Bering Strait School District

Health Care Plan

Effective Date: March 1, 1996
Restatement Date: March 1, 2011

P.O. BOX 27267
MINNEAPOLIS, MN 55427-0267

PREFACE

Introduction and Purpose
The Plan Sponsor has established the Plan for the benefit of eligible Employees, on the terms and conditions described herein. With the exception of large medical claims, for which the Plan Sponsor is protected by excess loss insurance, Plan benefits are paid by the Company and supplemented by the contributions you make to participate. The Company is independent of all health care providers and is not itself a provider of health care.

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

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

The Bering Strait School District Health Care Plan believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 907-624-3611. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov .

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

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

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

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

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

The Plan Administrator has hired a claims administration organization, Meritain Health, to perform certain administrative functions for the Plan and uses Meritain Health Medical Management for Utilization Review (UR). If you have questions regarding your coverage or how benefits have been paid, contact Meritain Health at 866-808-2609.

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

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

Customer service assistance provided by Meritain Health is not a guarantee of eligibility, coverage or benefits. Meritain Health relies upon the information provided by the Plan Administrator and will provide assistance to Covered Persons on that basis. This information is subject to changes which may not be available to Meritain Health at the time of the inquiry. Further, telephonic customer service support is never a guarantee of payment. All benefit determinations will be based upon the provisions of this Plan and the decision of the Plan Administrator in its sole discretion.

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ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT

THIS PLAN DOCUMENT, made by Bering Strait School District (the "Company" or the "Plan Sponsor") as of March 1, 2011, hereby amends and restates the Bering Strait School District Health Care Plan (the "Plan"), which was originally adopted by the Company, effective March 1, 1996.

Effective Date

The Plan Document is effective as of the date first set forth above, and each Amendment is effective as of the date set forth therein, or on such other date as specified in an applicable collective bargaining agreement (if any) with respect to the Employees covered by such agreement (the "Effective Date").

Adoption of the Plan Document

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

SCHEDULE OF BENEFITS

Major Medical Benefits

	Plan I	Plan II*	Plan III	Plan IV*
Cash Deductible per Calendar Year				
Single Coverage	$75	$75	$300	$300
Family Coverage**	$225	$225	$625	$625
Per Transplant Deductible (waived if transplant is pre-authorized	**$5,000**	**$5,000**	**$5,000**	**$5,000**
PRE-CERTIFICATION				
Pre-certification is required for all Hospital confinements as well as for certain Outpatient services. Refer to the "Special Features of Your Plan" section of this Summary Plan Description for a complete listing of these Outpatient services.				
Also, referrals by Indian Health Services ("IHS") to non-native Hospitals or medical facilities for any treatment or services not provided by IHS must be pre-certified.				
PENALTY IF NOT PRE-CERTIFIED	**$750**	**$750**	**$750**	**$750**
Out-of-Pocket Calendar Year Maximum (excludes Deductible)				
Single Coverage	$195	$0	$195	$0
Family Coverage (Each Covered Person)	$195	$0	$195	$0
Benefit Percentage (except as noted)				
Up to $1,950	90%	100%	90%	100%
After $1,950	100%	100%	100%	100%
Full Plan Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Full Plan Annual Maximum	$750,000	$750,000	$750,000	$750,000
Hospital Charges – Anchorage Facilities				
PPO Facility	90%	100%	90%	100%
Non-PPO Facility	60%	100%	60%	100%
Note: Anchorage non-PPO facility charges do not accrue toward the Out-of-Pocket Maximum limit.				
Hospital Charges - Outside Anchorage				
PPO Facility	90%	100%	90%	100%
Non-PPO Facility	90%	100%	90%	100%
Second Surgical Opinions (Deductible Waived)	100%	100%	100%	100%
Outpatient Surgery (Facility and Physician Charges)	90%	100%	90%	100%
Rehabilitation Facility	90%	100%	90%	100%
Room & Board Limit		Semi-Private room rate		

	Plan I	Plan II*	Plan III	Plan IV*
Physical Therapy	90%	100%	90%	100%
Calendar Year Limit	60 visits	60 visits	60 visits	60 visits
Speech/Pathology Therapy	90%	100%	90%	100%
Calendar Year Limit	60 visits	60 visits	60 visits	60 visits
Private Duty Nursing Care	90%	100%	90%	100%
Home Health Care	90%	100%	90%	100%
Calendar Year Maximum (one visit per day)	130 visits	130 visits	130 visits	130 visits
Subject to written order by Physician every 30 days				
Hospice Care	90%	100%	90%	100%
Skilled Nursing Facility (not for Custodial Care)	90%	100%	90%	100%
Calendar Year Limit	90 days	90 days	90 days	90 days
Organ and Bone Marrow Transplant Limits				
Lifetime Maximum	1 transplant	1 transplant	1 transplant	1 transplant
Donor Expense Maximum Per Transplant	$10,000	$10,000	$10,000	$10,000
Travel Maximum per Transplant	$10,000	$10,000	$10,000	$10,000
Spinal Manipulations	90%	100%	90%	100%
Calendar Year Maximum	$250	$250	$250	$250
Durable Medical Equipment & Medical Supplies	90%	100%	90%	100%
Per Rental up to Purchase Price	$5,000	$5,000	$5,000	$5,000
Pre-Admission Tests within 7 days of Hospital Admission - Calendar Year Deductible Waived	100%	100%	100%	100%
Mental Disorders				
Inpatient – Anchorage Facilities				
PPO Facility	90%	100%	90%	100%
Non-PPO Facility	60%	100%	60%	100%
Inpatient – Outside Anchorage				
PPO Facility	90%	100%	90%	100%
Non-PPO Facility	90%	100%	90%	100%
Outpatient – Anchorage Facilities				
PPO Facility	90%	100%	90%	100%
Non-PPO Facility	60%	100%	60%	100%
Outpatient – Outside Anchorage				
PPO Facility	90%	100%	90%	100%
Non-PPO Facility	90%	100%	90%	100%
Professional Services	90%	100%	90%	100%
Emergency Care (ambulance and emergency room)	90%	100%	90%	100%

	Plan I	Plan II*	Plan III	Plan IV*
Substance Use Disorders				
Inpatient – Anchorage Facilities				
PPO Facility	90%	100%	90%	100%
Non-PPO Facility	60%	100%	60%	100%
Inpatient – Outside Anchorage				
PPO Facility	90%	100%	90%	100%
Non-PPO Facility	90%	100%	90%	100%
Outpatient – Anchorage Facilities				
PPO Facility	90%	100%	90%	100%
Non-PPO Facility	60%	100%	60%	100%
Outpatient – Outside Anchorage				
PPO Facility	90%	100%	90%	100%
Non-PPO Facility	90%	100%	90%	100%
Professional Services	90%	100%	90%	100%
Emergency Care (ambulance and emergency room)	90%	100%	90%	100%
Preventive Care (Deductible Waived)	100%	100%	100%	100%
Covered exams are limited per Calendar Year to:				
Routine PAP, including lab and office visit	One	One	One	One
Routine physical exam, including diagnostic tests	One	One	One	One
Routine prostate exam, including PSA test	One	One	One	One
Routine colonoscopy (per five Calendar Years)	One	One	One	One
Routine Immunizations				
Mammograms (Routine or Medically Necessary) Calendar Year Deductible Waived	100%	100%	100%	100%
Preventive Well Baby/Child Care (Deductible Waived)	100%	100%	100%	100%

Covered Expenses for well baby and well Child care, including lab and x-rays, in excess of the Calendar Year maximum will be reimbursed subject to the applicable Deductible and Benefit Percentage.

Newborn Care	90%	100%	90%	100%

Hospital Newborn nursery care is covered. This includes Physician Inpatient Newborn examinations and circumcision during the initial Hospital confinement of the Newborn at birth.

* **Plans II and IV are designated for Administrative Level Employees and Dual Covered Employees. In place of 2 Explanation of Benefits (EOBs) being issued due to Coordination of Benefits, one EOB will be issued for the Primary Employee, which will provide coverage at 100% of the U&C allowed amount.**

** **The entire family Deductible must be met before any benefits will be paid by the Plan. Individual Deductibles do not apply to family coverage**

Prescription Drug Benefits

Participating Retail and Mail Order Pharmacy Benefit

No Deductible is required. Your copayment is 10% of the cost of the prescription or refill.

	Plans I & III	Plans II & IV*
Retail Pharmacy Benefit	90%	90%
Mail Order Pharmacy Benefit	90%	90%

Retail and Mail Order Pharmacy Benefits are subject to a 180 day dispensing limit per prescription. Your copayment amount of 10% is not reimbursable under the Major Medical Benefits of the Plan.

Non-Participating Pharmacy Benefit
(When you do not use your Retail Pharmacy Card)

Prescriptions dispensed by non-participating pharmacies are covered under the Major Medical Benefits of the Plan, subject to the Calendar Year Deductible, and paid based on the Benefit Percentage in the Schedule of Benefits. The balance of the Benefit Percentage amount paid by the Covered Person will accrue toward the Out-of-Pocket Calendar Year Maximum. These claims should be submitted directly to Meritain Health.

Summary of Cost Containment Benefits

The following benefits are NOT subject to the annual Deductible and are paid at 100% of the Usual and Customary Fee.

Second Surgical Opinion

Pre-Admission Testing within seven (7) days of the date of admission

Annual Physical – One routine physical per Calendar Year

Well-baby/well-child examinations, laboratory and X-ray services performed in connection with such examinations, subject to the Calendar Year Maximum shown in the Schedule of Benefits.

Routine Pap - One routine exam and lab work per Calendar Year

Routine Mammogram – One routine mammogram per Calendar Year

Routine Prostate Exam – One routine exam per Calendar Year

Routine Colonoscopy – One routine exam every five (5) Calendar Years

Immunizations

Dental Benefits

No Deductible is required.		Plans I & III	Plans II & IV*
Type I	Preventive	100%	100%
Type I	Restorative	80%	100%
Type I	Reconstructive	50%	100%
Calendar Year Maximum		$2,000	$2,000

Vision Benefits

No Deductible is required.	Plans I & III	Plans II & IV*
Examination	90% of U&C	100% of U&C
Lenses	90% of U&C	100% of U&C
Frames (per Calendar Year)	90% up to $100	90% up to $100
Contact Lenses (per Calendar Year)	90% up to $200	100% up to $200

Limitations:

One complete eye exam per Covered Person per Calendar Year
One set of eyeglass lenses, or one 12-month supply of contact lenses, per Calendar Year
One set of frames per Covered Person every Calendar Year

Note: The dental and vision benefits provided under this Plan are limited-scope benefits and are offered separately from any medical coverage offered under the Plan. An employee has a separate right to enroll in the dental and vision benefits under the Plan. If an employee chooses to enroll in such dental and vision benefits, the employee will be charged a contribution amount that is separate from what the employee is charged for any other benefit offered under the Plan. The amount of an employee's contribution will be communicated during the annual open enrollment period.

