Northwest Arctic Borough School District
Classified Health Plan

Group No.: 12431

Plan Document
and
Summary Plan Description

Originally Effective: January 1, 2015

Amended and Restated Effective: January 1, 2016

TABLE OF CONTENTS

ESTABLISHMENT OF THE PLAN

Northwest Arctic Borough School District (the “Employer” or the “Plan Sponsor”) has adopted this amended and restated Plan Document and Summary Plan Description effective as of January 1, 2016, for Northwest Arctic Borough School District Classified Health Plan hereinafter referred to as the “Plan” or “Summary Plan Description”), as set forth herein for the exclusive benefit of its Employees and their eligible Dependents. The Plan was originally adopted by the Employer effective as of January 1, 2014.

Purpose of the Plan
The Plan Sponsor has established the Plan for your benefit and for the benefit of your eligible Dependents, on the terms and conditions described herein. The Plan Sponsor’s purpose in establishing the Plan is to help to protect you and your family by offsetting some of the financial problems that may arise from an Injury or Illness. To accomplish this purpose, the Plan Sponsor must attempt to control health care costs through effective plan design and the Plan Administrator must abide by the terms of the Plan Document and Summary Plan Description, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to manage their healthcare costs.

The Plan is not a contract of employment between you and your Employer and does not give you the right to be retained in the service of your Employer.

The purpose of this Plan 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 health care expenses. This Plan is maintained by the Plan Administrator and may be inspected at any time during normal working hours by you or your eligible Dependents.

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

GENERAL OVERVIEW OF THE PLAN

The Plan Administrator has entered into an agreement with Aetna Choice® POS II (the "Network"). This Network offers you health care services at discounted rates. Using a Network provider will normally result in a lower cost to the Plan as well as a lower cost to you. There is no requirement for anyone to seek care from a provider who participates in the Network. The choice of provider is entirely up to you. However, with the use of a non-Network provider the participant's cost share will be higher.

Non-Participating Provider Exceptions
Covered services rendered by a Non-Participating Provider will be paid at the Participating Provider level when a:

(1) Covered Person has an Emergency Medical Condition requiring immediate care.

(2) Covered Person receives services by a Non-Participating Provider (e.g. anesthesiologists, radiologists, pathologists, etc.) who is under agreement with a Network facility.

(3) Participating Provider submits a specimen to a Non-Participating Provider laboratory.

(4) Referral is made by a Participating Provider to receive services from a Non-Participating Provider.

(5) Covered Person receives services from a Network surgeon who uses a non-Network Assistant Surgeon.

A current list of Participating Providers is available, without charge, through the Third Party Administrator at www.MERITAIN.com. If you do not have access to a computer at your home, you may contact your Employer or the Network at the phone number on the Employee identification card to obtain a paper copy of the Participating Providers available.

You have a free choice of any provider, and you, together with your provider, 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 Participating 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 Participating Provider.

Costs
You must pay for a certain portion of the cost of Covered Expenses under the Plan, including (as applicable) any Copay, Deductible and Coinsurance percentage that is not paid by the Plan, up to the Out-of-Pocket Maximum set by the Plan.

Coinsurance
Coinsurance is the percentage of eligible expenses the Plan and the Covered Person are required to pay. The amount of Coinsurance a Covered Person is required to pay is the difference from what the Plan pays as shown in the Schedule of Benefits.

There may be differences in the Coinsurance percentage payable by the Plan depending upon whether you are using a Participating Provider or a Non-Participating Provider. These payment levels are also shown in the Schedule of Benefits.

Note: Participating and Non-Participating Provider cost shares accumulate independently and are not combined.

Deductible
A Deductible is the total amount of eligible expenses as shown in the Schedule of Benefits, which must be Incurred by you during any Calendar Year before Covered Expenses are payable under the Plan. The family Deductible maximum, as shown in the Schedule of Benefits, is the maximum amount which must be Incurred by the covered family members during a Calendar Year. However, each individual in a family is not required to contribute more than one individual Deductible amount to a family Deductible.

Carry-Over Provision. If the medical Deductible is satisfied in whole or in part by eligible expenses Incurred during October, November or December, those expenses will apply to the Deductible applicable in the next Calendar Year.

If 2 or more covered family members suffer Injuries from the same Accident, only one Deductible will be applied to all charges Incurred for the treatment of those Injuries during the Calendar Year.

Out-of-Pocket Maximum
An Out-of-Pocket Maximum is the maximum amount of Coinsurance you and/or all of your family members will pay for eligible expenses Incurred during a Calendar Year before the percentage payable under the Plan increases to 100%.

The single Out-of-Pocket Maximum applies to a Covered Person with single coverage. When a Covered Person reaches his or her Out-of-Pocket Maximum, the Plan will pay 100% of additional eligible expenses for that individual during the remainder of that Calendar Year.

