining and/or a Special Participation Agreement approved by the Board of Trustees.

**"Enrollment Guide"** means the ASEA/AFSCME Local 52 Health Benefits Plan Enrollment Guide for the applicable Plan Year.

**"Family Information Form"** means the form supplied by the Administrative Agent to be completed, signed and returned listing any eligible Dependents and providing proof of dependent status.

**"Group Health Plan"** means the medical, prescription drug, hearing, dental and vision benefits available to Employees and their Spouses and eligible Dependents under Plans A, B, C and D, as described in the Benefit Booklet for the applicable Plan Year, and the Enrollment Guide for the applicable Plan Year, as amended by the Plan Administrator from time to time and incorporated herein.

**"HIPAA"** means the Health Insurance Portability and Accountability Act of 1996.

**"Health Care Reimbursement Account Plan"** means the ASEA/AFSCME Local 52 Health Care Reimbursement Account Plan established by the Plan Administrator effective July 1, 2001. The Health Care Reimbursement Account is part of the Cafeteria plan arrangement funded by the Trust, as described in a separate Plan Document which is incorporated by reference herein.

**"HRA Plan"** means the ASEA/AFSCME Local 52 Health Reimbursement Arrangement Plan, a health reimbursement arrangement as defined in IRS Notice 2002-45, which is offered only in conjunction with Group Health Plan, Plan D. The HRA Plan is described in a separate Plan Document which is incorporated herein by reference.

**"Layoff Employee"** means an Employee who—

- (a) has received notification of layoff by the Employer;
- (b) is not currently working for the Employer;
- (c) has a reserved position with the Employer; and
- (d) is subject to recall for a maximum of two years from the date they cease work for such Employer.

A Layoff Employee is not considered to have separated from service with the Employer unless—

- (e) they fails to return to work when recalled from the Employer;
- (f) two years expire from the date they cease work for the Employer due to layoff; or
- (g) they formally terminate or resign.

**"Named Fiduciary"** means the Board of Trustees of the ASEA/AFSCME Local 52 Health Benefits Trust.

**"Open Enrollment"** means the period specified by the Plan Administrator for annual election of benefits under the Plan.

**"Participant"** means an eligible Employee who becomes a Participant pursuant to Article II and/or eligible Dependents of the Employee.

**"Plan"** means the ASEA/AFSCME Local 52 Health Benefits Plan.

**"Plan Administrator"** means the Board of Trustees for the ASEA/AFSCME Local 52 Health Benefits Trust.

**"Plan Year"** shall be the 12-month period from July 1 until the following June 30, provided that a period of less than 12 months may be a Plan Year for the final Plan Year, and a transition period to a different Plan Year.

**"Qualified Benefit"** means any benefit excluded from the Employee's taxable income under Chapter 1 of the Code (other than Code § 106(b), 117, 124, 127, or 132) and any other benefits permitted by the Income Tax.

**"Salary Reduction Agreement"** means the actual or deemed agreement pursuant to which an eligible Employee or Participant properly completes and returns an Enrollment Form electing among Plans A, B, C, or D offered under the Group Health Benefit Plan and any optional enrollment into the Health Care Reimbursement Account Plan with Pre-tax Contributions during an Open Enrollment, upon being newly hired, or due to a Change in Status election change.

**"Special Agreement"** means an agreement whereby the Board of Trustees approves participation in the benefit plans offered through the Trust by Employees of an Employer other than an Employer participating pursuant to a Collective Bargaining Agreement.

**"Spouse"** means an individual who is legally married to an Employee and who is treated as a Spouse under the Code (may be separated but not divorced).

**"Terminated Employee"** means an Employee who has separated from employment with the Employer who is not on Layoff status.

**"Trust Agreement"** means the Trust Agreement for the ASEA/AFSCME Local 52 Health Benefits Trust, as amended from time to time by the Plan Administrator.

**"Trust Fund" or "Trust"** means the ASEA/AFSCME Local 52 Health Benefits Trust.



## ARTICLE II ELIGIBILITY AND PARTICIPATION

### 1. Eligibility to Participate

Benefits are provided under this Plan to Employees (and their Dependents) covered under a Collective Bargaining Agreement requiring participation in and contributions to the Trust, or Employees of Employers participating in the Plan pursuant to a Special Agreement, as described below:

- Full-time Employees (scheduled to work 30 or more hours a week on a regular basis);
- Full-time seasonal Employees; or
- Part-time Employees who elect to participate in the Plan (scheduled to work at least 15 but less than 30 hours a week on a regular basis). A part-time Employee must elect coverage within the first 31 consecutive calendar days of employment and complete an Enrollment Form in order to participate in the Plan.

The Employer and Employee Contribution rate will be set by the collective bargaining agreement in force at the time of coverage or as required by a Special Agreement. The Employee Salary Reduction for the election under this Plan must be designated by the Employee upon enrollment. Participation pursuant to a Special Agreement may provide for separate eligibility rules, such as hours of employment or probationary status.

Employees must be actively at work and receiving Compensation from the Employer as a result of their performance of their duties, or otherwise eligible to participate under the provisions of the underlying collective bargaining agreement in force for the Plan Year.

Employees must complete, sign and return a Family Information Form and proof of Dependent status before benefits will be paid on eligible Dependents.