Hearing Aid Benefit

No Deductible is required.	Plans I & III	Plans II & IV*
Hearing Aid Device	80% of U&C	100% of U&C

* **Plans II and IV are designated for Administrative Level Employees and Dual Covered Employees. In place of 2 Explanation of Benefits (EOBs) being issued due to Coordination of Benefits, one EOB will be issued for the Primary Employee, which will provide coverage at 100% of the U&C amount allowed.**

PREFERRED PROVIDER ORGANIZATIONS (PPOS)

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

Participating Providers

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

A "Participating Provider" or "Preferred Provider" is a provider in any state that has an agreement in effect with Multiplan or TAPPN, at the time services are rendered. The Plan has chosen Alaska Regional Hospital as its participating acute care Hospital in Anchorage. To determine if a particular provider is a "Participating Provider," call the Claims Administrator at 866-808-2609.

Benefits vary if covered services obtained in Anchorage are from Alaska Regional Hospital versus any non-Preferred Provider Hospital. Covered services obtained from a non-Preferred Acute Care Hospital in Anchorage will be covered at a lower benefit level (60%). The non-Preferred Provider benefit will be calculated based on 60% of the lesser of Alaska Regional Hospital's contracted per diem rates or the facilities actual charges. In addition, out-of-pocket payments to non-Preferred Anchorage Hospitals will not accrue towards the Calendar Year Out-of-Pocket Maximum.

Example:

Joe, an employee who has already satisfied his Calendar Year Deductible, receives services totaling $3,000 from a non-Preferred Hospital in Anchorage. In this example Alaska Regional Hospital's contracted charges for the same services would have only been $1,800. Joe's benefit would be calculated as follows:

Non-Preferred Hospital

Charge	Eligible Amount	Benefit Percentage	Benefit Payment	Employee Responsibility
$3,000	$1,800	60%	$1,080	* $1,920

Alaska Regional Hospital

Charge	Eligible Amount	Benefit Percentage	Benefit Payment	Employee Responsibility
$1,800	$1,800	90%	$1,620	$180

*Please note that none of the $1,920 paid by the claimant to the non-Preferred Hospital accrues towards Joe's Calendar Year Out-of-Pocket Maximum.

Exceptions will be made under the following circumstances:

1) If you must be taken to the nearest facility available for a life-threatening Accident or Emergency; or

2) Alaska Regional Hospital refers you to a non-Preferred Provider facility.

MultiPlan, the Plan's national Preferred Provider network, provides access to discounts from many other health care providers nationally; however, there is no benefit reduction when accessing services from any providers outside of Anchorage.

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

Non-Participating Providers

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

Acute Care Inpatient Hospitalization

To receive maximum benefits, you must use the Participating Providers listed below:

1. Alaska Preferred

Alaska Regional Hospital
Fairbanks Memorial Hospital
Providence Seward Medical Center
Providence Valdez Medical Center
Mat-Su Regional Medical Center

2. Multiplan - Outside Alaska

Multiplan has a listing of participating providers in all 50 states. If you are outside Alaska and require medical services, call Multiplan for a listing of participating providers at 800-557-6794 or Meritain Health at 866-808-2609. You can also view Multiplan's listing of participating providers by accessing their web page at www.multiplan.com.

3. TAPPN

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

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

SPECIAL FEATURES OF YOUR PLAN

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

Meritain Health Medical Management
800-242-1199

Meritain Health Medical Management has trained medical staff, Physicians and specialists who review and certify, in advance, Hospitalizations and surgeries. Think of them as your medical consumer advocates.

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

Please note, Meritain Health Medical Management certifies the medical necessity and appropriateness of services. It does not verify the eligibility for Plan coverage and reimbursement of any procedure or services.

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

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

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

Pre-certification and post-certification are not a guarantee of eligibility or payment of benefits. It only means that the Plan or its authorized representative has confirmed the Medical Necessity and appropriateness of all the services listed below. Payment of benefits is based on the provisions of this Plan and your eligibility for coverage at the time the expense is incurred.

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

- **Hospital Admissions**

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

- **Additional Hospital Days**

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

- **Emergency Admissions**

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

- **Additional Services Requiring Certification**

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

- Purchase of Durable Medical Equipment costing $1,000 or more
- Outpatient Surgeries
- Home Health Nursing, including the associated Physical Therapy and Occupational Therapy
- Hyperbaric Oxygen Treatments
- Diagnostic radiology (excluding x-rays) CT, MRI, MRA and PET scans
- Skilled Nursing Facility Services

Do not delay seeking medical care for any Covered Person who has a serious condition that may jeopardize his life or health because of the requirements of this program. For urgent, Emergency admissions, follow your Physician's instructions carefully, and contact Meritain Health Medical Management within the time limit specified above.

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

CAUTION: Failure to comply with the UR pre-certification requirement will reduce the benefits otherwise available under the Plan. Please refer to the Schedule of Benefits for penalty information.

Other Features

- **Alternate Course of Treatment**

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

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

- **Individual Case Management**

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

Through early notification from utilization review nurses, case management can promptly become involved in potentially catastrophic cases and serve as a vehicle to significantly reduce the cost of catastrophic claims. The Meritain Health Medical Management case manager becomes the patient's advocate. Patients and their families are often confused by the complexities of medical treatment and the variety of providers. This is a time when a patient whose Illness or Injury requires long-term or

costly medical care needs a case manager who can provide emotional support and help coordinate services such as home health care or a Hospice Care Program.

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

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

- **Hospital Bill Self-Audit**

The Plan Administrator wants you to carefully review your health claims. If you find an error, such as treatment billed but not received, incorrect arithmetic or drugs or supplies not received, and the error results in an overcharge, submit a copy of the bill with the error noted. If you are correct, you will be reimbursed 50% of the savings up to a maximum of $500.

ELIGIBILITY AND ENROLLMENT;
COMMENCEMENT AND TERMINATION OF COVERAGE

Eligibility for Individual Coverage

Each Employee will become eligible to enroll as a Covered Person on the 1st day of the month following his or her first day of Active Employment. A person who is an eligible Employee of more than one employer shall be covered as the Employee of only one employer. *Please see the definition of "Employee."* An Employee must actually begin work for the Company in order to be eligible.

A retired former Employee who is rehired into a full-time position is eligible to enroll as a Covered Person on the 1st day of the month following his or her date of rehire. This Plan will be primary to the *AlaskaCare Retiree Health Plan* (if that coverage is available to the Employee) during the period of the Employee's active reemployment.

Eligibility for Dependent Coverage

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

1. His or her date of eligibility for coverage as a Covered Person;
2. The date coverage for his or her Dependents first becomes available under the Plan;
3. The first date upon which he or she or she acquires a Dependent; and
4. For coverage of his or her eligible Dependents, the later of July 1, 2005, or the 1st day of the month following a retired former Employee's date of rehire into a full-time position. This Plan will be primary to the *AlaskaCare Retiree Health Plan*, if that coverage is available to the Dependent.

If the Dependent re-enrolls within 31 days of the start of the school term, eligibility will be effective on the first day of the month following the date of enrollment.

An Employee may enroll his or her Dependents for coverage under the Plan only if he or she is a Covered Person. In no event will any Dependent child be covered as a Dependent of more than one Employee who is covered under the Plan. In addition, no person may be simultaneously covered under this Plan as both an Employee and a Dependent. *Please see definition of "Dependent."*

Effective Date of Employee Coverage

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

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

Effective Date of Dependent Coverage

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

1. On the Employee's effective date, if application is made at the same time as the Employee's initial enrollment;
2. On the first day of eligibility, if application is made within 31 days of the date the Dependents become eligible for coverage; or
3. A Newborn Child is covered for the first 31 days from the date of birth, and will continue to be a Covered Person if the Plan Administrator receives the enrollment application within 31 days of birth. This will also apply to a Child who is adopted or placed for adoption. The requirement for enrollment will be waived for any Employee who currently has Dependent coverage and is making the maximum required contribution for that coverage.

If the Dependent re-enrolls within 31 days of the start of the school term, eligibility will be effective on the first day of the month following the date of enrollment.

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

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

Special Enrollment

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

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

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

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

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

If a Dependent loses eligibility for other coverage, an Employee who is already enrolled in the Plan may be eligible to change the current benefit election if the loss of coverage triggers a special enrollment right under the Plan. The change must be consistent with the event. You must make written application for special enrollment and your new Plan election within 31 days of the date the other health coverage was lost.

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

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

- **Special Enrollment for New Dependents**

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

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

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

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

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

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

Special enrollment due to coverage under Medicaid or under a State Children's Health Insurance Program (CHIP). If an employee or eligible dependent did not enroll in the Plan when initially eligible, but was otherwise eligible to enroll, they will be permitted to later enroll in the Plan under one of the following circumstances:

1. The employee or eligible dependent was covered under Medicaid or CHIP at the time of initial enrollment and such coverage subsequently terminates; or

2. The employee or eligible dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP subsequent to the time they were initially eligible.

The employee or dependent must request enrollment in the Plan within sixty (60) days after coverage under Medicaid or CHIP terminates or within sixty (60) days after their eligibility for a premium assistance subsidy under Medicaid or CHIP is determined, whichever is applicable.

"Enrollment Date" shall mean, for a person entering the Plan during the initial eligibility period, the first day of coverage or, if there is a waiting period, the first day of the waiting period. For a person entering the Plan after the initial eligibility period and for a Late Enrollee, Enrollment Date shall mean the first day of coverage under the Plan The definition of "Enrollment Date" is very important because it determines when the six-month look-back period begins and when the Pre-Existing Condition period begins and ends. *Please see the section entitled "Special Restrictions for Pre-Existing Conditions."*

Open Enrollment

A period between August 1st and August 31st of each Calendar Year has been designated as an annual open enrollment period during which individuals who are currently eligible for this Plan may add or delete themselves and their Dependents to or from coverage. Any such changes will become effective at 12:01 A.M. on September 1st next following open enrollment, unless the Employee has not satisfied any waiting period, in which event coverage for the Employee and his or her Dependents will become effective at 12:01 A.M. on the first day of the month following completion of the waiting period.

All individuals who are added to the Plan during an annual open enrollment period will be considered Late Enrollees and are subject to the special restrictions on Pre-Existing Conditions set forth in this Plan.

Late Enrollment

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

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

Qualified Medical Child Support Orders

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

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

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

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

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

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

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

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

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

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

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

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

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Covered Persons and Eligible Beneficiaries without regard to this Section 4.05, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

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

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

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

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

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

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

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

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order; and

2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

When Coverage Ends

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

1. For an Employee and his or her Dependents, on the date of termination of the Plan;
2. For an Employee or his or her Dependents, on the date of the expiration of the last period for which a contribution was made, in the event of a failure to make a contribution when due;
3. For an Employee and his or her Dependents on the last day of the month determined in accordance with a formal contract or agreement established between the Company and the Employee, or otherwise in accordance with the rules established by the Company;
4. For Dependents, on the last day of the month in which he or she ceases to be eligible for coverage under the Plan as a Dependent;
5. For Dependents, on the date of termination of Dependent Coverage under the Plan;
6. For Dependents, when a Dependent becomes covered as an Employee under the Plan; and
7. For an Employee and his or her Dependents, immediately after an Employee or his or her Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.
8. For an Employee and his or her Dependents, immediately after an Employee or his or her Dependent (or any other person acting on behalf of the Employee and/or his or her Dependent), performs an act, practice, or omission that constitutes fraud;
9. For an Employee and his or her Dependents, immediately after an Employee or his or her Dependent (or any other person acting on behalf of the Employee and/or his or her Dependent) makes an intentional misrepresentation of a material fact.

