


# Fairbanks North Star Borough School District

## HEALTH BENEFIT PLAN

**EFFECTIVE January 1, 2027**

**FAIRBANKS NORTH STAR BOROUGH SCHOOL DISTRICT**

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## DIRECTORY

**Health Plan Number: P62**

**Plan Fiduciaries**

Fairbanks North Star Borough Mayor & Fairbanks North Star Borough School District Superintendent

**Claims Office (Eligibility, Claim Processing & Travel Pre-Authorization)**

Welfare & Pension Administration Service, Inc. (WPAS)
PO Box 34840
Seattle, WA 98124-1840
(800) 331-6158 (press option 8)
www.fnsbandsd.com

*Note: When contacting the Claims Office regarding a payment, please be able to give the claims examiner the member's social security number or member's Participant ID number, name of patient, Health Provider's name and date of service. In addition, the name and telephone extension of the claims examiner who processed the claim is printed on the Explanation of Benefits.*

**Nationwide Preferred Provider Network: Aetna. www.aetna.com**

Select the "Aetna Choice® POS II (Open Access)" network or log in to the Aetna Navigator website.

*Note: It is important for you to confirm with your Health Provider that he or she is in-network prior to receiving services. When confirming, be sure to state the name of this plan.*

**Coalition Health Center:**

570 Riverstone Way, # 3
Fairbanks, AK 99709
(907) 450-3300
www.coalitionhealthcenter.com

**Teladoc:** 800-TEL-ADOC ((800) 835-2362) www.Teladoc.com

**24-Hour Nurseline Access:** (800) 556-1555**,** 24-hour

**Surgical Travel Benefit & SWORD Virtual Physical Therapy Benefit**

Transcarent
(844) 249-8108
www.transcarent.com
Company code FNSB2

**Anchorage/Mat-Su Preferred Provider (PPO) Facilities**

Alaska Regional Hospital
2801 DeBarr Road
Anchorage, AK 99508
(907) 276-1131
www.alaskaregional.com

Surgery Center of Anchorage
4001 Laurel Street, Suite A
Anchorage, AK 99508
(907)563-1800
www.surgerycenterofanchorage.com

Mat-Su Regional Medical Center
2500 S Woodworth Loop
Palmer, AK 99645
(907) 861-6000
www.matsuregional.com

Alaska Surgery Center
1230 Northway Drive
Anchorage, AK 99508
(907) 550-6100
www.aksurgery.com

Alpine Surgery Center
3801 Lake Otis Parkway, Suite 100
Anchorage, AK 99508
(907) 563-1555
www.alpinesurgery.com

**Fairbanks PPO Facilities**

Providers in the Aetna network, including but not limited to Fairbanks Memorial Hospital and the Surgery Center of Fairbanks.

**Utilization Review (Hospital Admission & Precertification):**

Aetna. Your provider may precertify benefits on your behalf.

**Hospital Accreditation Outside the US**

The Joint Commission International
www.jointcommissioninternational.org/JCI-Accredited-Organizations/

**Vision Network Service Provider**

Vision Service Plan (VSP)
PO Box 997105
Sacramento, CA 95899-7105
(800) 877-7195
www.vsp.com

**Pharmacy Network Services (Retail & Mail Order Prescription Drug Services)**

CVS Caremark
(866) 818-6911
www.caremark.com

**Other Contacts**

FNSB & SD Risk Management
PO Box 71267
Fairbanks AK 99707
(907) 459-1344
Fax (907) 459-1187

FNSBSD Human Resources
520 Fifth Ave
Fairbanks AK 99701
(907) 452-2000 x11311
Fax (907) 451-6008

FNSBSD Payroll
520 Fifth Ave
Fairbanks AK 99701
(907) 452-2000 x11320
Fax (907) 452-3567

American Fidelity
Tracy Fannin
866-576-0201
tracy.fannin@americanfidelity.com
https://americanfidelity.com

## IMPORTANT INFORMATION ABOUT THIS PLAN

This is a Self-Funded "public plan" and is not regulated by ERISA (Employee Retirement Income Security Act). The plan Sponsor reserves the right to amend or terminate the plan, subject to the provisions of applicable Collective Bargaining Agreements.

**Employer Identification Number:**

EIN: 92-6000096

**Type of Administration:**

Medical, Rx, Dental, Vision, Audio: Plan Document (Self-Funded)

**Plan Administrator:**

Fairbanks North Star Borough (Risk Management)
PO Box 71267
Fairbanks, AK 99707-1267
Telephone: (907) 459-1344
Fax: (907) 459-1187

**Plan Sponsor:**

Fairbanks North Star Borough School District
520 Fifth Ave
Fairbanks, AK 99701
Telephone: (907) 452-2000
Fax: (907) 451-6160

**Agent for Legal Service:**

Fairbanks North Star Borough (Mayor)
PO Box 71267
Fairbanks, AK 99707-1267
Telephone: (907) 459-1344
Fax: (907) 459-1187

**Type of Participants Eligible under the Plan:**

All Regular employees of the Fairbanks North Star Borough School District, provided they are Eligible Employees or Dependents as defined in this plan book.

**Sources and Methods of Contributions to the Plan:**

Employees who are covered by the plan are required to make a contribution for health benefits coverage. Employee contributions are negotiated through the collective bargaining process, if applicable. Contact your Union or the School District Human Resources Department for further details.

**Plan Year**

January 1 through December 31

**Ending Date of the Plan's Fiscal Year:**

June 30

If you have any questions about the plan, please contact the Plan Administrator.

## SCHEDULE OF BENEFITS

The Schedule of Benefits is a brief overview. Read the specific benefit sections for additional information regarding coverage, limitations and restrictions.

All covered expenses are subject to the Deductible and paid according to the Reimbursement Percentage, unless otherwise noted.

Only expenses that are Usual, Customary & Reasonable (UCR) for the service provided in the locale where the expenses are incurred are covered.

By accepting benefits under the plan, the Participant consents to all of the terms and conditions of the plan, including but not limited to personal jurisdiction, venue, choice of law, and subrogation/recovery.

*Note: Medical benefits are available only if the employee is enrolled in the Medical plan*

## Medical Benefit Summary

Treatment must be considered Medically Necessary for benefits to be paid.

| Plan Design | Medical Plan B | Medical Plan C |
|---|---|---|
| **Calendar Year Deductible** | $2,500 for single employee, $5,000 for Family. | $3,000 per Participant, maximum $6,000 per Family.<br>$3,000 Common Accident Deductible. |
| **Plan's Reimbursement Percentage** | The Plan pays 80% of Allowable Charges until the Out-of-Pocket Limit is reached. Your Coinsurance is 20%. The Plan pays 100% of the Allowable Charges thereafter, for the remainder of the Calendar Year.<br>Within Alaska: The Plan's Reimbursement Percentage at non-PPO facilities is 60% of Allowable Charges until the non-PPO Out-of-Pocket Limit is reached. Your Coinsurance is 40%. The Plan pays 100% of the Allowable Charges thereafter, for the remainder of the Calendar Year.<br>Outside Alaska: The Plan's Reimbursement Percentage at non-PPO providers (facilities and all other providers) is 60% of Allowable Charges until the non-PPO Out-of-Pocket Limit is reached. Your Coinsurance is 40%. The Plan pays 100% of the Allowable Charges thereafter, for the remainder of the Calendar Year. | |
| **Out-of-Pocket Limit** (does not include the Deductible) | $2,000 per Participant,<br>$8,000 per Family,<br>(*includes prescription drugs*).<br>Non-PPO: the Out-of-Pocket Limit is doubled, but not to exceed federal HDHP Out-of-Pocket Maximum Limits. | $2,000 per Participant,<br>$4,000 per Family,<br>(*does not include prescription drugs*).<br>Non-PPO: the Out-of-Pocket Limit is doubled. |
| **Prescription Benefit**<br>RX Out-of-Pocket Maximum | Not applicable. | $1,500 per Individual and $3,000 per Family per Calendar Year |

| Plan Design | Medical Plan B | Medical Plan C |
|---|---|---|
| Participating Retail Pharmacy<br>Your Copay:<br>Generic:<br><br>Preferred Brand Name:<br><br>Non-Preferred Brand Name:<br><br>Specialty Medications: | Up to a 30-day supply allowed.<br><br>Covered under Medical Benefit. Subject to Medical Deductible, Reimbursement Percentage and Out-of-Pocket Limit. | Up to a 30-day supply allowed.<br><br>$5<br><br>$30 + 15% of Allowable Charges[1]<br><br>$60 + 20% of Allowable Charges[1]<br><br>Not Covered |
| Participating Mail-Order Pharmacy<br>Your Copay:<br>Generic:<br><br>Preferred Brand Name:<br><br>Non-Preferred Brand Name:<br><br>Specialty Medications: | Up to a 90-day supply allowed.<br><br>Covered under Medical Benefit. Subject to Medical Deductible, Reimbursement Percentage and Out-of-Pocket Limit. Specialty medications will be limited to a 30-day supply. | Up to a 90-day supply allowed.<br><br>$0<br><br>$60 + 15% of Allowable Charges[1]<br><br>$100 + 20% of Allowable Charges[1]<br><br>30% of Allowable Charges if not enrolled in CVS Specialty with the Prudent Rx Program. Must use CVS Specialty Pharmacy and if enrolled in Prudent Rx $0 copay. Once the annual Specialty Rx Out-Of-Pocket Maximum is reached, 100% thereafter for the remainder of the Calendar Year. Up to a 30-day supply allowed. |
| Non-Participating Pharmacy<br>Your coinsurance<br>Generic:<br><br>Brand Name: | Up to a 30-day supply allowed.<br><br>Covered under Medical Benefit. Subject to Medical Deductible, Reimbursement Percentage and Out-of-Pocket Limit. | Up to a 30-day supply allowed; RX Out-of-Pocket Maximum does not apply.<br><br>40% of Allowable Charges.<br><br>40% of Allowable Charges. |
| **Preventive Benefit** | Paid at 100% of Allowable Charges. Not subject to Deductible.<br>PPO provisions apply. | |
| **Hospital Room & Board**<br>(semi-private and intensive care) room rates, for the first 365 days of confinement. | Subject to Deductible and Coinsurance. PPO provisions apply. | |
| **Extended Care or Skilled Nursing Facility** | Paid at the semi-private room daily rate, up to 90 days per Calendar Year. Subject to Deductible and Coinsurance. PPO provisions apply. | |

| Plan Design | Medical Plan B | Medical Plan C |
|---|---|---|
| [1] If you choose a brand-name medication when a generic equivalent is available, you will pay the difference in cost between the brand name and the generic, plus your brand name Copay. This provision will apply whether the brand is requested by you or by your doctor. The Copay will apply to the RX Out-of-Pocket Maximum. The difference in cost between the brand name and generic will not apply to the RX Out-of-Pocket Maximum. | | |
| **Chiropractic Services** | Limited to 24 visits per Participant per Calendar Year. Subject to Deductible and Coinsurance. *Services beyond the annual limit are **not** covered by the Plan regardless of medical necessity*. | |
| **Acupuncture Services** | Limited to 12 visits per Participant per Calendar Year. Subject to Deductible and Coinsurance. Services beyond the annual limit are not covered by the Plan regardless of medical necessity. | |
| **Dialysis Treatment - Outpatient** | Paid at 80% of the Usual and Reasonable Charge for Outpatient Dialysis Treatment until the Out of Pocket limit is reached. Paid at 100% of the Usual and Reasonable Charge for Outpatient Dialysis Treatment thereafter for the remainder of the Calendar Year | |
| **Outpatient Occupational, Speech & Hearing Therapy** | Limited to a total of 24 visits per Participant per Calendar Year for any combination of Occupational, Speech and/or Hearing Therapy. Subject to Deductible and Coinsurance. Services beyond the annual limit are not covered by the Plan regardless of medical necessity. | |
| **Pre-Admission Testing** | Paid at 100% of Allowable Charge, subject to the Deductible. | |
| **Second & Third Surgical Opinions** | Paid at 100% of Allowable Charges, subject to the Deductible | Paid at 100% of Allowable Charges, not subject to the Deductible |
| **Diagnostic Testing for Second & Third Surgical Opinions** | Subject to Deductible and Coinsurance. | |
| **Teladoc consultations** | $5 Copay<br>Not subject to Deductible | $5 Copay<br>Not subject to Deductible |
| **Surgery using the Transcarent program** | Subject to Deductible<br>Paid at 100% of Allowable Charges,.<br>See Transcarent Medical Surgery Benefit for travel benefits. | Not subject to Deductible<br>Paid at 100% of Allowable Charges<br>See Transcarent Medical Surgery Benefit for travel benefits |
| **SWORD offered by Transcarent**<br>**Virtual Physical Therapy** | $0 Copay.<br>Not subject to Deductible | $0 Copay.<br>Not subject to Deductible |

| Plan Design | Medical Plan B | Medical Plan C |
|---|---|---|
| **Coalition Health Center (CHC) Services** | No CHC access | $0 Copay for Preventive Services<br>$10 Copay per visit |

Plan B may include an employer contribution to the Health Savings Account (HSA) if the employee elects to participate in the HSA, subject to the employee's collective bargaining agreement.

Plan C shall include an employer contribution to a Health Reimbursement Arrangement (HRA) subject to the employee's collective bargaining agreement.

**Deductible**

The Deductible is the amount you pay for Allowable Charges each Calendar Year before the plan starts to pay benefits. The Deductible does not apply toward the Out-of-Pocket Limit. If an individual has an ongoing medical condition, the Deductible will still have to be met in the new Calendar Year.

Plan B

For Plan B, the Deductible is $2,500 for a single employee, and $5,000 for a family. Following are examples of how the Deductible in Plan B works:

- If only the employee is covered, the medical Deductible is $2,500 for the employee.
- If the employee and one or more Dependents are covered (spouse or children), the medical Deductible applied to the family is $5,000. No benefits will be paid until the family Deductible is met. There is no individual Deductible applied to each family member.

*Note: The Common Accident Deductible provision does not apply to Plan B.*

Plan C

For Plan C, the Deductible is $3,000 per person, with a maximum Deductible of $6,000 for a family. Following are examples of how the Deductible in Plan C works:

- If only the employee is covered, the medical Deductible is $3,000 for the employee.
- If the employee and one or more Dependents are covered (spouse or child), the maximum medical Deductible applied to the family is $6,000, which is the $3,000 Deductible applied to each person up to the family maximum.
- If the employee and two or more Dependents are covered (spouse or children), the maximum medical Deductible applied to the family is $6,000, which is no more than a $3,000 Deductible applied to each person.

If one covered individual has met the $3,000 medical Deductible, additional charges that individual incurs can never be applied against any unmet Deductibles for other covered family members.

When two or more persons in the same family are injured in the same accident, Allowable Charges for all treatment or service that results from the injuries may be combined, if doing so would result in higher benefit payment. In such cases, the injured persons' individual Deductibles for the Calendar Year in which the accident occurs will be replaced with a Common Accident Deductible. This Common Accident Deductible will be $3,000 of Allowable Charges for all combined treatment or service received by the injured persons during each Calendar Year.

However, this Common Accident Deductible will apply only to treatment or service resulting from the accident. For any other sickness or other injury, you and each of your Dependents must satisfy the Deductible in the normal manner before benefits will be payable under the medical benefit plan.

**Out-of-Pocket Limit**

Plan B

Unless stated otherwise, for Plan B, after the Deductible, the plan pays 80% of Allowable Charges until the $2,000 Out-of-Pocket Limit is met for an individual or until the $8,000 Out-of-Pocket Limit is reached for the family. The plan pays 100% of Allowable Charges thereafter. This does include prescription drug charges. This does not include audio, dental, or vision benefits.

Plan C

Unless stated otherwise, for Plan C, after the Deductible, the plan pays 80% of Allowable Charges until the $2,000 Out-of-Pocket Limit is met for an individual or until the $4,000 Out-of-Pocket Limit is reached for the family. The plan pays 100% of Allowable Charges thereafter. This does not include prescription drug charges, audio, dental or vision benefits.

## Dental Benefit Summary

*Note: Dental benefits are available only if the employee is enrolled in the Dental, Vision and Audio plan.*

**Calendar Year Deductible**

$ 50 per Participant, waived for preventive and diagnostic procedures.

**Reimbursement Percentage**

| | |
|---|---|
| Preventive and diagnostic procedures - | 100% of Allowable Charges. |
| Routine treatment and basic procedures - | 80% of Allowable Charges. |
| Major treatment procedures - | 50% of Allowable Charges. |

**Calendar Year Maximum**

$3,000 per Participant.

The dental plan does not utilize preferred providers. The patient is responsible for any charges which are above the Allowable Charge, or which are not paid by the dental plan.

## Vision Benefit Summary

*Note: Vision benefits are available only if the employee is enrolled in the Dental, Vision and Audio plan.*

**No Calendar Year Deductible**

- Vision benefits are administered by Vision Service Plan (VSP).
- A benefit differential will be applied depending on whether a VSP in-network or out-of network provider is utilized.

Benefits will be as follows:

| Services | Frequency | In-Network | Out-Of-Network |
|---|---|---|---|
| Comprehensive Well Vision Exam | Every Calendar Year | Covered in full | Covered up to $102 |
| Single Vision Lenses | Every Calendar Year | Covered in full | Covered up to $75 |
| Lined Bifocal Lenses | Every Calendar Year | Covered in full | Covered up to $100 |
| Lined Trifocal Lenses | Every Calendar Year | Covered in full | Covered up to $125 |
| Lenticular Lenses | Every Calendar Year | Covered in full | Covered up to $125 |
| Frames | Every 2 Calendar Years | Covered up to $120 | Covered up to $90 |
| Contact Lenses | Every Calendar Year | Covered up to $200 | Covered up to $185 |

The lens allowances for bifocals and trifocals are for lined lenses. Charges for lens options such as progressives, scratch-resistant coatings and anti-reflective coatings are not covered, but will be discounted when utilizing a VSP in-network provider.

## Audio (Hearing) Benefit Summary

*Note: Audio benefits are available only if the employee is enrolled in the Dental, Vision and Audio plan.*

**No Calendar Year Deductible**

Plan pays for exam and hearing aid devices:

- 80% of Allowable Charges up to a $600 benefit for each ear, and
- 50% of the remaining Allowable Charges up to a $2,500 maximum total benefit for each ear.

Note: Exam covered only if hearing device is prescribed and purchased.

**Maximum benefit in any consecutive 3-year period - $2,500 per ear.**

## SPECIAL BENEFIT PROGRAMS

### Transcarent Medical Surgical Benefit

The Transcarent Surgery Benefit Management Program provides assistance to Plan Members and their Covered Dependents ("Covered Persons") when a non-emergency surgery covered under the primary plan has been recommended. Please note that this benefit is only available when the Health Plan pays primary.

You should contact Transcarent for information about the program if you or your dependents have planned major surgeries such as:

- Hip surgery.
- Knee surgery.
- Shoulder surgery.
- Back surgery.
- Heart surgery.
- Women's health surgery.
- General surgery.

When a Transcarent surgical provider is elected, you will be assigned a care coordinator who will:

- Assist with requesting medical records for Transcarent surgery provider review.
- Assist with selecting a Transcarent in-network provider.
- Schedule surgery and provide pre-operative information.
- Assist with applicable travel and lodging accommodations.

Upon acceptance of your case, the following enhanced plan provisions will apply when you utilize Transcarent network providers:

- Deductible and coinsurance is waived for Plan C. For Plan B, Transcarent is responsible for verifying your deductible and arranging payment of your deductible to Transcarent.
- Benefits are paid at 100% of Allowable Charges for Plans B and C.
- Travel expenses are covered when a Transcarent Provider is not available within 100 miles from Member's home and if the travel and lodging is arranged by a Transcarent Care Coordinator. The plan covers expenses for travel and lodging for the patient and one companion as follows:
    - Transportation for the patient and one companion who is traveling on the same day(s) to and/or from the site of treatment for a surgical episode of care which typically includes a pre-operative evaluation, the surgical procedure and necessary post-operative follow-up. Reasonable transportation expenses include:
        - Airfare at coach rate (1st class as an exception only if medically necessary, and must be determined or recommended by provider).
        - Taxi or ground transportation.
        - Mileage reimbursement at the IRS medical rate for the most direct route between the patient's home and the Transcarent designated facility.
    - Lodging: One-room accommodation at a Transcarent-approved hotel for the surgical episode.
    - Incidental Expense Benefit: Provides $50 per day to cover incidental expenses for the patient while not admitted to the hospital and $50 per day for one companion. Incidental expense benefits are limited to the surgical episode days.

## Transcarent/SWORD Benefit

Plan members can receive physical therapy services virtually from the comfort of their home through the SWORD Physical Therapy benefit. There is no cost to members.

SWORD provides virtual physical therapy for all the major musculoskeletal issues, at any point in the journey: prevention, acute conditions, chronic pain and post-surgical recovery.

Plan members will be matched with a Doctor of Physical Therapy (DPT) who will create their personalized program and work with them every step of the way. A Digital Therapist tracks the members progress and corrects form in real time, so members get better, faster.

Deductible and coinsurance is waived for both plans. Note: This benefit is only available when the FNSBSD Health Plan pays primary.

## Coalition Health Center (CHC)

Fairbanks North Star Borough School District has contracted with the Coalition Health Center (CHC) to provide primary care to you and your dependents over age 2. Use of the CHC is voluntary. You are not required to obtain services through the CHC.

The CHC is staffed by professional health care providers, such as fully qualified nurse practitioners and physician assistants, who offer:

- Routine Care: Get treatment for an illness or injury (and referral to a specialist when needed).
- Preventive Care: Get routine exams and preventive tests, children's wellness visits, annual physicals, immunizations and lab tests.
- Urgent Care: Walk-in for help with urgent, but not life-threatening situations, such as cuts that need stitches, broken bones and serious illnesses.
- Health Management: Get help managing your chronic health conditions and improving your overall health.
- Pharmacy: The CHC can fill many prescriptions for conditions that are being treated there. This saves you a trip to the pharmacy and you don't have to pay a copay for generics. The CHC cannot fill prescriptions that are prescribed by other physicians.

**Appointments**

Call the CHC or complete an online contact form to schedule an appointment. Same day appointments or walk-in visits may be available for acute injury or illness.

Be sure to inform the clinic 24 hours in advance if you need to cancel your appointment. If you fail to cancel an appointment timely, the health plan will incur an expense for your visit. Chronic "no-shows" will lose the ability to schedule appointments.

CHC program co-payments will not be applied against any individual or family deductibles under the regular health plan, but may be reimbursed through a flexible spending account, or health reimbursement arrangement (HRA).

If you fail to appear for an appointment or if you cancel an appointment with less than 24 hours' notice, you may be assessed a $75 "no show" penalty. The "no show" penalty will not be applied to your deductible or out-of-pocket limit.

**Services NOT Covered by the CHC Clinic Program**

The following services are not covered by the CHC Program:

- Treatment by a Medical Doctor. The Physician's Assistant or Nurse Practitioner may make referrals to a Medical Doctor.
- Treatment of infants and children under 2 years of age.
- Lab tests, X-rays or medical supplies not prescribed as a result of the CHC Program visit.
- Treatment of patients who are not medically stable.
- Treatment of work-related injury or illness.

## Teladoc Consultations

The plan will cover a Teladoc phone or video consultation with a licensed provider. Teladoc provides access to a national network of board-certified doctors, mental health specialists and pediatricians in the U.S. who are available on-demand 24 hours a day, 7 days a week, 365 days a year to diagnose, treat and prescribe medication when necessary via phone, Teladoc application or online video consultations.