### 2. Election to Participate

- (a) ***Elections During Open Enrollment:*** During Open Enrollment with respect to a Plan Year, the Administrative Agent shall provide an Election form (by mail or electronically) to each Employee who is eligible to participate in this Plan. The Election form shall enable the Employee to participate in the various options of this Plan for the next Plan Year and to authorize the necessary Salary Reductions to pay for the benefits elected. The Election form must be postmarked or received electronically (or date stamped by the Administrative Agent if delivered by means other than U.S. Mail or electronically) on or before the last day of Open Enrollment. If an eligible Employee elects to participate during an Open Enrollment, they (and their eligible Dependents, when applicable) become a Participant on the first day of the applicable Plan Year. If an eligible full-time Employee fails to return the Election form or complete online enrollment within the time period required, they will be defaulted into the Group Health Benefits Plan A until a new election is made during the next Open Enrollment, or if they experience a Change in Status event and make a new

election pursuant to the Change in Status rules that is consistent with the Change in Status event. Part-time employees who fail to make an election during Open Enrollment will not be permitted to participate in the Plan unless they experience a Change in Status event and make an appropriate election based on that Event.

- (b) **Elections by Employees Hired During a Plan Year:** An Employee who is hired by the Employer during a Plan Year must timely complete and return an Employee Information Form to the Administrative Agent. Upon receipt, the Employee will be sent an Election Form (by mail or electronically) by the Administrative Agent. The Employee will have 31 days to return the Election Form indicating their elected benefits and Salary Reduction (if applicable) from the date the Employee was hired. If the Election Form for a full-time Employee is not received by the Administrative Agent postmarked or received electronically (or date stamped by the Administrative Agent if delivered by means other than the U.S. Mail or electronically) within 31 days of the date the Election Form was mailed to the Employee, the Employee will be defaulted into the Group Health Benefit Plan A, and will not be eligible to participate in any other Plan options until a new election is made during the next Open Enrollment, or they experience a Change in Status event and make a new election pursuant to the Change in Status rules that is consistent with the Change in Status event. Part-time employees who fail to make an election as a new hire will not be permitted to participate in the Plan unless they experience a Change in Status event and make an appropriate election based on that Event.

### 3. Commencement of Participation

- (a) **New Employees:** A Participant shall become covered under the Plan on the first day of the month following 30 consecutive days in paid status, provided that Contributions have been paid on the Employee's behalf. Employees must make an election within the first 30 days of employment or the Employee will be automatically defaulted into Group Health Plan, Plan A only.

A long-term nonpermanent part-time or part-time seasonal Employee who elects coverage during the first 30 days of employment will be eligible on the first day of the month following 30 consecutive days in paid status. Failure to elect coverage timely will result in no coverage under the Plan.

A Participant who has leave without pay during the first 30 days of employment will be covered on the first day of the month following the Employee's return to work and 31 consecutive days of paid status.

- (b) **Deferred Coverage Available for Seasonal Employees:** A seasonal Employee may elect to defer the effective date of coverage for one month, which will correspondingly result in coverage ending on the last day of the month following the month in which the Employee begins seasonal leave without pay. The Employee must follow the procedures established by the Plan to defer coverage, including completion and timely submission of the deferral form.
- (c) **Rehired Employees:** If a previously covered Employee is terminated from employment and is rehired within seven calendar days of the date the

Employee's coverage terminated, coverage will begin the day the Employee returns to work, provided that the corresponding required Contributions are paid to the Trust. If the Employee is rehired more than seven calendar days after the Employee's coverage terminated, the Employee will be considered a new Employee and coverage will begin as described in the preceding paragraph.

- (d) **Employees Returning From Leave Without Pay or Layoff:** If a previously covered Employee returns to work from leave without pay or layoff, coverage will begin the first day that the corresponding required Contributions are paid to the Trust, (unless the Employee defers coverage as described in Paragraph (b) above, provided the Employee is not subject to the Active at Work provision described below.
- (e) **Employees Moving from a Nonparticipating Unit:** Employees who move from another bargaining unit shall be covered on the first day of the month after the bargaining unit change occurs. If the Employee is not in pay status on day the bargaining unit change occurs, the Employee will not be covered until the day they return to pay status and the Trust receives Contributions on their behalf. If the Employee or one of the Employee's Dependents is hospitalized on the date coverage changes, the new coverage will start when the Employee or Dependent is discharged.
- (f) **Employees Moving from Part-Time to Full-Time Status:** An Employee who moves from part-time to full-time status will be covered on the first day of the month following the date of the status change. If the Employee elected coverage as a part-time employee, the Plan election will remain in effect, and the Employee will have 60 days from the date of the status change to change the Plan election. If the Employee did not elect coverage as a part-time employee, the Employee will have 30 days from the date of the status change to elect coverage as a full-time Employee. Failure to make an election will result in default into Group Health Plan A.
- (g) **Employees Moving from Non-Benefit-Eligible Status to Benefit-Eligible Status:** An Employee who moves from non-benefit-eligible status (such as short-term permanent or long-term nonpermanent) to benefit-eligible status (such as permanent or long-term nonpermanent) will be covered on the first day of the month following the date of the status change. The Employee must make a Plan election within the first 30 days of employment in benefit-eligible status, or the Employee will be defaulted into Group Health Plan, Plan A.
- (h) **Dependent Coverage:** Dependent coverage begins on the same date as the Employee coverage for each of the categories listed above.
- (i) **Active at Work Provision:** Any requirement regarding eligibility, or that an otherwise eligible person be actively at work before coverage may begin or remain in force is not applicable to health coverage, if the eligibility for coverage or the absence is due to a Health Status-Related Factor. Moreover, the actively at work provision will not apply when eligibility is afforded through the terms of the collective bargaining agreement in effect for the Plan Year under the donated leave or catastrophic leave provisions, provided the full Employer and Employee Contributions are received by the Trust.