Retroactive Termination of Coverage

Except in cases where an Employee or other Covered Person fails to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan for any Covered Person unless the Covered Person (or a person seeking coverage on behalf of that person) performs an act, practice, or omission that constitutes fraud with respect to the Plan, or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least thirty days advance written notice to each Covered Person who would be affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where required employee contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

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

Continuation during FMLA Leave

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

Continuation during USERRA Leave

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

Certificates of Coverage

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

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

SPECIAL RESTRICTIONS ON PRE-EXISTING CONDITIONS
(Does not apply to Covered Persons under age 19)

Special Restrictions for Pre-Existing Conditions

A Pre-Existing Condition limitation will apply for all Employees and Dependents entering or reentering the Plan on and after the effective date of the Plan, except as set forth in HIPAA. Limited coverage is provided for expenses in connection with a Pre-Existing Condition.

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

Up to $1,000 in benefits per Covered Person will be provided for otherwise Covered Expenses in connection with a Pre-Existing Condition. Benefits under this section will be determined by type of service, as shown in the Schedule of Benefits, and are subject to all other terms and conditions of the Plan. This benefit will apply to all Pre-existing Conditions combined during the limitation period.

Full coverage will be available for such condition on the day immediately following the expiration of 12 months or, in the case of a Late Enrollee, 18 months, after the Enrollment Date. A Covered Person has the right to demonstrate any Creditable Coverage, and the applicable period shall be reduced by any Creditable Coverage unless that Creditable Coverage occurred before a Significant Break in Coverage.

"Late Enrollee" shall mean a Covered Person who enrolls in the Plan other than during the first 30-day period in which the individual is eligible or during a Special Enrollment Period.

- **Proof of Creditable Coverage**

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

1. The Covered Person may present a written Certificate of Coverage from the source or entity that provided the coverage showing:

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

        (1) A statement that the Covered Person or Dependent has at least 12 months (365 days), or, for a Late Enrollee, 18 months (546 days), of Creditable Coverage, not counting days of coverage before a Significant Break in Coverage; or
        (2) The date any waiting period (and affiliation period, if applicable) began and the date Creditable Coverage began; and

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

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

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

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

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

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

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

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

CONTINUATION OF COVERAGE UNDER COBRA

Introduction

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

For purposes of COBRA Continuation Coverage provisions, a spouse will include a covered Domestic Partner. Please refer to the definition of "Dependent" for additional information.

COBRA Continuation Coverage

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

Qualifying Events

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

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

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

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

1. The spouse dies;
2. The spouse's hours of employment are reduced;
3. The spouse's employment ends for any reason other than his or her gross misconduct;
4. The spouse becomes entitled to Medicare benefits (under Part A, Part B, or both);
5. The spouse becomes divorced from his or her spouse; or
6. The Domestic Partner no longer meets the domestic partnership eligibility requirements for coverage under the Plan (*please refer to the definition for "Dependent"*).

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

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

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

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

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

The Plan Administrator is:

Bering Strait School District
Plan Administrator
PO Box 225
Unalakleet, AK 99684
907-624-3611

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

- **Deadline for providing the notice**

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

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

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

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

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

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

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

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

- **Who Can Provide the Notice**

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

- **Required Contents of the Notice**

The notice must contain the following information:

1. Name and address of the covered Employee or former employee;
2. Identification of the initial Qualifying Event and its date of occurrence, if the person is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period;
3. A description of the Qualifying Event (for example, divorce, cessation of dependent status, entitlement to Medicare by the covered Employee or former employee, death of the covered Employee or former employee, disability of a Qualified Beneficiary or loss of disability status);
4. In the case of a Qualifying Event that is divorce, name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan, date of divorce, and a copy of the decree of divorce;
5. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former employee, date of entitlement, and name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan;
6. In the case of a Qualifying Event that is a Dependent Child's cessation of dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age, lost student status, married or other);
7. In the case of a Qualifying Event that is the death of the covered Employee or former employee, the date of death, and name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan;
8. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;
9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
10. A certification that the information is true and correct, a signature and date.

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

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

Electing COBRA Continuation Coverage

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

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

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

Duration of COBRA Continuation Coverage

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

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

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

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

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

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

- **Disability Extension of COBRA Continuation Coverage**

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

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

If an Employee's family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the spouse and Dependent Children in the family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event properly is given to the Plan as set forth above. This extension may be available to the spouse and any Dependent Children receiving COBRA Continuation Coverage if the covered Employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

Shorter Duration of COBRA Continuation Coverage

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

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

Premium Requirements

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

Additional Information

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

Bering Strait School District
Plan Administrator
PO Box 225
Unalakleet, AK 99684
907-624-3611

Current Addresses

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

The Trade Act of 2002

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

Multiple Qualifying Events

A second qualifying event could occur during the initial period of COBRA coverage due to the death of the former Employee, or the spouse if he elected separately and covered eligible Dependents, divorce, or other loss of eligibility such as a Dependent reaching the limiting age. When such a qualifying event occurs, the requirements specified in the sections entitled "Notice and Election Requirements" and "Premium Requirements" will apply. The maximum time period for continuation following the second qualifying event will be combined with the preceding period of coverage under COBRA so that the total period of coverage will not exceed 36 months from date of the original qualifying event. Coverage may cease before the end of the maximum period as described in the section entitled "Maximum Time Periods."

MAJOR MEDICAL BENEFITS

Deductibles

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

Covered Expenses

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

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

Benefit Percentage

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

Lifetime and Calendar Year Maximums

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

Covered Major Medical Benefits

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

1. **Acupuncture**. Charges for acupuncture treatments.

2. **Ambulance.** Charges for transportation by professional air or ground ambulance from place of Illness or Injury to the nearest Hospital or transfer to the nearest facility having the capability to treat the condition.

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

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

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

6. **Chemotherapy.** Charges for chemotherapy.

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

8. **Cost Containment Benefits.** Charges for Cost Containment Benefits, as set forth in the Schedule of Benefits.

9. **Dental.** Charges for dental services rendered by a Physician or Dentist for the treatment of an Injury to the jaw or to the natural teeth, including the initial replacement of these teeth, and any necessary dental x-rays for an Injury resulting from an Accident, providing treatment is rendered within six months of the date of the Accident.

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

11. **Diagnostic Tests; Examinations.** Charges for x-rays, microscopic tests, laboratory tests, esophagoscopy, gastroscopy, proctosigmoidoscopy, colonoscopy and other diagnostic tests and procedures.

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

    a. Any purchase costs over $1,000 without its advance written approval;
    b. Repairs;
    c. Replacements for equipment still under warranty; or
    d. The rental or purchase of items which do not fully meet the definition of “Durable Medical Equipment.”

13. **Hemodialysis.** Charges for hemodialysis.

14. **Home Health Care.** Charges by a Home Health Care Agency:

    a. Registered Nurses or Licensed Practical Nurses;
    b. Certified home health aides under the direct supervision of a Registered Nurse;
    c. Registered therapist performing physical, occupational or Speech Therapy;
    d. Physician calls in the office, home, clinic or Outpatient department;
    e. Services, drugs and medical supplies which are Medically Necessary for the treatment of the Covered Person that would have been provided in the Hospital, but not including Custodial Care; and
    f. Rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.

    Each visit will count toward the maximum number of visits per Calendar Year as set forth in the Schedule of Benefits.

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

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

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

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

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

The Hospice Care Program must be renewed in writing by the attending Physician every 30 days. Hospice Care ceases if the terminal Illness enters remission.

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

a. Inpatient Treatment

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

b. Outpatient Treatment

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

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

18. **Mastectomy.** Charges in connection with a mastectomy (including partial mastectomies) will include the following:

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

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

19. **Maternity Inpatient Stays**. Charges in connection with Hospital Inpatient expenses related to the Pregnancy of a covered Employee, spouse or Domestic Partner. Charges in connection with Pregnancy for a Dependent daughter are not covered under the Plan; however, certain charges in connection with a Complication of Pregnancy may be covered. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

21. **Mental Disorders.** Charges in connection with treatment of Mental Disorders for:

    a. Inpatient and Outpatient treatment, including treatment of eating disorders (such as anorexia nervosa, bulimia, or any similar condition);
    b. Individual and group counseling;
    c. Individual and group psychotherapy;
    d. Psychological testing; and
    e. Family counseling for Family members who are Covered Persons.

22. **Newborn Care.** Charges for Hospital and Physician nursery care for Newborns who are natural children of the Employee, covered spouse or Domestic Partner during the first 31-day period from birth, as set forth below. Benefits will be provided under the child's coverage, and the child's own Deductible and Benefit Percentage provisions will apply.

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

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

    Benefits are also provided for Hospital and Physician nursery care for an ill or injured Newborn as any other medical condition.

    The Plan will cover a routine hearing exam during the first 31-day period from birth for a covered Dependent Child. A second exam will be covered if necessary to diagnose a condition identified during the initial hearing exam.

    Please note: Coverage following the first 31-day period from birth will be available **only if the Newborn is properly enrolled in the Plan <u>during</u> the first 31-day period following birth.** Please see the definition of "dependent".

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

24. **Obstetrical.** Physician's charges for obstetrical services are considered on the same basis as for an Illness, including the mother's prenatal care; obstetrical and gynecological care rendered by a Nurse or Nurse Midwife. Obstetrical services are not covered for the Pregnancy of a Dependent Child.

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

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

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

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

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

30. **Physician Services.** Charges for the services of a Physician for Medically Necessary care, including office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care, surgical opinion consultations, and virtual medicine/telemedicine (paid as an office visit).

31. **Qualified Clinical Trials.** Healthcare items or services that are furnished to a Covered Person enrolled in a Qualified Clinical Trial, which are consistent with the usual and customary standard of care for someone with the Covered Person's diagnosis, are consistent with the study protocol for the clinical trial, and would be covered if the Covered Person did not participate in the Qualified Clinical Trial.

    Notwithstanding the above, Qualified Clinical Trial expenses do not include any of the following:

    (a) An FDA approved drug or device shall be considered a Qualified Clinical Trial Expense only to the extent that the drug or device is not paid for by the manufacturer, the distributor or the provider of the drug or device; or
    (b) Non-healthcare services that a Covered Person may be required to receive as a result of being enrolled in the Qualified Clinical Trial; or
    (c) Costs associated with managing the research associated with the Qualified Clinical Trial; or
    (d) Costs that would not be covered for non-investigational/experimental treatments; or
    (e) Any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the Qualified Clinical Trial; or
    (f) The costs of services, which are not provided as part of the Qualified Clinical Trial's stated protocol or other similarly intended guidelines.