The plan will cover a Teladoc phone or video consultation with a licensed provider.

- For non-emergency medical care: Teladoc provides access to a national network of board-certified doctors and pediatricians in the U.S. who are available on-demand 24 hours a day, 7 days a week, 365 days a year to diagnose, treat and prescribe medication when necessary via phone or online video consultations.
- For dermatology services. A licensed dermatologist will consult with you to diagnose and treat skin-related conditions.
- For mental health care. You can schedule an appointment with a licensed psychiatrist or therapist for video visits, 7 days a week from 7am – 9pm. (Note: psychiatry appointments are available for participants age 18 and over. Therapist services are available for participants starting at age 13.)

## Wellness Benefits And Programs

The Plan may include wellness benefits or programs, including but not limited to wellness assessments, smoking cessation programs, weight loss or nutrition programs, health fairs, and seminars. Wellness benefits or programs may focus on specific medical conditions or may promote general health. Wellness benefits or programs may be offered on a one-time, limited or ongoing basis.

If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, call Human Resources at (907) 452-2000 and we will work with you to develop another way to qualify for the reward.

Plan coverage for a wellness benefit or program will be determined at the time a benefit or program is implemented, and will be communicated to plan participants at that time.

The program is offered at no cost to you. It is voluntary and confidential.

# IMPORTANT PLAN PROVISIONS

## Preferred Provider Provisions

**Preferred Provider (PPO) Provisions**
The plan has contracted with the following Preferred Providers:

- Alaska Regional Hospital, Alaska Surgery Center, Alpine Surgery Center, and the Surgery Center of Anchorage in Anchorage are the Preferred Provider (PPO) Facilities for Inpatient and Outpatient services obtained in the Municipality of Anchorage, Alaska.
- Mat-Su Regional Medical Center is the Preferred Provider (PPO) Facility for services obtained in the Mat-Su Borough, Alaska.
- Aetna is the nationwide network of Preferred Providers (PPO), including facilities and other Health Providers. In some cases, Aetna may use another network (such as Beech Street) to provide discounts for providers who are not in the Aetna network.

Non-PPO penalties will apply:

- In Alaska, if you use a non-PPO facility, and
- Outside Alaska, if you use a non-PPO facility or any other non-PPO provider.

The non-PPO penalties are:

- Services are reimbursed at 60% of the Allowable Charges, and
- The annual out-of-pocket maximum is doubled.

Non-PPO penalties are not assessed for:

- Services unavailable at a PPO facility.
- Emergency services at a non-PPO emergency facility. Once the patient is medically stable, he/she should be moved to a PPO facility. Services obtained at a non-PPO facility after the patient is stable for transfer are subject to non-PPO penalties.
- Services incurred outside the United States.

The plan uses the Aetna PPO network for services in Fairbanks.

Within the Municipality of Anchorage Only
Alaska Regional Hospital, Alaska Surgery Center, Alpine Surgery Center, and the Surgery Center of Anchorage are the only PPO Facilities for Inpatient and Outpatient services obtained in the Municipality of Anchorage. (PPO facilities within the Aetna network in Anchorage other than Alaska Regional Hospital, Alaska Surgery Center, Alpine Surgery Center, and the Surgery Center of Anchorage are considered non-PPO facilities.) If you use a facility other than Alaska Regional Hospital, Alaska Surgery Cetner, Alpine Surgery Center, or the Surgery Center of Anchorage for Inpatient or Outpatient services:

- The non-PPO penalties described above will apply.
- The Allowable Charges at a non-PPO facility in the Municipality of Anchorage for Inpatient services will be limited to the contracted rate at Alaska Regional Hospital. The Allowable Charges for Outpatient services at a non-PPO provider in the Municipality of Anchorage will be the case rate at Alaska Regional Hospital, if any, or 50% of the billed charges if no case rate is available. Examples of common Outpatient procedures include: Outpatient surgery and procedures, ultrasound, lab and diagnostic x-ray tests, MRIs and CT scans. This section may not apply for outpatient dialysis treatment. Please see the section on Dialysis Treatment - Outpatient for more information on such providers.

Within the Municipality of Anchorage, no non-PPO penalties are assessed for:

- Services unavailable at a PPO facility, or
- Services performed in a doctor's office, with doctor's staff, and the doctor's equipment, or

- Emergency services at a non-PPO emergency facility. Once the patient is medically stable, he/she should be moved to a PPO facility. Services obtained at a non-PPO facility after the patient is stable for transfer are subject to non-PPO penalties.

**Emergency Room Penalty**

An additional penalty of $500 is applied to each emergency room visit that occurs during the hours of operation of the Coalition Health Center. This penalty is not applied:

- in the case of an Emergency, or if a reasonable person could consider the situation an Emergency. An Emergency is a medical condition that is life-threatening and requires immediate treatment at a medical facility. The Attending Physician must certify that the condition was life threatening.
- if the Participant is admitted to the Hospital as a bed patient, or
- if the Participant is taken to the emergency room by a third party, who is not a member of the Participant's Immediate Family.

The Emergency Room Penalty does not apply to the Deductible or the Out-of-Pocket Limit.

## Utilization Review (Precertification)

In order to provide cost effective health coverage, the Plan requires precertification of:

- Inpatient Hospital admission,
- Inpatient surgical procedure performed in a Hospital or surgical facility,
- Inpatient mental health or alcoholism treatment, or
- Certain outpatient procedures *see*: https://www.aetna.com/health-care-professionals/precertification/precertification-lists.html.

The Utilization Review Provider must be contacted before Inpatient treatment begins. In the case of an Emergency admission your healthcare provider must contact the Utilization Review Provider within 48 hours or as soon as reasonably possible. The Utilization Review Provider will determine:

- the Medical Necessity of the treatment,
- the appropriate location for the treatment to be provided, and
- the number of days allowed for the Inpatient Hospital stay.

Services that are not certified by the Utilization Review Provider will not be considered Allowable Charges by this plan.

All inpatient and outpatient procedures, regardless of precertification, remain subject to the provisions of this plan, including but not limited to medically necessary treatment and Usual, Reasonable, and Customary charges.

**Penalty for not contacting the Utilization Review Provider**

The plan requires your health care provider to pre-certify the services you receive while an inpatient at a hospital or treatment facility. Your provider must contact the Utilization Review provider prior to admission. In the case of an emergency admission, contact the Utilization Review provider within 48 hours or as soon as reasonably possible. If Utilization Review is not contacted:

- The plan will not pay the first $250 of Allowable Charges for Hospital and or Inpatient surgery expenses.
- Thereafter, the Hospital and/or Inpatient surgery expenses will be paid at the lesser of 70% of Allowable Charges, or the Plan's Reimbursement Percentage, until the maximum penalty totals $1,000.
- Remaining Allowable Charges will be paid according to the Plan's Reimbursement Percentage.
- This penalty will not be applied to the Deductible or Out-of-Pocket Limit.

- This penalty is waived for maternity and newborn care for 48 hours following vaginal delivery or 96 hours following cesarean section. If the hospital stay exceeds these timeframes, Utilization Review procedures must be followed or penalties could apply.

Precertification is not required when this plan is the secondary payor.

## MEDICAL BENEFITS

Treatment must be considered Medically Necessary for benefits to be paid.

Only expenses that are Usual, Customary & Reasonable for the service provided in the locale where the expenses are incurred are covered.

Benefits may not cover the total cost of medical care services and supplies.

All Allowable Charges are subject to the Calendar Year Deductible and paid according to the Reimbursement Percentage, unless otherwise noted in the Schedule of Benefits.

Charges in excess of the Allowable Charges, as determined by the plan will not be paid by the plan, and will not apply to your Deductible or Out-of-Pocket limit.

Benefits will only be considered for treatment or services received after coverage begins and completed before coverage ends.

### Covered Expenses

The medical expenses listed below are covered by the plan. Some expenses have limited benefit coverage or restrictions. Please review the detailed information following this section and the Schedule of Benefits. Call the Claims Office if you have a question.

- Acupuncture and acupressure treatment.
- Anesthesia.
- Blood transfusions.
- Breast reconstruction following a mastectomy.
- Cervical collar, head halter or other traction apparatus.
- Chiropractic care.
- Cochlear implants.
- Colostomy bag, ileostomy supplies and catheters.
- Certain dental surgery procedures (example: accidental injury to the jaw & teeth).
- Gender dysphoria treatment, including Medically Necessary surgery and related treatment for gender reassignment.
- Health Provider fees (Must be a state-licensed Health Provider acting within the scope of his or her license, and the service or supply received must be covered under this plan).
- Hospital extras (Medically Necessary services and supplies other than room & board).
- Human-to-human organ and/or tissue transplant costs for confinement, treatment, service and materials (including charges for organ and/or tissue procurement) for the following:
    - heart, liver and kidney transplants,
    - cornea transplants,
    - skin transplants,
    - bone marrow transplants,
    - heart-lung transplants,
    - stem cell transplants, and
    - pancreas transplants.
- Infertility diagnostic procedures, prescriptions and Health Provider fees.
- Insulin, insulin syringe and clinitest.
- Massage therapy.

- Medical supplies dispensed by a covered Health Provider (excluding convenience items dispensed by an Outpatient pharmacy; example: bandages).
- Mental health treatment.
- Occupational therapy and speech therapy (Inpatient & Outpatient). The number of visits is limited. Refer to the Schedule of Benefits for more information.
- Oxygen.
- Physical therapy.
- Prescription birth control devices and medical services necessary to obtain the prescribed devices.
- Prescription drugs (review detailed information in Prescription Drugs and Medicines).
- Prostheses.
- Rental of wheelchair, bed rail, and hospital bed.
- Splints, orthopedic braces, casts, crutches, orthotics.
- Sterilization procedures (for example: vasectomy, tubal ligation).
- Telephone calls and consultations charged by a Health Provider.
- Travel expenses (review detailed information on travel benefits).
- X-ray, radium and radioactive isotope therapy.
- X-rays and lab tests.

**ALCOHOLISM**

- Inpatient alcoholism treatment must be provided in a regular Hospital or in a state-licensed alcoholism treatment facility.
- Outpatient Treatment services must be provided by a state-licensed Health Provider.
- Confinement for Custodial Care is not covered.

**BREAST RECONSTRUCTION**

The following will be considered covered expenses if received in connection with a mastectomy:

- reconstruction of the breast on which the mastectomy was performed,
- surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

**CLINICAL TRIALS**

Although the plan does not cover services provided as part of a clinical trial, the plan will not:

- deny a qualified individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition;
- deny, limit, or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the trial; or
- discriminate against the individual on the basis of the individual's participation in the trial.

A "Qualified Individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the participant provides medical and scientific information establishing that their participation is appropriate.

An "Approved Clinical Trial" is defined as a Phase I, II, III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition or disease (or other condition described in ACA, such as federally funded trials, trials conducted under an investigational new drug application reviewed by the FDA or

drug trials exempt from having an investigational new drug application). A life-threatening condition is any disease from which the likelihood of death is probable unless the course of the disease is interrupted.

"Routine Patient Costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis.

**COLON AND RECTAL CANCER SCREENING**

Expenses for preventive colon and rectal cancer screening will be covered according to the American Cancer Society Guidelines. The most current guidelines can be found on www.cancer.org.

**DENTAL SERVICES – FACILITY FEES AND ANESTHESIA**

Under certain circumstances medical benefits are provided for the facility fees and anesthesia associated with Medically Necessary dental services covered under Dental Benefits if it is determined that the care is Medically Necessary to safeguard the health of the patient during performance of dental services and:

- the patient is a child (age 6 and under); or
- the patient exhibits physical, mental, or medically compromising conditions which do not allow dental treatment with local anesthesia in a dental provider's office.

Please note that the services must be performed in an outpatient facility and not in a dental office. In order to expedite claims processing, it is recommended that you obtain prior approval from the Claims Office before services are obtained.

**DIALYSIS TREATMENT - OUTPATIENT**

This Section describes the Plan's Dialysis Benefit Preservation Program (the "Dialysis Program"). The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Plan members and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

**Reasons for the Dialysis Program**

The Dialysis Program has been established for the following reasons:

- the concentration of dialysis providers in the market in which Plan members reside may allow such providers to exercise control over prices for dialysis-related products and services,
- the potential for discrimination by dialysis providers against the Plan because it is a non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Plan members,
- evidence of (i) significant inflation of the prices charged to Plan members by dialysis providers, (ii) the use of revenues from claims paid on behalf of Plan members to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of the Plan and other non-governmental and non-commercial plans by the dialysis providers as profit centers, and
- the fiduciary obligation to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to Plan members, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the Plan members' interests, such as subsidies for other plans and discriminatory profit-taking.

**Dialysis Program Components**

The components of the Dialysis Program are as follows:

- **Application** - The Dialysis Program shall apply to all claims filed by, or on behalf of, Plan members for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims").

- **Claims Affected** - The Dialysis Program shall apply to all dialysis-related claims received by the Plan and incurred on or after September 1, 2015, regardless when the initial claim for such products or services was received by the Plan with respect to the Plan member.
- **Mandated Cost Review** - All dialysis-related claims will be subject to cost review by the Plan to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the Plan shall consider factors including:
    - **Market concentration**: The Plan shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.
    - **Discrimination in charges**: The Plan shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.
- In the event that the Plan's charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been a material factors resulting in an increase of the charges for outpatient dialysis products and/or services for the dialysis-related claims under review, the Plan may, in its sole discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, the Plan may subject the claims and all future claims for outpatient dialysis goods and services from the same provider with respect to the Plan member, to the following payment limitations, under the following conditions:
    - Where the Plan deems it appropriate in order to minimize disruption and administrative burdens for the Plan member, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.
    - Where the provider is or has been a participating provider under a Preferred Provider Organization (PPO) available to the Plan's members, upon the Plan's determination that payment limitations should be implemented, the rate payable to such provider shall be subject to the limitations of this Section.
    - **Maximum Benefit** - The maximum Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.
    - **Usual and Reasonable Charge for Outpatient Dialysis Treatment** - With respect to dialysis-related claims, the Plan shall determine the Usual and Reasonable Charge for Outpatient Dialysis Treatment based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.
    - **Additional Information related to Value of Dialysis-Related Services and Supplies** - The Plan member, or where the right to Plan benefits has been properly assigned to the provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Plan, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Plan based upon credible information from identified sources. The Plan may, but is not required to, review additional information from third-party sources in making this determination.
    - All charges must be billed by a provider in accordance with generally accepted industry standards.
- **Provider Agreements** - Where appropriate, and a willing appropriate provider acceptable to the Plan member is available, the Plan may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this Section of the Plan and clearly state that such agreement is intended to supersede this Section.

- **Discretion –** The Plan Administrator shall have full authority and discretion to interpret, administer and apply this Section, to the greatest extent permitted by law.

**DURABLE MEDICAL EQUIPMENT**

- Must be prescribed by a Health Provider.
- Contact the Claims Office *before* renting or purchasing durable medical equipment.
- If the monthly rental charges for the prescribed period exceeds the purchase price, purchase of the equipment may be considered.
- Rental fees in excess of the purchase price are covered if the equipment cannot be purchased. Evidence that the equipment cannot be purchased must be submitted to the Claims Office.
- Examples of durable equipment: wheelchair, bed rail, hospital bed, head halters and other traction devices.
- All claims for durable medical equipment received from non-PPO providers located outside Alaska will be covered at the in-network/in-Alaska rate of 80% of Allowable Charges until the Out-of-Pocket limit is reached, thereafter coverage increases to 100%. This includes durable medical equipment dispensed by a treating physician post-surgery, and/or dispensed at discharge by a hospital.

**EXTENDED CARE OR SKILLED NURSING FACILITY**

Expenses will be covered only if:

- they are recommended by a Physician,
- they are not incurred for Custodial Care, and
- the confinement follows within 7 days after a 3-day confinement in a Hospital and is for the same condition.

**HAIR PROSTHESIS**

Expenses will be covered only if the hair prosthesis is required to correct hair loss from a covered injury or illness or treatment of a covered injury or illness.

The maximum allowance for this item and related services is $1,600 every 12 calendar months.

A maximum of one hair prosthesis is allowed every 12 calendar months.

**HOME HEALTH AND HOSPICE**

Home health care benefits are provided to allow you and/or your dependents an alternative to hospital confinement.

Hospice care benefits are provided for a terminally ill patient. Terminally ill means the person is determined by a physician to have a terminal sickness with no reasonable prospect of cure, and has a life expectancy of 6 months or less.

Benefits are provided for home health care and hospice care subject to the following conditions:

- The care must be prescribed by a physician.
- The service provider must be licensed by the state in which the services are rendered.
- The services must be in place of a covered confinement in a hospital or skilled nursing facility. Custodial care is not covered.
- The patient's physician must establish and periodically review a written treatment plan which describes the care to be provided.

**HOSPITAL ROOM AND BOARD**

- Covers semi-private, coronary care, and intensive care room rates.
- Covers the first 365 days of confinement.
- Includes Hospital extras you require while confined in the Hospital as a registered Inpatient.
- See the Important Plan Provisions information on preferred providers and utilization review requirements.

- For non-emergent or elective procedures outside the US, the Hospital in which the service is rendered must be accredited by the Joint Commission International. Website: http://jointcommissioninternational.org/JCI-Accredited-Organizations/

**MATERNITY BENEFITS & NEWBORN CARE DURING THE FIRST 7 DAYS OF LIFE**

- No less than 48 hours of Inpatient care for mother and newborn following a vaginal delivery or 96 hours following a cesarean section, unless the mother and Attending Physician agree to an earlier discharge.
- Routine nursery charges, initial newborn examination by a Physician and charges for circumcision.
- Physician services while in the Hospital during the birth confinement.
- No benefits will be provided to the child born to a Dependent child, unless the newborn qualifies as the employee's Dependent as an adopted child of the employee or the employee's child through legal guardianship.

**MENTAL HEALTH TREATMENT**

**Inpatient Mental Health Treatment**

- Inpatient mental health treatment must be provided in a regular Hospital or in a state-licensed psychiatric treatment facility.
- Confinement in a psychiatric Hospital for Custodial Care is not covered.

**Out-Patient Mental Health Treatment**

- Health Provider must be licensed to practice mental health medicine in the state where the services are received.

**OBESITY TREATMENT**

- **Non-Surgical** - expenses for medical supervision of weight reduction programs will be covered as any other medical condition when medically necessary.

  Covered services for medical supervision of weight reduction include:

  - Diagnostic Testing,
  - Office visits with a licensed Health Provider, and
  - Prescription medications.

  Services not covered include:

  - Health club or gym memberships,
  - Fitness equipment,
  - Weight reduction programs by organized vendors, or
  - Special diet food, vitamins, minerals, and nutritional supplements.

- **Surgical** - treatment of obesity (including gastric bypass surgery, gastric band surgery, gastroplasty or other gastric restrictive surgery) is covered if all medically necessary criteria are met, as established by the Utilization Review provider.

**PRESCRIPTION DRUGS AND MEDICINES**

**Plan B:**

Retail and mail order prescription drugs are covered under the medical benefit, subject to the medical Deductible and medical Out-of-Pocket limits. You may use any pharmacy, but your costs may be lower at pharmacies that participate in the prescription drug network. Participants are encouraged to utilize the prescription drug card at point of sale to obtain discounts on prescription drugs.

Prescription drugs dispensed in a Hospital or by a Health Provider are payable under the medical benefit, subject to the medical Deductible and the medical Out-of-Pocket limits.

**Plan C:**

Retail and mail order prescription drugs (RX) are covered under the prescription drug card program. You may use any pharmacy, but your cost will be lower at pharmacies that participate in the prescription drug network.

- Prescription drugs are not subject to the medical Deductible and medical Out-of-Pocket limits. A separate RX Out-of-Pocket Maximum limit applies.
- The Plan's Reimbursement will be the difference between the Allowable Charge and the Participant's Copay. Once the Participant's accumulated Copays for prescriptions purchased at Participating Pharmacies reach the RX Out-of-Pocket Maximum, the Plan's Reimbursement will increase to 100% of Allowable Charges for the remainder of the Calendar Year.
- If you choose a brand name medication when a generic equivalent is available, you will pay the difference in cost between the brand name and the generic, plus your brand name Copay. This provision will apply whether the brand is requested by you or your doctor. The Copay will apply to the RX Out-of-Pocket Maximum. The difference in cost between the brand name and generic will not apply to the RX Out-of-Pocket Maximum.
- Charges for prescription drugs obtained at non-participating pharmacies do not apply to the annual RX Out-of-Pocket Maximum.
- If there is no participating pharmacy in your area, prescriptions purchased at the non-participating pharmacy will be paid according to the reimbursement percentage for a participating retail pharmacy and any Copay is applied toward the out-of-pocket maximum for the prescription plan, provided the non-participating pharmacy is located 20 miles or more from the nearest participating pharmacy.
- Prescription drugs dispensed in a Hospital or by a Health Provider are payable under the medical benefit, subject to the medical Deductible and the medical Out-of-Pocket limits.

*Note: Coordination of Benefits does not occur.*

**Plans B and C:**

- Prescriptions must be prescribed by a licensed Health Provider and dispensed by a licensed medical facility or pharmacy.
- The maximum quantity covered is a 30-day supply at a retail pharmacy and a 90-day supply through the preferred mail order pharmacy. Specialty medications will be limited to a 30-day supply.
- Not more than a 90-day supply will be covered at any one time at mail order.
- Refills may be obtained once 66% of a prescription has been used up. This guideline can be waived if you are going on vacation, if you have a dosage change, or if you lose your medication. Contact Risk Management for more information.
- Mail order service includes shipping charges for prescriptions received by standard postal delivery. Participants have the option to elect 2nd Day or Next Day delivery at their own expense.
- Prescription contraceptive medications are covered.
- Prior authorization is required for prescription weight reduction medications. The Pharmacy Network Services provider will preauthorize prescription weight reduction medications.
    - Prior authorization is required for fertility agents, impotency drugs and growth hormones (including Serostim/somatropin). The Pharmacy Network Services provider will preauthorize fertility medications for all plans.
- Prior authorization will be required for specialty medications. The Pharmacy Network Services provider will preauthorize specialty medications for all plans. The plan also requires step therapy for certain types of specialty medications, including but not limited to medications to treat multiple sclerosis, autoimmune conditions, fertility, and growth hormones. If you choose a non-preferred specialty drug without first trying the preferred medication, you may be responsible for the full cost of the non-preferred medication.
- Prior authorization is required for compound medications with a retail price of $500 or more, and compounds will be limited to one fill per 25 days. The Pharmacy Network Services provider will preauthorize compound medications for all plans.

- Generic medications are generally less expensive. You may wish to discuss your prescriptions with your doctor and ask if a generic drug might work for you. You are not required to use generic medication, but Plan C participants are responsible for the difference in cost between the brand name medication and the generic a brand name medication is purchased when a generic equivalent is available.
- Please contact the Pharmacy Network Services provider for a list of participating pharmacies. See the Directory for contact information.

**PRUDENTRx FOR SPECIALTY MEDICATIONS**

In order to provide a comprehensive and cost-effective prescription drug program for you and your family, Fairbanks North Star Borough School District has contracted to offer the PrudentRx Solution for certain specialty medications. The PrudentRx Solution assists members by helping them enroll in manufacturer copay assistance programs. Medications on the PrudentRx Program Drug List are included in the program and will be subject to a 30% co-insurance, after satisfaction of any applicable deductible. However, if a member is participating in the PrudentRx Solution, which includes enrollment in an available manufacturer copay assistance program for their specialty medication, the member will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Solution, unless the member has a health savings account (HSA). For members with HSAs: (i) for drugs listed on the plan's HDHP Preventive Drug List, the member will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Solution; and (ii) for all other drugs, the member will have a $0 out-of- pocket responsibility for their prescriptions covered under the PrudentRx Solution *after* the member's deductible has been satisfied.]

