



THE NELSON TRUST

HEALTH AND WELFARE BENEFITS GUIDE FOR ACTIVE EMPLOYEES

EFFECTIVE JANUARY 1, 2010



TABLE OF CONTENTS

Eligibility and Enrollment	1
Who is Eligible?.....	1
How to Enroll.....	1
When Coverage Ends.....	1
Stay Healthy with Medical Coverage	1
Medical Plan Highlights	2
How to Find a Provider.....	3
ID Cards.....	3
Filing Claims.....	3
Emergency Care.....	3
If You Have Other Coverage (Coordination of Benefits).....	3
Subrogation and Right of Recovery.....	3
Preventive Health Guidelines	4
Recommended Wellness Exams	4
Recommended Screenings.....	4
Recommended Immunization Schedule.....	5
Take Your Medicine with Prescription Drug Coverage	6
Retail Pharmacy	6
Prescription Drug Plan Highlights.....	6
Mail Order Prescription Program	6
See Clearly with Vision Coverage	7
How the Plan Works	7
Vision Plan Highlights.....	7
Enhance Your Smile with Dental Coverage	8
Dental Plan Highlights	8
Protect Your Loved Ones with Life and AD&D Insurance	9
Employee Life and AD&D Insurance	9
Dependent Life Insurance	9
How to File a Claim	9
Travel Assistance Benefit	9
Prepare for the Unexpected with Disability Coverage	10
Accident and Sickness Weekly Indemnity (A&S).....	10
California State Disability Insurance (SDI) Benefits (for California Employees).....	10
Family Medical Leave Act (FMLA)	11
Glossary of Terms	11
Tools to Help You Manage Your Health and Your Benefits	12
The Nelson Trust Benefits Portal	12
Visit Premera Online.....	12
Quick Reference Guide	13
Important Contact Information	back cover

As an active participant in The Nelson Trust, you have access to valuable benefits to cover you and your family. The Trustees have established comprehensive health and welfare benefits that are financed through collective bargaining between your union and your employer.

When managing benefit costs, we're all in this together. We ask your help in making the continued high quality of your benefits a reality by using your plans wisely and managing your own personal health (such as engaging in preventive care, exercising regularly, and quitting unhealthy habits like smoking). When you make smart, well-informed healthcare decisions, you reduce your out-of-pocket healthcare costs, and you also help control the Trust's healthcare expenditures. Only through this concerted effort will we be able to manage our healthcare costs in the coming years and continue to offer you and your families a competitive and affordable benefits program.

WHAT'S INSIDE

This guide provides you with an overview of the health and welfare benefit plans available to you. Keep this guide handy as a valuable resource to use throughout the remainder of the year when you have questions about your benefits. It will also be available on The Nelson Trust benefits portal. Your Trust Administrator's office is also available to help when you need it.

Who to Call

See Important Contact Information on the back cover for website addresses and phone numbers.



ELIGIBILITY AND ENROLLMENT

WHO IS ELIGIBLE?

In general, you are eligible to participate in The Nelson Trust-paid health and welfare benefit plans as of the first day of the second calendar month following two consecutive months in which you are credited with 100 or more compensable hours per month. In addition, you are covered by life insurance in the amount of \$20,000 at no cost to you beginning on the date you begin active full-time employment with a participating employer.

The following family members are eligible for health and welfare benefits from The Nelson Trust:

- Your wife or husband (provided your marriage is valid under state law and recognized as a marriage for federal tax purposes)
- Your unmarried child(ren) who are
 - Under age 19
 - Up to age 25 if a full-time student
 - Incapacitated due to a mental or physical disability and incapable of self-support continuously since their 19th birthday
 - Named in a Qualified Medical Child Support Order (QMCSO) as defined under federal law

Eligible Children

An eligible child is a natural child, stepchild, adopted child, child placed for adoption or other child who is dependent on you for support.

STUDENT CERTIFICATION

The Trust Administrator, A&I Benefit Plan Administrators, Inc. (A&I), maintains student verification information. You will not receive requests for this information from other health plan partners. A&I will ask you to provide student information when your child turns 19 years of age and to provide updated information once a year while your child remains in school full time. If your child loses full-time student status prior to the date you are asked for verification, you are required to notify the Trust Administrator's office immediately.

HOW TO ENROLL

You must file an enrollment form with the Trust Administrator's office to list your eligible dependents and designate your beneficiary for life and accidental death and dismemberment (AD&D) benefits. Be sure to list the birthdate and Social Security number for each of your eligible dependents. You may obtain an enrollment form online or from your employer or local Lodge office.

Change of Address

If your address changes, be sure to report it to the Trust Administrator's office. You can obtain an address change card online or from your employer or local Lodge office.

NEW HIPAA SPECIAL ENROLLMENT

There are two new circumstances under which special enrollment is available under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The enrollment period will be 60 days for a qualifying event due to CHIP (Children Health Insurance Program) for those active and retired employees and dependents who lose Medicaid or CHIP coverage or who become eligible for Medicaid or CHIP premium assistance subsidy. The federal model notices for the premium assistance notice and disclosure provisions recently became available. Participants will be receiving the initial notice that provides information about state Medicaid and CHIP premium assistance process by the start of the next plan year (2011). The new HIPAA special enrollment became effective April 1, 2009.