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

33. **Second Surgical Opinions.** Charges for second surgical opinions.

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

35. **Skilled Nursing.** Charges made by a Skilled Nursing Facility or a Convalescent Care Facility, up to the limits set forth in the Schedule of Benefits, in connection with convalescence from an Illness or Injury for which the Covered Person is confined, including:

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

Confinement must begin within 14 days following a Hospital stay, and your Physician must certify that 24-hour nursing service is Medically Necessary. Separate stays due to related causes will be treated as one if your stays are not separated by less than three months.

36. **Sleep Disorders**. Care and treatment for sleep disorders.

37. **Speech Therapy.** Charges for Speech Therapy, by a Physician or qualified speech therapist, when needed due to: (a) a Sickness or Injury; or (b) surgery performed as the result of a Sickness or Injury; or (c) a genetic disorder (i.e. autism, Downs Syndrome, etc.). This excludes Speech Therapy services that are educational in any part or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders, except as specified above. If the speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy, or due to a genetic disorder (i.e. autism, Downs Syndrome, etc.).

38. **Substance Use Disorders.** Charges in connection with Substance Use Disorders for:

a. Inpatient and outpatient charges;
b. Drugs and medicines;
c. Individual and group counseling;
d. Individual and group psychotherapy;
e. Psychological testing; and
f. Family counseling for Family members who are Covered Persons.

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

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

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

(1) 100% (full Usual, Customary and Reasonable value) for the first or major procedure;
(2) 50% for the second and subsequent procedures.

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

c. Charges made for services rendered by an assistant surgeon will be allowed at 25% of the Usual & Customary Fee allowance for the type of surgery performed.

40. **Travel.** In addition to the Ambulance benefits provided above, commercial airline travel (includes round trip) will be covered from the place where the Illness and/or Injury occurred to the nearest location where appropriate treatment can be obtained subject to the following limitations:

a. Round trip transportation by commercial airline or professional air ambulance from the place where the Illness or Injury occurred to the nearest Hospital where professional treatment can be obtained subject to the following limitations:

(1) The Illness or Injury must be a life-endangering situation that requires immediate transfer to a Hospital that has special facilities for treating the condition, or
(2) Surgery is needed that cannot be performed locally; or
(3) A condition exists which cannot be treated locally. In that case, transportation benefits for any one Illness or condition in any one Calendar Year will be limited to:
- one visit and one follow-up visit for a condition requiring therapeutic treatment which cannot be provided locally; or
- one pre or post-surgical visit and one visit for the actual surgical procedure which cannot be provided locally; or

(4) One visit for pre or post-natal maternity care and one visit for the actual maternity delivery which cannot be provided locally; or
(5) One visit for each allergic condition which cannot be provided locally.

Note: This benefit is limited to two visits per year.

If the covered person requires air transportation for (2) or (3) above, the **Physician must provide written certification and detailed medical documentation that the existing condition satisfies the terms of the Plan**.

b. If the patient is a Child under 12 years of age, the transportation charges of a parent or legal guardian accompanying the Child will be allowed if the attending Physician certifies the need for such attendance.

c. Transportation charges for a Physician and/or Registered Nurse may be covered **only** when determined to be Medically Necessary.

d. Travel benefits apply only to the conditions and treatments covered in the Major Medical Benefits section of your Summary Plan Description. They do not apply to the dental, vision, hearing or chiropractic services.

e. Travel may <u>not</u> be approved for diagnostic purposes or a second opinion diagnosis. Coverage will be determined on review of medical documentation of the necessity of these procedures.

41. **Voluntary Sterilization**. Charges for services and supplies in connection with voluntary sterilization procedures.

Coverage for Organ and/or Tissue Transplants

- **Pre-Authorization Requirement for Organ Transplants**

Expenses Incurred in connection with any organ or tissue transplant listed in this section will be covered subject to referral to, and pre-authorization by, the Plan's authorized medical review specialist, Meritain Health Medical Management (800-242-1199). Kidney and cornea transplants are not subject to this provision, but will be considered on the same basis as any other medical expense coverage under the Plan.

Transplant coverage is only offered under the Plan through a preferred provider network of specialized professionals and facilities. If one of these preferred facilities cannot provide the type of transplant needed, this benefit will cover transplant service provided by a transplant center not in the network.

As soon as reasonably possible, but in no event more than 10 days after a Covered Person's attending Physician has indicated that the Covered Person is a potential candidate for a transplant, the Covered Person or his or her Physician must contact the Claims Administrator for referral to the medical review specialist for evaluation and pre-authorization. A comprehensive treatment plan must be developed for the Plan's medical review, and must include such information as the diagnosis, the nature of the transplant, the setting of the procedure (for example, name and address of the Hospital), any secondary medical complications, a five-year prognosis, two qualified opinions confirming the need for the procedure, as well as a description and the estimated cost of the proposed treatment. One or both confirming second opinions may be waived by the Plan's medical review specialist. Additional attending Physician's statements may also be required. **The Covered Person may provide a comprehensive treatment plan independent of the preferred provider network, but this will be subject to medical appropriateness review and may result in a decrease in benefits.**

All potential transplant cases will be assessed for their appropriateness for large case management.

Please note: Failure to pre-authorize a transplant procedure will result in the application of a Transplant Deductible, shown in the Schedule of Benefits, to all Covered Expenses Incurred as a result of the transplant. This Deductible is in addition to any other Plan Deductible and copayment requirements which would normally be applicable to the transplant procedure.

Do not delay seeking medical care for any Covered Person for whom the requirements for pre-authorization may jeopardize his life or health. For urgent, Emergency care, follow your Physician's instructions carefully, and contact Medical Review Consultants within two business days following the Emergency care. The additional Deductible will not be applied to your benefits if contact is made within this time period. Please note that any such Emergency services that are not provided through the preferred provider transplant network may not be a Covered Expense under the Plan.

- **Organ Transplant Network**

As a result of the pre-authorization review, the Covered Person will be asked to consider obtaining transplant services at a participating transplant center. The term "participating transplant center" means a licensed health care facility which has entered into a participation agreement at fee arrangements as established with a network to provide health services to participants in the Plan. The transplant network's goal is to perform necessary transplants in the most appropriate setting for the procedure with consideration of and enhancement of the quality of patient care.

There is no obligation for the patient to use network services. However, benefits for the transplant and its related expenses will vary depending on whether services are provided in or out of the transplant network. If a transplant is performed out of the network, but the Covered Person has received approval from the Plan's medical review specialist for out-of-network services, then network benefits will apply to the transplant and its related expenses. If services are provided out of the network without approval from the medical review specialist, then out-of-network benefits will apply.

The Plan is not responsible for a Covered Person's decision to receive treatment, services or supplies provided by a participating transplant center.

- **Transplant Benefit Period**

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

- **Covered Transplant Expenses**

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

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

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

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

    a. Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ.
    b. Coverage for organ procurement from a living donor will be provided for the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant, as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow-up care.
    c. If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or donated marrow (allogeneic). Coverage will also be provided for search charges to identify an unrelated match, treatment and storage costs of the marrow, up to the time of re-infusion. The harvesting of the marrow need not be performed within the transplant Benefit Period.
    d. Charges Incurred for follow-up care, including immuno-suppresent therapy.
    e. Charges for transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual, or in the event that the recipient or the donor is a minor, two other individuals. In addition, all reasonable and necessary lodging and meal expenses Incurred during the Transplant Benefit Period will be covered up to the maximum shown in the Schedule of Benefits per Transplant Benefit Period.

- **Re-Transplantation**

Re-transplantation will be covered for up to two re-transplants, for a total of three transplants per Covered Person per lifetime. Each transplant and re-transplant will have a new Transplant Benefit Period and a new Transplant Benefit Period Maximum benefit will apply.

- **Accumulation of Expenses**

Expenses Incurred during any one Transplant Benefit Period for the recipient and for the donor will accumulate toward the recipient's benefit and will be included in the Plan's overall per-person maximum lifetime benefit.

- **Donor Expenses**

Medical expenses of the donor will be covered under this provision to the extent that they are not covered elsewhere under this Plan or any other benefit plan covering the donor. In addition, medical expense benefits for a donor who is not a Covered Person under this plan are limited to a maximum shown in the Schedule of Benefits per Transplant Benefit Period **when the transplant services are provided out of network.** This does not include the donor's transportation and lodging expenses.

GENERAL EXCLUSIONS AND LIMITATIONS

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

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

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

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

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

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

6. **Dental**. Charges Incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or a molar process and any other dental, orthodontic or oral surgical charges, except as specifically included.

7. **Dependent Children**. Maternity, family planning and sterilization benefits for Dependent children.

8. **Employment**. Charges arising out of or in the course of any employment or occupation for wage or profit, or for which the Covered Person is entitled to benefits under any Workers' Compensation or occupational disease law, or any such similar law, except for your Employee routine physical that is required by the State of Alaska every three years.

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

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

11. **Experimental.** Expenses for services or supplies which are not medically recognized or are Experimental/Investigational in nature, except when such expenses are considered Qualified Clinical Trial expenses.

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

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

14. **Hair Loss**. Charges for care and treatment for hair loss, including wigs, hair transplants and any drug that promises hair growth, whether or not prescribed by a Physician.

15. **Hearing**. Charges for services and supplies in connection with hearing aids or exams for their fitting, except for the initial purchase of a hearing aid if the loss of hearing is the result of surgery performed, or as otherwise listed for coverage.

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

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

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

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

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

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

22. **Miscellaneous**. Charges Incurred for education or training (except as specifically included), marital or family counseling, hypnosis, standby Physician services, completion of forms, mailing and shipping expenses, unkept appointments, telephone calls (except virtual medicine/telemedicine), massage therapy, or chelation therapy (except to treat heavy metal poisoning).

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

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

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

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

27. **Orthotics**. Charges for Orthotic Appliances.

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

29. **Other Types of Medicine**. Charges for homeopathy; naturopathy; and charges Incurred for holistic, environmental or ecologic health care, including drugs and ecologicals.

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

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

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

33. **Prior Plan**. Charges Incurred for which the Covered Person is entitled to receive benefits during an extension period of his or her previous health plan.

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

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

36. **Self-Inflicted**. Charges Incurred in connection with any intentionally self-inflicted Injury or Illness, including attempts at suicide unless the Illness or Injuries were caused by the Covered Person's medical condition. This includes medical conditions resulting from the illegal use of drugs or narcotics, alcohol intoxication and Injuries and Illnesses resulting from fighting, brawls or similar encounters unless sustained in necessary self defense against unprovoked assault by a person not related to the injured person.

37. **Sexual**. Charges Incurred in connection with voluntary sterilization for dependent children; charges Incurred in connection with voluntary reversal of surgical sterilizations, sexual dysfunctions or inadequacies, penile prosthetic implants, sex transformations, surrogacy, in-vitro fertilization, immunotherapy for treatment of infertility, embryo transfer procedure, G.I.F.T. (Gamete Intrafallopian Transfer), artificial insemination, fertility drugs, impotency drugs such as Viagra™, oral contraceptives used for birth control, or any type of artificial impregnation procedure, whether or not such procedure is successful.