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, specialty medications. The PrudentRx Solution will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible medications thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with HIPAA.

If you currently take one or more specialty medications included in the PrudentRx Program Drug List, you will receive a welcome letter from PrudentRx that provides information about the PrudentRx Solution as it pertains to your medication. All eligible members must call PrudentRx at 1-800-578-4403 to register for any manufacturer copay assistance program available for your specialty medication as some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications. If you do not call PrudentRx, PrudentRx will make outreach to you to assist with questions and enrollment. If you choose to opt out of the PrudentRx Solution, you must call 1-800-578-4403. Eligible members who fail to enroll in an available manufacturer copay assistance program or who opt out of the PrudentRx Solution will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx Solution.

If you or a covered family member are not currently taking, but will start a new medication covered under the PrudentRx Solution, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx Solution. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Solution.

The PrudentRx Program Drug List may be updated periodically.

Payments made on your behalf, including amounts paid by a manufacturer's copay assistance program, for medications covered under the PrudentRx Solution will not count toward your plan deductible or out-of-pocket maximum (if any), unless otherwise required by law. Also, payments made by you for a medication that does not qualify as an "essential health benefit" under the Affordable Care Act (ACA), will not count toward your ACA out-of-pocket maximum (if any), unless otherwise required by law. A list of specialty medications that are not considered to be "essential health benefits" under the Affordable Care Act is available. An exception process is available for determining whether a medication that is not an "essential health benefit" under the Affordable Care Act is medically necessary for a particular individual.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Solution

**PREVENTIVE BENEFIT**

Routine physical exams and associated services recommended by a licensed health care provider. Coverage for preventive services is subject to all other plan provisions, must be appropriate for age and sex, and must be generally accepted medical practice.

The plan shall cover the following preventive care services at 100% of Covered Expenses, and those expenses will not be subject to deductibles or Copays:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (Task Force) with respect to the individual involved.
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved. A recommendation of the Advisory Committee is considered to be "in effect" after it has been adopted by the Director of the Centers for Disease Control and Prevention. A recommendation is considered to be for routine use if it appears on the Immunization Schedules of the Centers for Disease Control and Prevention.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force).

The complete list of recommendations and guidelines that must be covered by plans is located at https://www.healthcare.gov/what-are-my-preventive-care-benefits/ . This list is subject to change.

**SECOND AND THIRD SURGICAL OPINION**

- Travel expenses are subject to the Non-Emergency Travel benefit provisions.
- If the second opinion does not agree with the first opinion, a third opinion may be covered.
- No benefits are payable for any duplicate Diagnostic Testing.
- The second or third opinion Physicians cannot be financially associated with each other or the first Physician.

**TRAVEL EXPENSES**

**Emergency Transportation**

Emergency transportation is covered provided the Participant has a medical condition which is a life-threatening situation that requires immediate transfer to a Hospital that has special facilities for treating the condition. Emergency transportation includes:

- Professional ground ambulance, and
- Round trip transportation by commercial airline or professional air ambulance from the place where the medical condition occurred to the nearest location where professional treatment can be obtained.

**Non-Emergency Travel**

- Non-emergency travel should be pre-authorized before travel costs are incurred. Contact the Claims Office for pre-authorization and procedures for submitting reimbursable expenses.
- If treatment is available locally, or if the treatment location selected by the participant is not the nearest location where treatment can be provided, non-emergency travel is only reimbursable if services can be provided at a lesser expense elsewhere. The combined cost of treatment at the selected place of service and travel to the selected location combined must be at least $2,000 less than the estimated cost of service at the local provider or the provider at the nearest location where services can be provided.
- Travel Pre-Authorization may be approved for:
    - surgery or treatment of a medical condition,
    - Diagnostic Testing, or

- second opinion.

- Travel is not reimbursable under the dental, vision, or hearing benefits. No travel benefit is payable for trips for dental, vision or hearing benefit care.
- Travel benefits in one Calendar Year are limited to two reimbursable trips per person. For example:
  - 1 visit and 1 follow-up visit for a condition requiring therapeutic treatment which cannot be provided locally, or
  - 1 pre-surgical or post-surgical visit and 1 visit for the actual surgical procedure which cannot be performed locally.
- Your doctor must provide written certification and detailed medical documentation of the existing condition in advance of your trip.
- Round trip airfare is covered to the nearest location where services can be provided. The airline ticket must be purchased as soon as practicable. Airfare receipt must list the name of the person traveling, total paid, dates of travel and destinations. Receipts and/or itineraries from a travel agency will not be accepted.
- Airfare for one parent or legal guardian accompanying a minor (under 18) dependent child is reimbursable if pre-authorized by the Claims Office.
- Airfare for an adult accompanying an incapacitated adult is reimbursable if pre-authorized by the Claims Office. To qualify, a written statement from the treating Health Provider must provide proof that the incapacitated adult is or will be mobility impaired and requires a greater degree of assistance by another adult than is normally available through pre-requested services and equipment provided by the airline, airport, or other transportation provider. The mobility impairment may be physical, mental or developmental. The written statement must identify what the mobility impairment is and type of assistance required.
- Ground transportation may be covered in lieu of airfare, if the most direct one-way distance exceeds 100 miles. Reimbursement of expenses for ground transportation shall be calculated by applying the IRS medical mileage allowance for the distance traveled. Round-trip ground transportation reimbursement shall not exceed the cost of coach class commercial air transportation from the site of illness or injury to the nearest professional treatment.
- Ground transportation while in the treatment locale includes rental car, taxi, gasoline, and parking fees. Written vendor receipts must be provided. The maximum benefit for ground transportation is $35 per day.
- Lodging cost only includes room charge and taxes. Written vendor receipts must be provided. The maximum benefit for lodging is $80 per day for the patient only, or $100 per day for the patient and an adult companion.
- Charges for ground transportation and lodging will only be reimbursed for periods when medical services are provided. Ground transportation and lodging will not be paid during periods of Inpatient Hospital care.
- Transportation cost for a Physician and/or registered nurse is reimbursable when deemed Medically Necessary.
- These expenses may be denied unless pre-authorized by the Claims Office.
- The plan will not pay more for one class of benefit simply because the maximum for another class of benefit has not been exhausted. For example, the plan will not pay additional ground transportation benefits if the lodging benefit has not been exhausted.

Note: Frequent flyer miles and/or hotel or auto vouchers are not reimbursable by the plan.

**Incentive to Use PPO Providers in Anchorage and Outside Alaska for Non-Emergency Services**

The plan will cover travel costs for the patient and a travel companion for participants who choose to travel to Anchorage to utilize Alaska Regional Hospital or who travel outside Alaska to use an Aetna PPO provider.

- This benefit is available for non-emergency surgery or treatment that is expected to cost $5,000 or more at the site the services are provided. This benefit is not available for diagnostic testing, second opinions, dental, vision or hearing services.

- For services outside Alaska, both the facility and the doctor/surgeon must participate in the Aetna network. To find an Aetna provider, please log in to Aetna Navigator or refer to the website: www.aetna.com/docfind. Select the "Aetna Choice POS II (Open Access)" network. It is also important for you to confirm with your Health Provider that he or she is in-network prior to receiving services. When confirming, be sure to state the name of this plan.
- Travel costs include
    - Round trip coach airfare from the patient or companion's location to the place of service, by the most direct route. The airline ticket should be purchased as soon as practicable. Airfare receipt must list the name of the person traveling, total paid, dates of travel and destinations. Receipts and/or itineraries from a travel agency will not be accepted.
    - Ground transportation, including rental car, taxi, gasoline, and parking fees. Written vendor receipts must be provided. The maximum benefit for ground transportation is $35 per day.
    - Lodging costs, limited to room charge and taxes. Written vendor receipts must be provided. The maximum benefit for lodging is $100 per day. Lodging costs are covered for the travel companion on days when inpatient charges are incurred.
- Non-emergency travel should be pre-authorized before travel costs are incurred. Contact the WPAS Claims Office for Pre-Authorization and procedures for submitting reimbursable expenses. These expenses may be denied unless pre-authorized by the Claims Office.

Note: Frequent flyer miles and/or hotel or auto vouchers are not reimbursable by the plan.

Please contact Risk Management with questions or to assist in the process.

## Non-Covered Medical Expenses

There may be other expenses not paid by the plan. Call the Claims Office if you have a question.

- Any service that is not Medically Necessary.
- Any part of a charge for confinement, treatment or service that exceeds the Usual, Customary and Reasonable or Allowable Charge.
- Any part of a charge for confinement, treatment or service that exceeds any of the plan's benefit limits.
- Artificial insemination or in-vitro fertilization.
- Charges by a Health Provider for access fees, a broken appointment or completion of a claim form.
- Charges that would not have been made or that the patient would have no obligation to pay in the absence of this plan.
- Confinement, treatment or service that is paid for or furnished by the United States Government or one of its agencies (except as required by law).
- Confinement, treatment, service, or materials for surgery to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea, including but not limited to radial keratotomy and keratomileusis surgery, unless corrected vision in the operated eye is worse than 20/70 prior to surgery and can be corrected to 20/70 or better only by such surgery.
- Cosmetic Surgery, Hospital confinement or any other service associated with Cosmetic Surgery, except to correct deformities resulting from illness or injury, or such congenital defects that interfere with function, or as described in the breast reconstruction benefit. Genital or breast surgery that is Medically Necessary for the treatment of gender dysphoria diagnoses shall not be considered Cosmetic Surgery.
- Custodial Care in a psychiatric Hospital or substance abuse treatment facility.
- Dental Services (see Dental Benefits).
- Drug dependency or abuse – cost of confinement, treatment or service.
- Educational or training problems - cost of confinement, treatment or service.
- Experimental or Investigational treatment or procedure.

- Eyeglasses, contacts and eye exams (see Vision Benefits).
- Genetic testing, except when there are symptoms or signs presented indicating a possible disease presence and genetic testing is needed to identify the disease in order for the attending physician to prescribe appropriate treatment, or as allowed under the preventive benefit.
- Hearing aids and hearing tests (see Hearing Benefits).
- Hospital services for non-emergent or elective procedures incurred outside the US, unless the hospital in which the service is rendered is accredited by the Joint Commission International.
- Injury, accident or illness to the extent for which there is or may be a recovery against a third party. See the "Subrogation" and "Right of Reimbursement" sections of this plan document for additional information.
- Marriage and family counseling.
- No benefits will be provided to the child born to a Dependent child, unless the newborn qualifies as the employee's Dependent as an adopted child of the employee or the employee's child through legal guardianship.
- Organ and/or tissue transplants or replacements involving:
    - animal-to-human organ transplants;
    - implantation within the human body of artificial or mechanical devices designed to replace a human organ; or
    - any human-to-human organ and/or tissue transplant not specified under Covered Expenses.
- Reversal of any sterilization procedure.
- Travel expenses in excess of the cost to the nearest location where treatment is available, except as specified by the plan.
- Travel expenses when services are available locally, except as specified by the Plan.
- Services or supplies by a Health Provider who normally resides in the patient's home.
- Services or supplies provided by an Immediate Family member.
- Services or supplies required as a result of:
    - intentionally self-inflicted injury (unless as a result of a medical condition).
    - war (declared or undeclared).
    - engaging in a riot or insurrection.
    - voluntary participation in criminal activities.
    - working for wage or profit.
    - events covered by workers' compensation or similar law.
- Vitamins, minerals, nutritional supplements.

## Allowable Charges for Multiple Surgical Procedures and Assistant Surgeon Fee

Multiple surgical procedures are defined as more than 1 procedure performed on the same day during the same operative session.

The following guidelines are used to process these claims:

- When 2 or more surgeries are performed through the same incision or in the same operative field, allow 100% of the Usual, Customary and Reasonable charge for the major procedure and 50% of the Usual, Customary and Reasonable charge for each subsequent procedure.
- When 2 or more surgeries are performed through separate incisions or in different operative fields, allow 100% of the Usual, Customary and Reasonable charge for each of the procedures.

**Assistant Surgeon Fee**

The plan allows 25% of the Usual, Customary and Reasonable surgeon fee.

## Health Provider Audit Reward Program

Health Providers sometimes make mistakes. Because these mistakes can add up to substantial lost money for you and your employer, we encourage you and your Dependents to ask for an itemized bill.

- Make sure all dates of services, procedures and medications were actually received.
- Check that the charges for these services/supplies are what the Health Provider indicated verbally to you or on your invoice copy.

To encourage you to check your bills, the plan will reward you with **50%** of the amount paid by the Claims Office on the overcharge up to a maximum reward of **$5,000**/per occurrence if you find an undetected error after the bill is reviewed and paid by the Claims Office.

Example: If you find a $1,000 erroneous overcharge on a Health Provider bill and the Claims Office paid the claim, you may receive $500 from the plan.

A second look can help control the cost of your health coverage and may put some dollars back in your pocket. Here are the procedures to follow:

- If you find an error or have questions about any charges, call the Health Provider's billing office and ask them to review your records.
- If there is an erroneous overcharge, request a corrected bill.
- Submit a written reward request to Risk Management explaining the overcharge, along with copies of the original bill showing the error, the Claims Office explanation of benefit statement showing that the error was paid, a corrected/revised billing, and any other pertinent information.
- Risk Management will contact the Claims Office, and the Claims Office will request a refund from the Health Provider.
- The Claims Office will issue your reward check after they receive the refund from the Health Provider.
- The Claims Office may issue you a 1099 tax form depending on the amount of reward you receive in a Calendar Year.

*Important notes:*

- *Occasionally, participants detect errors made by the Claims Office in processing a valid, accurate heath provider bill (such as improper Coordination of Benefits). Although we recognize the value in participants reporting those errors, this reward program applies only to mistakes detected in itemized Health Provider invoices.*
- *Participants are encouraged to promptly report any claim processing error to the Claims Office.*

## DENTAL BENEFITS

Only expenses that are Usual, Customary and Reasonable for the service provided in the locale where the expenses are incurred are covered.

This benefit may not pay the total cost of your dental care services and supplies.

Benefits will only be considered for treatment or service received after coverage begins and completed before coverage ends.

The plan will cover pediatric oral care as federally defined and required.

**PREVENTIVE AND DIAGNOSTIC PROCEDURES**

- Periodic oral examination – 2 per Calendar Year, not more than once in a 5-month period.
- Teeth cleaning (prophylaxis) - 2 per Calendar Year, not more than once in a 5-month period.
- Bite-wing x-rays - 2 sets per Calendar Year, not more than once in a 5-month period.
- Full-mouth x-rays (intraoral) – once every 24 months.
- Extraoral x-rays – only one type listed below is covered in each 6-month period:
    - Panoramic,
    - TMJ,
    - Cephalometric film,
    - Posterior-anterior or lateral skull and facial bone survey, or
    - Other extraoral.
- Topical fluoride application - 2 per Calendar Year, not more than once in a 5-month period – *only applies to dependents under 18 years old.*
- Space maintainers for missing primary teeth.
- Habit-breaking appliances.

**ROUTINE AND BASIC PROCEDURES**

- Restorations.
    - Fillings (amalgam, silicate, plastic or composite).
    - Pin retention when necessary.
    - Gold may be substituted for other types of restoration materials, but benefit may be reduced to allowable charge of less expensive type of restoration material.
- Oral surgery.
    - Tooth extraction.
    - Alveoloplasty.
    - Removal of dental cysts and tumors.
    - Incision and drainage of dental abscesses.
    - Tooth replantation.
    - Exposure to aid eruption.
    - Repositioning of tooth.
    - Excision of hyperplastic tissue.
- Periodontic service.
    - Surgical procedures.

        - Gingivectomy.
        - Gingival curettage.
        - Osseous surgery.
        - Osseous graft.

      *Note: only one of these listed procedures is covered for each quadrant in a 12-month period.*

    - Scaling and root planing – once per each quadrant each 6-month period.
    - Periodontal appliance – 1 appliance each 3-year period.
    - Periodontal prophylaxis - 2 per Calendar Year, not more than once in a 5-month period.
- Endodontic services.
    - Pulp cap.
    - Vital pulpotomy.
    - Root canal therapy (treatment plan, diagnostic x-ray, clinical procedures & follow-up care).
    - Apexification.
    - Apicoectomy.
    - Retrograde filling.

    *Note: Apicoectomy and retrograde filling covered as a separate procedure only if performed more than 1 year after the root canal therapy is completed.*
- Pit and fissure sealants.
    - Once in a 3-year period per tooth.
    - Limited to 3 treatments per tooth per lifetime.
    - Applies only to unrestored permanent first and second molars.
- General anesthesia – covered as a separate procedure for complex oral surgeries.
- Specialty or detailed oral examination.
- Treatment for relief of dental pain. Treatment is limited to Palliative Treatment and does not include curative treatment.
- Injected medication and administering of injection (including antibiotics).
- Consultations.
- Repairs to Bridges and complete or partial Dentures.
- Adding a tooth to partial Denture.
- Relining complete or partial Denture (upper or lower) – covered only if relining is done more than 1 year after the initial installation and then not more than once each 2-year period.
- Recementing – inlay, crown, Bridge, and space maintainer.

**MAJOR PROCEDURES**

- Restorations – if for a replacement, at least 5 years must have lapsed since last replacement.
    - Gold foil.
    - Gold inlays and onlays.
    - Porcelain inlay.
    - Crowns.
        - Crowns only covered if a filling cannot restore the tooth If patient elects to have the tooth crowned when a restoration would suffice, the plan will pay up to the cost of a restoration.

- Replacement of a crown is covered if:
  - original crown cannot be made serviceable,
  - the individual is covered under the plan for at least 12 consecutive months, and
  - 5 years has lapsed since the last placement;

- Dental Implants, including surgery and prosthetics.
  - Only covered if determined to be necessary and the most appropriate level of service, as determined by the Claims Office.
  - Prosthetics placed on implants will be reimbursed based on the same allowance for a standard crown, bridge, partial denture or full denture. No benefit will be allowed for any replacement prosthetic within 5 years of initial placement.
  - All benefits are subject to plan provisions including the deductible and annual dental maximum.
- Prosthodontics, Fixed Bridges.
  - Initial placement of fixed Bridges to replace teeth that were missing prior to the individual's coverage date will be considered after the individual is covered under this plan for 24 consecutive months, unless it includes replacement of a natural tooth extracted while covered by the plan.
  - Replacement of a fixed Bridge is covered if:
    - original Bridge cannot be made serviceable,
    - the individual is covered under the plan for at least 12 consecutive months, and
    - 5 years has lapsed since the last placement.
- Prosthodontics, Full or Partial Dentures
  - Initial placement of full or partial Dentures to replace teeth that were missing prior to the individual's coverage date will be considered after the individual is covered under this plan for 24 consecutive months, unless the Denture includes replacement of a natural tooth extracted while covered by the plan.
  - Replacement of a full or partial Denture is covered if:
    - original Denture cannot be made serviceable,
    - the individual is covered under the plan for at least 12 consecutive months, and
    - 5 years has lapsed since the last placement;

    unless replacement is necessary because of the initial placement of an opposing full Denture.

*Note: Carefully review "Non-Covered Expenses" before treatment begins.*

- Orthodontic Services.
  - Initial orthodontic consult and related x-rays.
  - Following the surgical correction of cleft palate, and only to the extent necessary to correct the congenital deformity resulting from the palate defect.

**BEGINNING DATE FOR TREATMENT OR SERVICE**

- Root canal therapy - date the pulp chamber is opened and the pulp canal explored to the apex.
- Crowns, fixed Bridgework, inlays, or onlays restoration – the date the tooth is fully prepared.
- Complete or partial Dentures – the date the master impression is made.
- All other – the date the treatment or service is performed.

**COMPLETION DATE FOR TREATMENT OR SERVICE**

- Crowns – the date the crown is seated.
- Fixed Bridgework – the date the Bridge is seated.

- Inlay or onlay restoration – the date the inlay or onlay is seated.
- Complete or partial Dentures – the date the Denture is seated.
- Implants – the date the prosthesis is placed on the implant.

**NON-COVERED EXPENSES**

- Any service that is not Medically Necessary.
- Any part of a charge for service that exceeds the Usual, Customary and Reasonable or Allowable Charge.
- Fluoride application at age 18 and over.
- Injury, accident or illness to the extent for which there is or may be a recovery against a third party.
- Orthodontic Treatment, exceptions-see Major Procedures Orthodontic Service.
- Nitrous oxide.
- Replacement of existing Dentures, crowns, or Bridgework, including prosthesis placed on implants, unless:
    - required because of the extractions of one or more natural teeth after the individual's coverage effective date,
    - the existing Denture, crown, Bridgework or prosthesis is at least 5 years old and cannot be made serviceable, and is replaced 12 months or more after the individual's coverage effective date,
    - the existing Denture, crown, Bridgework or prosthesis was temporarily installed after the individual's coverage effective date and is replaced by a permanent appliance within 12 months,
    - the replacement Denture, crown, Bridgework or prosthesis is necessary because of an initial placement of an opposing Denture while covered, or
    - the replacement Denture, crown Bridgework or prosthesis is necessary because of an accident while covered.
- If a permanent partial denture, complete denture or crown is not placed within 12 months following placement of a temporary appliance, the 5-year replacement provision will apply. If the temporary is replaced with a permanent appliance within 12 months, the benefit paid toward the temporary will be deducted from the permanent appliance.
- Charges for the use of gold which are in excess of the charges for a reasonable substitute. Gold onlays are subject to review and may be reimbursed as if the reasonable substitute was used.
- Cosmetic, Experimental or Investigational treatment.
- Dietary planning or oral hygiene instructions.
- Expense of Dentures which were lost, mislaid or stolen.
- Appliances or restorations done solely to increase vertical dimension or to restore occlusion.
- Services or supplies by a Health Provider who normally resides in the patient's home.
- Services or supplies provided by an Immediate Family member.
- Charges that would not have been made or that the patient would have no obligation to pay in the absence of this plan.
- Treatment or service that is paid for or furnished by the United States Government or one its agencies (except as required by law).
- Services or supplies required as a result of:
    - intentionally self-inflicted injury (unless required under law).
    - war (declared or undeclared).
    - engaging in a riot or insurrection.
    - voluntary participation in criminal activities.

- working for wage or profit.
- events covered by workers' compensation or similar law.

- Charges for access fee, broken appointment or completion of a claim form.
- No benefits will be provided to the child born to a Dependent child, unless the newborn qualifies as the Employee's Dependent as an adopted child of the Employee or the Employee's child through legal guardianship

**TREATMENT PLAN**

If a treatment's cost estimate is $400 or more, you should have the Dentist submit a pre-treatment plan to the Claims Office before the dental work begins. The Claims Office will send you a notice of what the plan will pay and you will know what the treatment will cost you.

Provided a treatment plan has been submitted to the Claims Office and that treatment continues into the next Calendar Year, the Deductible will be applied only once for this course of treatment.

The proposed treatment should start within 90 days of the date on the Claims Office's written pre-treatment plan notice, or a new treatment plan should be submitted.

## VISION BENEFITS

These benefits are designed to assist with the payment of your eye care expenses when prescribed by a Physician, an Optometrist, or an Ophthalmologist. This benefit may not pay the total cost of your eye care services and supplies. Benefits differ for Preferred Provider. Please see www.vsp.com for a list of preferred providers.

The plan pays the vision care expenses listed below up to the maximums specified in the Schedule of Benefits.