Eligibility (Michelle's Law)

This legislation ensures that a seriously ill or injured college student can continue to receive health care coverage through his or her family's health insurance program for up to one year under the same terms as if the child were a full-time student (unless the child's coverage would terminate earlier for another reason, for example, exceeding the plan's dependent eligibility age). Certification is required. This law applies to a medically necessary leave of absence commencing on or after January 1, 2010.

WHEN COVERAGE ENDS

You and your dependents lose eligibility for coverage on the first day of the second month following the month in which you do not have credited:

- 100 or more compensable hours with one or more participating employers, or
- At least one hour in that month and an accumulation of at least 300 hours during that month and the immediately preceding two months.

However, coverage may be extended during a period of disability.

Dependents who reach the age limits are covered through the end of the month in which their birthday occurs.

When you lose active Trust-paid employee coverage, you may be eligible to continue coverage through a self-payment arrangement. Dependents who lose eligibility may also be permitted to continue coverage by self-payment.

USERRA

Uniformed Services Employment and Reemployment Rights Act (USERRA) continuation coverage is a continuation of plan coverage when coverage would otherwise end because you will be serving in the uniformed service for more than 31 days. Refer to your Summary Plan Description or contact your military superior for more information.

STAY HEALTHY WITH MEDICAL COVERAGE

Nothing is more important than your good health. That is why The Nelson Trust offers a medical plan administered by Premera Blue Cross to help you and your family members live healthier lives.

In-Network Care: When you seek medical services from a provider that participates in the Premera network (or BlueCard® network if you live outside Washington or Alaska), you receive the higher, in-network level of

benefits. This means when you use network providers, you reduce the amount both you and the Trust pay for medical services. Your provider also files your claims.

Out-of-Network Care: You may choose to receive care from a provider that is not a part of the designated network, that is, a non-preferred provider, but you receive a lower level of benefits. Your benefits are based on the maximum allowable charge and you are responsible for any amount above the allowed charges. You may also have to file your own claims.

MEDICAL PLAN HIGHLIGHTS JANUARY 1, 2010

	In-Network Provider	Out-of-Network Provider
Calendar Year Deductible (applies except as noted)		
Individual	\$300	Shared with in-network deductible
Family	\$600	
Coinsurance	80%	70%
Stop Loss Limit (per calendar year)		
Individual	\$5,000 in allowable charges	\$5,000 in allowable charges
Family	\$10,000 in allowable charges	\$10,000 in allowable charges
Out-of-Pocket Annual Maximum		
Individual	\$1,300	\$1,800
Family	\$2,600	\$3,600
Lifetime Benefit Maximum	\$2,000,000	
PREVENTIVE CARE AND HEALTH EDUCATION		
Preventive Office Visit (up to \$300 per calendar year; does not include annual women's exam or immunizations)	100%; deductible waived	70%
Immunizations	100%; deductible waived	100%; deductible waived
Annual Women's Exam	100%; deductible waived	70%
Diabetes Health Education	100%; deductible waived	100%; deductible waived
PROFESSIONAL CARE		
Professional Office Visit (including urgent care)	80%	70%
Preventive Diagnostic Imaging and Laboratory Services - Including Pap/PSA	100%; deductible waived	70%
Outpatient Diagnostic Imaging & Laboratory	80%	70%
Outpatient Mammography (diagnostic)	100%; deductible waived	70%
Inpatient Professional Services	80%	70%
Contraceptive Management	80%	70%
FACILITY CARE		
Inpatient Facility	80%	70%
Skilled Nursing Facility (up to 120 days per calendar year following a three-day hospitalization)	80%	70%
Outpatient Surgery Facility	80%	70%
EMERGENCY CARE		
Emergency Care (copay waived if admitted or accidental injury)	\$150 copay, then 80%	\$150 copay, then 80%
Ambulance Transportation	80%	80%
Air Ambulance	80%	80%
OTHER SERVICES		
Transplants		
Facility Services	100%; deductible waived	70%
Professional Services	80%	70%
Chemical Dependency Treatment (up to \$14,000 in 24 months)	80%	70%
Mental Health Inpatient Facility Care (up to 7 days per calendar year)	80%	70%
Mental Health Outpatient Professional Care (up to 15 visits per calendar year)	80%	70%
Hospice (12 days inpatient, 240 hours respite, up to 6 months)	100%; deductible waived	70%
Home Health Care (up to 130 visits per calendar year)	100%; deductible waived	70%
Medical Supplies, Equipment, Prosthetics and Orthotics	80%	70%
Chiropractic and Other Manipulations	100% up to \$16 per day	100% up to \$16 per day
Rehabilitation Inpatient Facility (massage therapy and massage therapist not covered)	80%	70%
Rehabilitation Outpatient Care Including Physical, Occupational & Speech Therapy; Cardiac & Pulmonary Rehabilitation; Chronic Pain (massage therapy and massage therapist not covered)	80%	70%

Please note: Balance billing may apply if a provider is not contracted with Premera Blue Cross. Plan Participants are responsible for amounts in excess of the allowable charge.

HOW TO FIND A PROVIDER

If you need to see a physician, always verify that the physician is a participating provider. You can easily verify this as follows:

- Visit
 - www.nelson.aibpa.com; click on the Premera logo and select Find a Doctor
 - www.premera.com; select Find a Doctor (the network is Heritage and Heritage +1 in Washington; AK HeritagePlus in Alaska; and BlueCard PPO in other states)
- Call
 - One of the BlueCard PPO Provider Locator Lines (see Important Contact Information on the back cover for phone numbers)
 - Your physician's office

BlueCard Worldwide®

If you are traveling outside the United States, you have access to a worldwide Blue Cross/Blue Shield network.