38. **Subrogation**. Charges for or in connection with any Injury or Sickness subject to the "Third Party Recovery, Subrogation and Reimbursement" provision of this Plan, unless and until the required, unaltered subrogation agreement has been properly signed, returned to, and received by the Plan Administrator.

39. **TMJ Syndrome**. Charges in connection with temporomandibular joint (TMJ) syndrome or dysfunction.

40. **Travel**. Charges Incurred for travel, whether or not recommended by a Physician, unless specifically included for coverage under the Plan.

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

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

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

PRESCRIPTION DRUG BENEFITS

Participating Retail and Mail Order Pharmacy Benefit

Participating pharmacies ("Participating Pharmacies") have contracted with the Plan to charge reduced fees for covered drugs. Covered Persons will be issued an identification card to use at the pharmacy at time of purchase. Covered Persons will be held fully responsible for the consequences of the use of any pharmacy identification card after termination of coverage

The Mail Order Option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of the volume buying, Scrip World, the mail order pharmacy, is able to offer significant savings for maintenance medication prescriptions.

Your copayment amount is shown in the Schedule of Benefits. Your copayment amount is not counted toward any Out-of-Pocket Maximums under the Plan.

Non-Participating Pharmacy Benefit
(When you do not use your Retail Pharmacy Card)

Prescriptions dispensed by non-Participating Pharmacies are covered under the Major Medical Benefits of the Plan subject to the Calendar Year Deductible and paid based on the Benefit Percentage in the Schedule of Benefits. The balance of the Benefit Percentage amount paid by the Covered Person will accrue toward the Out-of-Pocket Calendar Year Maximum. These claims should be submitted directly to Meritain Health.

Covered Expenses
The following are covered under the Plan:

1. All drugs prescribed by a Physician that require a prescription either by federal or state law, except the drugs excluded below;
2. All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity; and
3. Insulin, insulin syringes and needles, urine tests, lancets and insulin-related chemical strips, when prescribed by a Physician.

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

1. Refills only up to the number of times specified by a Physician;
2. Refills up to one year from the date of order by a Physician;
3. With respect to the Pharmacy Option, any one prescription is limited to a 180-day supply;
4. With respect to the Mail Order Option, any one prescription is limited to to a 180-day supply;
5. Growth promoting agents are covered following a clinical prior authorization performed by Scrip World; and
6. Xolair is covered following a clinical prior authorization performed by Scrip World.

Exclusions
The following are not covered by the Plan:

1. **Contraceptives.** Contraceptive medications, devices or appliances, regardless of their intended use, except as specifically included.
2. **Devices.** Devices or appliances, support garments and other non-medicinal substances, regardless of their intended use, except as specifically included.

3. **Dispensing Limits.** At a pharmacy - More than a 180-day supply in any one prescription or refill. Through the Mail Order Option - Less than a 30-day or more than a 180-day supply (or the amount otherwise limited by state law), when dispensed in any one prescription or refill. Through either method - Any prescription refill in excess of the number specified by the Physician or allowed by law, or any refill dispensed after one year from the order of the Physician or the maximum time allowed by law if less than one year.
4. **Experimental.** Drugs labeled "Caution - limited by federal law to Investigational use," or Experimental drugs, even though a charge is made to the individual.
5. **Government**. Prescriptions which an eligible person is entitled to receive without charge from any governmental program.
6. **Injectables**. Immunization agents, biologicals, blood or blood plasma.
7. **Injection**. Charges for the administration or injection of any medication.
8. **Inpatient**. Medication which is taken or administered, in whole or part, while the person is confined in a Hospital or other health care facility
9. **Job-Related**. Prescriptions which an eligible person is entitled to receive without charge under any workers' compensation or similar law.
10. **Legend Drugs**. Anorexiants (weight-loss drugs) and anti-obesity drugs; fertility drugs; isotretinoin; hormone replacement drugs; nutritional supplements; fluoride products; hair growth agents; smoking deterrent products; erectile dysfunction drugs; and vitamins.
11. **OTC**. Over-the-counter drugs, except for insulin, even if prescribed.

Prescription Drug Coordination of Benefits
There is no Coordination of Benefits (COB) provision with the Prescription Drug Benefit.

CuraScript Pharmacy

The CuraScript Pharmacy is available to service specialty medication prescription needs. Specialty medications tend to be more complex to administer and monitor than traditional medications. These medications treat chronic conditions such as rheumatoid arthritis, multiple sclerosis, cancer, hepatitis, psoriasis, growth hormone, hemophilia and HIV/AIDS.

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

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

DENTAL BENEFITS

(No Deductible Required)

Benefits are available for the services and supplies described in this section which are furnished in connection with the diagnosis and treatment of a covered dental condition when such services and supplies meet all of these requirements:

They must be dentally necessary; that is, they must be:

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of disease, accidental Injury, or condition harmful or threatening to your dental health.
- Consistent with standards of good dental practice within the organized dental community.
- Not primarily for the convenience of you or your Dentist.

The fact that the covered services were furnished, prescribed, or approved by a Dentist does not in itself mean that the services were dentally necessary.

They must not be excluded from coverage under this Plan.

They must be furnished by a Dentist, except that they may also be provided by a licensed Dental Hygienist or other individual performing within the scope of his or her license as allowed by law. These services must be rendered under the supervision and guidance of the Dentist.

The Covered Person is responsible for furnishing to us all diagnostic evaluative material, such as study models, dental X rays, and charts which may be required to determine available benefits. The Plan will not provide benefits for those dental services which cannot be verified as covered services when any necessary material is not furnished upon request.

Benefits are provided at the percentages specified in the Schedule of Benefits for all covered dental services (subject to the allowable charge), up to the maximum benefit listed in the Schedule of Benefits.

Alternative Benefits

To determine benefits available under this Plan, the Plan Administrator will consider alternative procedures or services carrying different fees which are consistent with acceptable standards of dental practice. In all cases where there is an alternative course of treatment carrying different fees, the Plan will only provide benefits for the treatment carrying the lesser fee. If you and the Dentist decide upon a more costly treatment, then you are responsible for the additional charges beyond those for the less costly alternative treatment.

Type I: Preventive Services

The Plan will pay, according to the Schedule of Benefits, the Usual and Customary charges for the following preventive services:

1. Examination, including periodic oral examination, once every six (6) consecutive months;

2. Full-mouth x-rays are limited to one (1) in any consecutive three (3) year period;

3. Bitewing x-rays are limited to one (1) in any consecutive six (6) month period;

   Note: If the procedure for the benefits of item 2 and 3 listed above are accomplished in conjunction with one another, it will be deemed a full-mouth x-ray, and the combined allowance for these procedures shall not exceed the amount payable for a full-mouth x-ray.

4. Topical fluoride application for Covered Persons under age twenty (20) is limited to two (2) applications each Calendar Year. Topical application of fluoride to the prepared portion of a tooth prior to placement of a final restoration and fluoride for use in prophylaxis past and/or in restorative materials is not covered.

5. Prophylaxis, including cleaning, scaling and polishing is limited to one (1) prophylaxis in any consecutive six (6) months. Benefits are not available for curettage and root planing performed as a part of a course of treatment of periodontal disease. Curettage and scaling performed in conjunction with and on the same day as a prophylaxis will be deemed to be included within the prophylaxis procedure.

6. Sealants for Dependent Children under age fourteen (14) are limited to use on permanent teeth.

Type II: Restorative Services

The Plan will pay, according to the Schedule of Benefits, the Usual and Customary charges for the following restorative services.

1. Space maintainers that replace prematurely lost teeth for Covered Persons under the age of twenty (20).

2. Emergency palliative treatment.

3. Extractions.

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

5. Oral surgery performed on the teeth or gums.

6. General anesthetics administered in connection with covered oral or dental surgery.

7. Injection of antibiotic drugs by an attending Dentist.

8. Root canal therapy.

Type III: Reconstructive Services

The Plan will pay, according to the Schedule of Benefits, the Usual and Customary charges for the following reconstructive services.

1. Repair or re-cementing of crowns, inlays, onlays, bridgework or dentures.

2. Relining or rebasing of dentures more than six (6) months after initial placement or replacement of dentures, but not more than one relining or rebasing in any period of thirty-six (36) consecutive months.

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

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

5. Replacement of an existing partial or full removable denture including precision attachments and any adjustments during the six (6) month period following installation.

6. Replacement of an existing partial or full removable denture, new bridgework, or the addition of teeth to an existing partial or full removable denture or bridgework.

However, only replacements and additions that meet the "Prosthesis Replacement Rule" below will be covered.

Prosthesis Replacement Rule

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

1. The existing denture cannot be made serviceable and was installed at least five (5) years prior to its replacement; or

2. The existing denture is an immediate temporary denture, which cannot be made permanent and replacement by a permanent denture is required and takes place within twelve (12) months from the date of initial installation of the immediate temporary denture.

Dental Exclusions and Limitations

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

1. Charges Incurred by a Late Enrollee for restorative services until six months from the date his or her coverage begins; and reconstructive services until 12 months from the date his or her coverage begins.

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

3. Oral hygiene instructions, plaque control or dietary planning.

4. Replacement of dentures and removable or fixed prosthesis due to theft, misplacement or loss.

5. Any full-mouth x-ray rendered within three years from the date of the Covered Person's full-mouth x-ray; and any bitewing x-ray or prophylaxis rendered within six months of the previous bitewing x-ray or prophylaxis.

6. Appliances or restorations used solely to increase vertical dimensions, restore occlusion or to correct temporomandibular joint dysfunction (TMJ) or pain syndrome.

7. Adjustment to or relining of partial or full removable dentures for which like services were rendered within the immediately preceding 36 months.

8. Charges for dentures, crowns, inlays, onlays, bridgework or other treatment, material or supplies provided to alter vertical dimension or alter occlusion, except as specifically included.

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

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

11. An expense will be considered Incurred as follows:

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

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

12. Tooth implants, tooth transplants or surgical repositioning of the jaw.

13. Charges for temporary restorations.

VISION BENEFITS

(No Deductible Required)

Vision care services and supplies will be eligible for reimbursement if they meet all of the following requirements:

1. They must be prescribed by an ophthalmologist or Optometrist;
2. They must be furnished by an ophthalmologist, Optometrist or optician;
3. They must not be excluded from coverage under this Plan; and
4. They must be specified as covered under the Plan.

Any Deductible and Benefit Percentages that apply to other benefits in this Plan do not apply to this benefit.

Examinations

Benefits are available for one routine vision examination per Covered Person each Calendar Year. Covered routine examination services are:

1. Examination of the outer and inner parts of the eye;
2. Evaluation of vision sharpness (refraction);
3. Binocular balance testing;
4. Routine tests of color vision, peripheral vision and intraocular pressure; and
5. Case history, recommendations and prescriptions.