Only expenses that are Usual, Customary and Reasonable for the service provided in the locale where the expenses are incurred are covered.

Benefits will only be considered for treatment or service received after coverage begins and completed before coverage ends.

If you have both primary and secondary coverage with VSP, talk with your provider about the best way to coordinate coverage to meet your eye care needs and maximize your benefit.

### COVERED EXPENSES

The following are covered expenses once every Calendar Year:

- One eye examination.
- One pair of spectacle lenses.
- Contact lenses, which includes the fitting fee.
- Pediatric vision care as Federally defined and required.

Reimbursement is limited to either glasses (frames and spectacle lenses) or contacts during a Calendar Year, but not both.

> Exception: if it is Medically Necessary to wear both glasses and contacts at the same time, the plan will allow reimbursement for both within the same Calendar Year. Supporting documentation from your medical provider must be submitted to the Vision Service Provider.

Frames:

One pair of frames is eligible for reimbursement every 2 Calendar Years.

> Exception: when new frames are necessary because of a change in a prescription that cannot be accommodated by existing frames, or cranial growth.
>
> Frames are then limited to one set per Calendar Year. Supporting documentation from your medical provider must be submitted to the Plan.

### NON-COVERED VISION EXPENSES

- Any service that is not Medically Necessary.
- Any part of a charge for service and/or benefits that exceeds the Usual, Customary and Reasonable Allowances or the Schedule of Benefits.
- Artificial eyes (refer to Medical Benefits Section).
- Charges by a Health Provider for an access fee, broken appointment or completion of a claim form.
- Charges that would not have been made or that the patient would have no obligation to pay in the absence of this plan.
- Injury, accident or illness to the extent for which there is a recovery against a third party.
- Lens allowances for bifocals and trifocals are for lined lenses. Charges for lens options such as progressives, scratch-resistant coatings and anti-reflective coatings are not covered, but will be discounted when utilizing a VSP in-network provider.
- Non-prescription eyeglasses.
- Non-prescription safety glasses.

- Non-prescription sunglasses.
- Replacement of lost or stolen materials.
- Services and supplies received principally for cosmetic purposes.
- Services or supplies by a Health Provider who normally resides in the patient's home.
- Services or supplies provided by an Immediate Family member.
- Services or supplies that are paid for or furnished by the United States Government or one its agencies (except as required by law), or for which a government agency prohibits payment of benefits.
- Services or supplies required as a result of:
    - intentionally self-inflicted injury (unless required by law).
    - war (declared or undeclared).
    - engaging in a riot or insurrection.
    - voluntary participation in criminal activities.
    - working for wage or profit.
    - events covered by workers' compensation or similar law.
- No benefits will be provided to the child born to a Dependent child, unless the newborn qualifies as the employee's Dependent as an adopted child of the employee or the employee's child through legal guardianship.

## AUDIO (HEARING) BENEFITS

These benefits are designed to assist with the payment of your audio (hearing) care expenses when prescribed by a Physician or Audiologist. This benefit may not pay the total cost of these services and supplies.

The plan pays the audio (hearing) care expenses listed below up to the maximums specified in the Schedule of Benefits. Only expenses that are Usual, Reasonable and Customary for the service provided in the locale where the expenses are incurred are covered.

### COVERED EXPENSES

The patient must submit to the Claims Office a written certification from the examining Health Provider, that the hearing loss may be lessened by use of a hearing device. *The hearing device must be purchased within 3 months of this certification, or the claim may be denied.*

The following are covered expenses once every three-year period:

- Hearing examination.
- Hearing aid devices.

### NON-COVERED AUDIO EXPENSES

- Any service that is not Medically Necessary.
- Any part of a charge for service that exceeds the Usual, Customary and Reasonable or Allowable Charge.
- Hearing examination fee if a hearing aid device is not prescribed and purchased.
- Charges by a Health Provider for an access fee, broken appointment or completion of a claim form.
- Charges for a hearing aid device more expensive than the one prescribed by the examining Physician.
- Charges for batteries or other ancillary equipment other than that obtained upon the purchase of the hearing aid device.
- Charges for expenses incurred after coverage termination except for expenses for a hearing aid device:
    - prescribed by a Physician or Audiologist,
    - ordered prior to termination, and
    - delivered to the covered individual within 30 days after the coverage termination date.
- Charges for expenses incurred prior to coverage effective date.
- Charges for repairs, servicing, or alterations of the hearing aid device.
- Charges that would not have been made or that the patient would have no obligation to pay in the absence of this plan.
- Injury, accident or illness to the extent for which there is a recovery against a third party.
- Replacement of lost or stolen devices.
- Services or supplies by a Health Provider who normally resides in the patient's home.
- Services or supplies provided by an Immediate Family member.
- Services or supplies that are paid for or furnished by the United States Government or one of its agencies (except as required by law), or for which a government agency prohibits payment of benefits.
- Services or supplies required as a result of:
    - intentionally self-inflicted injury (unless required by law).
    - war (declared or undeclared).
    - engaging in a riot or insurrection.
    - voluntary participation in criminal activities.
    - working for wage or profit.

- events covered by workers' compensation or similar law.

- No benefits will be provided to the child born to a Dependent child, unless the newborn qualifies as the employee's Dependent as an adopted child of the employee or the employee's child through legal guardianship.

## ELIGIBILITY REQUIREMENTS

**EMPLOYEE**

- All Regular Employees regularly scheduled to work a minimum of 15 hours a week,
- Eligible elected officials, and
- Other employees extended Eligibility through a collective bargaining agreement.
- Employees who do not gain Eligibility in one of the categories listed above, but who are regularly scheduled to work a minimum of 30 hours a week or who worked an average of 30 hours a week during the most recent lookback period.

**DEPENDENTS**

- Legal spouse.
- Child who is under the age of 26 years old and who is the employee's:
  - Natural child,
  - Adopted child,
  - Child through legal guardianship, or
  - Stepchild.
- No benefits will be provided to the child born to a Dependent child, unless the newborn qualifies as the employee's Dependent as an adopted child of the employee or the employee's child through legal guardianship.
- Disabled Dependent Children - The age limitation may not apply for a mentally or physically Disabled Dependent Child. Contact the Claims Office for instructions and application form. The Claims Office must receive the completed form 31 days before the child's 19th birthday.

***Important:***
*If you a) enroll a Dependent who does not meet the eligibility requirements of this plan; or b) fail to notify the plan of your divorce or other loss of Dependent eligibility within 30 days of the event; you are intentionally misrepresenting a material fact and the plan will retroactively terminate coverage for your ineligible Dependent. If the plan pays claims based on your misrepresentation, you may be responsible for any claims paid on your Dependent's behalf.*

# Enrollment and Initial Coverage Period

**EMPLOYEE**

You must complete the benefit enrollment process before any claims are paid. Coverage is effective the first day of the month after the employee has been employed in a benefit eligible position for 30 days. For employees who gain coverage through a lookback period, coverage is effective the first day of the corresponding stability period.

**DEPENDENTS**

You must complete the benefit enrollment process before any claims are paid. If you gain or lose a Dependent after the date of your initial Eligibility, you must complete an updated benefit enrollment / change form and submit it directly to Human Resources within 30 days of the gain or loss of a dependent. The employee must elect the appropriate plan (employee and spouse, employee and children or employee and family) in order to cover Dependents under the plan.

*Note: For Dependent coverage, you must provide the following document copies to Human Resources before any plan benefits can be paid:*

- *spouse - marriage certificate.*
- *children - birth certificates, adoption decrees, or court approved legal guardianship documents.*

A state agency may direct the employer to enroll a child if an employee is required by a child support order or other court document to provide health insurance/benefits and fails to enroll the child. Please contact Risk Management for more information about Dependent enrollment due to a Qualified Medical Child Support Order.

If you have a Dependent child from a prior marriage, and/or stepchild in your current marriage, the Claims Office will request copies of court documents specifying which natural parent is responsible for health coverage and/or support. You must comply with the Claims Office request before claims will be paid for this Dependent.

**Spouse**

If the employee is enrolled in a spouse or family plan, coverage begins on the:

- employee's effective date, if married at the time of the employee's initial Eligibility.
- date of marriage, if married after the employee's initial effective date.

If the employee is not enrolled in a spouse or family plan option, the employee must elect a spouse or family plan option in order to cover his/her spouse. The election must be made within 30 days of marriage. A copy of the marriage certificate must be provided as soon as practical. Coverage will be effective on the first day of the month following receipt of a valid enrollment.

**Natural Child**

If the employee is enrolled in a child(ren) or family plan, coverage begins on the:

- employee's effective date, if the child is a current dependent at the time of the employee's initial Eligibility.
- birth date, if the child is born after the employee's initial effective date.
- effective date of a state Qualified Medical Child Support Order or other court document, if the effective date is on or after the employee's initial effective date.

Newborns - the newborn is covered and claims will be paid for services incurred within the first 31 days after birth. In order to continue coverage beyond the first 31 days, you must submit an updated Enrollment/Change Form to Human Resources within 30 days after the child's birth. A birth certificate must be provided as soon as practical.

If the employee is not enrolled in a child(ren) or family plan option, the employee must elect a child(ren) or family plan option in order to continue to cover his/her child after the first 31 days after birth.

**Adopted Child**

If the employee is enrolled in a child(ren) or family plan, coverage begins on the:

- employee's effective date, if the child is a current Dependent at the time of the employee's initial Eligibility.

- date of birth if a written agreement between the birth mother and/or adoption agency and the employee adopting the child is completed prior to the birth, if the child is born after the employee's initial effective date. You must submit an updated Enrollment / Change Form to Human Resources within 30 days after the child's birth to continue coverage beyond the first 31 days.
- the date legal documents are signed by all parties concerned granting legal custody of the child to the employee, in the absence of a pre-birth agreement, if the documents are signed after the employee's initial effective date. You must submit an updated Enrollment / Change Form to Human Resources within 30 days after the date of adoption. A copy of supporting legal documentation must be provided as soon as practical. The legal document may be:
    - a legal adoption agreement of the United States of America or a foreign country, or
    - a legal document enabling the adoption, i.e. petition for adoption and relinquishment of the birthparents' rights.

If the employee is not enrolled in a child(ren) or family plan option, the employee must elect a child(ren) or family plan option in order to cover his/her child after the first 31 days after birth. You must submit an updated Enrollment / Change Form to Human Resources within 30 days after the date of birth or adoption (whichever is later).

**Legal Guardianship**

If the employee is enrolled in a child(ren) or family plan, coverage begins on the:

- employee's effective date, if the child is a current Dependent at the time of the employee's initial Eligibility.
- effective date of the court approved legal guardianship, if the documents are signed after the employee's initial effective date.

If the employee is not enrolled in a child(ren) or family plan option, the employee must elect a child(ren) or family plan option in order to cover his/her child. You must submit an updated Enrollment / Change Form to Human Resources within 30 days after the effective date of guardianship. Coverage will be effective on the first day of the month following receipt of a valid enrollment form.

**Step Child**

If the employee is enrolled in a child(ren) or family plan, coverage begins on the:

- employee's effective date, if the child is a current Dependent at the time of the employee's initial Eligibility.
- marriage date of their natural or legal parent to the employee, if the date of marriage is after the employee's initial effective date.

If the employee is not enrolled in a child(ren) or family plan option, the employee must elect a child(ren) or family plan option in order to cover his/her stepchild. You must submit an updated Enrollment / Change Form to Human Resources within 30 days after the marriage date. Coverage will be effective on the first day of the month following receipt of a valid enrollment form. See Benefit Elections.

***Important:*** *If you a) enroll a Dependent who does not meet the eligibility requirements of this plan; or b) fail to notify the plan of your divorce or other loss of Dependent eligibility within 30 days of the event; you are intentionally misrepresenting a material fact and the plan will retroactively terminate coverage for your ineligible Dependent. If the plan pays claims based on your misrepresentation, you may be responsible for any claims paid on your Dependent's behalf.*

# Enrollment Election Changes

Elections are made when you are first eligible or during an open enrollment period. For active employees, employee contributions for coverage consistent with your elections will be taken as pretax payroll deductions, unless you specify otherwise at the time of your election, or unless prohibited by law.

If you experience a Qualifying Status Change Event, you may be allowed to change your plan election (Plan B or C; or employee only, employee and spouse, employee and children or employee and family). To change your election, submit a new Enrollment / Change Form and proof of the qualifying event to Human Resources within 30 days of the event, or you will be required to wait until the next open enrollment period, or another Qualifying Status Change Event to make a change. *Election changes made as a result of qualification for or termination of coverage from Medicaid or Denali Kid Care must be made within 60 days of the Event.*

Your new plan election will be effective on the first day of the month after Human Resources receives your new Enrollment / Change Form and proof of the Qualifying Status Change Event. The election change must be consistent with the Qualifying Status Change Event.

*Note: For Dependent coverage, you must provide copies of the following documents to Human Resources before any plan benefits can be paid:*

- *spouse - marriage certificate.*
- *children - birth certificates, adoption decrees, or court approved legal guardianship documents.*

Eligible Qualifying Status Change Events include:

- Marriage.
- Divorce or legal separation,
- Birth or adoption of a child,
- Death of a Dependent,
- Dependent gaining or losing coverage,
- Change in coverage under another employer plan, or
- A change in employment status.

Participants are permitted to revoke health plan elections due to a reduction in hours if:

- The employee was in a position that was expected to average 130 or more hours of service per month during the look-back measurement period and the employee experiences a change in status in which the employee is now expected to be part-time (less than 130 hours of service per month) but the employee would not lose eligibility for coverage because eligibility would be continued through the end of the applicable stability period; and
- The employee and any dependents for whom coverage elections are revoked intends to enroll in another health plan providing minimum essential coverage no later than the first day of the second month following the revocation of coverage.

Participants are permitted to revoke health plan elections due to qualified health plan coverage availability if:

- The participant chooses to enroll for a qualified health plan during the public Marketplace (Exchange) annual open enrollment period or the participant qualifies for a special enrollment period to enroll in a qualified health plan through a public Marketplace (Exchange); and
- The participant(s) for whom coverage elections are revoked intends to enroll in a qualified health plan no later than the day immediately following the revocation of coverage.

Employees may decline health coverage at initial enrollment, open enrollment, or if timely elected following a Qualifying Status Change Event, *provided the employee attests he/she has other health coverage*. In the event the employee loses other coverage, the employee must notify Human Resources within 30 days and make an election change.

Benefit eligible part-time employees may decline health coverage without having other health coverage.

Employees may elect to cover dependents.

In the absence of an initial election, the default election shall be coverage for the employee only in Medical Plan B, and employee only Dental, Vision, and Audio benefits.

## Unpaid Leave of Absence & Reinstatement of Benefits

Nothing in this provision is intended to provide any greater benefit than that agreed upon when a voluntary leave of absence is granted and specifically is not intended to alter or change any pre-arranged health coverage stop and start dates.

**Unpaid Leave of Absence**

An employee on an unpaid authorized leave of absence, for a continuous period exceeding one (1) month will lose benefit Eligibility until reinstated. This may also include unpaid disability leave. Exception – refer to the Family and Medical Leave section.

The employee has the option of continuing benefits by enrolling in COBRA and making monthly premium payments. Refer to the COBRA section. Contact Human Resources or Risk Management for details.

**Reinstatement of Benefits**

In order to be reinstated as eligible for School District health plan benefits, an employee who has lost Eligibility must be actively at work for five (5) working days within a 14-day District pay period.

If this requirement is met, the employee will be considered eligible for health benefits retroactive to the first day of the calendar month in which they are actively at work for five (5) days within a 14-day District pay period.

If the unpaid leave of absence or loss of Eligibility is for three (3) consecutive months or less:

- coverage will be reinstated retroactive to the first day of the month in which the employee has begun and completed five (5) days of paid work for the District within a 14-day District pay period,
- reinstated benefit levels will remain the same, and
- any Calendar Year Deductibles and benefit maximums will be reinstated.

If the unpaid leave of absence or loss of Eligibility exceeds three (3) consecutive months:

- coverage will be reinstated retroactive to the first day of the month in which the employee has begun and completed five (5) days of paid work for the District within a 14-day District pay period,
- If employee is reinstated in same Calendar Year, any Deductibles met in that Calendar Year will not have to be met again that Calendar Year.

Benefits will be reinstated to the same plan option selected (Plans A, B, or C; employee only, employee and spouse, employee and children or employee and family) during the most recent open enrollment period, unless the Participant has experienced a Qualifying Status Change Event and has made a timely election change.

An employee who experiences a break in service of 26 weeks or greater shall be treated as a new hire for the purposes of the initial coverage date.

Contact Human Resources for further details.

## Termination of Coverage

**EMPLOYEE**

Coverage terminates for yourself and your Dependents on the last day of the month in which:

- your employment terminates (see the exception for terminating certified and classified school term employees, and for twelve month ESSA employees),
- you retire (see the exception for terminating certified and classified school term employees),
- your FMLA/AFLA rights expire,
- you cease to belong to an employee group eligible for health benefits,
- your paid hours are less than the minimum required by a bargaining agreement,

- you stop making timely monetary contributions for continuing health benefits, (refer to the COBRA section), or
- the group plan terminates.

**Job Share Agreement Exception**

- Job share employees may maintain their health coverage in accordance with the negotiated agreements.

  Contact Human Resources for details and forms.

**Terminating Certified Employee Exception**

- Must have completed a full year contract.
- Must be in a paid status on the last day of the school year.
- Benefit coverage remains in effect through August 31st, unless your negotiated agreement states otherwise.

**Terminating Classified School Term Employee Exception**

- Must complete a full year contract.
- Must be in a paid status on the last day of the school year.
- Benefit coverage remains in effect through August 31st, unless your negotiated agreement states otherwise.

**Terminating Twelve Month ESSA Employees**

- Benefit coverage remains in effect through August 31st if you are a twelve month ESSA employee who works through June 30, unless your negotiated agreement states otherwise.

**DEPENDENT**

Coverage terminates for:

- the spouse and dependent children– in the event of the employee's death, on the last day of the month two years after the date of the employee's death (refer to the Extended Benefits & Continuation of Coverage, Death of Employee section).
- Dependent– on the last day of the month of the child's 26th birthday.

If the above employee or Dependent qualifying events do not apply, then coverage terminates on the exact date of:

- Spouse – divorce date.
- Dependent– termination of legal guardianship.
- Stepchildren – divorce date of employee and natural parent, or natural parent's death.

Exception:

- Age limitation may not apply for a mentally or physically Disabled Dependent Child. Contact the Claims Office for instructions and form. The Claims Office must receive the completed form 31 days prior to the child's 19th birthday.

***Important:***
*If you a) enroll a Dependent who does not meet the eligibility requirements of this plan; or b) fail to notify the plan of your divorce or other loss of Dependent eligibility within 30 days of the event; you are intentionally misrepresenting a material fact and the plan will retroactively terminate coverage for your ineligible Dependent. If the plan pays claims based on your misrepresentation, you may be responsible for any claims paid on your Dependent's behalf.*

Continuing health coverage may be available; refer to the following sections for more information:

- FML – Family and Medical Leave.
- Extended Benefits & Continuation of Coverage.
- COBRA – Consolidated Omnibus Budget Reconciliation Act.

- USERRA – Uniformed Services Employment and Reemployment Rights Act.

## Family and Medical Leave

Eligible employees are provided health coverage continuation period in accordance with the Federal Family and Medical Leave Act (FMLA) and the Alaska Family Leave Act (AFLA).

Contact Human Resources for details of how FMLA/AFLA impacts benefit Eligibility.

- FML provisions are in addition to any other continuation provisions of this plan.
- FML benefit periods run concurrently with other continuation provisions of this plan, except for COBRA. Refer to the COBRA section.
- FML benefit periods run concurrently for both state and federal FML continuation, when both laws apply.

## Extended Benefits & Continuation of Coverage

**Total Disability on Benefit Eligibility Termination Date**

If you or your Dependent's Eligibility terminates and if you or your Dependent qualify, the plan will pay medical benefits for confinement, treatment or service received for **up to** 12 consecutive months from the date coverage would have otherwise terminated, only if these benefits would have been paid if Eligibility had not terminated.

The individual must be Totally Disabled when Eligibility terminates. Benefits are only covered for the disabling medical condition that was diagnosed by a Health Provider before Eligibility terminated.

You must contact the Claims Office within 60 days after termination of Eligibility in order to continue coverage for the disabling condition.

The medical expenses for this disabling condition will be covered if they are incurred before the earliest of the following:

- the date the Total Disability ends,
- 90 days after this plan terminates,
- the date on which the individual received maximum benefits,
- the date on which the individual received benefits for a period equal in length to the period for which they were covered by the plan,
- the date the individual is covered by another plan for this medical condition, or
- 12 months after this coverage continuation began.

You do not have to pay for continued coverage for the disabling condition, but the coverage will run concurrently with your COBRA coverage period, if you elect COBRA continuation coverage. COBRA coverage will not be offered at the end of the disability extension.

**Death of Employee**

In case of your death, if your Dependents elect to maintain coverage on this plan through COBRA, the School District will pay for COBRA continuation coverage under this plan for your Dependents for 2 years, until COBRA coverage terminates, or until your spouse remarries, whichever is earlier. If a Dependent child ceases to qualify for Eligibility as a Dependent, the School District's COBRA payments will terminate on the date of the qualifying event.

Extension Provision - If a Dependent is Totally Disabled on the date the School District terminates COBRA benefit payments under this provision, benefits for this disabling condition will continue until the earliest of the following:

- the date the Total Disability ends,
- the date on which the Dependent receives maximum benefits, or
- the date that is 90 days after the School District terminates the COBRA benefit payments under this provision.

Note: Review COBRA section for COBRA election and benefit information.

# COBRA Continuation Coverage

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the plan and under federal law, you should contact Risk Management.

## WHAT IS THE AFFORDABLE CARE ACT MARKET PLACE?

There may be other coverage options for you and your family. For example, you may be able to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees.

For more information, you can visit https://www.healthcare.gov/

## WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of group health plan coverage when it would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in the section entitled "When Will COBRA Become Available?" The plan is not required to offer COBRA following some qualifying events unless it receives proper notice of those qualifying events.

### Qualified Beneficiaries

An employee, the employee's spouse (as defined in federal law), and the employee's Dependent children can be Qualified Beneficiaries who are entitled to elect COBRA coverage if they lose coverage under the plan because of a qualifying event. After a qualifying event has occurred (and, if applicable, proper notice has been given to Human Resources of the qualifying event), COBRA coverage must be offered to each of these "Qualified Beneficiaries" that would lose plan coverage as a result of that qualifying event.

Certain children of a Participant that are born, adopted or placed for adoption during a period of COBRA coverage may also be Qualified Beneficiaries, as explained in the section entitled "COBRA Rights for New Dependent Children."

### Requirement to Pay for COBRA Coverage

Under the plan, Qualified Beneficiaries who elect COBRA coverage must pay for that coverage. In most cases, the amount a Qualified Beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly-situated plan Participant or beneficiary who is not receiving COBRA coverage. Payment requirements are discussed in more detail later in the section entitled "How Much Does COBRA Cost?"

## WHEN WILL COBRA BECOME AVAILABLE?

In order for COBRA coverage to become available, a Qualified Beneficiary (as described above) must have a loss of coverage due to certain events (listed below). When one of these events causes a Qualified Beneficiary to lose coverage under the Plan it is referred to as a "qualifying event."