Health Status-Related Factor means any of the following:

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

- (j) **HIPAA Special Enrollment Rights:** If an Employee, or their Dependent(s), is entitled to a special enrollment right under a group health plan, as required by HIPAA under Code Section 9801(f), then an Employee may revoke a prior election for Benefits Plan coverage and make a new election, provide that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right shall arise if:
- (i) An Employee declined to enroll their Dependent(s) in the Benefit Plan because they had other coverage, and eligibility for such other coverage is subsequently lost due to divorce, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period, or other coverage was non-COBRA coverage and employer contributions for such coverage were terminated; or
  - (ii) A new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption. An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may be effective retroactively up to 30 days.
- (k) **New Dependents:** Subject to the terms of this Plan, elections made to add medical coverage for a newborn child or child placed for adoption will be retroactive for up to 31 days subject to the special enrollment requirements of HIPAA. Other new dependents' coverage shall be prospective, commencing on the first day of the month following the date the Employee files their new election for a family coverage option and Family Information Form with the required documentation.

#### 4. Termination of Participation

Participation and/or coverage under the Plan will terminate as follows:

**Employees on Leave Without Pay or Layoff:** Participation and coverage under the Plan terminates on the last day of the month in which the Employee was last in pay status or in which the Employee begins seasonal overtime conversion. If coverage ends while the Employee is on Family Medical Leave Act (FMLA) leave, coverage will be extended to the end of the month in which FMLA leave ends.

**Employees Who Terminate Employment:** Participation and coverage ends on the last day of the month in which the Employee last worked.

**Employees Moving to a Nonparticipating Unit:** Participation and coverage ends on the last day of the month in which the Employee moves out of the unit that entitled the Employee to participate in the Group Health Plan.

**Employees Moving from Full-Time to Part-Time Status:** An Employee who moves from full-time status to part-time status will cease to be covered on the last day of the month in which the status change occurred, unless the Employee elects to continue coverage as a part-time Employee within 30 days of the status change and makes a valid election to participate as a part-time Employee.

**Employees Moving from Benefit-Eligible Status to Non-Benefit Eligible Status:** Coverage will end on the last day of the month in which the Employee is in benefit-eligible status.

**Failure to Pay the Required Premium:** Participation and coverage terminates at the end of the month for which the last required contributions were paid (including COBRA and continuation coverage).

**Dependent Participation and Coverage:** Coverage for a Dependent ends on the same day as the Employee's coverage ends, except in the case of—

- Divorce – coverage terminates for the Spouse on the date the divorce is final.
- Dependent Child Ceases to Meet Eligibility Requirements – coverage ends on the last day of the month in which the Dependent Child fails to meet any of the requirements for eligibility.

#### 5. Participation in Group Health Benefit Plan

All full-time permanent and full-time seasonal Employees must participate in the Group Health Benefit Component of this Plan (Plans A, B, C, or D) and the appropriate Contributions from the Employer and the Employee will be contributed to the Trust to pay for such coverage through the Plan. Part-time Employees may voluntarily elect to participate in the Group Health Benefit Plan as provided in Section 1. Employees who elect to participate in the Group Health Benefit Plan (Plans A, B, C, or D) will also have the ability to elect to participate in the Health Care Reimbursement Account Plan offered through the Trust as described in the Benefit Booklet and Enrollment Guide. An election of Group Health Benefit Plan D includes participation in the Health Reimbursement Account Plan.



## **6. Special Rules for Employees on Leave Without Pay and Layoff**

Employees on leave without pay and on layoff will still be considered Employees of the Employer for purposes of Open Enrollment election of benefits and Change in Status election changes, and the notification thereof. Employees on leave without pay and layoff are Participants who are ineligible to receive benefits under the Plan until they elect to participate under the terms of the Plan (or are defaulted into the Group Health Benefits Plan A) and return to work for the Employer. Upon election to receive benefits under the terms of the Plan and return from leave without pay or recall from layoff status by the Employer, the Employee's benefit election will take effect the first day that the corresponding Employee and Employer Contributions are received by the Trust, unless the Employee defers coverage under Section 3(b) above. Change dates on footer. I thought I did but it only changed the first page.

## **7. Annual Open Enrollment**

The Plan will take reasonable and necessary steps to notify each Employee who is a Participant in this Plan or who is eligible to become a Participant in this Plan prior to each Anniversary Date of this Plan of the Annual Open Enrollment, during which the Plan will mail to the Employee at their last known address an Enrollment Guide and Enrollment Forms which will enable the Employee to elect among the Benefit Plans offered by the ASEA/AFSCME Local 52 Health Benefits Plan. The Enrollment Guide and the Enrollment Forms are also available to Employees electronically through the Trust's website at [www.aseahealth.org](http://www.aseahealth.org). The Employee shall be given a reasonable period of time in which to exercise such election right. An election shall be made by submitting the Election Forms (either by mail or electronically) to the Administrative Agent (and Family Information Form, if applicable) during the Open Enrollment and shall be effective for the entire Plan Year beginning on the Anniversary Date. The Election Form also constitutes a Salary Reduction Agreement for the election of benefits which are subject to Section 125 of the Code.