Lenses

One set of lenses per Covered Person each Calendar Year, at the reimbursement level shown in the Schedule of Benefits. This includes single, bifocal or trifocal lenses.

Benefits for the following are included in the maximum benefit for the type of lenses prescribed:

- Special features, such as tinting or coating.
- Fitting of eyeglass lenses to frames.
- Fitting contact lenses to the eyes.

Benefits will be provided for either eyeglass lenses or contact lenses during the same Calendar Year, but not both.

Frames

Benefits for frames are provided at the Plan's reimbursement level shown in the Schedule of Benefits. This benefit includes parts of frames and fitting the frames to the face.

Charges for vision services or supplies that exceed what is covered under this benefit are not covered under other benefits of this Plan.

Limitations

In addition to "General Limitations and Exclusions," the following limitations will apply to this benefit.

1. We do not provide this benefit for:

    - Services or supplies that are not named above as covered, or that are covered under other provisions of this Plan.
    - Services or supplies that are not furnished by a licensed ophthalmologist, Optometrist, or optician.
    - Nonprescription glasses, or other special purpose vision aids (such as magnifying attachments), sunglasses or light-sensitive lenses, even if prescribed.

- Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics) or pleoptics.
- Supplies used for the maintenance of contact lenses.
- Replacement of lost, broken or stolen lenses, frames or replacement frames for any other reason unless required to accommodate replacement lenses which are covered under this benefit.
- Duplicate or spare lenses or frames.
- Any eye examination required by your employer as a condition of employment and which your employer is required to provide due to a labor agreement.

2. Services or supplies received after the enrollee's coverage terminates. However, benefits for covered eyeglasses (eyeglass lenses or frames) or covered contact lenses ordered before the Covered Person's termination date will be allowed if the Covered Person received a covered routine vision examination, which included a refraction, during the 30-day period immediately before the termination date, and the eyeglasses or contact lenses are delivered to the former Covered Person within 30 days after the date that coverage terminated.

HEARING BENEFITS

(No Deductible Required)

Your Plan will pay, according to the Schedule of Benefits, for a hearing aid device for you or your Dependents. The maximum benefit is also shown in the Schedule of Benefits.

In order to receive your hearing aid benefit, you must be examined by a Physician licensed as a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) before obtaining a hearing aid. You must also provide the Plan with a written certificate from the examining Physician stating that you are suffering a hearing loss that may be lessened by the use of a hearing aid. Such written certification must be obtained within a three-month period prior to purchase of a hearing aid. Physician certification and your claim for the examination must be submitted with your claim for the hearing aid device. Benefits will not be provided without this certification. (This requirement will be waived if you replace a hearing aid that was originally provided under this benefit.)

When the Plan provides benefits for a hearing aid, benefits will also be provided for:

- An otologic (ear) examination by a physician licensed as a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.).
- An audiologic (hearing) examination and hearing evaluation by a certified or licensed audiologist including a follow-up consultation.
- The hearing aid (monaural or binaural) prescribed as a result of the examination.
- Ear mold(s).
- The hearing aid instrument.
- The initial batteries, cords and other necessary ancillary equipment.
- A warranty.
- Follow-up consultation within 30 days following delivery of the hearing aid.
- In the event that a Covered Person elects to return the hearing device before actual purchase, this Plan will pay 80 percent of the allowable rental charges for the use of the instrument for a period of up to but not to exceed 30 days.

Exclusions Under The Hearing Aid Benefit

In addition to "General Limitations and Exclusions," the following limitations will apply to this benefit.

- Replacement of a hearing aid for any reason more often than once in a three-year period.
- Batteries or other ancillary equipment unless obtained upon purchase of the hearing aid.
- Repairs, servicing or alteration of hearing aid equipment.
- A hearing aid which exceeds the specifications prescribed for correction of hearing loss.
- Expenses incurred after your coverage ends under this Plan unless a hearing aid was ordered prior to that date and was delivered within 90 days after the day your coverage ended.
- Hearing aid charges in excess of the hearing aid benefit are not eligible under Major Medical Benefits.
- Hearing aids purchased prior to your effective date of coverage under this Plan.

PLAN ADMINISTRATION

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

Plan Administrator

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

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

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

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

Amending and Terminating the Plan

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

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

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

CLAIM PROCEDURES; PAYMENT OF CLAIMS

This section applies to Medical, Dental, Vision, Hearing and Prescription Drug claims.

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

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

Meritain Health
P.O. Box 27267
Minneapolis, MN 55427-0267
866-808-2609

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

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

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

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

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

   A "Pre-service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

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

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

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

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

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

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

- **When Health Claims Must Be Filed**

Health claims must be filed with the Claims Administrator within 90 days of the date charges for the service were Incurred. Benefits are based upon the Plan's provisions at the time the charges were Incurred. **Claims filed later than that date shall be denied.**

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

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

- **Timing of Claim Decisions**

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

1. Pre-service Non-urgent Care Claims:

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

2. Concurrent Claims:

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

3. Post-service Claims:

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

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

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

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

- **Notification of an Adverse Benefit Determination**

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

1. A reference to the specific portion(s) of the summary plan description upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary;
4. A statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Covered Person's claim for benefits;

5. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
6. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Covered Person, free of charge, upon request); and
7. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental Treatment), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, or a statement that such explanation will be provided to the Covered Person, free of charge, upon request.

Appeals of Adverse Benefit Determinations

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

In cases where a claim for benefits is denied, in whole or in part, and the Covered Person believes the claim has been denied wrongly, the Covered Person may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Covered Person with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

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

First Appeal Level

- **Requirements for First Appeal**

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

Meritain Health
Appeals Department
P. O. Box 1380
Amherst, NY 14226-1380

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

1. The name of the Employee/Covered Person;
2. The Employee/Covered Person's social security number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Covered Person will lose the right to raise factual arguments and theories which support this claim if the Covered Person fails to include them in the appeal**;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Covered Person has which indicates that the Covered Person is entitled to benefits under the Plan.

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

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

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

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

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

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

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

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

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

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

8. A description of the Plan's review procedures and the time limits applicable to the procedures; and
9. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

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

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

Second Appeal Level

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

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

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

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

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

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

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

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

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

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

1. A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is needed; and

2. A description of the Plan's review procedures and the time limits applicable to the procedures. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

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

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

- **Decision on Second Appeal to be Final**

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

or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.**

Appointment of Authorized Representative

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

Physical Examinations

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

Autopsy

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

Payment of Benefits

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

- **Assignments**

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

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

- **Right to Audit**

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

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

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

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

- **Recovery of Payments**

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

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

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

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

- **Medicaid Coverage**

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

COORDINATION OF BENEFITS

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

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

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

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

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

Other Plans

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

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

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

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

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

4. A licensed Health Maintenance Organization (HMO);

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

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

7. Group automobile insurance;

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

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

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

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

12. Individual homeowner's insurance coverage;

13. Individual renter's insurance coverage; or

14. Individual boat owner's insurance coverage.

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

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

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

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

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

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

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

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

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

The Plan Administrator has the right:

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

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

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

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

MEDICARE

Applicable to Active Employees and Their Spouses Ages 65 and Over

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

Applicable to All Other Covered Persons Eligible for Medicare Benefits

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

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Beneficiaries Who Are Covered Under This Plan

If any Covered Person is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

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

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

The Covered Person must:

1. Execute and deliver a Subrogation and Reimbursement agreement;

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

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

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

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

When a right of Recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other Illnesses or Injuries), the Covered Person will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the Injuries or Illness. The Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other benefits for the Injuries or Illness before these papers are signed and things are done (for example, to obtain a prompt payment discount); however, in that event, the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Covered Person will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines. A Covered Person who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Covered Person who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because the Covered Person

is not the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed.

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

Amount Subject to Subrogation or Reimbursement

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

When Recovery Includes the Cost of Past or Future Expenses

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

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

"Another Party"

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

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

"Recovery"

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

"Subrogation"

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

"Reimbursement"

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

When a Covered Person retains an Attorney

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

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

When the Covered Person is a Minor or is Deceased

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

When a Covered Person Does Not Comply

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

GENERAL PROVISIONS

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

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

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

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

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

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

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

Right to Receive and Release Necessary Information
For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Covered Person for benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action; however the Plan Administrator at all times will comply with the Privacy Standards. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

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

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

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

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

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

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

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

Child or Children
"Child" or "Children" shall mean your natural born son or daughter, stepson or stepdaughter, a legally adopted child (including a child placed with the Employee in anticipation of adoption), or a child for whom the Employee is the legal guardian (coverage will remain in effect until the date the child no longer meets the age and support and maintenance requirements of an eligible Dependent under the terms of this Plan, regardless of whether or not such child has attained age 18 or any other applicable age of emancipation of minors).

Claims Administrator
"Claims Administrator" shall mean Meritain Health, PO Box 241569, Anchorage, AK 99524-1569.

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

Company
"Company" shall mean Bering Strait School District.

Complications of Pregnancy
"Complications of Pregnancy" shall mean:

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

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

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

Complications of Pregnancy does not mean:

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

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

Successive Confinements are considered one Confinement unless:

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

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

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

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

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

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

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

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

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

Creditable Coverage
"Creditable Coverage" shall mean coverage of an individual under any of the following: a group health plan, health insurance coverage, Medicare, Medicaid (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines), medical and dental care for members and certain former members of the Uniformed

Services and their dependents, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under Section 5(e) of the Peace Corps Act, or Title XXI of the Social Security Act (State Children's Health Insurance Program). To the extent that further clarification is needed with respect to the sources of Creditable Coverage listed in the prior sentence, please see the complete definition of Creditable Coverage that is set forth in 45 C.F.R. § 146.113(a).

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

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

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

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

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

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

Dependent
"Dependent" shall mean:

1. The Employee's legal spouse, including common law spouse, who is a resident of the same country in which the Employee resides. Such spouse must have met all requirements of a valid marriage contract or common law certification in the state of marriage of such parties.
2. The Employee's same-sex Domestic Partner. Please refer to the definition for Domestic Partner for the requirements to establish a domestic partnership that will establish eligibility under the Plan.
3. The Employee's Dependent Child until the date the child attains age twenty-six (26), provided such child is not eligible for other employer sponsored coverage (other than through that of a parent).
4. The Employee's Dependent Child who is unmarried, and who is mentally or physically incapable of sustaining his or her own living. Such child must have been mentally or physically incapable of self-sustaining employment and suffered such incapacity prior to the date in which he/she attained age twenty-six (26). The Plan may require subsequent proof of the child's disability, including a Physician's statement at any time, in its sole discretion.
5. Any Child born to an Employee or an Employee's spouse or Domestic Partner while such Employee or Employee's spouse or Domestic Partner is covered under this Plan shall also be considered an eligible Dependent under this Plan. The Newborn Child is covered for the first 31 days from the date of birth, and will continue to be a Covered Person if the Plan Administrator receives the enrollment application within 31 days of birth. The Newborn must rely on the Employee for support. This will also apply to a Child who is adopted or placed for adoption. The requirement for

enrollment will be waived for any Employee who currently has Dependent Coverage and is making the maximum required contribution for that coverage.