<u>To an Employee</u>

If you are an employee, you will be entitled to elect COBRA if you have a loss of coverage under the plan because either one of the following events occurs:

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

<u>To a Spouse of an Employee</u>

If you are the spouse of an employee, you will be entitled to elect COBRA if you have a loss of coverage under the plan because any of the following events occurs:

- Your spouse (the employee) dies,
- Your spouse's hours of employment are reduced,
- Your spouse's employment ends for any reason other than his or her gross misconduct,
- Your spouse becomes entitled to (covered under) Medicare benefits (under Part A, Part B, or both), or
- You become divorced or legally separated from your spouse, but only if notice of the divorce or legal separation is given to Human Resources as specified in the section entitled "In Some Cases Qualified Beneficiaries Are Required to Give Notice."

To an Employee's Dependent Child

If you are the Dependent child of an employee, you will be entitled to elect COBRA if you have a loss of coverage under the plan because any of the following events occurs:

- The employee that is your parent dies,
- The employee that is your parent has a reduction in hours of employment,
- The employee that is your parent terminates employment for any reason other than his or her gross misconduct,
- The employee that is your parent becomes entitled to (covered under) Medicare benefits (Part A, Part B, or both),
- The employee that is your parent becomes divorced or legally separated, but only if notice of the divorce or legal separation is given to Human Resources as specified in the section entitled "In Some Cases Qualified Beneficiaries Are Required to Give Notice," or
- You stop being eligible for coverage under the plan as a "Dependent Child" of the employee, but only if you notify Human Resources as specified in the section entitled "In Some Cases Qualified Beneficiaries Are Required to Give Notice."

**Requirement of Plan Coverage**

Normally, there is no right to COBRA coverage for individuals who are not covered under the plan on the day before a qualifying event occurs. There are some exceptions to this rule, however.

**Special Rule If Coverage is Lost Before a Qualifying Event**

If an individual's coverage under the plan is eliminated or reduced before one of the qualifying events listed above occurs, and the elimination or reduction was made in anticipation of that event, the individual whose coverage was eliminated or reduced may still have COBRA coverage rights under the plan due to the qualifying event. This may occur, for example, if an employee drops his or her spouse's coverage in anticipation of a divorce or legal separation. In that case, if the Plan is properly notified of the later divorce or legal separation, the spouse whose coverage was dropped may be entitled to obtain continuation coverage starting on the date of the divorce or legal separation.

**Special Rule for Actions in Violation of Applicable Law**

In addition, if one of the listed events occurs with respect to an individual who has no coverage under the plan because coverage was terminated or withheld in violation of applicable law, that individual may still be entitled to elect COBRA coverage. The plan makes every effort to comply with all applicable laws, and it is doubtful you would ever have any reason to believe that coverage had been terminated or withheld in violation of law. Nonetheless, if you believe that this rule might apply to you, it is important to alert Human Resources or Risk Management so that a determination can be made and continuation coverage offered if appropriate.

**ARE QUALIFIED BENEFICIARIES REQUIRED TO GIVE NOTICE OF A QUALIFYING EVENT?**

The type of qualifying event determines whether a Qualified Beneficiary is required to give notice of the qualifying event.

**In Some Cases Qualified Beneficiaries Are Required to Give Notice**

If a qualifying event is an employee's divorce or legal separation, or a Dependent Child's losing eligibility for coverage under the plan, COBRA will not be offered (or available) unless written notice of these events is

provided according to the procedures described in the section entitled “Procedures for Giving Notice of Qualifying Events.”

The notice must be given within 60 days after the later of the event (the divorce or legal separation, or the event causing the Dependent Child’s ineligibility) or the date the plan says coverage will end because of the event. If notice is not provided to Human Resources or Risk Management within the 60-day period, and according to the procedures in the section entitled “Notice Procedures,” COBRA coverage will not be available as a result of that event. Also, any claims paid by the plan after the date coverage should have ended must be refunded to the plan. Note that, under the plan, the covered employee is responsible for ensuring that:

- His or her spouse is promptly removed from plan coverage following a divorce or legal separation, and
- His or her Dependent Children are promptly removed from plan coverage when they become ineligible.

Coverage will terminate automatically when an individual becomes ineligible, but the plan may inadvertently continue to pay claims and/or confirm coverage for that individual. In that case, the covered employee will be responsible to repay to the plan any claims incurred after eligibility ended. Any confirmation of coverage or payment of a claim after coverage terminates does not extend the time for providing notice to the plan of a qualifying event.

**In Other Cases, No Notice is Required**

If a qualifying event is an employee’s termination of employment, reduction in hours of employment, Medicare entitlement (the actual receipt of Medicare benefits) or death, you are not required to give notice of the event in order for COBRA coverage to be offered. COBRA coverage will be offered to the Qualified Beneficiaries with respect to these events even if no notice is provided.

**WHEN WILL COBRA COVERAGE BE OFFERED?**

When Human Resources either is notified of a divorce, legal separation, or loss of dependent status, or determines that a Participant has terminated employment, had a reduction in hours, become entitled to (covered under) Medicare or died, the plan will in turn determine whether one or more Qualified Beneficiaries has had a loss of coverage because of the event. If so, the plan will notify the Qualified Beneficiary(ies) having a loss of coverage due to the event of any COBRA election rights by sending an election notice to the address(es) the Participant has provided to the plan for those Qualified Beneficiaries.

**Single Notice for Multiple Qualified Beneficiaries**

In most cases, the plan will send a single election notice to all Qualified Beneficiaries who reside together, according to the plan’s records.

**HOW IS COBRA ELECTED?**

As noted above, when the plan determines that a Qualified Beneficiary should be offered COBRA, the offer is made by sending an election notice. As directed in the election notice, a Qualified Beneficiary obtains COBRA coverage by electing it in writing, on the proper form and as specified in the election notice. The election must be made before the end of the election period. The election period ends 60 days after the date of the election notice or, if later, the date the plan terms call for the Qualified Beneficiary to lose coverage because of the qualifying event. The postmark date on the envelope in which the election of COBRA coverage is sent will be deemed the date the election was made.

If your COBRA coverage election is not made before the end of the 60-day election period as described above, you will lose the right to obtain COBRA coverage and your health coverage under the plan will end as of the date determined by plan terms.

If you reject COBRA continuation coverage before end of the 60-day election period, you may change your mind as long as you make your COBRA coverage election before the 60-day election period ends.

**Independent Election Rights**

Each Qualified Beneficiary losing coverage due to a qualifying event (and for whom any required notice has been provided) has an independent right to elect COBRA coverage, meaning that each may elect COBRA coverage even if other family members do not.

In the remainder of this Notice, the words "you" and “your” refer to an individual who has an independent right to elect COBRA coverage, as described above.

**Effective Date of COBRA Coverage**

Following a qualifying event, your coverage under the plan will be terminated, subject to retroactive reinstatement following receipt of your timely election of COBRA coverage and timely initial payment for that coverage as described below. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If the required election and payment are made in the time periods allowed, COBRA coverage will be effective retroactive to the date coverage under the plan ended.

**Initial Payment for COBRA Coverage**

You are not required to send payment with your election of COBRA, but COBRA coverage under the plan will not become effective until you have both properly elected coverage within the election period and paid your initial COBRA premium on time. Your initial COBRA premium is due no later than the 45th day after your election date. That initial payment must cover the premium for the period of COBRA coverage from the date on which plan coverage would have ended if COBRA had not been elected through the last day of the month that ends before the due date for the initial payment. The plan will not send you a bill for this amount.

If the required payments for a Qualified Beneficiary's COBRA coverage, as detailed in the election notice, are not brought current within 45 days after the election date, that Qualified Beneficiary will lose the right to obtain COBRA coverage. The postmark date on the envelope in which payment for your coverage is sent is deemed the date of your payment. If your initial payment for COBRA coverage is not made during this 45-day period, your group health coverage will end as of the date determined by plan terms, and you will have no right to obtain COBRA coverage.

If the required payment is made during this 45-day period, COBRA coverage will be effective retroactive to the date coverage under the plan would have ended if COBRA had not been elected. Thereafter, for COBRA coverage to continue, timely payments for that coverage must be made on a monthly basis.

**Several Different People Can Make the Election**

Participants or former Participants may elect COBRA coverage on behalf of all the Qualified Beneficiaries losing coverage due to a qualifying event. Likewise, the spouse or former spouse of a Participant or former Participant may elect COBRA coverage on behalf of all Qualified Beneficiaries losing coverage due to a qualifying event if the spouse is also a Qualified Beneficiary. Parents may elect COBRA on behalf of their minor children.

**Effect of Other Coverage or Medicare**

Qualified Beneficiaries who are entitled to elect COBRA may do so even if covered by another group health plan or Medicare prior to the election date. COBRA coverage will terminate automatically if, after electing COBRA, a Qualified Beneficiary first becomes entitled to (covered under) Medicare benefits or becomes covered under another group health plan.

**WHAT COVERAGE CAN BE ELECTED?**

If COBRA coverage is elected and paid for, it will be identical to the coverage provided under the plan to similarly-situated Participants or dependents, as of the time coverage is being provided. This means that if the coverage for similarly-situated Participants or dependents is modified, your COBRA coverage will be modified in the same manner. In addition, Qualified Beneficiaries receiving COBRA coverage have the same choices with respect to the plan during annual election periods as an active employee.

A Qualified Beneficiary can only elect COBRA coverage under the benefit(s) providing coverage to the Qualified Beneficiary at the time of the qualifying event. At any annual election period that occurs while the Qualified Beneficiary has COBRA coverage in effect, the Qualified Beneficiary will be entitled to switch among the various options, however.

**Enrolling Dependents in COBRA Coverage**

Once COBRA coverage becomes effective, Qualified Beneficiaries receiving COBRA have the same rights to enroll Dependents and change elections with respect to the plan as apply to similarly-situated active employees. Except in the case of a Participant's new child, as described below in the section entitled "COBRA Rights for New Dependent Children," however, no Dependent added to a Qualified Beneficiary's COBRA coverage will have any independent rights to COBRA coverage. The Dependent's coverage will end at the same time as that of the individual who enrolled him or her, and the added dependent will not have any COBRA rights.

**HOW LONG CAN COBRA COVERAGE BE AVAILABLE?**

If the qualifying event was an employee's termination of employment or reduction in hours of employment, the maximum COBRA coverage period for health benefits generally is 18 months.

If the qualifying event is something other than the employee's termination of employment or reduction in hours, the maximum COBRA coverage period generally will be 36 months from the date of the event triggering the right to continuation coverage (the qualifying event). If a 36-month maximum COBRA coverage period applies, it cannot be extended under any circumstances.

**Events Potentially Extending an 18-Month Maximum COBRA Coverage Period**

The 18-month maximum COBRA coverage period that usually applies when a termination of employment or reduction in hours qualifying event occurs can be extended in three situations.

1. Medicare Entitlement Before Termination of Employment or Reduction in Hours. If an employee becomes entitled to (covered under) Medicare during the 18 months before a qualifying event consisting of the employee's terminating employment or reducing hours, an extended maximum COBRA coverage period can apply to that Participant's spouse and dependent children who become Qualified Beneficiaries due to the termination of employment or reduction in hours. The Participant's maximum COBRA coverage period will remain 18 months in this case, but the other Qualified Beneficiaries will have a maximum continuation period that ends 36 months after the date of the employee's Medicare entitlement (the actual receipt of Medicare benefits). If, for example, a Participant became entitled to Medicare on July 1, 2005 and terminated employment on September 15, 2005, the Participant's maximum COBRA coverage period would end on March 15, 2007. The Participant's spouse and dependent children would have a maximum COBRA coverage period that ends on July 1, 2008.

2. Social Security Administration Determination of a Qualified Beneficiary's Disability. The 18-month maximum COBRA coverage period (or the period of coverage resulting from Medicare entitlement) may be extended to a total of 29 months from the date of termination of employment or reduction in hours if a Qualified Beneficiary receives a Social Security Administration determination that the Qualified Beneficiary is disabled. This extension will apply only if the Social Security Administration determines that you (or another individual who is entitled to COBRA coverage because of the same qualifying event) were disabled at any time during the first 60 days of COBRA coverage, you notify Human Resources in a timely fashion, and you remain disabled throughout the extension period. For this extension to be available, Human Resources must be notified in writing of the Social Security Administration determination according to the procedures described in the section entitled "Procedures for Giving Notice of Disability." This notice must be given within 60 days after the date of the Social Security Administration determination and within the first 18 months of COBRA coverage. If you were determined to be disabled before the employee's termination of employment or reduction in hours, the notice is required to be given according to the procedures in the section entitled "Procedures for Giving Notice of Disability" within the first 18 months of COBRA coverage and within 60 days after the later of:

    - The date of the employee's termination of employment or reduction of hours.
    - The date on which you lose (or would lose) coverage under the terms of the plan as a result of the covered employee's termination or reduction of hours.

    If notice is not provided to Human Resources within the applicable 60-day period, and according to the procedures described in the section entitled "Procedures for Giving Notice of Disability," the extension of the maximum COBRA coverage period described in this paragraph will not be available.

3. Second Qualifying Event. For an employee's spouse and Dependent children, the maximum COBRA coverage period may be extended to a total of 36 months from the date of the employee's termination or reduction in hours if, during the first 18 months (or 29 months, if a disability extension applies) that COBRA coverage is in effect, a second qualifying event occurs.

    A second qualifying event for a Participant's spouse may consist of the employee's death, Medicare entitlement (the actual receipt of Medicare benefits), legal separation or divorce, but only if the event would have caused the spouse to lose coverage under the plan had the first qualifying event not occurred.

    A second qualifying event for an employee's Dependent child may consist of the employee's death, Medicare entitlement (the actual receipt of Medicare benefits), legal separation or divorce, or the Dependent child's ceasing to meet the dependent eligibility requirements under the plan, but only if the

event would have caused the dependent child to lose coverage under the plan had the first qualifying event not occurred.

For this extension to be available, written notice of the event must be properly given to Human Resources according to the procedures described in the section entitled "Procedures for Giving Notice of Second Qualifying Event." The notice must be given within 60 days after the later of:

- The date of the second qualifying event, or
- The date on which the Qualified Beneficiary would lose coverage under the terms of the plan as a result of the second qualifying event (if it had occurred with respect to a similarly-situated individual receiving non-COBRA coverage under the plan).

If notice is not provided to Human Resources within the applicable 60-day period, and according to the procedures described below in the section entitled "Procedures for Giving Notice of Second Qualifying Event," the extension of the maximum COBRA coverage period will not be available as a result of that event.

**Limits on Extensions of the Maximum COBRA Coverage Period**

In no case will the total maximum COBRA coverage period for anyone be more than 36 months, and in no case will the total COBRA coverage period for an employee be more than 18 months (29 months in the case of disability, as provided above). For a child born to, adopted by, or placed for adoption with, a Participant during continuation coverage (see "COBRA Rights for New Dependent Children"), these periods are measured from the date of the event that triggered the continuation coverage in effect at the time of birth, adoption, or placement. In no event is the coverage period for such a child based on the date of birth, adoption, or placement.

All of the COBRA coverage periods described above are maximums. COBRA coverage can end before the end of these maximum coverage periods for several reasons, which are described in the following section.

**ARE THERE ANY CIRCUMSTANCES IN WHICH CONTINUATION COVERAGE MAY BE CUT SHORT?**

Your COBRA coverage will end before the end of the maximum COBRA coverage period if any of several events occurs. The plan will provide notice if termination occurs before the end of the maximum COBRA coverage period, but COBRA coverage will terminate on the date noted below regardless of when the notice is given. This means that you will not receive advance notice of termination of your COBRA coverage in most cases.

In some cases, the plan may pay claims after the date of termination as described below. In that event, you will be required to pay the plan back for any claims paid with respect to periods after your COBRA coverage ended.

1. Other Group Health Plan Coverage. Your COBRA coverage will terminate automatically if, after electing COBRA, you become covered under any other group health plan (as an employee or otherwise). You must notify Human Resources promptly after such coverage becomes effective. Regardless of whether the notice is provided, termination of COBRA coverage will be effective on the date that the other coverage becomes effective or the first date that the exclusion or limitation is no longer applicable.
2. Medicare Entitlement. Your COBRA coverage will terminate automatically if, after electing COBRA, you first become entitled to (covered under) any Medicare benefits (Part A, Part B or both). You must notify Human Resources promptly after Medicare becomes effective. Regardless of whether the notice is provided, termination of COBRA coverage will be effective on the date of Medicare entitlement.
3. Failure to Pay Required Premiums. Your COBRA coverage will terminate automatically if the premium for your continuation coverage is not paid by the due date and any applicable grace period for paying the premium has expired without the past due premium being paid. Termination of COBRA coverage will be effective at the end of the last month for which the full premium was paid before expiration of the grace period for that payment.
4. Plan Termination. Your COBRA coverage will terminate automatically on the first date that neither the Company nor any of its affiliates provides any group health coverage to any employee.
5. Cessation of Disability. Your COBRA coverage will terminate automatically if, after becoming entitled to a 29-month maximum coverage period due to your own or another Qualified Beneficiary's disability, during the extension, there is a final Social Security Administration determination that the disabled individual ceased to be disabled. Within 30 days after receipt of the Social Security Administration

determination, the plan must be notified in writing of that determination according to the notice procedures described in the section entitled “Procedures for Giving Notice of Disability Cessation.” Termination of COBRA coverage will be effective on the first day of the first month that is more that 30 days after the date of the Social Security Administration determination, regardless of whether you give the required notice.

6. For Cause. Occurrence of any event that permits termination of coverage under the plan for an individual covered other than pursuant to COBRA (submitting fraudulent claims or enrollment materials, or failing to provide proof of eligibility when requested, for example). Termination of COBRA coverage will be effective on the date that best puts the plan in the position it would have been in if the “for cause” event had not occurred. For example, if the plan requests proof of the date a Dependent child reached the limiting age, and the proof provided shows that the plan was not notified within the applicable 60-day notice period following that event, the dependent’s COBRA coverage will terminate retroactive to the date it began because the dependent was never entitled to COBRA coverage due to the late notice.

**HOW MUCH DOES COBRA COVERAGE COST?**

In general, you must pay 102 percent of the cost to the plan for providing plan coverage to similarly-situated non-COBRA individuals in order to obtain and continue COBRA coverage. If the maximum COBRA coverage period is extended to 29 months due to an individual's disability (see the section above entitled “Social Security Administration Determination of a Qualified Beneficiary’s Disability”), the required payment during the extension period for the family coverage unit that includes the disabled individual is 150 percent of the cost to the plan for providing plan coverage to similarly-situated non-COBRA individuals. Special rules apply in some situations so that the higher premium does not apply during the disability extension. Please contact Human Resources if you have questions concerning this premium.

After the initial COBRA coverage payment (see the section entitled “Initial Payment for COBRA Coverage”), payments for COBRA coverage are due on the 1st of each month for that month's COBRA coverage. There is, however, a grace period for late payment, which expires on the 30th day after the 1st of the month. If premium payment is not made within the 30-day grace period, COBRA coverage will end effective as of the last day of the last month for which payment was made in full. The grace period does not apply to the initial COBRA coverage payment. If that payment is not made by the 45th day after the election date, COBRA coverage will not become effective.

If, for whatever reason, you receive any medical benefits under the plan with respect to expenses incurred during a month for which the required COBRA payment was not made before the end of the grace period, you will be required to reimburse the plan for the benefits received.

If you pay a COBRA premium later than the first day of the month to which it applies, but before the end of the grace period for that month, your coverage under the plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the month) when the payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

All payments must be made by check. If a check "bounces" (i.e., is not honored by your bank), the payment represented by the check is deemed not to have been made. In such cases, the plan has no responsibility to give notice of the payment problem. COBRA coverage will not become effective, in the case of the initial payment, or will terminate, in the case of later payments, without further notice or opportunity for payment if, after a payment check bounces, the full required payment is not made within the time required. That is, a bounced check does not extend the due date or grace period for any payment.

**ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?**

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov

**SPECIAL RULES ON FMLA LEAVES OF ABSENCE**

The School District is subject to the Family and Medical Leave Act of 1993 (FMLA), and, when allowing leaves protected under the FMLA, the School District allows Participants to continue group health plan coverage at regular contribution levels while on the leave. Beginning an FMLA leave is not an event which qualifies you for

continuation coverage (beginning a non-FMLA leave may be a COBRA qualifying event, however). If one of the qualifying events listed earlier occurs during an FMLA leave, however, and, under the terms of the plan, it normally would result in loss of coverage, then the normal rules described above concerning COBRA coverage would apply. In addition, if a Participant who takes an FMLA leave does not return at the end of that leave, the last day of that leave may be treated as a reduction in hours for purposes of determining whether COBRA rights apply.

**COBRA RIGHTS FOR NEW DEPENDENT CHILDREN**

A child born to, adopted by, or placed for adoption with, a Participant during a period of COBRA coverage is eligible for coverage as a Qualified Beneficiary to the same extent as the other Qualified Beneficiaries listed above, provided the child satisfies the otherwise applicable plan eligibility requirements. Human Resources must be notified within 30 days of a child's birth to, adoption by, or placement for adoption with, the Participant during a period of COBRA coverage. Coverage for the new child may be elected (and the child's rights as a Qualified Beneficiary preserved) only if Human Resources is notified of the child's birth, adoption or placement within 30 days of the event. From the time such a child is properly enrolled as described in this paragraph, the child will be treated as a Qualified Beneficiary for COBRA purposes.

**NOTICE PROCEDURES**

**Procedures for Giving Notice of Qualifying Events**

The notice of a qualifying event that is required for a divorce, legal separation or Dependent child's ineligibility must be in writing and must be mailed or hand delivered to the person at the address below. Giving notice of a qualifying event by any other means will not protect COBRA rights, and COBRA will not be offered to any Qualified Beneficiary whose notice is provided by any other means. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notice is not acceptable.

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| **Timing:** | The notice of qualifying event must be provided within 60 days after the later of:<br>• The date of the qualifying event (for example, the date of the divorce or the date of a dependent's birthday when reaching the limiting age)<br>• The date on which the Qualified Beneficiary loses (or would lose) coverage under the terms of the plan as a result of the qualifying event<br>This means that the notice of qualifying event must be postmarked or hand delivered to the person at the address indicated below no later than the last day of the 60-day notice period described above.<br>If providing notice of a divorce or legal separation after plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, as described in the section "Special Rule if Coverage is Lost Before a Qualifying Event," the notice must be provided within 60 days of the divorce or legal separation, not at the time of the loss of coverage. |
| **Form:** | Notice of a qualifying event must be in writing and must include all of the following information:<br>• The name of the plan<br>• The name and address of the Participant who is or was covered under the plan<br>• The name(s) and address(es) of all Qualified Beneficiary(ies) who have a loss of coverage due to the qualifying event (divorce, legal separation, or child's becoming ineligible)<br>• The qualifying event (divorce, legal separation, or child's ineligibility)<br>• The date that the divorce or legal separation, or the event causing the child's ineligibility occurred<br>• The name and contact information for the individual sending the notice |
| **Address:** | Mail or hand deliver notice to:<br>Fairbanks North Star Borough School District<br>Human Resources Department<br>520 Fifth Avenue<br>Fairbanks, AK 99701 |

A written notice that is provided within the 60-day notice period described above will be rejected if it does not contain all of the information and documentation described above, unless all of the following conditions are met:

- From the written notice provided, Human Resources can both
    - Determine that the notice concerns the plan, and
    - Identify the Participant and Qualified Beneficiary(ies), the qualifying event (the divorce, legal separation, or child's ineligibility) and the date of the qualifying event.
- The notice is supplemented in writing with the additional information and documentation necessary to meet the plan's requirements within fifteen (15) days after a written or oral request for more information (or, if later, by the end of the 60-day notice period described above).