ID CARDS

You will receive an ID card for yourself and one for each of your covered dependents from Premera that identifies you as a member of the plan. You can order replacement cards by calling Premera Customer Service or by visiting Premera's website. Show your card whenever you go to the doctor or use other healthcare services.

FILING CLAIMS

One of the advantages of this plan is that you usually do not need to file claim forms when you obtain services from network providers. Show your ID card to a network provider and the provider will use the information on the card to submit your claim. If you incur any out-of-pocket medical expenses that are covered under the plan, you may need to file a claim to be reimbursed for that cost. You can obtain a claim form online or by phone. Complete the form and attach an itemized bill from the provider, then mail your claim to the address on the form. We recommend that you keep a copy for your records.

EMERGENCY CARE

If you need emergency medical care, regardless of where you are in the world, you are covered under the plan. You should go directly to the nearest hospital, immediate care center or physician.

WHAT IS CONSIDERED AN EMERGENCY?

A sudden illness or injury is considered to be a medical emergency if it causes severe pain, and/or a prudent lay person believes it is life threatening or it places your health in serious jeopardy. Examples of medical emergencies include suspected heart attacks, strokes and broken bones.

IF YOU HAVE OTHER COVERAGE (COORDINATION OF BENEFITS)

If you or your covered dependent has healthcare coverage under more than one plan and The Nelson Trust plan pays second (after the primary plan has made its payment), benefits are limited so the total benefits available under all plans are not greater than what The Nelson Trust plan would have paid if there were no other coverage. In other words, if the primary plan paid as much or more than The Nelson Trust plan would have paid if it were the primary plan, then no additional payment is made on the claim. If the primary plan paid less than what The Nelson Trust plan would have paid as the primary plan, then the plan would make an additional payment up to what it would have paid as the primary plan. (Coordination of benefits is sometimes referred to as "maintenance of benefits.")

SUBROGATION AND RIGHT OF RECOVERY

The Nelson Trust plan contains a subrogation provision, which gives it the right to recover the amount it pays for your medical bills if you recover money from another party as a result of an injury or illness and the other party is at fault.

For example, if you suffer an injury or illness through the fault of a third party, such as in an automobile accident, you may receive benefits from The Nelson Trust healthcare plan. Then, the claims administrator will contact the insurance company of the person who was at fault in the accident to seek reimbursement for plan benefits attributable to the accident.

This arrangement allows you to receive prompt payment of benefits and, at the same time, places the expense of medical coverage where it belongs—with the person who caused the injury. As a condition of receiving benefits under this plan, you are expected to cooperate with the plan administrator in recovering any amounts for which the plan is entitled to be reimbursed, and to repay the plan any amounts you may receive to which the plan has a right to reimbursement.

PREVENTIVE HEALTH GUIDELINES

You can make a difference in your health. Lifestyle choices and health behaviors directly impact your health, well-being and the quality of your life. Positive lifestyle choices include a balanced diet, weight management, stress management and staying physically active. The following preventive care services and immunizations are recommended by the U.S. Preventive Services Task Force. We hope you find these guidelines useful when you schedule appointments with your provider.

Benefits for routine preventive care services are shown in Medical Plan Highlights on page 2.



RECOMMENDED WELLNESS EXAMS

Routine Physicals/Wellness Exams	Recommended Schedule
0-18 months	2-7 days of age and at 2, 4, 6, 9, 12 and 15 months of age
2-6 years	Annually
7-18 years	Every 2 years
19-64 years	Every 1-3 years
65+ years	Annually

Be informed and involved.

- Set a regular schedule for your routine exams and screening tests.
- Work with your provider to decide the best combination of services and activities to meet your lifestyle and health needs.
- Enlist the support of family, friends and colleagues when making lifestyle changes to provide help and encouragement.

RECOMMENDED SCREENINGS

Regular Screenings	Recommended Schedule
Blood pressure	Every 1-3 years for adults age 18 and older
Breast cancer screening	Every 1-2 years for women beginning at age 40
Cervical cancer screening	Begin when sexually active, but no later than age 21, every 1-3 years Routine screening may discontinue: <ul style="list-style-type: none"> • at age 65 if pap results have been normal, or • if you have had a hysterectomy for benign disease
Cholesterol screening	Men—beginning at age 35, every 1-5 years Women—beginning at age 45, every 1-5 years
Colon cancer screening	All men and women beginning at age 50. Screening options include: fecal occult blood test, sigmoidoscopy, double-contrast barium enema or colonoscopy. Ask your doctor what is best for you.
Depression screening	All adults
Obesity screening	All adults

RECOMMENDED IMMUNIZATION SCHEDULE

The following vaccines covered by your health plan are listed under routinely recommended ages. Light shaded boxes indicate the range of acceptable ages for vaccinations. Darker boxes indicate catch-up vaccinations.