6. Any child who is an alternate recipient under a Qualified Medical Child Support Order (QMCSO) as required by the federal Omnibus Budget Reconciliation Act of 1993.

The term Dependent excludes these situations:

1. A spouse who is divorced from the Employee. Such spouse must have met all requirements of a valid divorce decree in the state granting such divorce;
2. A same-sex Domestic Partner whose partnership with the Employee no longer meets all of the requirements to qualify as a same-sex domestic partnership under the Plan;
3. A Child of the Employee's same-sex Domestic Partner if the domestic partnership no longer meets all of the requirements to qualify as a same-sex domestic partnership under the Plan; or
4. Any person (other than a Dependent Child) on active military duty.

Dependent Coverage
"Dependent Coverage" shall mean coverage under the Plan for eligible Dependents of a covered Employee.

Domestic Partner
"Domestic Partner" shall mean the Employee's same-sex domestic partner if the partnership meets all of the following conditions. In order for a domestic partner to be eligible for coverage as a Dependent under the Plan, the Employee and his or her domestic partner must:

1. Have resided together in the same common primary residence for the last 12 consecutive months and intend to continue to share the same permanent residence indefinitely; and
2. Have been in an exclusive, committed and intimate relationship for the last 12 consecutive months and intend it to be permanent and continue indefinitely; and
3. Not be married to anyone else; and
4. Each be 18 years of age or older; and
5. Not be related by blood to the degree which would bar marriage in the State of Alaska if they were of the opposite sex from each other; and
6. Be mentally competent to consent to contract; and
7. Be one another's sole domestic partner and are each responsible for the common welfare of the other; and
8. Consider each other to be members of each other's immediate family; and
9. Have not executed an affidavit affirming same-sex partner status with anyone else within the last 12 consecutive months; and
10. Be financially interdependent, share joint responsibility for basic living and household expenses including, but not limited to, the cost of food, shelter, transportation and health care expenses; and
11. Be able to demonstrate the financial interdependency set forth in paragraph 10 (above) by demonstrating at least **five** of the following circumstances:
    a. Joint interest in real property, as evidenced by title or mortgage, lease, or rental agreement, by the Employee and the same-sex partner;
    b. Joint ownership or purchase of a motor vehicle by the Employee and same-sex partner;
    c. Joint ownership of a checking, savings or investment account or joint liability for a loan or credit by the Employee and the same-sex partner;
    d. The same-sex partner is named as beneficiary for a life insurance policy of the Employee;
    e. The same-sex partner is named as beneficiary for the Employee's pension or annuity plan benefits, deferred compensation plan, Individual Retirement Arrangement or Account, 401(k) plan, Keogh plan, or other tax deferred or taxable plan;
    f. The same-sex partner is named as primary beneficiary in the Employee's will;
    g. The same-sex partner has authority to deal with property owned by the Employee under a valid written power of attorney;

h. The Employee has given the same-sex partner written authority to make decisions concerning the Employee's health and well being if the Employee is unable to do so; or
i. The Employee must provide more than one-half of the same-sex partner's support in accordance with IRS regulations.

Documentation, satisfactory to the Plan Administrator, will be required to establish the eligibility of a Domestic Partner.

Durable Medical Equipment
"Durable Medical Equipment" shall mean equipment that is:
1. Able to withstand repeated use;
2. Primarily and customarily used to serve a medical purpose; and
3. Not generally useful for a person in the absence of Illness or Injury.

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

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

Employee
"Employee" shall mean a person who is classified as a regular status employee and is regularly scheduled to work the minimum 30 hours per week required by the Company. For the purposes of this Plan, Employee does not refer to temporary or seasonal employees who are not eligible for Plan benefits.

Experimental or Experimental Treatment
"Experimental" or "Experimental Treatment" shall mean services, supplies, care and treatment which do not constitute accepted and appropriate medical practice considering the facts and circumstances of the case and by the generally accepted standards of a reasonably substantial, qualified, responsible, relevant segment of the appropriate medical community or government oversight agencies at the time services were rendered, as determined by the Plan Administrator as set forth below.

The Plan Administrator must make an independent evaluation of the Experimental or non-Experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. In addition to the above, the Plan Administrator will be guided by the following principles to determine whether a proposed treatment is deemed to be Experimental and/or investigational:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished, then it is deemed to be Experimental and/or investigational; or

2. If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval, then it is deemed to be Experimental and/or investigational; or

3. If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials, or is the subject of the research, Experimental, study, Investigational or other arm of

on-going Phase III 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 a standard means of treatment or diagnosis, then it is deemed to be Experimental and/or investigational; or

4. If 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 a standard means of treatment or diagnosis, then it is deemed to be Experimental and/or investigational.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, 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.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the FDA for general use.

Expenses related to off-label drug use (the use of a drug or a purpose other than that for which it was approved by the FDA) will be eligible for coverage when all of the following criteria have been satisfied:

1. The named drug is not specifically excluded under the General Limitations of the Plan; and

2. The named drug has been approved by the FDA; and

3. The off-label drug use is appropriate and generally accepted by the medical community for the condition being treated; and

4. If the drug is used for the treatment of cancer, the American Hospital Formulary Service Drug Information or the NCCN Drugs and Biologics Compendia recognize it as an appropriate treatment for that form of cancer.

Expenses for drugs, devices, services, medical treatments or procedures related to an Experimental and/or investigational treatment (related services) and complications from an Experimental and/or investigational treatment and their related services are excluded from coverage, even if such complications and related services would be covered in the absence of the Experimental and/or investigational treatment.

Final determination of Experimental and/or investigational, Medical Necessity and/or whether a proposed drug, device, medical treatment or procedure is covered under the Plan will be made by and in the sole discretion of the Plan Administrator.

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

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

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

Full-Time Employment
"Full-Time Employment" shall mean a basis whereby an Employee is employed, and is compensated for services, by the Participating Employer for at least the number of hours per week stated in the eligibility requirements. The work may occur

either at the usual place of business of the Participating Employer or at a location to which the business of the Participating Employer requires the Employee to travel.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Is established by and periodically reviewed by:

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

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

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

1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an Inpatient basis at the patient's expense;
2. It is constituted, licensed and operated in accordance with the applicable laws of the jurisdiction in which it is located;
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an Illness or an Injury;
4. Such treatment is provided for compensation by and under the supervision of Physicians with continuous 24-hour nursing services by Registered Nurses;
5. It qualifies as a hospital or a Psychiatric Hospital and is licensed by the appropriate state authority; and
6. It is not, other than incidentally, a place for rest, the aged, or a nursing home.

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

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

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

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

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

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

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

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

Medically Necessary
Treatment which is generally accepted by medical professionals in the United States as proven, effective and appropriate for the condition based on recognized standards of the health care specialty involved.

"Proven means the care is not considered Experimental/Investigational, meets a particular standard of care accepted by the medical community and is approved by the Food and Drug Administration (FDA) for general use.

"Effective" means the treatments beneficial effects can be expected to outweigh any harmful effects. Effective care is treatment proven to have a positive effect on your health, while addressing particular problems caused by disease, Injury, Illness, or a clinical condition.

"Appropriate" means the treatment's timing and setting are proper and cost effective.

Medical treatments which are not proven, effective and appropriate are not covered by the Plan.

All criteria must be satisfied. When a Physician recommends or approves certain care it does not mean that care is Medically Necessary.

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

Mental Disorder
"Mental Disorder" shall mean any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Classification of Diseases, published by U.S. Health and Human Services.

Minor Emergency Medical Clinic
"Minor Emergency Medical Clinic" shall mean a freestanding facility, regardless of its name, including an Ambulatory Surgical Center, that is engaged primarily in providing minor Emergency and episodic medical care to a Covered Person. A Physician, Registered Nurse and registered X-ray technician must be in attendance at all times that the clinic is open. The clinic's facilities must include X-ray and laboratory equipment, and a life support system.

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

Nurse Midwife
"Nurse Midwife" means a Registered Nurse who is licensed and certified as a midwife by the state in which the services are provided.

Occupational Therapy
"Occupational Therapy" shall mean rehabilitation to attain the maximum level of physical and psycho-social independence following acute disease, Injury or loss of body part. This includes fine motor coordination, perceptual-motor skills, sensory testing, adaptive/assistive equipment, activities of daily living and specialized upper extremity and hand therapies.

Optometrist
"Optometrist" shall mean a licensed optometrist.

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

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

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

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

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

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

Physician
"Physician" shall mean a legally licensed medical or dental doctor or surgeon, chiropractor, osteopath, podiatrist, certified consulting Psychologist or psychiatrist to the extent that same, within the scope of their license, are permitted to perform services provided in this Plan. The term "Physician" also includes a Nurse Midwife, a nurse practitioner and a social worker with the degree "MSW."

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

Plan
"Plan" shall mean the Bering Strait School District Health Care Plan.

Plan Administrator
"Plan Administrator" shall mean Bering Strait School District.

Plan Sponsor
"Plan Sponsor" shall mean Bering Strait School District.

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

Pre-Admission Tests
"Pre-admission Tests" shall mean those diagnostic tests done prior to a scheduled admission, provided that:

1. The tests are approved by both the Hospital and the Physician;
2. The tests are performed on an Outpatient basis within 7 days prior to the Hospital admission; and
3. The tests are performed at the Hospital into which Confinement is scheduled, or at a qualified facility designated by the Physician who will perform the surgery.

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

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

Provider
Provider shall mean a Physician or other practitioner or facility defined or listed herein, or approved by the Plan Administrator.

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

Qualified Clinical Trial
A Qualified Clinical Trial is defined as a clinical trial that meets all the following conditions:

1. The clinical trial is intended to treat cancer in a Covered Person who has been so diagnosed; and
2. The clinical trial has been peer reviewed and is approved by at least one of the following:
   (a) One of the United States National Institutes of Health;
   (b) A cooperative group or center of the National Institutes of Health;
   (c) A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants;
   (d) The United States Food and Drug Administration pursuant to an investigational new drug exemption;
   (e) The United States Departments of Defense or Veterans Affairs;
   (f) Or, with respect to Phase II, III and IV clinical trials only, a "qualified institutional review board". A "qualified institutional review board" shall mean a committee of physicians, statisticians, researchers, community advocates and others that ensures a clinical trial is ethical and that the rights of the trial participants are protected; and
3. The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise as determined by the Plan Administrator; and
4. The Covered Person meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial; and
5. The Covered Person has provided informed consent for participation in the clinical trial in a manner that is consistent with current, generally accepted, legal and ethical standards; and
6. The available clinical or pre-clinical data provides a reasonable expectation that the Covered Person's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial; and
7. The clinical trial does not unjustifiably duplicate existing studies; and
8. The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the Covered Person.