Unless all of these conditions are met, the incomplete notice will be rejected and COBRA will not be offered. If all of these conditions are met, the plan will treat the incomplete notice as if it had been provided within the 60-day notice period, but for all other purposes will treat the notice as having been provided on the date that the plan has received all of the items requested to supplement the incomplete notice.

**Procedures for Giving Notice of Second Qualifying Events**

The notice of a second qualifying event that is required for an employee's death, Medicare entitlement (actual receipt of Medicare benefits), divorce, legal separation or Dependent child's ineligibility must be in writing and must be mailed or hand delivered to the person at the address indicated below. Giving notice of a qualifying event by any other means will not protect COBRA rights, and extension of the maximum COBRA coverage period will not be available to any Qualified Beneficiary whose notice is provided by any other means. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notice is not acceptable.

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| **Timing:** | The notice of second qualifying event must be provided within 60 days after the later of:<br>• The date of the qualifying event (for example, the date of the divorce or the date of a Dependent's birthday when reaching the limiting age)<br>• The date on which the Qualified Beneficiary would lose coverage under the terms of the plan as a result of the second qualifying event (if it had occurred while the Qualified Beneficiary was still covered under the plan due to the Participant's employment)<br>This means that the notice of qualifying event must be postmarked or hand delivered to the person at the address indicated below no later than the last day of the 60-day notice period described above. |
| **Form:** | Notice of a second qualifying event must be in writing and must include all of the following information:<br>• The name of the plan<br>• The name and address of the employee or former employee<br>• The date of the employee's or former employee's termination of employment or reduction in hours<br>• The name(s) and address(es) of all Qualified Beneficiary(ies) receiving COBRA coverage at the time of the notice who would have a loss of coverage due to the qualifying event (Participant's death, Medicare entitlement (actual receipt of Medicare benefits), divorce, legal separation, or child's becoming ineligible) if it had occurred while still covered under the plan due to the Participant's employment<br>• The second qualifying event (the Participant's death, Medicare entitlement (actual receipt of Medicare benefits), divorce, legal separation, or child's ineligibility)<br>• The date that the qualifying event occurred<br>• The name and contact information for the individual sending the notice |

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| **Address:** | Mail or hand deliver notice to:<br>Fairbanks North Star Borough School District<br>Human Resources Department<br>520 Fifth Avenue<br>Fairbanks, AK 99701 |

A written notice that is provided within the 60-day notice period described above will be rejected if it does not contain all of the information and documentation described above, unless all of the following conditions are met:

- From the written notice provided, Human Resources can both
    - Determine that the notice concerns the plan, and
    - Identify the Participant and Qualified Beneficiary(ies), the first qualifying event (the covered employee's termination of employment or reduction of hours), the date on which the first qualifying event occurred, the second qualifying event (the Participant's death, Medicare entitlement, (actual receipt of Medicare benefits) divorce, legal separation or child's ineligibility), and the date of the second qualifying event.
- The notice is supplemented in writing with the additional information and documentation necessary to meet the plan's requirements within fifteen (15) days after a written or oral request for more information (or, if later, by the end of the 60-day notice period described above).

Unless all of these conditions are met, the incomplete notice will be rejected and COBRA will not be offered. If all of these conditions are met, the plan will treat the incomplete notice as if it had been provided within the 60-day notice period, but for all other purposes will treat the notice as having been provided on the date that the plan has received all of the items requested to supplement the incomplete notice.

**Procedures for Giving Notice of Disability**

The notice of a disability that is required for an extension of coverage due to disability must be in writing and must be mailed or hand delivered. Giving notice of a disability by any other means will not protect COBRA rights, and no extension of COBRA coverage due to disability will apply to any Qualified Beneficiary whose notice is provided by any other means. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notice is not acceptable.

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| **Timing:** | The notice of disability must be provided within 60 days after the date of the Social Security Administration's determination of disability and within the first 18 months of COBRA coverage. If the disability determination occurs before the employee's termination of employment or reduction in hours, this notice is required to be given within the first 18 months of COBRA coverage and within 60 days after the later of:<br>• The date of the employee's termination of employment or reduction of hours<br>• The date on which you lose (or would lose) coverage under the terms of the plan as a result of the covered employee's termination or reduction of hours<br>This means that the notice of disability must be postmarked or hand delivered to the person at the address indicated below no later than the last day of the 60-day notice period described above. |

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| **Form:** | Notice of disability must be in writing and must include all of the following information:<br>• The name of the plan<br>• The name and address of the Participant or former Participant who is or was covered under the plan<br>• The qualifying event that started COBRA coverage (must be an employee's termination of employment or reduction in hours)<br>• The date that the employee's termination of employment or reduction of hours happened<br>• The name(s) and address(es) of all Qualified Beneficiary(ies) who had a loss of coverage due to the employee's termination of employment or reduction in hours, elected COBRA when it was offered, and have COBRA coverage in effect at the time of the notice<br>• The name of the disabled Qualified Beneficiary<br>• The date that the Qualified Beneficiary became disabled according to the Social Security Administration determination<br>• The date that the Social Security Administration made its determination of disability<br>• The name and contact information for the individual sending the notice<br>A copy of the Social Security Administration's determination of disability must be included with the notice of disability. |
| **Address:** | Mail or hand deliver notice to:<br>Fairbanks North Star Borough School District<br>Human Resources Department<br>520 Fifth Avenue<br>Fairbanks, AK 99701 |

A written notice that is provided within the 60-day notice period described above will be rejected if it does not contain all of the information and documentation described above, unless all of the following conditions are met:

- From the written notice provided, Human Resources can both
    - Determine that the notice concerns the plan and a Qualified Beneficiary's disability.
    - Identify the employee or former employee and Qualified Beneficiary(ies) and the date on which the employee or former employee terminated employment or reduced hours of employment.
- The notice is supplemented in writing with the additional information and documentation necessary to meet the plan's requirements within fifteen (15) days after a written or oral request for more information (or, if later, by the end of the 60-day notice period described above).

Unless all of these conditions are met, the incomplete notice will be rejected and the extension of the maximum COBRA coverage period due to disability will not be available. If all of these conditions are met, the plan will treat the incomplete notice as if it had been provided within the 60-day notice period, but for all other purposes will treat the notice as having been provided on the date that the plan has received all of the items requested to supplement the incomplete notice.

**Procedures for Giving Notice of Disability Ceasing**

The notice of cessation of a disability that is required when a disability that resulted in an extension of the maximum COBRA coverage period has ended. The notice must be in writing and must be mailed or hand delivered to the person at the address indicated below. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notice is not acceptable.

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| **Timing:** | The notice of disability must be provided within 30 days after the date of the Social Security Administration's determination that disability has ceased. This means that the notice of disability must be postmarked or hand delivered to the person at the address indicated below no later than the last day of the 30-day notice period described above. |
| **Form:** | Notice of disability cessation must be in writing and must include all of the following information: |

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| | • The name of the plan<br>• The name and address of the Participant or former Participant who is or was covered under the plan<br>• The qualifying event that started COBRA coverage (must be a Participant's termination of employment or reduction in hours)<br>• The date that the Participant's termination of employment or reduction of hours happened<br>• The name(s) and address(es) of all Qualified Beneficiary(ies) who had a loss of coverage due to the Participant's termination of employment or reduction in hours, elected COBRA when it was offered, and have COBRA coverage in effect at the time of the notice<br>• The name of the previously disabled Qualified Beneficiary<br>• The date that the Qualified Beneficiary ceased to be disabled according to the Social Security Administration determination<br>• The date that the Social Security Administration made its determination that disability has ceased<br>• The name and contact information for the individual sending the notice<br>A copy of the Social Security Administration's determination of disability cessation must be included with the notice of disability ceasing |
| **Address:** | Mail or hand deliver notice to:<br>Fairbanks North Star Borough School District<br>Human Resources Department<br>520 Fifth Avenue<br>Fairbanks, AK 99701 |

**IF YOU HAVE QUESTIONS**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to Risk Management. For more information about your rights under the COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov

## Uniformed Services Employment and Reemployment Rights (Userra)

On October 13, 1994, Congress enacted and the President signed, the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), a law governing reemployment rights of returning veterans. USERRA was amended by the Veterans Benefits Improvement Act of 2004 and may be described as follows:

- If you are covered by the Fairbanks North Star Borough School District Health Plan and might otherwise lose coverage because of an absence due to service in the U.S. military, you and your qualified Dependents may be entitled to elect continuation coverage for a period of up to 24 months following the date the absence begins. (This is available to you regardless of whether you are otherwise entitled to COBRA coverage, and the continuation period under USERRA and any continuation period under COBRA will run concurrently.)
- Those entitled to elect continuation coverage are the same covered individuals who are Qualified Beneficiaries for purposes of COBRA continuation coverage.
- If you do not choose continuation coverage, your group health coverage will end.
- If you do choose continuation coverage, the plan is required to give you coverage which, as of the time coverage is provided, is identical to the coverage provided under the plan to similarly situated employees or family members.

- The USERRA requires that you be afforded the opportunity to maintain continuation coverage for up to 24 months beginning from the date on which the absence for military service begins. If you are released from military service and do not apply for, or return to employment, within the time periods specified in the law, your continuation coverage period can be shorter than 24 months.

- If you elect continuation coverage during the period of absence for military service reasons, you will be required to pay the premium for such coverage. If the period of military service does not exceed 31 days, the premium amount will be the same employee premium charged to similarly-situated active employees. If the period of military service is longer than 31 days, the premium amount will be 102% of the total premium amount (both the employer and employee premium cost) for such coverage under the plan.

## HOW TO FILE A CLAIM

Medical, Dental and Vision claims must be submitted within 90 days after receiving the service or supply. If this is not reasonably possible, the claim will still be accepted beyond the 90-day period, but not later than one year after the original 90 days end.

***Important:*** *Claims not received within this 15-month period will be denied. No further consideration will be given for payment, and an appeal will not be accepted.*

If you are submitting the claims yourself, there is one claim form for filing medical, dental, vision and hearing claims to the Claims Office. One claim form may be submitted for a combination of any of these benefits for 1 person. A separate claim form must be submitted for each individual in a family.

Claim forms are available online www.fnsbandsd.com or from Human Resources or Risk Management. The claim forms are not available from the Claims Office.

Here are the steps for employees or dependents to file a claim:

Provide your health plan ID card with the pharmacy plan information and run through for any discounted pricing.

***Note:*** *It is your or your Dependent's responsibility to make sure the claim is received within the time frame outlined above and to supply any other information necessary to process the claim. If the claim and/or any other requested information is not received by the Claims Office within the 15-month period, the claim will be denied.*

*Many providers will submit claims for you. Health care providers should submit medical claims to Aetna and dental claims to the Claims Office. If a provider submits claims on your behalf, do not submit the claims yourself. This causes unnecessary duplication of paperwork.*

*If you do not get a written Explanation of Benefits notice from the Claims Office within 45 days after receiving the service or supply, please contact the Claims Office to make sure the claim was received. You may need to contact your Health Provider to follow up.*

***Note:*** *Even if the provider submits the claim, you or your dependent need to make sure the claim is received within the specified time frame and supply any other information necessary to process the claim. If you do not provide a claim and/or any other requested information to the Claims Office within the 15-month period following the date of service, the claim will be denied.*

### Foreign Country Medical Services

Health Providers must be licensed as a Health Provider in the country where the services are performed. If possible, have the health fee invoice translated into English, including the U.S. currency exchange rate, before submitting to the Claims Office.

Hospital services for non-emergent or elective procedures incurred outside the U.S. will be covered only if hospital in which the service is rendered is accredited by the Joint Commission International.

### Prescription Drug Claims

Most prescription claims are processed when a prescription is purchased at the pharmacy or at time of mail order. For non-participating pharmacy claims, forms can be found at www.caremark.com.

### Vision Claims

Vision claims must be submitted to VSP within 90 days after receiving the service or supply. If this is not reasonably possible, the claim will still be accepted beyond the 90-day period, but no later than 9 months after the original 90 days end.

***Important:*** *Claims not received by VSP within this 12-month period will be denied. No further consideration will be given for payment, and appeal will not be accepted.*

There is one claim form for filing vision claims to VSP. This form can be found at www.vsp.com. A separate claim form must be submitted for each individual in a family.

**Change of Address**

To change an address for an employee, contact Human Resources. Human Resources will update your address for health benefits and notify Risk Management. Human Resources and Risk Management are the only departments authorized to change a mailing address for an employee under this health benefit plan.

## Claim Review, Processing And Appeal Procedures

The laws of the State of Alaska will govern the provision of benefits and the plan's rights of subrogation and recovery as contained herein. Venue regarding any dispute in litigation shall be in Fairbanks, Alaska. Participants under the plan are subject to the personal jurisdiction of such court(s).

The Claim review and appeal processes are described below. Please note that "you" and "your" refers to the Participant, whether an employee or a Dependent.

**CLAIM REVIEW**

Claims are divided into 3 types.

**Pre-Service Non-Urgent Health Claims**

Pre-Service Claims include only the following services that require precertification or preauthorization:

- services which must be precertified by the Utilization Review provider; or
- prescription drugs which must be preauthorized by the Pharmacy Network Services provider or Claims Office; or
- travel preauthorization determinations which address medical necessity or the appropriate level of care.

If the services have been provided already and the only issue is what payment, if any, will be made, the Claim will be processed as a Post-Service Health Claim.

**Please note: If you need emergency medical care for a condition which could seriously jeopardize your life, the plan does not require you to contact the plan for prior approval. You should obtain such care without delay.** Further, if the plan does not require you to obtain approval of a medical service prior to getting treatment, then there is no Pre-Service Claim. You simply follow the plan's procedures with respect to any notice which may be required after receipt of treatment and file the Claim as a Post-Service Claim.

Pre-Service Non-Urgent Health Claims will be processed as follows:

- Generally within 15 days of receipt.
- The processing period may be extended for up to 15 days, if the extension is necessary due to matters beyond the plan's control. You will be notified within the initial 15-day period of the reason for the extension and the date by which the plan expects to make a decision regarding the Claim.

  If the extension is necessary because you need to provide additional information for the plan to process the Claim, the plan will provide you notice within 5 days after receipt of the Claim. The notice will describe the specific information necessary to process the Claim and you will have at least 45 days from receipt of the notice to submit the additional information. The plan's processing time does not include the period from the date the request for information is sent until the information is received by the plan

**Concurrent Care Claims**

Concurrent Care Claims are Pre-Service Claims involving an ongoing course of treatment to be provided over a period of time or for a number of treatments.

- A Claim to extend a course of treatment beyond the period of time or number of treatments previously approved will be treated as a new Claim and processed within the timeframes appropriate to that type of claim.
- If the Claim involves urgent care, it will be processed within 72 hours after receipt of the Claim.
- If the plan reduces or terminates certification for a course of treatment before the end of the previously approved period or number of treatments, the plan will notify you in advance of the reduction or termination and will allow you to appeal. You will receive a determination on the appeal before the benefit is reduced or terminated.

**Post-Service Health Claims**

This includes Claims in which treatment or services have already been provided. See the "How to file a claim" section.

Post-Service Health Claims will be processed as follows:

- Generally, within 30 days of receipt.
- The processing period may be extended for up to 15 days, if the extension is necessary due to matters beyond the plan's control. You will be notified within the initial 30-day period of the reason for the extension and the date by which the plan expects to make a decision regarding the Claim.

  If the extension is necessary because you need to provide additional information for the plan to process the Claim, the plan will provide you notice within 5 days after receipt of the Claim. The notice will describe the specific information necessary to process the Claim and you will have at least 45 days from receipt of the notice to submit the additional information. The plan's processing time does not include the period from the date the request for information is sent until the information is received by the plan.

**Adverse Benefit Determinations**

If benefits are denied, in whole or in part, or if you experience a rescission of coverage, you will receive written notice of the denial, and will have the opportunity to appeal.

You may appoint an authorized representative to act on your behalf with respect to a Claim, provided the individual satisfies the plan's requirements to be an authorized representative. Please note, a healthcare provider is not an authorized representative simply because of an assignment of benefits. Contact the Claims Office for information on the plan's procedures for appointing an authorized representative.

A written Claim denial will contain the following information:

- Information to identify the Claim, including, the date of service, the health care provider, the Claim amount (if applicable);
- The specific reasons for the denial;
- Specific reference to pertinent plan provision(s) on which the denial is based;
- A description of any additional material or information necessary and an explanation of why such material or information is necessary;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy will be provided to you free of charge upon request;
- If the denial is based on medical necessity, or experimental or investigational treatment, or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request;
- A statement that you are entitled to receive, upon request, and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your Claim for benefits;
- A description of the plan's Internal Review and External Review Procedure and the applicable time limits;
- The identity of any medical or vocational experts consulted in connection with a Claim, even if the plan did not rely upon their advice (or a statement that the identity of the expert will be provided upon request and free of charge); and
- The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established by the Public Health Service Act Section 2793.

If you have questions about the denial of benefits, you should contact the Claims Office.

**CLAIM APPEAL – OVERVIEW**

You may appeal the denial of benefits. The plan's review process provides:

- You have 180 days following the notification of an adverse benefit determination to appeal the initial determination to Level 1 Internal Review;

- You have the opportunity to submit written comments, documents, records, and other information relating to the Claim for benefits when you submit your appeal;
- Someone who is neither the individual who made the original adverse benefit determination, nor the subordinate of such individual will conduct a review that does not rely upon a previous adverse benefit determination;
- The review will take into account all comments, documents, records and other information you submit relating to the Claim, without regard to whether this information is new or was submitted or considered in any prior benefit determination;
- If the determination is based upon a medical judgment, the plan shall consult with a health care professional who has appropriate training and expertise in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the original adverse benefit determination, nor the subordinate of any such individual;
- The plan will identify any medical or vocational experts whose advice was obtained on behalf of the plan in connection with a Claim, even if the plan did not rely upon their advice; and
- You will receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim for benefits in possession of the plan; any internal rule, guidelines, protocol, or other similar criterion relied upon in making the adverse benefit determination; and any explanation of the scientific or clinical judgment for the determination, applying the terms of the plan your medical circumstances.

The plan offers a two-level Internal Review procedure to provide you with a full and fair review of an adverse benefit determination. If you complete two levels of Internal Review and are dissatisfied with the determination, you may request an External Review. You must follow the steps in the order listed below.

**Step 1 – Level 1 Internal Review**

Appeal to the Claims Office or Prescription Network Services provider in writing **within 180 days** of the written notice of adverse benefit determination.

**Step 2 – Level 2 Internal Review**

If the Claim is not resolved to your satisfaction, notify Risk Management in writing after completing Step 1. You must file your Step 2 appeal in writing **within 60 days** following the date on the notice of adverse benefit determination for the Level 1 Internal Review.

**Step 3 – External Review**

If you are dissatisfied with the decision of the Level 2 Internal Review, you may submit a written request for External Review conducted by a qualified Independent Review Organization (IRO). You must follow both Internal Review steps prior to requesting an External Review. The request must be submitted to the Claims Office in writing within 4 months after the date of the notice of the adverse benefit determination for the Level 2 Internal Review. Contact Risk Management for an External Review Form.

**Note:** *If there is no corresponding day 4 months after the date of the notice on the Level 2 Internal Review, then the request must be filed by the 1st day of the fifth month following the date of the notice.*

Each of the steps is outlined in detail below and a flow chart is provided at the end of this section.

**LEVEL 1 INTERNAL REVIEW**

When a Claim has been denied or partially denied, you may seek an appeal under these Internal Review procedures. You must follow steps in this appeal process in the order and time periods described or you will lose the right to further review of the Claim denial.

The first level of review will be performed by the Claims Office, Utilization Review Provider or Prescription Network Services provider, depending on the type of Claim.

**Your Responsibility**

You or your authorized representative must file the appeal in writing **within 180 days** following the date on the written notice of an adverse benefit determination. To file an appeal in writing, the appeal must be addressed as follows:

Medical, Dental, and Hearing Appeals:
Attn: Appeals
c/o WPAS, Inc.
P.O. Box 34203
Seattle, WA 98124-1203

Prescription Drug Appeals and Specialty Medications:
CVS/Caremark, Inc
Appeals Department
MC109
P.O. Box 52084
Phoenix, AZ 85072-2084

Vision Appeals:
Vision Service Plan (VSP)
P.O. Box 9971405
Sacramento, CA 95899-7105

It is your responsibility to submit proof that the Claim for benefits is covered and payable under the provision of the plan. Any appeal must include:

- The name of the Participant;
- The Participant's social security number or alternative plan identification number (if applicable);
- All facts or theories supporting the Claim for benefits;
- A statement in clear and concise terms of the reason or reasons for the disagreement with the handling of the Claim (why you believe the claim should not be denied); and
- Any material or information which indicates that the Participant is entitled to benefits under the terms of the plan.

It is also helpful for you to provide:

- A copy of the adverse benefit determination;
- Names of anyone you contacted regarding the original claim or the appeal, and the dates the individual(s) were contacted; and
- Copies of documents supporting your appeal, such as medical chart notes, Health Provider letter(s) in support of your appeal, etc.

**The Plan's Responsibility**

The Claims Office, Utilization Review provider or Prescription Network Services provider will notify you of the plan's benefit determination on review within the following time frames:

- Pre-Service Non-Urgent Care Claims – within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
- Concurrent Claims – the response will be made in the appropriate time period based on the type of Claim (Pre-Service Non-Urgent or Post-Service).
- Post-Service Claims – within a reasonable period of time, but not later than 30 days after receipt of the appeal.

The period of time within which the plan's determination is required to be made shall begin at the time the Level 1 Internal Review is filed, as determined by the post-mark (or if hand delivered or delivered electronically, the date of receipt by the Claims Office, Utilization Review Provider or Prescription Network Services provider), regardless of whether all information necessary to make a determination accompanies the filing.

The plan's determination will include the same information as described in the section entitled Adverse Benefit Determinations.

**LEVEL 2 INTERNAL REVIEW**

If the Claim is not resolved to your satisfaction during the Level 1 Internal Review, you may proceed to Level 2 Internal Review. The Level 2 Internal Review will be done by Risk Management, as Plan Administrator.

**Your Responsibility**

You or your authorized representative must file a written appeal **within 60 days** following the date on the written notice of an adverse benefit determination on Level 1 Internal Review. The appeal must be addressed as follows:

FNSB Risk Management
907 Terminal Street
P.O. Box 71267
Fairbanks, AK 99707-1267

It is your responsibility to submit proof that the Claim for benefits is covered and payable under the provision of the plan. Any appeal must include:

- The name of the Participant;
- The Participant's social security number or alternative plan identification number (if applicable);
- All facts or theories supporting the Claim for benefits;
- A statement in clear and concise terms of the reason or reasons for the disagreement with the handling of the Claim (why you believe the claim should not be denied); and
- Any material or information which indicates that the Participant is entitled to benefits under the terms of the plan.

It is also helpful to provide:

- A copy of the adverse benefit determination;
- Names of anyone you contacted regarding the original claim or the appeal, and the dates the individual(s) were contacted; and
- Copies of documents supporting your appeal, such as medical chart notes, Health Provider letter(s) in support of your appeal, etc.

**The Plan's Responsibility**

If the Claim involves Medical Necessity, Risk Management will verify that the Claim has been reviewed by two separate medical professionals (such as the Utilization Review provider and an independent medical consultant or the Prescription Network Service provider and an independent medical consultant). If the Claim has not been reviewed by two separate medical professionals prior to Level 2 Internal Review or if you provided additional information that necessitates additional review, Risk Management will ask the Claim Office to send the appeal to an independent medical consultant prior to making a determination on the Level 2 Internal Review. Risk Management will verify that the opinions of two independent medical professionals are in concurrence. Risk Management will not review medical records or obtain additional medical opinions.