Vaccines	Birth	1 mo.	2 mos.	4 mos.	6 mos.	12-15 mos.	15-18 mos.	24 mos.	4-6 yrs.	11-12 yrs.	13-18 yrs.	19-26 yrs.	27-49 yrs.	50+ yrs.
Hepatitis B (Hep B)	✓ 1st shot		✓ 2nd shot			✓ 3rd shot			✓ if missed earlier					
Tetanus/ Diphtheria (Td), Pertussis (DTaP)			✓ 1st shot	✓ 2nd shot	✓ 3rd shot		✓ 4th shot		✓ 5th shot	✓ DTaP	✓ if missed earlier	✓ Td booster every 10 years		
Rotavirus			✓ 1st shot	✓ 2nd shot	✓ 3rd shot									
H. influenzae type B (Hib)			✓ 1st shot	✓ 2nd shot	✓ 3rd shot	✓ 4th shot		✓ if missed earlier (18 mos. to 5 yrs.)						
Polio (IPV)			✓ 1st shot	✓ 2nd shot	✓ 3rd shot				✓ 4th shot	✓ if missed earlier				
Pneumonia (PCV or PPV)			✓ 1st shot PCV	✓ 2nd shot PCV	✓ 3rd shot PCV	✓ 4th shot PCV								✓ PPV
Measles, Mumps, Rubella (MMR)						✓ 1st shot			✓ 2nd shot	✓ if missed earlier		✓ 1-2 doses		
Varicella¹ (Chicken Pox)						✓ 1st shot		if missed earlier, consult healthcare provider				✓ if missed earlier		
									✓ 2nd shot					
Influenza (Flu)					✓ yearly during flu season									✓ yearly
Hepatitis A					✓ 2 doses									
Meningococcal										✓ 1st shot	✓ if missed earlier			
Quadrivalent HPV (females only)										✓ +*3 doses	✓ if missed earlier			
Zoster														✓ 1st shot

¹Varicella vaccine is recommended for all individuals 13 years of age or older who do not have a reliable history of chicken pox.

This schedule is based on recommendations made by the U.S. Centers for Disease Control and Prevention and the Advisory Committee on Immunization Practices (ACIP), and is endorsed by Premera Blue Cross. This schedule may change. Check with your healthcare provider regarding new recommendations.

TAKE YOUR MEDICINE WITH PRESCRIPTION DRUG COVERAGE

RETAIL PHARMACY

The Nelson Trust provides prescription drug coverage from Medco Health Solutions for a wide selection of drugs available at almost 60,000 pharmacies nationwide. Your prescription drug coverage is in the form of a three-tier benefit structure based on a formulary.

WHAT IS A FORMULARY?

A formulary is a list of commonly prescribed medications that are selected based on their clinical effectiveness and money-saving potential. An independent committee of physicians and pharmacists review these FDA-approved medications for their safety and effectiveness. For many conditions, several comparable drugs are available, both brand name and generic. A formulary is a preferred list of such items.

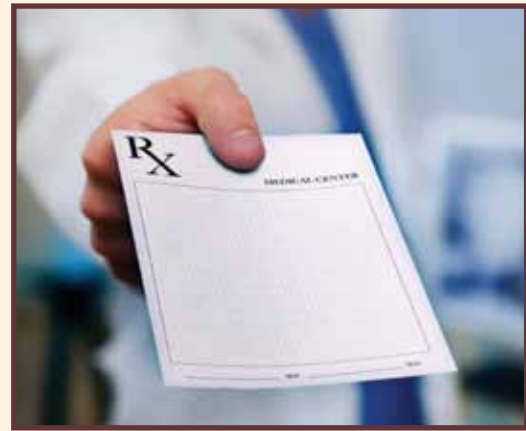
Your copay varies, depending on the type of prescription.

- Tier 1 – generic drugs
- Tier 2 – formulary brand name drugs
- Tier 3 – non-formulary brand name drugs

PRESCRIPTION DRUG PLAN HIGHLIGHTS

Prescription Drugs	Retail Pharmacy (30-day supply)	Mail Order (90-day supply)
Tier 1 - Generic	\$5	\$10
Tier 2 Formulary Brand Name	30%, with a minimum of \$30 and a maximum of \$60	30%, with a minimum of \$75 and a maximum of \$150
Tier 3 Non-Formulary Brand Name	50%, with a minimum of \$50 and a maximum of \$100	50%, with a minimum of \$125 and a maximum of \$250
Diabetic Supplies	10% copay	10% copay

Prescription drugs are covered at 100% after your copay when you use a participating retail pharmacy.



Using Participating Pharmacies Is Easy

- Show your Medco prescription drug ID card to your pharmacist when you fill a prescription.
- Use a participating pharmacy to receive the highest level of benefits.
- Find a participating pharmacy online or by phone (see Important Contact Information on the back cover).

Generic drugs are an excellent value. To help control the rising cost of prescription drugs, use a generic drug whenever possible. By law, the active ingredient(s) in generic and brand name drugs must meet the same standards for purity, strength and quality. Generic drugs cost less because they are created without the costly development, advertising, and sales expenses required for brand name drugs.

More information is available about your prescription drug coverage online, including the formulary list, which tier your prescription falls under, and specialty pharmacy programs.

MAIL ORDER PRESCRIPTION PROGRAM

Use the mail order program for drugs you take on an ongoing basis. This program is a great option to help you save on copayments. You can order up to a 90-day supply of Tier 1 maintenance medication by mail for the same copay as two 30-day supplies at the pharmacy. This is the same as buying two months of prescriptions and getting one month free. And, most medications are delivered **right to your doorstep usually within 3 to 5 days after you place your order** (8-10 days for an initial order). Standard shipping is free. Once your order is set up, you can request refills online or by phone. Order forms are available online.