Except as otherwise provided for in the Enrollment Guide a full-time Employee who fails to complete, sign, and timely return the Enrollment Forms shall be deemed to have elected Group Health Benefits Plan A with no other Plan enrollments. An Employee will have the opportunity to actively enroll for Health Care Reimbursement Account Plan benefits each year in conjunction with their enrollment into the Group Health Plan option by timely submitting the completed and signed Enrollment Forms including the Health Care Reimbursement Account Plan election together with the Group Health Plan election. Elections into the Group Health Plan (Plan Options A, B, C and D) will roll over from Plan Year to Plan Year if no new election is made during Open Enrollment. Elections in the Health Care Spending Account Plan do not roll-over from Plan Year to Plan Year and a new enrollment must be made during each Open Enrollment Period to participate, except that an Employee who has rolled over funds up to the \$500.00 maximum may continue to submit claims for reimbursement until such roll-over funds are exhausted or are depleted to \$25.00 or less.

If an Employee fails to complete and return the Family Information Form with the required Dependent information during Open Enrollment, claims for Dependents will not be allowed until such time as the completed Family Information Form and documentation are received.

## ARTICLE III BENEFIT ELECTIONS

### 1. Election of Benefits

The Enrollment Guide sets forth and prescribes the manner and timing of the election of benefits under the Plan. Employees will have the option of electing between Group Health Plans A, B, C, or D, and to elect to participate in the Health Care Reimbursement Account Plan at Open Enrollment, upon new hire, or in the occurrence of a qualified change-in-status event or HIPAA Special Enrollment event. The Benefits Booklet for the applicable Plan Year describes in detail the differences between the Group Health Plan options and the requirements for election each option for the applicable Plan Year. An Employee who does not actively enroll in one of the Group Health Plan options will be defaulted into Plan A with no opportunity to enroll in the Health Care Spending Account Plan. Group Health Plan elections will roll over from year to year if a new enrollment is not made during the annual Open Enrollment. Enrollments do not roll over from year to year for the Health Care Reimbursement Account Plan and an Employee wishing to participate in the option must actively enroll each year at Open Enrollment, except an Employee with roll-over funds may continue to submit claims for reimbursement until such funds are exhausted or reduced to \$25.00 or less.

### 2. Change of Election

No Employee shall be allowed to change their election for benefits under the Plan during the Plan Year, or after the close of Open Enrollment but before the commencement of the Plan Year, except if (1) the Plan is served with a court order or other order as provided in paragraph (c) below; (2) HIPAA's special enrollment rules apply as provided in paragraph (b) below; (3) the Employee ceases to be an eligible Employee, in which case the Participant's election will be automatically revoked; or (4) as a result of a Change in Status as provided by Section 125 of the Code and regulations.

- (a) **HIPAA Special Enrollment Rights:** If an Employee, an Employee's Spouse or an Employee's Dependent is entitled to a special enrollment right under a group health plan, as required by Code § 9801(f), then the Employee may revoke a prior election for health or accident coverage and make a new election (including salary reduction election), provided that the election corresponds with such special enrollment right. For purposes of this provision a HIPAA special enrollment election attributable to the birth or adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, will be effective retroactively (to the date of the birth, placement for adoption or adoption, provided the enrollment is made timely).

An Employee entitled to make a new election under this Section 2, Change in Status, must do so within 60 days of the event. Subject to the provisions of the underlying group health plan, elections made to add medical coverage for a newborn or newly adopted Dependent child pursuant to a HIPAA special enrollment right may be retroactive to the date the dependent was acquired, provided the election was timely made. All other new election shall be effective prospectively commencing on the first day of the month following the date the Employee files their new Salary Reduction Agreement with the Plan Administrator. Elections made pursuant to this Section shall be effective for the balance of the Plan Year in which the election is made

unless a subsequent event allows a further election change. A detailed description of the qualified change in status events is set forth in the Benefits Booklet for applicable Plan Year.

### **3. Impact of Termination of Employment on Election**

Termination of employment shall automatically revoke any Salary Reduction Agreement. Except as provided below, if revocation occurs under this Section 3, then no new election with respect to Pre-tax Contributions may be made by such Employee during the remainder of the Plan Year. Except as otherwise provided in the applicable Benefit Plans, former Employees who are rehired within seven calendar days or less of the date of termination of employment will be reinstated with the same election(s) that such individual had before termination. If a former Employee is rehired more than seven calendar days following termination of employment and is otherwise eligible to participate in the Plan, the individual must make a new election.

### **4. Qualifying Leave under Family and Medical Leave Act**

Notwithstanding any provision to the contrary in this Plan, if an Employee goes on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), then to the extent required by the FMLA, the Employer will continue to maintain the Employee's group health plan benefits on the same terms and conditions as if the Employee were still an active Employee. That is, if the Employee elects to continue their coverage while on leave, the Employer will continue to pay its share of the contributions to the Trust Fund to fund the coverage and the Employee must continue to pay their portion of the contributions for coverage with after-tax dollars, in a manner provided by the Administrative Agent. If an Employee does not elect to continue coverage during FMLA leave, or does not pay the required Employee share of the premium, then, upon return to work after FMLA leave, coverage will be reinstated on the day of return to work on the same basis that it was in force prior to leave, subject to any changes that may have occurred in the Plan. Any partially satisfied waiting periods, which were interrupted while on FMLA leave, will continue to be applied once coverage is reinstated. Other than the federal mandates of FMLA, the terms and conditions of entitlement to FMLA leave are defined by the Employer, not the Plan.

If the Employee elects to continue coverage while on leave, then the Employee will be permitted to pay their share of the premium for the Group Health Benefit Plan in one of the following ways, depending upon the elections in place at the time of the leave, and at the discretion of the Plan Administrator:

With pretax salary reduction if the Employee's payroll is sufficient at the time of taking leave;

with after-tax dollars, by sending monthly payments to the Administrative Agent; or

under another arrangement agreed upon between the Employee and the Administrative Agent.