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

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

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

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

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

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

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

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

Speech Therapy
"Speech Therapy" shall mean restoration of speech due to impairment following a recent physiological disturbance or Injury, such as CVA, tracheostomy, swallowing disorders, laryngectomy, neuromuscular disease, and genetic disorders (i.e. autism, Downs Syndrome, etc.).

Substance Use Disorder
"Substance Use Disorder" shall mean any disease or condition that is classified as a Substance Use Disorder in the current edition of the International Classification of Diseases, published by U.S. Health and Human Services.

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

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

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

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

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

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

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

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

HIPAA PRIVACY PRACTICES

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

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

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

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

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

- Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- Make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);
- Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);
- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

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

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

      Assistant Superintendent
      Accountant

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

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

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

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

- The Plan documents have been amended to incorporate the above provisions; and

- The Plan Sponsor agrees to comply with such provisions.

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

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage
The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the third party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

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

HIPAA SECURITY

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

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

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

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

Health Information Technology for Economic and Clinical Health (HITECH) Act

The Plan will comply with all applicable requirements of final Regulations issued by the Department of Health and Human Services pursuant to Subtitle D of the HITECH Act and any authoritative guidance issued pursuant to that Act, if and as they become applicable to the Plan. If there is any conflict between the requirements of Subtitle D of the HITECH Act, and any provision of this Plan, applicable law will control. Any amendment or revision or authoritative guidance relating to Subtitle D of the HITECH Act is hereby incorporated into the Plan as of the date that the Plan is required to comply with such guidance.

The Plan Sponsor will promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

GENERAL PLAN INFORMATION

Name of Plan:	Bering Strait School District Health Care Plan
Plan Sponsor:	Bering Strait School District PO Box 225 Unalakleet, Alaska 99684-0225 (907) 624-3611
Plan Administrator: **(Named Fiduciary)**	Bering Strait School District PO Box 225 Unalakleet, Alaska 99684-0225 (907) 624-3611
Plan Sponsor ID No. (EIN):	92-0157503
Fiscal Plan Year:	March 1st through February 28th
Plan Type:	Medical Dental Prescription Drug Vision Care
Claims Administrator:	Meritain Health P.O. Box 27267 Minneapolis, MN 55427-0267 Phone: (866) 808-2609 Internet: www.myMERITAIN.com
Participating Employer(s):	Bering Strait School District
Agent for Service of Legal Process:	Bering Strait School District 225 Main Street Unalakleet, Alaska 99684 (907) 624-3611
Type of Administration:	The Plan Administrator administers this Plan with the assistance of Meritain Health, a claims administration organization.
Contributions:	The Plan Sponsor and Employees make contributions. Contributions are calculated and based upon the estimated monthly cost of operating the Plan, and are allocated based upon the cost of Employee and Dependent Coverage.
Requirements:	Eligibility requirements, termination provisions, circumstances which may result in disqualification, denial or loss of benefits, the procedure to follow in presenting claims for benefits and the remedies regarding claims which are denied in whole or in part are described in this Plan Document.

SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #1
TO THE
BERING STRAIT SCHOOL DISTRICT
HEALTH CARE PLAN
Group No. AK035

This Summary of Material Modification and Amendment describes changes to the Bering Strait School District Health Care Plan effective March 1, 2011. **These changes are effective as of March 1, 2012** unless otherwise specified below and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

Bering Strait School District (the "Plan Administrator") is amending the Bering Strait School District Health Care Plan (the "Plan") as follows:

1. The **Full Plan Annual Maximum** under the **Schedule of Benefits** is amended to read as follows:

SCHEDULE OF BENEFITS

Major Medical Benefits

	Plan I	Plan II*	Plan III	Plan IV*
Full Plan Annual Maximum	$1,250,000	$1,250,000	$1,250,000	$1,250,000
Effective as of March 1, 2013	$2,000,000	$2,000,000	$2,000,000	$2,000,000
Effective as of March 1, 2014	Unlimited	Unlimited	Unlimited	Unlimited

2. Under the **Schedule of Benefits**, **Outpatient Surgery** is amended to read as follows:

SCHEDULE OF BENEFITS

Major Medical Benefits

	Plan I	Plan II*	Plan III	Plan IV*
Outpatient Surgery (Facility and Physician Charges)	90%	100%	90%	100%

Certain surgical procedures are covered at 100% (deductible waived) when they are received through the BridgeHealth Surgery Benefit Option. Not all surgical procedures are eligible for coverage under this option. Please refer to the BridgeHealth Surgery Benefit Option for a more detailed description of this benefit.

3. The **Preferred Provider Organizations (PPOs)** section of the Plan is hereby deleted and replaced with the following:

PREFERRED PROVIDER ORGANIZATIONS (PPOS)

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

Participating Providers

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

A "Participating Provider" or "Preferred Provider" is a provider in any state that has an agreement in effect with Aetna PPO or TAPPN, at the time services are rendered. To determine if a particular provider is a "Participating Provider," call the Claims Administrator at 866-808-2609.

Benefits vary if covered services obtained in Anchorage are from a Preferred Hospital versus a non-Preferred Provider Hospital. Covered services obtained in Anchorage from a non-Preferred Acute Care Hospital will be covered at a lower benefit level (60%). In addition, out-of-pocket payments to non-Preferred Hospitals in Anchorage will not accrue towards the Calendar Year Out-of- Pocket Maximum.

Example:

Joe, an employee who has already satisfied his Calendar Year Deductible, receives services totaling $3,000 from a non-Preferred Hospital in Anchorage. In this example the Preferred Hospital's contracted charges for the same services would have only been $1,800. Joe's benefit would be calculated as follows:

Non-Preferred Hospital in Anchorage

Charge	Eligible Amount	Benefit Percentage	Benefit Payment	Employee Responsibility
$3,000	$1,800	60%	$1,080	* $1,920

Preferred Hospital in Anchorage

Charge	Eligible Amount	Benefit Percentage	Benefit Payment	Employee Responsibility
$1,800	$1,800	90%	$1,620	$180

*Please note that none of the $1,920 paid by the claimant to the non-Preferred Hospital in Anchorage accrues towards Joe's Calendar Year Out-of-Pocket Maximum.

Exceptions will be made under the following circumstances:

(1) If you must be taken to the nearest facility available for a life-threatening Accident or Emergency; or

(2) A Preferred Hospital refers you to a non-Preferred Provider facility.

Aetna PPO, the Plan's national Preferred Provider network, provides access to discounts from many other health care providers nationally; however, there is no benefit reduction when accessing services from any providers outside of Anchorage.

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

Non-Participating Providers

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

Acute Care Inpatient Hospitalization

To receive maximum benefits, you must use the Participating Providers listed below:

1. Aetna PPO

Aetna PPO has a listing of participating providers in all 50 states. If you require medical services, call Meritain Health at 866-808-2609. You can also view Aetna's listing of participating providers by accessing their web page at www.aetna.com/docfind/custom/mymeritain.

2. TAPPN

TAPPN has a listing of participating providers in Alaska. If you require medical services in Alaska, call Meritain Health at 866-808-2609. You can also view the TAPPN providers at www.tappn.com.

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

3. Under the Major Medical Benefits section of the Plan, #39 - **Surgery** is hereby deleted and replaced with the following:

MAJOR MEDICAL BENEFITS

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

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

(1) 100% (full Usual, Customary and Reasonable value) for the first or major procedure;
(2) 50% for the second and subsequent procedures.

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

c. Charges made for services rendered by an assistant surgeon will be allowed at 25% of the Usual & Customary Fee allowance for the type of surgery performed.

BridgeHealth Surgery Benefit*TM* Option

The Plan provides a Covered Person with an option to receive certain surgical procedures through the *BridgeHealth Surgery BenefitTM* Option when a treating Physician recommends certain covered expenses and the Covered Person elects to receive treatment at certain medical providers participating in the BridgeHealth Network ("BridgeHealth Providers"). The BridgeHealth Surgery Benefit Option is only available to those Covered Persons who have primary coverage under the Plan. Covered expenses include all medical costs incurred under the *BridgeHealth Surgery Benefit*™, with no copay, deductible or coinsurance applied, as well as transportation, lodging, meals and incidentals for the Covered Person and one companion. For a list of covered surgical procedures, please contact BridgeHealth, Inc. at www.bridgehealthmedical.com/meritain or toll-free at 1-800-680-1366. Please note that although a surgical procedure may be covered by BridgeHealth, Inc., it is only covered under the Plan as long as the surgical procedure is Medically Necessary and not otherwise excluded under the terms of the Plan.

(1) Transportation and lodging includes round trip first class transportation for the Covered Person and one companion between the Covered Person's home location and the location of the BridgeHealth Provider where treatment is to be performed; and hotel accommodations near the BridgeHealth Provider. Hotel accommodations are limited to one room to be shared by the Covered Person and companion. All transportation and lodging must be reserved and scheduled through BridgeHealth Medical, Inc.

(2) Meals and Incidentals includes a daily allowance calculated for the number of days the Covered Person and companion are at the destination and is intended to cover incidental and "out-of-pocket" expenses incurred by the Covered Person in connection with his/her treatment. The meals and incidentals allowance shall be established and payable at initiation of the travel associated with such treatment.

Certain examinations, tests, treatments or other medical services may be required prior to or following travel for care under the *BridgeHealth Surgery Benefit*™. Any medical services performed by anyone other than a BridgeHealth Provider, including such pre and post care as may be required, shall be subject to the coverage limits and other terms of the Plan (including any required cost-sharing).

The *BridgeHealth Surgery Benefit*™ is included toward and subject to any Calendar Year Maximum for covered expenses under the Plan. The Plan shall remain responsible for *BridgeHealth Surgery Benefit*™ costs, in accordance with the applicable terms of the Plan, if a change is required once travel and other accommodations have been made. The Plan will also cover any Medical Emergency required as a result of any medical procedures or health services received by the Covered Person under the *BridgeHealth Surgery BenefitTM*, subject to the applicable coverage limits and other terms of the Plan (including any required cost-sharing).

BridgeHealth Medical, Inc. is a Delaware corporation that communicates the availability of medical and surgical diagnostic, treatment and care services and coordinates the delivery of such services with travel, communication and other non-medical aspects of the interaction with the service providers to institutional healthcare purchasers and the Covered Person. BridgeHealth Medical, Inc. does not provide any medical care or medical advice and does not evaluate or recommend any medical Providers or procedure.

The non-medical benefits provided under the *BridgeHealth Surgery Benefit*™ may be subject to taxation as income to the Covered Person; particularly any amounts paid to a Covered Person as meals and incidentals. BridgeHealth will provide appropriate documentation for benefits paid under the *BridgeHealth Surgery Benefit*™.

4. Under the **General Exclusions and Limitations** section of the Plan, #30 - **Outside USA** is hereby deleted and replaced with the following:

GENERAL EXCLUSIONS AND LIMITATIONS

30. **Outside USA**. Charges Incurred outside the United States if the Covered Person traveled to such a location for the primary purpose of obtaining medical services, drugs or supplies except for covered expenses under the BridgeHealth™ Surgery Benefit Option.

All other provisions of the Plan will remain unchanged.