The family Out-of-Pocket Maximum applies collectively to all Covered Persons in the same family. The family Out-of-Pocket Maximum is the maximum amount that must be satisfied by covered family members during a Calendar Year. The entire family Out-of-Pocket Maximum must be satisfied; however each individual in a family is not required to contribute more than the single Out-of-Pocket amount to the family Out-of-Pocket Maximum before the Plan will pay 100% of covered expenses for any Covered Person in the family during the remainder of that Calendar Year

Your Out-of-Pocket Maximum may be higher for Non-Participating Providers than for Participating Providers. Please note, however, that not all Covered Expenses are eligible to accumulate toward your Out-of-Pocket Maximum.

The types of expenses, which are not eligible to accumulate toward your Out-of-Pocket Maximum, ("non-accumulating expenses") include:

(1) Charges this Plan does not cover, including precertification penalties.

(2) Charges over Usual and Customary Charges for Non-Participating Providers.

(3) Dental and vision benefits, other than those dental and vision expenses paid under the major medical component of the Plan.

The Plan will not reimburse any expense that is not a Covered Expense. In addition, you must pay any expenses that are in excess of the Usual and Customary Charges for Non-Participating Providers. This could result in you having to pay a significant portion of your claim. None of these amounts will accumulate toward your Out-of-Pocket Maximum.

Reimbursement for any eligible non-accumulating expenses will continue at the percentage payable shown in the Schedule of Benefits, subject to the Plan maximums.

Once you have paid the Out-of-Pocket Maximum for eligible expenses Incurred during a Calendar Year, the Plan will reimburse additional eligible expenses Incurred during that year at 100%.

If you have any questions about whether an expense is a Covered Expense, or whether it is eligible for accumulation toward your Out-of-Pocket Maximum, please contact your Plan Administrator for assistance.

The Coinsurance percentage, Deductibles and Out-of-Pocket Maximum are shown in the Medical Schedule of Benefits.

Integration of Deductibles and Out-of-Pocket Maximums
If you use a combination of Participating Providers and Non-Participating Providers, your total Deductible amount and Out-of-Pocket Maximum amount required to be paid are separate amounts and do not integrate. In other words, you will be required to satisfy the Deductible amount and Out-of-Pocket Maximum amount for Participating Providers and Non-Participating Providers separately.

MEDICAL MANAGEMENT PROGRAM

Medical Rehabilitation Consultants – 800-827-5058

You, your eligible Dependents or a representative acting on your behalf, must call the Medical Management Program Administrator to receive certification of Inpatient admissions (other than admissions for an Emergency Medical Condition), as well as other non-Emergency Services listed below. This call must be made at least 48 hours in advance, or as soon as possible prior to Inpatient admissions or receipt of the non-Emergency Services listed below. If the Inpatient admission is with respect to an Emergency Medical Condition, you must notify the Medical Management Program Administrator within 48 hours, or if later, by the next business day after the Emergency Medical Condition admission. Failure to obtain precertification or notify the Medical Management Program Administrator within the time frame indicated above may result in eligible expenses being reduced or denied. Please refer to the penalty section below.

Medical Management is a program designed to help ensure that you and your eligible Dependents receive necessary and appropriate healthcare while avoiding unnecessary expenses. The program consists of:

(1) Precertification of Medical Necessity. The following items and/or services must be precertified before any medical services are provided:

- (a) Air ambulance when used for non-Emergency Medical Conditions
- (b) Renal dialysis
- (c) Durable Medical Equipment (other than breast pumps covered as a preventive service) – in excess of $500
- (d) Genetic testing
- (e) Home health care, including IV therapy
- (f) Inpatient admissions, including inpatient admissions due to a Mental Disorder or Substance Use Disorder
- (g) Imaging (high technology radiology – i.e. CAT scans, PET scans and MRIs)
- (h) Transplant evaluations
- (i) Outpatient Surgical procedures, excluding Surgery rendered in a Physician's office
- (j) Prescription drugs that need to be reviewed for Medical Necessity. This includes, but is not limited to:
  - (i) certain drugs that are used for specialized medical treatment, to ensure that the drugs are used appropriately. Examples of medical conditions that may require specialized drugs include: arthritis, growth deficiencies and immune disorders; and
  - (ii) certain drugs that have multiple uses, to ensure that the drug is used according to acceptable medical practice and FDA guidelines.
- (k) Transplants

(2) Concurrent Review for continued length of stay and assistance with discharge planning activities.

(3) Retrospective review for Medical Necessity where precertification is not obtained or the Medical Management Program Administrator is not notified.