If an Employee's coverage ceases while on FMLA leave, the Employee will be permitted to re-enter the Plan upon return from such leave on the same basis the Employee was participating in the Plan prior to the leave, or as otherwise required by the FMLA.

Under the FMLA, an Employee is entitled to continue their Group Health Plan coverage on the same basis as if they were an active-at-work employee, for up to 12 weeks during the 12 month period, as defined by the Employer, for any of the following reasons:



to care for their child after the birth or placement of a child for adoption or foster care; so long as such leave is completed within 12 months after the birth or placement of the child;

to care for their spouse, child, foster child, adopted child, stepchild, or parent that has a serious health condition (as defined in by the FMLA); or

to care for their own serious health condition (as defined by the FMLA).

The Employee must also (1) have worked for the Employer for at least one year (2) have worked at least 1,250 hours over the previous 12 months, and (3) continue to pay the Employee share of the contribution for coverage.

FMLA leave ends on the earliest of—

- (a) the day the Employee returns to work,
- (b) the day the Employee notifies the Employer that they are not returning to work; 3) the day the Employee's coverage would otherwise have ended under the terms of the Plan, or
- (c) the last day of the 12 week FMLA leave period.

If the Employer grants FMLA-like leave to an Employee to care for a child born to or placed for adoption or foster care with a Same-Sex Partner, or to care for a Same-Sex Partner or Child of a Same-Sex Partner that has a serious health condition, Plan coverage will be extended to the Employee on the same basis that coverage would be extended in the event of FMLA leave, subject to any limitations or restrictions imposed on the Plan.

## **5. Uniformed Services Employment and Reemployment Rights**

Under the Uniformed Services Employment and Reemployment Act of 1994 (USERRA), if an Employee's coverage ends because they are required to perform duty, as defined in USERRA, on a voluntary or involuntary basis, in a uniformed service under the competent authority, the Employee may elect to continue coverage under this Plan under USERRA until the earlier of (a) the end of the period during which the Employee is eligible to apply for employment in accordance with USERRA, or (b) 18 consecutive months after coverage ended.

Coverage under USERRA will end on the earliest of (a) the day the Trust ceases to provide any group health coverage to any Employee; (b) the day that contributions are due and not paid; 3) the day the Employee or Employee's Dependent again become covered under the Plan; or 4) the expiration of the time period noted in (a) or (b) in the preceding paragraph.

To continue coverage the Employee, or Employee's Dependent must pay the required contributions (including the Employer's share of the contributions), unless the service in the uniformed service is less than 31 days, in which event the Employee must only pay the Employee share of the contributions. The Administrative Agent will provide the Employee with the rules and procedures for contribution payment to continue coverage while on USERRA leave. The Employer will provide the Employee with a summary of their reemployment rights upon discharge from uniformed service under USERRA.

## **6. Trade Act of 2002**

Employees who have been terminated or experienced a reduction of hours and who qualify for a 'trade readjustment allowance' or 'alternative trade adjustment assistance' under the Trade Act of 1974 are entitled to special COBRA rights. Such Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days (or less) and only during the six months immediately after group health coverage under this Plan ended. Employees affected by these rules must contact the Administrative Agent promptly after qualifying for assistance under the Trade Act of 1974 or they will lose these special COBRA rights.

## **ARTICLE IV BENEFIT FUNDING**

### **1. Source of Benefit Funding**

The cost of coverage under the Group Health Benefit Plan shall be funded by Employee Salary Reduction Contributions and the Contributions required from the Employer under the terms of the Collective Bargaining Agreement or the terms of the Special Agreement in effect during the Plan Year.

### **2. Participant Salary Reduction**

The Employer shall withhold from an Employee's Compensation on a pre-tax basis (as elected and specified by the Employee on the completed Enrollment Form and directed by the Plan Administrator, or as a default election) the Contributions required from the Employee for coverage of the Employee or the Employee's Spouse or Dependents, under the Benefit Plan elected by the Employee under this Plan. Amounts withheld from an Employee's Compensation as Pre-tax Contributions shall be transmitted to the Trust Fund to fund benefits as soon as administratively feasible. If an Employee fails to complete an Enrollment Form, then the Employee will be automatically enrolled in Group Health Benefit Plan A, and the required Salary Reduction Contributions will be withheld automatically from the Employee's Compensation.

## **ARTICLE V RULES RELATING TO BENEFITS**

### **1. COBRA Continuation Coverage**

An Employee or Employee's Dependent who is a qualified beneficiary who loses coverage under the Core Benefit Plan (Group Health Plans A, B, C, or D) due to a COBRA Qualifying Event generally will have the opportunity to elect continuation coverage under that Plan in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). A Qualifying Event for purposes of COBRA continuation coverage is:

For Employee—

- Termination of the Employee's employment (for reasons other than gross misconduct), or
- Reduction of your work hours resulting in a loss of coverage.

For the Dependent Child—

- The death of the Employee parent;
- The termination of the Employee parent's employment (for reasons other than gross misconduct) or reduction of the Employee parent's hours of employment with the Employer resulting in a loss of coverage;
- The parent's divorce or legal separation;
- A loss of Dependent status for purposes of eligibility for coverage.

For a Qualifying Event other than a change in the Employee's employment status or death, it will be the obligation of the Participant who experiences the Qualifying Event to inform the Administrative Agent within 60 days of the occurrence of the Qualifying Event, or the Participant will lose their right to elect COBRA continuation coverage. The Administrative Agent will furnish the Participant with separate, written options to continue the coverage provided at stated COBRA contribution rates with respect to each option in which the Participant is participating. The notification provided by the Administrative Agent will explain all of the terms and conditions of the continued coverage under COBRA. A description of COBRA rights, the length of the COBRA continuation coverage entitlement, and how to elect COBRA continuation coverage is set forth in the Benefits Booklet, incorporated herein by reference for applicable Plan Year.