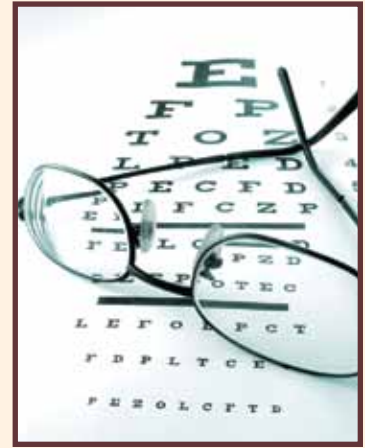
SEE CLEARLY WITH VISION COVERAGE

The Nelson Trust provides vision coverage administered by Vision Service Plan (VSP). The plan covers eye exams, prescription lenses, frames or contact lenses for you and your eligible family members.

When you seek vision services from a doctor who participates in the VSP network, you receive the higher, in-network level of benefits. Your doctor also files your claims. You may choose to receive care from a provider who is not a part of the network, but you receive a lower level of benefits and you have to file your own claims.

HOW THE PLAN WORKS

- Make an appointment with a VSP doctor.
 - Identify yourself as a VSP member.
 - Pay the \$25 copay for lenses and/or frames and the cost of any non-covered services.
 - VSP will pay the doctor directly.
- If you choose a provider who does not participate in the VSP network:
 - Call VSP first (see back cover for phone numbers).
 - Pay the vision care bill in full.
 - File the claim within six months for claim reimbursement. Find claim forms online at www.nelson.aibpa.com or www.vsp.com.



VISION PLAN HIGHLIGHTS

Plan Provision	In-Network	Out-of-Network Reimbursement Amounts
Eye Exams (once every 12 months)	Covered in full	Up to \$45
Lenses (once every 12 months) <ul style="list-style-type: none"> • Single Vision • Lined Bifocal • Lined Trifocal • Polycarbonate for dependent children 	Covered in full after \$25 copay	Up to \$45 Up to \$65 Up to \$85
Frames (once every 24 months)	Covered up to \$120 after \$25 copay plus 20% discount off any out-of-pocket costs	Up to \$47
Contacts and Exam (in lieu of glasses)	Covered up to \$120	Up to \$105

The Plan also provides discounts for lens options such as scratch-resistant and anti-reflective coatings, progressives, additional glasses, sunglasses, and contact lens exams (fitting and evaluation). Laser vision correction discounts are also available.

ENHANCE YOUR SMILE WITH DENTAL COVERAGE

The Nelson Trust offers a dental plan from Oregon Dental Services (ODS), including the Delta Dental network of over 100,000 providers nationwide, for you and your eligible family members.

The plan covers most necessary dental services and supplies, including diagnostic and preventive care (such as exams, cleanings, and X-rays), basic and major restorative services (such as fillings, crowns, and dentures).

Claims processing and administration are provided by Oregon Dental Services (ODS). The plan has contracted with over 1,800 dentists in Oregon (more than 90% of the licensed dentists in the state) and uses the Delta Dental Plan network for access to over 100,000 dental professionals nationwide for participants outside the ODS service area. When you see an ODS or Delta Dental provider, benefits are paid based on the schedule below. If you visit a dentist who is not a participating provider, his or her charge could be more than the ODS

contracted rate and you would be responsible for the balance.

You can check your benefits, review the plan, find a dentist, and print replacement or family member dental ID cards online. For new employees, an ODS Dental Plan ID card is mailed to your home address. Show this ID card to your dentist when you are receiving services. You can request a new or replacement ID card from ODS at any time.



ODS provides additional oral health benefits to members with diabetes and pregnant women in their third trimester through its Oral Health, Total Health program.

In addition to routine oral cancer exams, ODS covers ViziLite and Brush Biopsy, two nonsurgical screenings designed to aid in the early detection of abnormal cells in the mouth.

DENTAL PLAN HIGHLIGHTS

Services	ODS Dental Plan In-Network
Calendar Year Deductible (applies to Class II and III services) <ul style="list-style-type: none"> • Per person/per year • Annual family maximum 	\$50 \$100
Office Visit	Not applicable
Class I: Diagnostic and Preventive Services <ul style="list-style-type: none"> • Exams • Bitewing X-rays • Cleanings 	Plan pays 100% Once every 6 months Once every 6 months Once every 6 months
Class II: Basic and Restorative Services <ul style="list-style-type: none"> • Fillings • Routine Extraction • Surgical Extraction • Root Canal <ul style="list-style-type: none"> - Anterior - Bicuspid - Molar • Periodontal Root Planing (per quadrant) 	Plan pays 80% Once every 6 months
Class III: Major Services <ul style="list-style-type: none"> • Crowns • Bridges • Dentures 	Plan pays 65% Once every 5 years Replacement once every 5 years Replacement once every 5 years
Annual Maximum Benefit Per Person (January 1 – December 31)	\$2,000
Orthodontia (adults and children)	Not covered

PROTECT YOUR LOVED ONES WITH LIFE AND AD&D INSURANCE

Life insurance protects your family or other beneficiary in the event of your death while you are still actively employed. Your coverage amount will be paid to the beneficiary of your choice.

If your death is due to an accident, your beneficiary will receive an additional amount through Accidental Death and Dismemberment (AD&D) coverage. AD&D benefits are payable if you pass away, lose a limb, or have a loss of speech, hearing, or eyesight because of a covered accident (either on or off the job) and the loss occurs within one year of the covered accident. The payable amount of your AD&D benefit depends on the type of loss. In the event of death due to an accident, your beneficiary may receive both your life and AD&D benefits.