Medical Management Does Not Guarantee Payment. All benefits/payments are subject to the patient's eligibility for benefits under the Plan. For benefit payment, services rendered must be considered an eligible expense under the Plan and are subject to all other provisions of the Plan.

This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other healthcare provider.

How the Program Works

Precertification
Before you or your eligible Dependents are admitted to a medical facility or receive items or services that require precertification on a non-Emergency Medical Condition basis (that is an Emergency Medical Condition is not involved), the Medical Management Program Administrator will, based on clinical information from the provider or facility, certify the care according to the Medical Management Program Administrator's policies and procedures.

The Medical Management Program is set in motion by a telephone call from you, the patient, or a representative acting on your behalf or on behalf of the patient.

To allow for adequate processing of the request, contact the Medical Management Program Administrator prior to receiving any item or service that requires precertification or an Inpatient admission for a Non- Emergency Medical Condition with the following information:

(1) Name, identification number and date of birth of the patient;

(2) The relationship of the patient to the covered Employee;

(3) Name, identification number, address and telephone number of the covered Employee;

(4) Name of Employer and group number;

(5) Name, address, Tax ID #, and telephone number of the admitting Physician;

(6) Name, address, Tax ID #, and telephone number of the medical facility with the proposed date of admission and proposed length of stay;

(7) Proposed treatment plan; and

(8) Diagnosis and/or admitting diagnosis.

If there is an Inpatient admission with respect to an Emergency Medical Condition, you, the patient, or a representative acting on your behalf or on behalf of the patient, including, but not limited to, the Hospital or admitting Physician, must contact the Medical Management Program Administrator within 48 hours after the start of the confinement or on the next business day, whichever is later.

Hospital stays in connection with childbirth for either the mother or newborn may not be less than 48 hours following a vaginal delivery, or 96 hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother.

You, the patient, and the providers are NOT REQUIRED to obtain precertification for a maternity delivery admission, unless the stay extends past the applicable 48 or 96 hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth. If a newborn remains hospitalized beyond the time frames specified above, the confinement must be precertified with the Medical Management Program Administrator or a penalty will be applied.

The Medical Management Program Administrator, in coordination with the facility and/or provider, will make a determination on the number of days certified based on the Medical Management Program Administrator's policies, procedures and guidelines. If the confinement will last longer than the number of days certified, a representative of the Physician or the facility must call the Medical Management Program Administrator before those extra days begin and obtain certification for the additional time.

If the patient does not obtain precertification for their Inpatient admission at least 48 hours in advance, or as soon as possible prior to the admission, or notify the Medical Management Program Administrator within 48 hours after an Emergency Medical Condition admission, or if precertification is obtained or notification received outside the time frames specified, eligible expenses may be reduced or denied. Please refer to the penalty section below.

Penalty
If you fail to obtain precertification or fail to notify the Medical Management Program Administrator within the time periods described above, benefits under the Plan will be reduced as follows:

(1) Covered Expenses will be reduced by 50% per occurrence. The amount of the precertification penalty is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

If the Plan's required review procedures are not followed, a retrospective review will be conducted by the Medical Management Program Administrator to determine if the services provided met all other Plan provisions and requirements. If the review concludes the services were Medically Necessary and would have been approved had the required phone call been made, benefits will be considered, subject to the penalty outlined above. However, any charges not deemed Medically Necessary will be denied.

Concurrent Review, Discharge Planning
Discharge planning needs is part of the Medical Management Program. The Medical Management Program Administrator will assist and coordinate the initial implementation of any services the patient will need post hospitalization with the attending Physician and the facility. If the attending Physician feels that it is Medically Necessary for a patient to stay in the medical care facility for a greater length of time than has been precertified, the attending Physician or the medical facility must request the additional service or days.

Concurrent Inpatient Review
Once the Inpatient setting has been precertified, the on-going review of the course of treatment becomes the focus of the program. Working directly with your Physician, the Medical Management Program Administrator will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses.

To File a Complaint or Request an Appeal to a Non-Certification
Verbal appeal requests and information regarding the appeal process should be directed to the Medical Management Program Administrator as identified on the General Information page of this Plan.

Case Management
When a catastrophic condition, such as a spinal cord injury, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps lifetime care. After the patient’s condition is diagnosed, the patient might need extensive services or might be able to be moved into another type of care setting, even to the patient’s home.

Case management is a program whereby a Case Manager contacts the patient to obtain consent for case management services. The Case Manager monitors the patient and explores, discusses and recommends coordinated and/or alternate types of appropriate medical care. The Case Manager consults with the patient, family and the attending Physician in order to develop a plan of care for approval by the patient’s attending Physician and the patient.