Risk Management will notify the Participant of the plan's benefit determination on the Level 2 Internal Review according to the following timeframes:

- Pre-Service Non-Urgent Care Claims – within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
- Concurrent Claims – the response will be made in the appropriate time period based on the type of Claim (Pre-Service Non-Urgent or Post-Service).
- Post-Service Claims – within a reasonable period of time, but not later than 30 days after receipt of the appeal.

The period of time within which the plan's determination is required to be made shall begin at the time the Level 2 Internal Review is filed, as determined by the post-mark (or if hand delivered or delivered electronically, the date of receipt by Risk Management), regardless of whether all information necessary to make a determination accompanies the filing.

The plan's determination will include the same information as described in the section entitled Adverse Benefit Determinations.

## EXTERNAL REVIEW PROCEDURE

If the Claim is not resolved to your satisfaction during the Level 2 Internal Review, you may proceed to External Review. You cannot proceed to External Review unless you complete the Level 1 and Level 2 Internal Review processes within the timeframes specified above. If your Internal Review appeal is not decided timely, it is considered denied, and you may proceed to External Review. External Reviews are conducted by a qualified Independent Review Organization (IRO).

### Your Responsibility

You or your representative may request a review by an IRO within 4 months after the date of the notice of the plan's adverse decision regarding the Level 2 Internal Review. If there is no corresponding day 4 months after the date of the notice on the Level 2 Internal Review appeal determination notice, then the request must be filed by the 1st day of the fifth month following the date of the notice.

Your request for External Review must be in writing and include:

- The name of the Participant;
- The Participant's social security number or alternative plan identification number (if applicable);
- All facts or theories supporting the Claim for benefits;
- A statement in clear and concise terms of the reason or reasons for the disagreement with the handling of the Claim (why you believe the claim should not be denied); and
- Any material or information which indicates that the Participant is entitled to benefits under the terms of the plan.

The plan is entitled to charge a fee of $25 to initiate an External Review.

For an adverse benefit determination to be eligible for External Review, you must complete the required forms to process an External Review. You may obtain the appropriate forms and information on the filing process by contacting Risk Management.

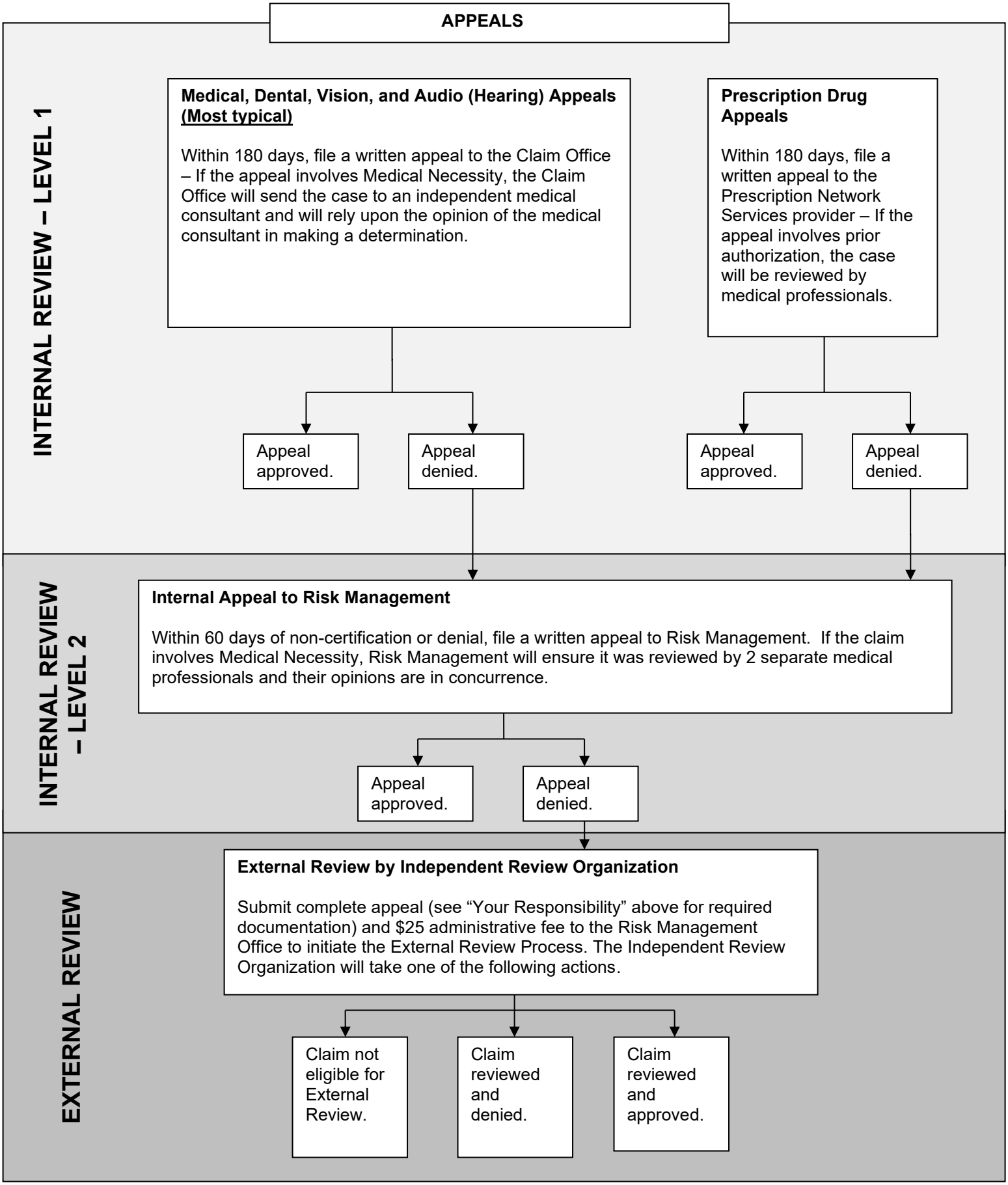
### The Plan's Responsibility

Within six (6) business days following the date of receipt of the External Review request, the IRO will provide you a written notice stating whether your request is eligible for External Review and if additional information is necessary to process the request.

- If the request is determined to be ineligible, the notice will include the reasons for ineligibility and provide contact information for the appropriate State or federal oversight agency.
- If additional information is required to process the External Review request, the notice will describe the information needed and you may submit the additional information within the 4-month filing period or within 48 hours of receipt of the notification, whichever is later.

The IRO will make a final determination and provide written notice to you and to the plan no later than 45 days from the date the IRO receives your request for External Review. The notice from the IRO will contain a discussion of its reason(s) and rationale for the decision, including any applicable evidence-based standards used, and references to evidence or documentation considered in reaching its decision.

The decision of the IRO is binding upon you and the plan, except to the extent other remedies may be available under applicable law. Before filing a lawsuit against the plan, you must exhaust all available levels of review as described in this section, unless an exception under applicable law applies. Any legal action to obtain benefits must be commenced in the 4$^{th}$ Judicial District of the State of Alaska within one (1) year of the date of the Notice of Determination on the final level of Internal or External Review, whichever is applicable.


APPEALS
INTERNAL REVIEW – LEVEL 1
Medical, Dental, Vision, and Audio (Hearing) Appeals (Most typical)
Within 180 days, file a written appeal to the Claim Office – If the appeal involves Medical Necessity, the Claim Office will send the case to an independent medical consultant and will rely upon the opinion of the medical consultant in making a determination.
Prescription Drug Appeals
Within 180 days, file a written appeal to the Prescription Network Services provider – If the appeal involves prior authorization, the case will be reviewed by medical professionals.
Appeal approved.
Appeal denied.
Appeal approved.
Appeal denied.
INTERNAL REVIEW – LEVEL 2
Internal Appeal to Risk Management
Within 60 days of non-certification or denial, file a written appeal to Risk Management. If the claim involves Medical Necessity, Risk Management will ensure it was reviewed by 2 separate medical professionals and their opinions are in concurrence.
Appeal approved.
Appeal denied.
EXTERNAL REVIEW
External Review by Independent Review Organization
Submit complete appeal (see "Your Responsibility" above for required documentation) and $25 administrative fee to the Risk Management Office to initiate the External Review Process. The Independent Review Organization will take one of the following actions.
Claim not eligible for External Review.
Claim reviewed and denied.
Claim reviewed and approved.

## Coordination of Benefits

Coordination of Benefits (COB) is a method of integrating benefits payable under more than one health plan so that the covered person's benefits from all sources do not exceed 100% of Allowable Expenses. Benefits under this plan will be coordinated with those of the other plans.

COB affects all medical, dental, audio and vision benefits. This plan does not coordinate prescription drug benefits for Participants in Plan C. For Participants in Plan B, prescription drug benefits are coordinated under the medical benefit.

This plan coordinates benefits with the following:

- this plan,
- group health care programs issued by insurers, health care services contractors, health maintenance organizations (HMO's) and prepayment plans,
- other arrangements of insured or self-insured group coverage,
- any labor-management trustee plan, union welfare plan, employer organization plan or employee benefit organization plan, and
- any government plan or statute providing benefits for which COB is not prohibited by law (including Medicare).

When married couples are both covered under the Borough or School District plans, each plan will be considered a separate plan with respect to these Coordination of Benefits provisions. The amount payable will not exceed 100% of the Allowable Charges for the covered treatment or service.

When the COB provision reduces the benefits payable under this plan:

- each benefit is reduced proportionately, and
- only the reduced amount is charged against any benefit limits under this plan.

Allowable Expense means the Usual, Customary and Reasonable charge for any Medically Necessary expense, at least part of which is covered under at least one of the plans covering the person for whom the claim is made or service is provided. Allowable Expenses do not include the difference between the cost of a private Hospital room and a semi-private Hospital room unless the patient's stay in a private Hospital room is Medically Necessary.

Benefits under a government plan will be taken into consideration without expanding the definition of Allowable Expense beyond the Hospital, medical and surgical benefits as may be provided by such governmental plan.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

For this purpose, benefits payable under other plans will include the benefits that would have been paid had a claim been made for them. Also, for any person eligible for Medicare Part A, benefits payable will include benefits provided by Medicare Part B whether or not the person is enrolled under that Part B.

If you are covered under automobile fault or no-fault insurance, or if a third party is or may be liable for your injuries, see the "Subrogation" and "Right of Reimbursement" sections of this document.

**ORDER OF BENEFIT DETERMINATION**

Certain rules are used to determine which of the plans will pay benefits *first*. This is done by using the *first* of the following rules which apply:

**No Plan COB Provision**

That plan will determine its benefits before a plan with a COB provision.

**Nondependent/Dependent**

A plan that covers a person other than as a dependent will determine its benefits before a plan that covers such person as a dependent.

**Dependent Child-Parents Not Separated or Divorced, or Unmarried Parents who Live Together**

When a claim is made for a dependent child who is covered by more than one plan:

- the benefits of the plan of the parent whose birthday falls earlier in the year will be determined before the benefits of the plan of the parent whose birthday falls later in that year, but
- if both parents have the same birthday, the benefits of the plan which covered the parent longer will be determined before those of the plan that covered the other parent for a shorter period.

  *Note: This method of determining the order of benefits is referred to as the "birthday rule".*
- However, if the other plan does not have the "birthday rule", but instead has a rule based on the gender of the parent, and, if consequently, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

**Dependent Child - Separated or Divorced Parents**

If two or more plans cover a dependent child of divorced or separated parents, benefits for the child are determined in this order:

- first, the plan of the natural parent with custody of the child will pay its benefits,
- then, the plan of the spouse of the natural parent with custody of the child will pay, its benefits,
- then, the plan of the natural parent without custody of the child will pay its benefits, and
- finally, the plan of the spouse of the natural parent without custody of the child will pay its benefits.

If the parents were never married and do not live together, use the same rule applied to divorced parents.

However, if there is a court decree stating:

- which parent is responsible for the health care expenses of the child, then the plan covering the child as a dependent of that parent will determine its benefits before any other plan, or
- that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules for dependent children of parents who are not separated or divorced.
    - The benefits of the plan of the parent whose birthday falls earlier in the year will pay first,
    - Then the plan of the spouse of that parent will pay its benefits,
    - Then the plan of the parent whose birthday falls later that year will pay its benefits,
    - Then the spouse of that parent will pay its benefits.
    - If both parents have the same birthday, the benefits of the plan which covered the parent longer will be determined first. The order of determination of the spouses and other parent shall follow in the same way described above.

**Active/Inactive Employee**

Benefits of a plan which covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, are determined *before* the benefits of a plan which covers that person as a laid-off or retired employee or as the employee's dependent.

If one of the plans does not have this rule, and if, therefore, the plans do not agree on the order of benefits, this rule will not apply.

**Longer/Shorter Length of Coverage**

If none of the above rules establish the order of payment, a plan under which the person has been covered for the longer time will determine its benefits before a plan covering that person for a shorter time.

Two successive plans of the same group will be considered one plan if the person was eligible for health benefits under the new plan within 24 hours after the old plan terminated. A change in the amount or scope of benefits, or a change in the carrier, or a change from one type of plan to another (e.g., single employer plan to a multiple employer plan) will not constitute the start of a new plan.

**Medicare Exception**

This provision applies to an active employee or spouse who is 65 years old or more. Benefits under this plan will not be reduced by any Medicare benefits that person is entitled to. Unless otherwise required by Federal law, benefits payable under Medicare will be determined after the benefits payable under this plan.

In addition, this provision applies to an active employee or eligible dependent that qualifies for Medicare benefits because of a disability. Benefits under this plan will not be reduced by any Medicare benefits that person is entitled to. This plan is considered primary for Coordination of Benefits purposes.

**Coverage Under Medicare and This Plan for End-Stage Renal Disease**

If, while actively employed, an eligible individual under this plan becomes entitled to Medicare because of end-stage renal disease (ESRD), this plan generally pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this plan pays second.

**Secondary Coverage**

Plan members who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the Plan member incurring costs, which are not covered by the Plan and which would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which would have been payable by such secondary coverage, except to the extent that such costs are payable in any event by the Plan.

# Subrogation and Right of Recovery

## THIRD PARTY LIABILITY

A third party may be liable or legally responsible for expenses incurred by you or a Dependent for a health condition. The plan does not provide benefits for an injury, accident or illness to the extent for which there is a recovery against a third party. However, if you or your Dependent has medical expenses as a result of an injury, accident or illness for which a third party is or may be held responsible, the plan, as a convenience to you or your Dependent, may advance payment of such expenses on the condition that you or your dependent and/or legal counsel , if any, sign and return a Subrogation and Reimbursement Agreement and provide any other information as requested by the plan. The plan may suspend benefits until such Agreement is executed and returned to the Claims Office along with all other requested information.

You and/or your Dependent must notify the Claims Office promptly of any injury, accident, or known illness for which any third party is or may be liable. The Claims Office must also be notified immediately if you hire an attorney and/or file a lawsuit relating to any injury, accident or illness for which a third party is or may be liable. Failure to provide required notice may cause the claimant to be personally liable to the plan for any and all medical benefits paid relating to the applicable accident/injury/illness.

The plan shall be entitled to subrogation and/or reimbursement of all rights of recovery of a participant (you or your Dependent), his or her parent(s) and dependent(s) or a representative, guardian or trustee of the participant, parent(s) or dependent(s), or any other individuals or entities that may receive a recovery on a participant's behalf (hereinafter, collectively "claimant"). The plan is subrogated to any and all rights of recovery and causes of action that the claimant may have against any third party, whether by suit, settlement or otherwise, that may be liable for a claimant's injury or illness for which the plan has paid or may pay on the claimant's behalf.

The plan will not pay benefits for an injury, accident, or illness for which a third party may be responsible until medical payment coverage is exhausted from any and all other sources, including but not limited to the third party's or claimant's automobile, uninsured/underinsured motorist, other policies of insurance, or any other recovery source. Claimant will be required to provide proof of payment/exhaustion of applicable coverage to the Claims Office.

Benefits may be withheld or denied until claimant is in full compliance with all plan provisions regarding subrogation and recovery.

The laws of the State of Alaska will govern the provision of benefits and the plan's subrogation right / first right of recovery. Venue regarding any dispute in litigation shall be in Fairbanks Alaska. Participants under the plan are subject to the personal jurisdiction of such court(s).

### Claimant's Responsibilities

Claimant shall provide all requested information as well as sign and return appropriate documents to the Claims Office. Claim payments may be withheld until claimant complies fully with the Claims Office, making sure all information and documents are received in a timely manner.

The plan has the right to take over claimant's right to receive benefit payment from any third party. Claimant shall:

- upon request, transfer to the plan any rights to take legal action against any third party for benefits paid under this plan subject to this provision,
- cooperate fully with the plan in asserting its right to reimbursement, and
- not take any action which would prejudice the plan's subrogation and reimbursement rights.

Claimant shall notify the Claims Office upon entering into a settlement with a third party, entry of judgment against a third party, and upon receipt of funds relating to the accident, injury, or illness from any third party or its insurer/guarantor or any other recovery source.

### 100% First-Dollar Right of Recovery

The plan has the right to recover or subrogate 100% of the benefits paid or to be paid under this plan that the claimant is entitled to receive from any third party and/or any other recovery source on a priority first-dollar basis, without apportionment of value, reduction, or offset of any kind, whether by suit, settlement or otherwise, regardless of whether the total recovery amount is less than the actual loss suffered, and regardless of whether

the recovery is described as being related to medical costs. Once the plan makes or is obligated to make payments on behalf of a claimant, the plan is granted and the claimant consents to an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement or judgment received by claimant from any source to the extent of payments made or to be made by the plan on the claimant's behalf. The plan will have a first lien on any recovery (by settlement, judgment or otherwise) claimant receives from:

- any third party or its insurer or guarantor, and
- Any other recovery sources. Other recovery sources include, but are not limited to a responsible party and/or responsible party's insurer or self-funded protection, any no-fault protection, personal injury protection, medical payments coverage, financial responsibility, uninsured or underinsured insurance coverage, an employer under the provisions of a workers' compensation law and an individual policy of insurance maintained by a claimant.

This lien will be for the benefit amount paid under this plan to treat the health condition for which the third party is or may be liable or legally responsible. If claimant:

- makes any recovery as described in this provision, and
- fails to reimburse the plan fully for any benefits paid under this provision,

then claimant will be personally liable to the plan to the extent of the recovery up to the amount of the first lien.

The plan may pursue equitable or legal relief, or both, to recover the lien amount. The plan may pursue your other assets in order to obtain repayment of the benefits paid under this section to the extent of your recovery, regardless of your disbursement of the recovery to others.

The plan may charge any reimbursement due the plan under this provision against any future benefit payments. The plan has the right to reduce any future benefit payments made to or on behalf of you or your Dependents by the amount of the recovery. This will not reduce the right of first recovery.

The plan's right to reimbursement/recovery does not terminate with settlement of your or your Dependent's claim with a third party or his/her insurer, or with the entry of a judgment by any court but continues on until all applicable treatment has been completed and the plan has been repaid in full. The plan has the right to seek recovery of benefits by any means legally available, including the initiation of litigation against the claimant.

After reimbursement of benefits paid by the plan, the plan may be relieved of any obligation to pay further benefits to claimant, up to the entire net amount of the balance of the settlement judgment recovered by claimant.

The plan's subrogation and reimbursement rights apply to any recovery by the claimant without regard to legal fees and expenses of the claimant. The claimant shall be solely responsible for paying all legal fees and expenses in connection with any recovery for the underlying injury, sickness, accident or condition, and the plan's recovery shall not be reduced by such legal fees or expenses, unless the plan administrator, in his or her sole discretion, agrees in writing to discount the plan's claim by an agreed-upon amount of such fees or expenses.

The plan specifically disavows any federal or state common law defense including, but not limited to, the make-whole doctrine and/or the common fund doctrine.

The Plan reserves the right to pursue the Plan's subrogation interest. The Plan does not authorize you or your Dependent to recover the Plan's lien unless the Plan specifically agrees to such authorization.

**Disputes Regarding Subrogation/Recovery Amount**

Presentation, inclusion or incorporation of any medical bill or cost in any manner, whether via hardcopy, electronic transmission, or oral argument, within any demand for damages or at a proceeding in any court or before any tribunal or administrative body, including but not limited to arbitration and/or mediation, as proof of damages incurred or in furtherance of any demand for settlement, repayment, reimbursement, or recompense of any kind from any third party or other recovery source whatsoever shall be conclusive proof that the medical bill or cost is related to the injury or accident. Such bill or cost shall be included within the plan's subrogation/right of recovery. Claimant must provide copies or itemization of all such bills or costs to the plan upon request.

Claimant may dispute the plan's subrogation/right of recovery through the plan's Claim Review and Appeal Procedures.

## Claim Payment Recovery

The plan also has the right to recover any payments made by the plan that exceed the maximum amount allowed under this plan. The Claims Office will determine the amount and from which party to recover the excess payment. Recovery may be requested from:

- any persons to, or for whom the payments were made,
- any insurance companies, and
- any other organizations.

You or your Dependent must cooperate fully with the plan in asserting its right to recover overpayments.

*Note: Be sure to notify Human Resources right away of any change that terminates health plan eligibility for a Dependent.* ***If you fail to provide timely notice, you may be liable to reimburse the plan for claims paid on this ineligible Dependent.***

The plan has the right to reduce any future benefit payments made to or on behalf of you or your Dependents by the amount of the overpayment. The Plan has the right to seek recovery of any overpayment by any means legally available, including litigation.

## Plan Administration

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan member's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

The Plan Administrator has the discretionary authority to decide whether a charge is an Allowable Charge or a Usual and Reasonable Charge for Outpatient Dialysis Treatment. Benefits under this Plan shall be paid only if the Plan Administrator decides in his or her discretion that a Plan member is entitled to them.

## HIPAA NOTICE OF PRIVACY PRACTICES

## Privacy Rule of the Administrative Simplification Provision of The Health Insurance Portability & Accountability Act of 1996 (HIPAA)

Federal regulations, effective April 14, 2003, affect the Fairbanks North Star Borough School District Health Plan.

### NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

### USE AND DISCLOSURE OF HEALTH INFORMATION

The Fairbanks North Star Borough School District Health Benefit Plan ("Health Plan") may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of making or obtaining payment for your care and conducting health care operations. Health Plan has established a policy to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

**To Make or Obtain Payment**. Health Plan may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, Health Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits and/or to adjudicate or subrogate health benefits claims, including but not limited to settlement and reimbursement. .

**To Conduct Health Care Operations**. Health Plan may use or disclose health information for its own operations to facilitate the administration of Health Plan and as necessary to provide coverage and services to all of Health Plan's Participants. Health care operations includes such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, Case Management and care coordination.
- Contacting health care providers and Participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of Health Plan, including customer service and resolution of internal grievances.

For example, Health Plan may use your health information to conduct Case Management, quality improvement and utilization review, and provider monitoring activities or to engage in customer service and claim appeal activities.