### **2. Special Rule for Plan D COBRA Election**

Election of COBRA under Plan D includes participation in the ASEA/AFSCME Local 52 Health Benefits HRA Plan. A Participant electing COBRA under Group Health Plan D includes COBRA election under the HRA Plan and requires appropriate COBRA premiums to the HRA Plan to continue coverage under Plan D. There is no right to elect Group Health Plan D under COBRA independent from a COBRA election also of the HRA Plan.

### **3. Effect of Other Laws**

The Plan, where applicable, is also subject to the requirements of the, Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), the Mental Health Parity Act of 1996 (MHPA), Uniformed Services Employment and Reemployment Rights Act (USERRA), and the Women's Health and Cancer Act of 1998 (WHCRA). Where applicable, the requirements of such Acts are set forth in the Plan Benefit Booklet.

## **ARTICLE VI PLAN ADMINISTRATION**

### **1. The Plan Administrator**

The Board of Trustees shall perform its duties as Plan Administrator and in its sole discretion shall determine the appropriate courses of action in light of the reason and purpose for which the Plan is established. In particular, the Plan Administrator shall have full and discretionary authority to interpret all Plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties. Any interpretation, determination, or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious, or otherwise an abuse of discretion. The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties hereunder, including, but not limited to the following:

- (a) To construe and interpret this Plan, in its sole discretion and with the sole authority, and to decide all questions of fact, questions relating to eligibility and participation, and questions regarding interpretation of entitlement to benefits under this Plan.
- (b) To prescribe procedures to be followed and the forms to be used by the Employees and Participants to make elections pursuant to the Plan.
- (c) To prepare and distribute information explaining this Plan and the benefits under this Plan in such a manner as the Plan Administrator determines to be appropriate.
- (d) To request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time deem necessary for the proper administration of this Plan.
- (e) To furnish each Employee and Participant with such reports and notices with respect to the administration of the Plan as the Plan Administrator deems to be reasonable and appropriate.
- (f) To receive, review and keep on file such reports, records, and information concerning the benefits covered by this Plan as the Plan Administrator determines to be necessary and proper.
- (g) To appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel, benefits consultants, investment advisors, computer specialists and programmers, and accountants.
- (h) To sign documents for the purpose of administering this Plan, or to designate an individual or entity to sign such documents for the purposes of administering this Plan.

- (i) To maintain the books of accounts, records and other data in the manner necessary for the proper administration of this Plan, and to meet any applicable disclosure and reporting requirements under State and Federal law.

## **2. Provision for Third-Party Plan Service Providers**

The Plan Administrator may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan and to rely upon all tables, valuations, certificates, reports, and opinions furnished thereby, as set forth in the Trust Agreement. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Plan Administrator.

## **3. Fiduciary Liability**

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan. Each member of the Board of Trustees as Plan Administrator shall be covered by a policy of Fiduciary Liability Insurance at all times while serving as a member of the Board of Trustees.

## **4. Compensation of Plan Administrator**

The members of the Board of Trustees, as Plan Administrator, shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties of administering the benefits Plan shall be paid by the Trust Fund.

## **5. Payment of Administrative Expenses**

All reasonable expenses incurred in administering the Plan are currently paid by the Trust Fund.

## **6. Funding Policy**

The Group Health Plan is self-funded. However, the Plan Administrator shall have the right to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan and to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such insurance contract shall be property of the Trust Fund.

The Group Health Plan options described in this Plan Document shall be funded, as legally appropriate, with Employer and Employee Contributions as negotiated in the Collective Bargaining Agreement and amounts withheld from Compensation pursuant to Salary Reduction Agreements (pre-tax Employee Contribution). The Plan Administrator will apply all such amounts to pay for the benefits provided herein as soon as administratively feasible and shall comply with all applicable federal regulations and laws affecting the administration of group health welfare benefits plans.

## **7. Reimbursement of Overpaid Benefits or Fraudulent Claims**

Upon discovery of overpaid benefits relating to any claim submitted by an Employee on their own behalf or for an eligible Dependent of the Employee, the Plan shall notify the Employee in writing of the value of the overpayment and advise the Employee of the necessity to repay the amount of the overpaid benefits within 60 days of the notification by the Plan. If the Employee fails to repay the amount of the overpaid benefits to the Plan, the Plan has the right to offset the

value of the overpaid benefits against future benefits payable from the Plan. If the Employee fails to repay the value of overpaid benefits, and is no longer participating in the Plan so no future benefits will accrue, the Plan has the right to file a lawsuit to enforce its right to reimbursement of the value of overpaid benefits.

Upon discovery of the submission of fraudulent claims or the fraudulent enrollment of ineligible Dependents by an Employee, the Plan shall demand in writing that the Employee repay the value of the overpaid benefits within 60 days of the notification by the Plan. The Plan may also terminate all future entitlement to benefits from the Plan upon proof of fraud upon the Plan. The Plan may also file suit to collect the value of the overpaid benefits, and/or refer the matter for criminal prosecution. Fraudulent submission of a claim, or misrepresentation of a material fact relating to a claim or the eligibility of a Participant to enroll and participate in the Plan will result in a retroactive rescission of coverage to the date of the fraudulent claim or enrollment based on the misrepresentation of material fact.