Beneficiary Designations

- A primary beneficiary is defined as the person you name to receive any benefits if you die.
- A contingent beneficiary is defined as the person you name to receive any benefits if the primary beneficiary is deceased.

EMPLOYEE LIFE AND AD&D INSURANCE

The Trust automatically provides you with life insurance in the amount of \$20,000 on the date you begin full-time employment.

Once you become eligible, the Trust also automatically provides you with accidental death and dismemberment (AD&D) insurance in the amount of \$20,000.



DEPENDENT LIFE INSURANCE

The Trust provides life insurance for your spouse equal to \$2,000 and for your children according to age:

Age of Child	Amount of Coverage
14 days but less than 6 months	\$200
6 months but less than 2 years	\$400
2 years but less than 3 years	\$800
3 years but less than 4 years	\$1,200
4 years but less than 5 years	\$1,600
5 years but less than 19 years	\$2,000
Incapacitated children over age 19	\$2,000

Note: The plan will continue to cover a dependent child up to age 25 if the child is enrolled full time in an accredited institution of higher learning.

HOW TO FILE A CLAIM

To file a claim for life and/or AD&D benefits, notify the Trust Administrator's office within one year of the date of death.

TRAVEL ASSISTANCE BENEFIT

Beginning September 1, 2009, coverage includes a travel benefit offered by Regence for you and your family.

You and your dependents who are traveling with you 100 or more miles away from home or outside your home country can obtain emergency medical, travel, and personal security assistance 24 hours a day, anywhere in the world. These benefits are provided by MEDEX, a leading provider of international travel assistance services with more than 30 years of experience.

For more information regarding the MEDEX travel benefits and a wallet card you can print and carry with you, please visit the Regence website at http://www.regencelife.com/Brochure_final.pdf.

Please note that the MEDEX services have not been tested or approved by The Nelson Trust and are provided through an arrangement between Regence and MEDEX. Many of the services available are advisory or facilitating arrangements and you are responsible for the associated costs.

PREPARE FOR THE UNEXPECTED WITH DISABILITY COVERAGE

ACCIDENT AND SICKNESS WEEKLY INDEMNITY (A&S)

Accident and Sickness (A&S) Weekly Indemnity benefits continue a portion of your income if you become disabled and are unable to work due to a non-work-related illness or injury. The plan pays you a weekly benefit equal to 60% of your current straight time hourly rate times your normally scheduled hours, up to a maximum of \$350, if you have hourly/flat rate eligibility when the disability begins. Weekly benefits are limited to \$40 if your disability begins after termination of employment but before your eligibility for benefits ends.

DISABILITY

To be considered disabled, your disability must be certified by a physician or surgeon and you must be under the care of a physician or surgeon. You need not be confined to your home, but you must be wholly and continuously disabled due to a non-work-related illness or injury and prevented from performing each and every function pertaining to your employment. You must have been seen in person and treated by the physician or surgeon to be deemed "under the care of a physician or surgeon."

A&S benefits begin on the first day of disability due to accident or on the fourth day of disability due to sickness. Benefits continue up to a maximum of 26 weeks as long as you remain disabled.

A&S benefits are reduced by the amount of any California SDI benefits you receive.

No benefits are payable for disability that begins before your month of coverage or while you are eligible by self-payment, or for disability that qualifies for A&S benefits under a non-participating employer's plan.

How to File a Claim

To file a claim for A&S benefits, submit a claim form to the Trust Administrator's office immediately. The form must be completed by you, your attending physician and your employer. If your claim is not filed within 90 days of the date disability begins, it could be denied. You can find claim forms online or obtain one from your employer or local Lodge office.

Please note:

- Benefits cannot be paid until your completed claim form is received.
- Attending physician medical records sufficient and complete enough to document disability are required.

CALIFORNIA STATE DISABILITY INSURANCE (SDI) BENEFITS (FOR CALIFORNIA EMPLOYEES)

The California state disability insurance (SDI) plan is designed to provide income if you should be unable to work because of an illness or injury, the illness or injury of a family member, or the birth, adoption, or foster care placement of a new child. Benefits are financed by payroll tax deductions.

SDI Benefits

You must have wages of at least \$300 during the 12-month base period prior to the date your claim begins to qualify for SDI benefits.

Benefits begin after a one-week waiting period.

Weekly benefits range from \$50 to \$959 in 2009, depending on your high-quarter base-period wages. The maximum amount of benefits is 52 times the weekly rate, but not more than your total base period wages.

Paid Family Leave

The California state-paid family leave program provides up to six weeks of wage-replacement benefits if you take time off work to care for a seriously ill child, spouse, parent, or domestic partner or to bond with a new child.

How to Claim State Plan Benefits

1. Request a claim form by telephone, internet, TTY or writing to EDD (see back cover for Important Contact Information).
2. Fill out and sign the "Claim Statement of Employee." Print clearly, and be sure that your answers are complete and correct because errors may delay payments.
3. Have your doctor complete the "Doctor's Certificate." Usually a claim cannot begin more than seven days before you were examined by or under the care of a certifying doctor.
4. Mail your claim within 49 days from the first day you were disabled. If your claim is late, you could lose benefits.