**For Treatment Alternatives**. Health Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**For Distribution of Health-Related Benefits and Services.** Health Plan may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

**For Disclosure to the Plan Sponsor.** Health Plan may disclose your protected health information (PHI) to the plan sponsor for plan administration functions performed by the plan sponsor on behalf of Health Plan. PHI will generally only be used by the FNSB Risk Management Division in carrying out its Health Plan functions as well as its plan sponsor functions in support of Health Plan. However, disclosure to the plan sponsor may include to employees in the FNSBSD Human Resources Department, FNSB Financial Services Department, the FNSB Digital Services Department, FNSBSD Information Technology Department, the FNSB Records Management Division, and the FNSB Department of Law. These plan sponsor employees are given access only to the minimum necessary PHI in order to perform the employee's Health Plan administration function. For example, Health Plan may disclose to FNSBSD Human Resources that you enrolled or disenrolled in Health Plan or may disclose limited PHI to FNSB Financial Services in order to issue a refund check.

In addition, Health Plan may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids from health insurers or modify, amend or terminate the plan.

The plan sponsor has agreed to restrict access to and use of PHI by the plan sponsor's employees consistent with the administrative functions that the plan sponsor performs for the Health Plan and only in compliance with HIPAA.

If there is any non-compliance with the required commitments to the Health Plan, the plan sponsor has agreed that the issue of noncompliance will immediately be brought to the attention of the Risk Manager for immediate attention and resolution.

**When Legally Required.** Health Plan will disclose your health information when it is required to do so by any federal, state or local law.

**To Conduct Health Oversight Activities**. Health Plan may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. Health Plan, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

**In Connection With Judicial and Administrative Proceedings**. As permitted or required by state law, Health Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when Health Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

**For Law Enforcement Purposes**. As permitted or required by state law, Health Plan may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if Health Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

**In the Event of a Serious Threat to Health or Safety**. Health Plan may, consistent with applicable law and ethical standards of conduct, disclose your health information if Health Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

**For Specified Government Functions**. In certain circumstances, federal regulations require Health Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

**For Workers' Compensation**. Health Plan may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.

## AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, Health Plan will not disclose your health information other than with your written authorization. If you authorize Health Plan to use or disclose your health information, you may revoke that authorization in writing at any time.

**Authorization for Psychiatric Notes, Genetic Information, Marketing, & Sales**
In general, and subject to specific conditions, we will not use or disclose psychiatric notes without your authorization; we will not use or disclose Protected Health Information (PHI) that is genetic information for underwriting purposes; we will not sell your PHI, i.e. receive direct or indirect payment in exchange for your PHI, without your authorization; we will not use your PHI for marketing purposes without your authorization; and we will not use or disclose your PHI for fundraising purposes unless we disclose that activity in this Notice.

## YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that Health Plan maintains:

**Right to Request Restrictions**. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on Health Plan's disclosure of your health information to someone involved in the payment of your care. However, Health Plan is not required to agree to your request. If you wish to make a request for restrictions, please contact the designated privacy officer, the Fairbanks North Star Borough Risk Manager at (907) 459-1396.

**Right to Receive Confidential Communications**. You have the right to request that Health Plan communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that Health Plan only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the designated privacy officer, the Fairbanks North Star Borough Risk Manager at PO Box 71267, Fairbanks, Alaska 99707-1267. You may fax your request to (907) 459-1187. Health Plan will attempt to honor your reasonable requests for confidential communications.

**Right to Inspect and Copy Your Health Information**. You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the designated privacy officer, the Fairbanks North Star Borough Risk Manager at PO Box 71267, Fairbanks, Alaska 99707-1267. You may fax your request to (907) 459-1187. If you request a copy of your health information, Health Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

**Right to Amend Your Health Information**. If you believe that your health information records are inaccurate or incomplete, you may request that Health Plan amend the records. That request may be made as long as the information is maintained by Health Plan. A request for an amendment of records must be made in writing to the designated privacy officer, the Fairbanks North Star Borough Risk Manager at PO Box 71267, Fairbanks, Alaska 99707-1267. You may fax your request to (907) 459-1187. Health Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by Health Plan, if the health information you are requesting to amend is not part of Health Plan's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if Health Plan determines the records containing your health information are accurate and complete.

**Right to an Accounting**. You have the right to request a list of certain disclosures of your health information that Health Plan is required to keep a record of under the Privacy Rule, such as disclosures for public purposes authorized by law or disclosures that are not in accordance with the Plan's privacy policies and applicable law. The request must be made in writing to the designated privacy officer, the Fairbanks North Star Borough Risk Manager at PO Box 71267, Fairbanks, Alaska 99707-1267. You may fax your request to (907) 459-1187. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. Health Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. Health Plan will inform you in advance of the fee, if applicable.

**Right to a Paper Copy of this Notice**. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the designated privacy officer, the Fairbanks North Star Borough Risk Manager (907) 459-1396.

## DUTIES OF HEALTH PLAN

Health Plan is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. Health Plan is required to abide by the terms of this Notice, which may be amended from time to time. Health Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If Health Plan changes its policies and procedures, Health Plan will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to Health Plan and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to Health Plan should be made in writing to the designated privacy officer, the Fairbanks North Star Borough Risk Manager at P.O. Box 71267, Fairbanks, Alaska 99707-1267. You may fax your request to (907) 459-1187. Health Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

## CONTACT PERSON

Health Plan has designated the Fairbanks North Star Borough Risk Manager as its contact person for all issues regarding patient privacy and your privacy rights. You may contact this person at the Fairbanks North Star Borough, P.O. Box 71267, Fairbanks, Alaska 99707-1267. Telephone (907) 459-1396, Fax (907) 459-1187.

## EFFECTIVE DATE

This Notice is effective September 19, 2013.

**IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT**

Fairbanks North Star Borough Risk Manager at the Fairbanks North Star Borough Human Resources Department, P.O. Box 71267, Fairbanks, Alaska 99707-1267. Telephone (907) 459-1396, Fax (907) 459-1187

# DEFINITIONS

**Acupuncture**

A branch of medicine in which needles are inserted into a patient's skin as therapy for various disorders.

**Allowable Charges**

Charges for Medically Necessary covered services rendered or supplies furnished by a covered provider to the extent that such charges are Usual, Customary & Reasonable (UCR) for the area and type of service, except for charges for outpatient dialysis.

The Term "Allowable Charges" for outpatient dialysis is the "Usual and Reasonable" amount as that term is defined in the provisions for Outpatient Dialysis.

The Allowable Charges at a non-PPO facility in the Municipality of Anchorage for Inpatient services will be limited to the contracted rate at the Preferred Provider Facility.

The Allowable Charges for Outpatient services at a non-PPO provider in the Municipality of Anchorage will be the case rate at the Preferred Provider Facility, if any, or 50% of the billed charges if no case rate is available.

**Allowable Expenses**

For the purpose of Coordination of Benefits (COB), Allowable Expense means the Usual, Customary and Reasonable charge for any Medically Necessary expense, at least part of which is covered under at least one of the plans covering the person for whom the claim is made or service is provided. For more information, see the Coordination of Benefits section. This section may not apply for outpatient dialysis services. Please see Dialysis Treatment - Outpatient for more information on such providers.

**Ancillary Charges**

Hospital Charges for services and supplies that are Medically Necessary for the comfort and care of a patient. Examples: lab tests, x-rays, personal-use items, etc. These charges do not include items such as room and board, or telephone/television charges. Also known as Hospital Extras.

**Attending Physician**

The Physician who has principal responsibility and authority for a patient's care in the Hospital. Resident Physicians may perform various procedures for that patient but do so under the direction and supervision of the Attending Physician.

**Audiologist**

A licensed specialist that can diagnose and treat hearing and speech-related problems:

- conduct hearing tests to determine the degree of damage done to the hearing ability by injury or disease,
- can recommend hearing aids, and train people to overcome problems related to hearing loss or speech impediments,
- Audiologists are not Physicians and therefore cannot treat infections or other diseases.

**Beneficiary**

See Qualified Beneficiary.

**Bridge (Dental)**

False teeth (usually no more than 4) attached to natural teeth on either side of a gap left by a missing tooth or teeth. Some Bridges are removable. Unlike a Denture, a Bridge has no baseplate (artificial gum).

**Calendar Year**

A year that begins January 1st and ends December 31st.

**Case Management**

Review of the Medical Necessity and appropriateness of healthcare services, supplies, equipment and care that is recommended or that a patient is receiving.

**Chiropractor**

A person licensed and certified to practice chiropractic services. Chiropractic is the system that uses the recuperative powers of the body and relationship between the musculoskeletal structures and functions of the body, particularly of the spinal column and the nervous system, in the restoration and maintenance of health.

**Claim**

A request for a plan benefit, made by a Participant that complies with the plan's reasonable procedures for filing benefit Claims. A Claim does not include an inquiry on a Participant's eligibility for benefits.

**Claims Office**

The company contracted by the Fairbanks North Star Borough School District Health Plan to receive, review and process health plan claims according to the plan provisions.

**COBRA**

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is federal legislation that requires certain employers that offer group health plans to provide continuation coverage under the plan for a specified period of time to employees and their dependents who incur certain qualifying events that cause termination of their coverage.

**Coinsurance**

The percentage of Allowable Charges for which you are liable.

**Common Accident**

When two (2) or more persons in the same family, (you and your Dependents) are injured in the same accident.

**Coordination of Benefits (COB)**

A method of integrating benefits payable under more than one health plan so that the covered person's benefits from all sources do not exceed 100% of Allowable Expenses.

**Copay or Copayment**

A specified dollar amount you pay when receiving certain treatments, services, or supplies.

**Cosmetic Surgery**

- to change the texture or appearance of the skin, and/or
- to change the relative size or position of any part of the body
- performed primarily for psychological purposes, and
- not needed to correct or improve a bodily function.

**Custodial Care**

Services that may be performed in a facility or home environment and provide assistance with activities of daily living that require no medical intervention and are non-invasive. Services extend from basic housekeeping to complex personal care, such as meal preparation, transportation, and/or bathing.

**Deductible**

The amount you pay for Allowable Charges each Calendar Year before the plan starts to pay benefits.

**Dental Hygienist**

The role of this person is to assist members of the dental profession in providing oral health care. Some of the services this person may perform are:

- remove calcareous deposits, accretions, and stains from the exposed surfaces of the teeth,
- apply topical preventive or prophylactic agents,
- apply pit and fissure sealants,
- perform root planing and periodontal soft tissue curettage, and
- perform other dental operations and services delegated by a licensed Dentist if the dental operations are not prohibited by state law.

**Dental Services**

Confinement, treatment, or service provided to diagnose, prevent, or correct:

- periodontal disease (disease of the surrounding and supplemental tissues of the teeth, including deformities of the bone surrounding the teeth),
- malocclusion (abnormal positioning and/or relationship of the teeth), and
- ailments or defects of the teeth and supporting tissue and bone.

**Dental Treatment Period**

- All the sessions of dental care resulting from the same initial diagnosis and any related complications.

**Dental Treatment Plan**

Dentist's report of proposed treatment which:

- lists the procedures and fees required for the Dental Treatment Period,
- includes diagnostic materials the Claims Office may require, and
- expires if proposed treatment does not commence within 3 months of the date of the Claims Office's written proposed benefit notification.

**Dentist**

A person licensed to practice Dentistry. A Dentist may be designated as a Doctor of Dental Surgery (D.D.S.) or Dental Medicine Doctorate (D.M.D.). Both designations perform the same type of Dentistry. The designation only denotes the university where the Dentist obtained the dental degree.

**Denture**

A removable appliance that replaces missing natural teeth, and consists of a baseplate on which artificial teeth are mounted.

**Dependent**

An individual who meets the eligibility requirements under "Dependent" in the "Eligibility" section.

**Diagnostic Testing**

This includes, but is not limited to, laboratory tests, x-rays, ultrasounds, CT scanning MRI and radionuclide scanning.

**Disabled Dependent Child (Physically or Mentally)**

Under the health plan, a Dependent child is considered physically or mentally disabled if he or she meets the following criteria:

- The disability existed prior to the Dependent child's 19th birthday.
- The child must be chiefly dependent on you for support and maintenance.
- The child has been continuously not capable of self-sustaining employment due to a physical or mental disability.
- The child is unmarried.
- The child is 19 years old or greater.

The Claims Office must receive the completed proof of disability form 31 days before the child's 19th birthday, and may require periodic proof of the continued disability from a medical professional.

**Durable Medical Equipment (DME)**

Products include, but are not limited to manual or motorized wheelchairs, walkers, canes, hospital beds, and oxygen and pulmonary equipment.

**Eligibility**

Conditions that must be met to qualify for coverage under a plan, such as Regular employment status, hours worked, and relationship to employee.

**Emergency**

A medical condition that is life-threatening and requires immediate treatment at a medical facility. The Attending Physician must certify that the condition was life threatening.

**Employer**

Fairbanks North Star Borough School District.

**Employment Year**

The period of September 1st to August 31st of the following Calendar Year.

**Endodontist**

A Dentist who is specially trained to treat the nerves and pulp in teeth and the surrounding gum tissues. Root-canal therapy is a common endodontic procedure.

**ERISA**

Employee Retirement Income Security Act of 1974 (ERISA) is also called the Pension Reform Act. The Fairbanks North Star Borough & School District Health Plans are "public plans" and are not subject to ERISA.

**Exclusions**

Specific conditions or circumstances for which the plan will not provide benefit payments or coverage.

**Experimental or Investigational**

Means that:

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

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

**Explanation of Benefits (EOB)**

A written notice from the Claims Office that shows:

- the person who received the services or supplies,
- the covered person's name,
- the health provider or facility rendering the services or supplies,
- the date an expense was incurred,

- the Allowable Charges,
- the benefit paid on a claim,
- an explanation for any portion of an expense not paid, and
- the claim examiner's name and contact information.

**Extended Care Facility**

An institution that provides Long-Term Care.

**Fiduciary**

A person who exercises discretionary authority or control of a plan or its assets, renders investment advice, or has discretionary authority or responsibility for plan administration.

**FMLA**

Family and Medical Leave Act of 1993 is a federal law that requires employers who meet certain criteria to provide a specific number of weeks of unpaid leave to employees. The law establishes that such leaves are not COBRA qualifying events. State law may extend this period. Federal and state law requires that eligible employees be provided a health coverage continuation period in accordance with FMLA.

**Health Provider**

An individual licensed to provide health services in the state where the services are provided; including but not limited to medicine, dentistry, ophthalmology, optometry, and audiology.

**Hospital**

An institution that is:

- licensed as a hospital by the proper authority of the state in which it is located, and
- recognized as a hospital by the Joint Commission on Accreditation of Healthcare Organizations.

Outside the US, the hospital must be accredited by the Joint Commission International for nonemergent or elective services to be covered under this plan.

JCI website: www.jointcommissioninternational.org/JCI-Accredited-Organizations/

*Note: Does not include any institution, or part thereof, that is used primarily as a clinic, convalescent home, rest home, home for the aged, nursing home, Custodial Care facility, or training center.*

**Hospital Charges**

Include Hospital room, board, and other usual services. The charges must be incurred while the person is confined for at least 15 consecutive hours.

**Hospital Extras**

Charges made by the Hospital for Medically Necessary services and supplies other than room and board. Examples: operating room, recovery room, medications and surgical dressings.

Also known as Ancillary Charges.

**Hospital Precertification**

Required Medical Necessity review by the plan's Utilization Review Provider of any Inpatient hospitalization. The Utilization Review Provider must be contacted before Inpatient treatment begins. In the case of an Emergency admission you must contact the Utilization Review Provider within 48 hours or as soon as reasonably possible.

**Immediate Family**

An eligible person's spouse, dependent children, as defined in the Eligibility Requirements section.

**Inpatient**

Medical care given to a patient who has been admitted to the Hospital and registered to a room and bed.

**Lookback Period**

For hourly employees, the 12-month period during which the hours of service are measured in order to determine if the employee qualifies for health benefits. The lookback period for FNSBSD is November 1 through October 31.

**Long-Term Care**

Health and Custodial Care provided both in institutional and non-institutional settings to individuals with debilitating chronic health and mental conditions that prohibit them from taking care of themselves.

**Medicaid**

A program sponsored by the federal and state governments that pays for medical services for individuals who meet established income criteria.

**Medically Necessary or Medical Necessity**

Services or supplies that are:

- prescribed by a health care provider,
- appropriate and necessary for the symptoms, diagnosis or treatment of the health condition,
- provided for the diagnosis or direct care and treatment of the health condition,
- meet the standards of good medical practice within the medical community where the services or supplies are received,
- not primarily for the convenience of the patient or Health Provider,
- most appropriate level or supply of service which can safely be provided,
- non-Experimental or non-Investigational, and
- not in conflict with accepted medical standards.

**Medicare**

A program sponsored by the federal government to pay for certain medical expenses for qualified individuals, primarily those over age 65 and the disabled. The program includes separate but coordinated programs: (1) hospital insurance (Part A), (2) supplementary medical insurance (Part B) and (3) prescription drug coverage (Part D).

**Ophthalmologist**

A licensed Physician who specializes in the care of the eyes. They conduct examinations to determine the quality of vision and the need for corrective glasses or contact lenses. Ophthalmologists also check for the presence of any disorders, such as glaucoma or cataracts. They may prescribe glasses, contact lenses, medication, and perform surgery.

**Optician**

A person who fits, supplies and adjusts glasses or contact lenses. Because their training is limited, they may not examine or test eyes or prescribe glasses or drugs.

**Optometrist**

A licensed specialist trained to examine the eyes and to prescribe, supply and adjust glasses or contact lenses. They are not Physicians and may not prescribe drugs or perform surgery. An Optometrist refers patients requiring these types of services to an Ophthalmologist.

**Orthodontic Treatment or Service**

Any procedure for straightening of teeth including, but not limited to, formal, full-banded retention and treatment, related x-rays and other diagnostic procedures.

**Osteopathy**

A system of diagnosis and treatment that recognizes the role of the musculoskeletal system (bones, muscles, tendons, tissues, nerves, and spinal column) in the healthy functioning of the human body.

An osteopathic Physician uses manipulation techniques, as well as traditional diagnostic and therapeutic procedures, to diagnose and treat dysfunction. Manipulation includes thrusting techniques and rhythmic stretching and pressure to restore motion to the joints.

**Outpatient Treatment**

Medical care given to a person on a day-basis in a Hospital, clinic or other medical facility. The patient is not registered to a room and bed.

**Out-of-Pocket Limit**

The maximum amount you will pay for medical Allowable Charges each calendar year, after you satisfy the deductible. The Out-of-Pocket Limits for Plan C do not include prescription drugs. The Out-of-Pocket Limit for Plan B does include prescription drugs. The plan pays 100% of Allowable Charges for the remainder of the year, once the Out-of-Pocket Limit is met.

**Palliative Treatment**

Action that relieves pain but is not curative.

**Participant**

An eligible employee or Dependent as defined by this Plan.

**Physician**

A person licensed to practice medicine and surgery in all branches of medicine under the title of:

- licensed doctor of medicine - MD, or
- licensed doctor of Osteopathy - DO.

**Pre-admission Testing Charges**

Diagnostic tests that are performed:

- on an Outpatient basis, and
- within 7 days of a planned admission to a Hospital for surgery or other Inpatient treatment.

**Preferred Provider (PPO)**

A provider that has a negotiated agreement to provide services to plan Participants. If you use a Preferred Provider, you may receive a discounted rate for services and plan benefits may be more favorable.

**Primary Payer**

When a health plan Participant is covered by more than one health plan, this is the plan that processes benefits for a claim first. The determination of which plan processes benefits first is based on each plan's coordination of benefits provision.

**Qualified Beneficiary**

An employee, the employee's spouse (as defined in federal law), and the employee's Dependent children can be Qualified Beneficiaries who are entitled to elect COBRA coverage if they lose coverage under the plan because of a qualifying event. After a qualifying event has occurred (and, if applicable, proper notice has been given to Human Resources of the qualifying event), COBRA coverage must be offered to each of these "Qualified Beneficiaries" that would lose plan coverage as a result of that qualifying event.

Certain children of a Participant that are born, adopted or placed for adoption during a period of COBRA coverage may also be Qualified Beneficiaries, as explained in the section entitled "COBRA Rights for New Dependent Children."

**Qualified Medical Child Support Order**

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

- Either:
    1. Relates to medical benefits under the plan and provides for your child's support or health benefits coverage pursuant to a state domestic relations law (including a community property law); or

2. Enforces a law relating to medical child support described in Section 1908 of the Social Security Act;

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

**Regular Employee**

Is an employee filling a budgeted benefit eligible position.

**Reimbursement Percentage**

The percentage of the Allowable Charges paid by the plan.

**Second Opinion Physician**

An appropriate specialist for the particular surgery recommended, who is not a partner or associate of the Physician who recommended surgery.

**Secondary Payer**

When a health plan Participant is covered by more than one health plan, this is the plan that processes benefits for a claim after the primary plan has processed the claim and made any applicable payments. Normally the secondary plan will request a copy of the primary plan's EOB. The determination of which plan processes benefits first is based on each plan's coordination of benefits provision.

**Self-Funded Health Plan**

A plan that provides for the reimbursement of eligible health expenses incurred by covered employees and their dependents. The plan is funded by the employer, rather than through an insurance contract.

**Skilled Nursing Facility**

An institution, or distinct part thereof, that is licensed to provide skilled nursing care for persons recovering from a health condition and that:

- is supervised on a full-time basis by a Physician or a graduate registered nurse,
- has transfer arrangements with one or more Hospitals, a utilization review plan, and operating policies developed and monitored by a professional group that includes at least one Physician,
- has a contract for the services of a Physician, maintains daily records on each patient and is equipped to dispense and administer drugs, and
- provides 24-hour nursing care and other medical treatment.

Not included are rest homes, homes for the aged, or facilities for treatment of mental disease, drug addiction, or alcoholism.

**Stability Period**

The 12-month period during which health benefits shall be provided, if earned during the lookback period. The stability period is January 1 through December 31.

**Subrogation**

The right of the plan to recoup benefits paid to or on behalf of participants, if the action causing the illness or injury and subsequent medical expenses was the fault of a third party.

**Surgery Related Charges**

- Physician fee for performing a surgery (including charges for a surgical suite, if any).
- Physician fee for pathology, radiology, or the administration of anesthesia required for the surgery.
- a Hospital or other licensed medical facility for room and board and other usual services.

**Total Disability**

- Employee - A health condition that prevents an employee from performing his or her job or any job for which he or she is qualified by training, education or experience.
- Spouse - A health condition that prevents a dependent from (1) performing his or her job or any job for which he or she is qualified by training, education or experience, or (2) being able to carry on the regular and usual activities of a healthy person of the same age and gender.
- Dependent Child - A health condition that prevents a Dependent from being able to carry on the regular and usual activities of a healthy person of the same age and gender, such as attending school.

**Usual and Reasonable Charge for Outpatient Dialysis Treatment**

With respect to dialysis-related claims, the Plan shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

**Usual, Customary & Reasonable (UCR)**

The charge the plan determines to be the prevailing rate charged in the geographic area where the service is provided, or the provider's usual charge, whichever is less.

In some cases, data may be insufficient to determine a UCR rate. The plan may consider items such as the following:

- The prevailing charges in a greater geographic area,
- The complexity of the service or supply,
- The degree of skill needed,
- The type or specialty of the provider, and
- The range of services or supplies provided by a facility.

The term "Usual, Customary & Reasonable (UCR)" is not intended to be the same as the term "Usual and Reasonable for Outpatient Dialysis Treatment," as that term is defined in the Dialysis Treatment – Outpatient provision.

**Utilization Review Provider**

The company contracted by the plan to provide medical review of Inpatient hospitalizations and medical procedures, and to provide Case Management.

**Visual Exam**

The exam may involve:

- case history of patient and professional consultation,
- examination for disease or abnormalities,
- determination of the ranges of clear single vision,
- measurement of refraction, eye muscle coordination, and balance, and/or
- special working distance analysis.