## **ARTICLE VII CLAIMS PROCEDURES**

### **1. Claims for Benefits**

The Plan Administrator shall prescribe the manner, method, and procedure for submission of claims for benefits. Appropriate forms for submission of claims will be supplied by the Administrative Agent.

### **2. Hearing and Appeal Provisions**

The Plan Administrator shall prescribe the manner, method, and procedure for submission the submission of an appeal of an adverse determination by the Plan relating to eligibility or the entitlement to benefits pursuant to the terms of the Plan. The Benefits Booklet for the Plan shall contain a clear and concise description of the full and fair claims procedures, as amended from time to time by the Board of Trustees to comply with applicable State and federal law. The Benefits Booklet is incorporated herein by reference.

## **ARTICLE VIII CONDITIONAL BENEFITS AND SUBROGATION**

### **1. Conditional Benefit Payments**

If an Employee or Eligible Dependent has medical expenses as a result of an injury, sickness or accident for which a third party is, or may be, held responsible, the Plan Administrator may make advance expense reimbursements to, or payments on behalf of, such Employee or Dependent, subject to the Plan's subrogation rights. However, before any such reimbursements or payments will be conditionally made, the Employee or Dependent (or the Dependent's legal guardian if the Dependent is a minor) shall execute an agreement that acknowledges and affirms (1) the conditional nature of the reimbursements or payments; and (2) the Plan's rights of subrogation, as provided for below in Section 2.

### **2. Subrogation**

If an Employee or Dependent receives any benefits arising out of an injury or illness for which the Employee or Dependent (or the Employee's or Dependent's guardian or estate) has, may have, or asserts any claim or right to recovery against a third party or parties, then any payment or payments under this Plan for such benefits shall be made on the condition and with the understanding that this Plan will be reimbursed. Such reimbursement will be made by the Employee or Dependent (or the Employee's or Dependent's guardian or estate) to the extent of, but not exceeding, the total amount payable to or on behalf of the Employee or Dependent (or the Employee's or Dependent's guardian or estate) from—

- (a) any policy or contract from any insurance company or carrier (including the Employee's or Dependent's insurer); and/or
- (b) any third party, plan, or fund as a result of a judgment or settlement. The Employee or Dependent on behalf of themselves (or their guardian or estate) acknowledges and agrees that this Plan will be reimbursed in full before any amounts (including attorney fees incurred by the Employee or Dependent or their guardian or estate) are deducted from the policy, proceeds, judgment, or settlement.

This Plan will be subrogated to all claims, demands, actions, and rights of recovery against any entity, including, but not limited to, third parties and insurance companies and carriers (including the Employee's or Dependent's insurer) to the fullest extent permitted by law in the appropriate jurisdiction. The amount of such subrogation will equal the total amount paid under this Plan arising out of the injury or illness for which the Employee or Dependent (or the Employee's or Dependent's guardian or estate) has, may have, or asserts a cause of action. In addition, this Plan will be subrogated for attorney's fees incurred in enforcing its subrogation rights under this Section. Such subrogation and reimbursement right will not be reduced on the basis that the recovery, judgment, or settlement with the third party or its insurer is not described as being related to medical costs. The Plan is entitled to reimbursement on a first-dollar basis, regardless of whether the recovery, judgment or settlement fully compensates the Employee or Dependent (or Employee's or Dependent's estate) for the injury or sickness incurred.

As a condition of coverage, the Employee or Dependent on behalf of themselves (or their guardian or estate) must specifically agree to do nothing to prejudice this Plan's rights to reimbursement

or subrogation. In addition, the Employee or Dependent on behalf of themselves (or their guardian or estate) must agree to cooperate fully with the Plan and Administrator in asserting and protecting the Plan's subrogation rights. The Employee or Dependent on behalf of themselves (or their guardian or estate) must agree to execute and deliver all instruments and papers (in their original form) and do whatever else is necessary to fully protect this Plan's subrogation rights.

Further, as a condition of coverage, the Employee or Dependent must specifically agree on behalf of themselves (or their guardian or estate) to notify the Administrator, in writing, of whatever benefits are paid under this Plan that arise out of any injury or illness that provides or may provide the Plan subrogation rights under this Section. Further, the Employee or Dependent must agree that any funds received, as a result of the injury or sickness caused by the third party for which the Plan has advanced medical benefits, constitute a constructive trust in favor of the Plan and the Plan has an equitable right to receive reimbursement of such funds to the extent that benefit payments have been made.

Failure to comply with the requirements of this Section by the Employee or Dependent (or their estate or guardian) may, at the Plan Administrator's discretion, result in a forfeiture of benefits under this Plan.

## ARTICLE IX HIPAA PRIVACY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Plan's ability to use and disclose protected health information. The following definition of PHI applies to this Plan:

**Protected Health Information.** Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

It is the intent of the Plan to fully comply with HIPAA's requirements, including the Privacy and Security Rules and the provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act. The Board of Trustees and its designated staff shall have access to PHI only as permitted under this Plan Document or as otherwise required or permitted by HIPAA.

The Plan shall adopt a Privacy Policy and provide the Employee a Notice of Privacy Practices as required by HIPAA and shall make such Notice of Privacy Practices available for review by Plan Participants at the Administrative Offices. The Plan shall ensure that a Privacy Policy is in place governing the approved uses and disclosures of PHI by the Board of Trustees and its designated staff, in compliance with HIPAA and the interpretive regulations issued thereunder.