FAMILY MEDICAL LEAVE ACT (FMLA)

The FMLA provides up to 12 work weeks of leave in a calendar year for the following reasons:

- An employee's own serious health condition
- The serious health condition of the employee's child, spouse, domestic partner or parent
- The birth of a child
- Bonding with the employee's newborn, newly adopted child, or a child newly placed in the employee's foster care (Leave taken for this purpose must be completed within a year of the birth or placement in the adoptive or foster home.)



GLOSSARY OF TERMS

Here are some key terms that will help you understand your health and welfare benefits.

Allowable charge—the amount that network doctors and other contracted healthcare providers have agreed to accept as full payment for covered healthcare services and supplies

Balance billing—additional charges for which a non-network provider (one who is not in your plan's network) may hold you responsible

Benefit—the portion of the cost for covered healthcare services and supplies that your health plan is responsible for paying

Coverage—the range of healthcare services and supplies for which your health plan provides benefits

Network—a group of doctors, hospitals and other healthcare providers that have been contracted to provide healthcare services and supplies at agreed amounts called "allowable charges"

Out-of-pocket expenses—costs that are paid by you, not your health plan—such as:

Coinsurance—the percentage of the cost you will pay for a covered medical service, after your health plan has paid its portion

Copayment (copay)—a set fee your health plan may require you to pay your doctor or other healthcare provider at each visit for certain covered services

Deductible—a fixed amount your health plan may require you to pay for certain covered services and supplies each year before your health plan starts paying specified benefits. Copays are not credited toward your deductible

Provider—a doctor, hospital or other medically-licensed or medically-certified person or facility that provides healthcare services or supplies

TOOLS TO HELP YOU MANAGE YOUR HEALTH AND YOUR BENEFITS

THE NELSON TRUST BENEFITS PORTAL

The Nelson Trust benefits portal at www.nelson.aibpa.com provides easy online access to your claims administrators, insurance carriers and other Trust resources and planning tools. When you visit the portal, tabbed sections will help you understand and use your benefits. You can get information about:

- Eligibility for you and your dependents
- Employer contribution history
- Plan documents and booklets
- Details of plan coverage and comparison information
- Link to the Premera website to find a doctor or view your claim information
- “How to” instructions and Frequently Asked Questions
- Downloadable/printable forms
- Links and contact information for A&I, Premera, Medco, ODS, and VSP



VISIT PREMERA ONLINE

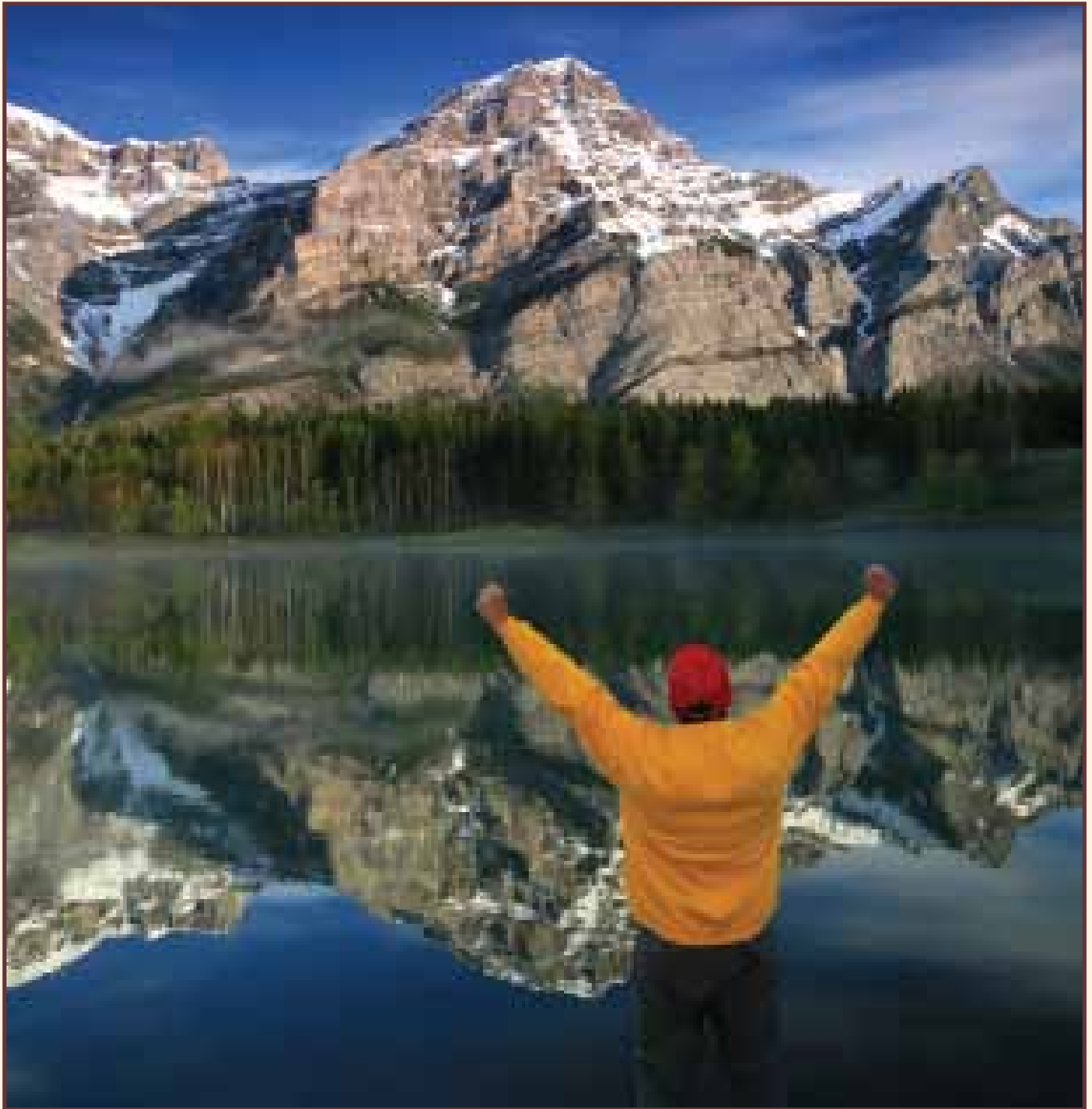
Check out Premera’s website via The Nelson Trust benefits portal or log on at www.premera.com. You can access the following tools:

- Find a Doctor—search for a physician or other provider in your plan’s network
- Using Your Health Plan—find information on provider networks and benefits
- Staying Healthy—learn about diseases, medications, treatments, nutrition, fitness and more
- Discounts—special values and discount offers for eyewear, hearing aids and more
- Member Forms—download and print forms on demand
- My Plan Information—check eligibility, view and update personal information, order ID cards and review benefit information
- Claim Center—check on the status and details of your claims
- Health Helpers—
 - Find easy-to-understand information about your condition or recommended procedure
 - View comparison data on hospitals
 - Estimate the costs of specific services
- Medical Library—
 - Access an online medical encyclopedia

QUICK REFERENCE GUIDE

This handy reference provides a snapshot of services available to you. If more than one channel is available for the service you need, simply pick the easiest.

Service	The Nelson Trust Benefits Portal www.nelson.aibpa.com Virtually 24 hours/ day 7 days/week	Trust Administrator's Office 503-222-7696 800-811-8853 8:30 a.m.– 5:00 p.m. PT	Your Employer	Local Lodge Office	Premera Website www.premera.com Virtually 24 hours/day 7 days/week	Premera Customer Service 800-722-1471 8:00 a.m. to 5:00 p.m. PT weekdays TDD: 800-842-5357
Access and print forms	✓	✓		✓	✓	
Review your benefit plans and dependent information	✓	✓			✓	✓
Check the status of a medical claim	✓				✓	✓
Request replacement ID cards	✓	✓			✓	✓
Search for medical service providers	✓				✓	✓
Review plan documents and booklets	✓	✓				
Change your address	✓	✓		✓		
Update your dependent information		✓				
Report life events and change coverage as permitted (birth of a child, marriage, divorce)		✓				
Report a disability claim		✓	✓			



This benefit guide is a summary of the benefits and provisions available through The Nelson Trust Health and Welfare plans. If there is a discrepancy between this guide and the official plan documents or insurance policies, the plan documents or insurance policies will govern plan provisions and how benefits are paid. The Trustees reserve the right to make any changes in the plan that they deem necessary including benefit and eligibility changes, termination of all, or a portion of, the coverages, or to require or change monthly employee contributions.

IMPORTANT CONTACT INFORMATION

For questions about ...	Contact ...	Websites and Phone Numbers
Trust Administration Life and Accidental Death and Dismemberment (AD&D) Insurance Accident and Sickness Weekly Indemnity (A&S)	A&I Benefit Plan Administrators, Inc. 1220 S.W. Morrison Street, Suite 300 Portland, OR 97205-2222	www.nelson.aibpa.com 503-222-7696 800-811-8853 Fax: 503-228-0149
Medical	Premera Blue Cross P. O. Box 91059 – MS 143 Seattle, WA 98111-9159 Group # 1035171 Provider Locator Anti-Fraud Hotline	www.premera.com 800-722-1471 8:00 a.m. to 5:00 p.m. PT weekdays TDD: 800-842-5357 BlueCard WA and AK: 800-722-1471 Nationwide: 800-810-2583 Outside the U.S. call collect: 804-673-1177 800-848-0244
Prescription Drug	Medco Health Solutions, Inc. Member Services Medco by Mail	www.medco.com 800-309-7139 TTY: 800-759-1089 800-309-7139
Specialty Care Pharmacy	Accredo Health Group	800-309-7139
Dental	Oregon Dental Services (ODS) 601 S.W. Second Avenue Portland, OR 97204-3156 Group #10004450 Spanish Dental Customer Service (Servicio al Cliente Area Dental)	www.odscpanies.com/members 503-265-5680 877-277-7280 TDD/TTY: 800-433-6313 503-265-2963 877-299-9063 (llamado gratis)
Vision	Vision Service Plan (VSP) P.O. Box 997105 Sacramento, CA 95899-7100	www.vsp.com 800-877-7195
California State Disability Insurance (SDI) Benefits (for California employees)	EDD, Disability Insurance P.O. Box 13140 Sacramento, CA 95813-3140	www.edd.ca.gov/direp/dirq2501.htm 800-480-3287 (English) 866-658-8846 (Spanish) TTY (teletypewriter for deaf, hearing-impaired and speech-impaired persons only) 800-563-2441
Travel Assistance Benefit	Regence Life/MEDEX	http://www.regencelife.com/Brochure_final.pdf

Note: No participating employer, employer association or labor organization, or any of their employees, are authorized to answer questions concerning the Trust fund and the plan. Please direct all inquiries to the Trust Administrator's office and insert the employee's identification number on all correspondence.