The Plan shall also ensure that all Business Associates of the Plan enter into a Business Associate Agreement as required by HIPAA and the HITECH Act, assuring that any uses or disclosures of PHI by the Business Associate are consistent with the permitted uses and disclosures set forth in HIPAA and comply with the "minimum necessary" requirement and documentation requirements of HIPAA.

## **ARTICLE X AMENDMENT OR TERMINATION OF PLAN**

### **1. Permanency**

While the Plan Administrator expects that this Plan will continue indefinitely, due to unforeseen, future contingencies, permanency of the Plan will be subject to the Board of Trustee's right to amend or terminate the Plan, as provided in Section 2 below, and the Plan Sponsor's right to collectively bargain with the State over Employee benefits. The distribution of Plan and Trust assets upon termination is controlled by Article XII of the Trust Agreement. Nothing in this Plan is intended to be or shall be construed to entitle any Participant, retired or otherwise, to vested or non-terminable benefits.

### **2. Plan Administrator's Right to Amend**

The Plan Administrator reserves the right to amend at any time any or all of the provisions of the Plan, subject to any limitations in the Trust Agreement. All amendments shall be made in writing and shall be approved by the Board of Trustees in accordance the powers granted by the Trust Agreement. Such amendments may apply retroactively or prospectively. Each Benefit Plan or Policy shall be amended in accordance with the terms specified therein, or, if no amendment procedure is prescribed, in accordance with this section.

## **ARTICLE XI GENERAL PROVISIONS**

### **1. Expenses**

All administrative costs shall be borne by the Trust Fund.

### **2. Funding of this Plan**

All of the amounts payable under this Plan shall be paid from the Trust Fund. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Trust Fund from which any payment under this Plan may be made.

### **3. Amendment and Termination**

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Plan Administrator may terminate this Plan at any time by resolution of the Board of Trustees for the Trust Fund. In addition, the Plan may terminate if the Participating Labor Organizations and the Participating Employers fail to provide for the existence of the Trust Fund and Plan(s) offered through the Trust Fund in the collective bargaining agreements. In either event, the provisions of Article XII of the Trust Agreement will control.

### **4. Governing Law**

The Plan shall be construed, administered and enforced in accordance with the laws of the State of Alaska, to the extent not superseded by the Code or other federal law.

### **5. Non-Assignability of Rights**

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to be taken by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized except to such extent as may be required by law.

### **6. Tax Effects**

The Plan Administrator makes no warranty or other representation as to whether any Pre-tax Contributions made to or on behalf of any Participant hereunder will be treated as excludable from gross income for local, state, or federal income tax purposes. If for any reason it is determined that any amount paid for the benefit of a Participant or Beneficiary is includible in an Employee's gross income for local, federal, or state income tax purposes, then under no circumstances shall the recipient have any recourse against the Plan Administrator with respect to any increased taxes or other losses or damages suffered by the Employees as a result thereof. The Plan is designed and intended to be operated as a "Cafeteria Plan" under Code § 125.

## **7. Gender and Number**

Except when otherwise indicated by the context, any masculine terminology used herein shall also include the feminine and the definition of any term herein shall also include the plural.

## **8. Headings**

The Article and Section headings contained herein are for convenience of reference only and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision of this Plan.

## **9. Plan Provisions Controlling**

In the event that the terms or provisions of the Plan Booklet, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as herein set forth, the provisions of this Plan shall be controlling.

## **10. Incorporation by Reference**

Employees entitled to participate in Group Health Plans offered as Plans A, B, C, or D are also entitled to elect to participate in the Health Care Reimbursement Account Plan, and the HRA Plan (offered exclusively in conjunction with a Plan D election) also offered through the Trust. The terms and conditions of the Health Care Reimbursement Account Plan and the HRA Plan are contained in separate written plan documents governing those specific benefit options, and they shall govern the terms and conditions of those specific benefit options, and are hereby incorporated by reference.

## **11. Severability**

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder thereof shall be given effect to the maximum extent possible.

## **12. Effect of Mistake**

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator shall, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which they are properly entitled under the Plan. Such action by the Plan Administrator may include directing the Employer to withholding of any amounts due the Plan from Compensation paid by the Employer.

## **13. Code and Regulatory Compliance**

It is intended that this Plan meet all applicable requirements of the Code, and all regulations issued thereunder. The Plan is classified as a Governmental Plan and as such is exempt from Titles I and II of ERISA. However, the Board of Trustees as Plan Administrator, in their discretion may refer to the standards set forth in ERISA and the case law interpreting such standards as guidance for the administration of this Plan, insofar as it does not conflict with the provisions of the Public Health Service Act (PHSA). This Plan shall be construed, operated, and administered accordingly. In the event of any conflict between any part, clause, or provision of

this Plan and the Code or the Plan and the PHSA, the provisions of the Code or PHSA shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

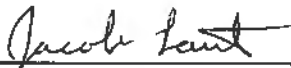


## SIGNATURES

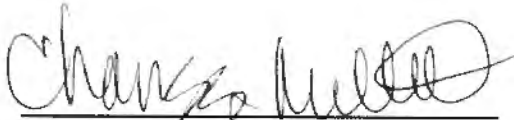
IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the ASEA/AFSCME Local 52 Health Benefits Plan, the Board of Trustees as Plan Administrator has caused this Amended and Restated Plan to be executed and effective this February 19, 2020.



Michael Williams



Jacob Lauten



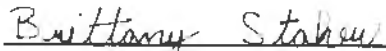
Charisse Millett



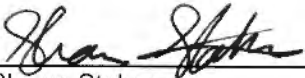
Rich Sewell



Chelsea Sieh



Brittany Staker



Shawn Staker