This plan of care may include some or all of the following:

(1) Personal support to the patient;

(2) Contacting the family to offer assistance and support;

(3) Monitoring Hospital or skilled nursing care or home health care;

(4) Determining alternative care options; and

(5) Assisting in obtaining any necessary equipment and services.

Case management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The Case Manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan staff, attending Physician, patient and patient’s family must all agree to the alternate treatment plan.

Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

Medical Management 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.

The Medical Management Program Administrator contact information for this Plan is identified on the Employee identification card and also on the General Information page of this Plan.

Maternity Management
The primary objective of the Maternity Management program is to anticipate the possibility of a high or moderate risk Pregnancy and help coordinate effective medical care.

It is highly recommended, but not a requirement of the Plan, that expectant mothers call Medical Management during the first trimester of Pregnancy or upon confirmation of Pregnancy. At this time, an RN will ask questions about the expectant mother's general health and medical history. This information will be discussed with the Covered Person's Physician to help determine the risk factor of the Pregnancy.

MEDICAL SCHEDULE OF BENEFITS – CERTIFIED PLAN

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
OVERALL CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE (combined with Prescription Drug Card benefits)		
Single	$50	$200
Family	$150	$500
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible and Coinsurance - combined with Prescription Drug Card benefits)		
Per Individual	$1,500	$4,000
Per Family	$3,000	$8,000
Penalty If you fail to obtain precertification or fail to notify the Medical Management Program Administrator within the time periods described under Medical Management, Covered Expenses will be reduced by 50% per occurrence and this penalty amount will not accumulate toward any Out-of-Pocket Maximum limit.		
MEDICAL BENEFITS		
Allergy Services (all)	90% after Deductible	
Air Ambulance/Commercial Airlines	90% after Deductible	
Ambulance Services		
Ground	90% after Deductible	
Air (other than through Guardian Flight)	90% after Deductible	
Air (provided by Guardian Flight)*	90% after Deductible of allowable rate listed below:	
One way transport (fixed wing or rotary)	225% of the Medicare/CMS Rural rate**	
Fixed wing air mileage per statue mile	600% of the Medicare/CMS Rural rate**	
Rotary wing air mileage, per statue mile	200% of the Medicare/CMS Rural rate**	
*NOTE: If the provider is Guardian Flight, allowable charges will be payable at the Medicare/CMS Rural Rate set forth above shall be used as the Usual and Customary level and no discount will be given.		
**NOTE: Amounts paid by the Covered Person in excess of the Medicare/CMS Rural rate do not accrue toward the Plan Year Out-of-Pocket Maximum Expense.		
Audiocare (hearing exams and hearing aids)	80%; Deductible waived	
Maximum Benefit	One pair of hearing aids every 3 year period	
Birthing Center	100%; Deductible waived	
Chemotherapy (Outpatient)	90% after Deductible	
Chiropractic Care/Spinal Manipulation	90% after Deductible	
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	90% after Deductible	
Durable Medical Equipment (DME)	90% after Deductible	

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Emergency Services/Emergency Room Services (includes x-ray and lab)	90% after Deductible	
Home Health Care	90% after Deductible	
Calendar Year Maximum Benefit	100 visits; one visit per day	
Hospice Care		
Inpatient and Outpatient	100%; Deductible waived	
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient		
Providence Alaska Medical Center and Participating Provider Facilities	90% after Deductible	
Non-Participating Provider Facility	70% after Deductible	
Services Outside Participating Provider Network Area	80% after Deductible	
Room and Board Allowance*	*Semi-Private Room rate	
Room and Board Allowance – Long-Term Acute Care Facility	First 60 days at 50% and the next 30 days 25% of the semi-private rate of the last Hospital confined	
Intensive Care Unit	3 times semi-private room rate	
Miscellaneous Service and Supplies (includes x-ray and lab)		
Providence Alaska Medical Center and Participating Provider Facilities	90% after Deductible	
Non-Participating Provider Facility	70% after Deductible	
Services Outside Participating Provider Network Area	80% after Deductible	
Outpatient		
Providence Alaska Medical Center and Participating Provider Facilities	90% after Deductible	
Non-Participating Provider Facility	70% after Deductible	
Services Outside Participating Provider Network Area	80% after Deductible	
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Maternity (Professional Fees)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100% Deductible waived	
Lactation Consultations	100% Deductible waived	
All Other Prenatal, Delivery and Postnatal Care	90% after Deductible	
* See Preventive Services under Eligible Medical Expenses for limitations.		

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Mental Disorders and Substance Use Disorders		
Inpatient and Outpatient Facility Charges		
Providence Alaska Medical Center and Participating Provider Facilities	90% after Deductible	
Non-Participating Provider Facility	70% after Deductible	
Services Outside Participating Provider Network Area	80% after Deductible	
Inpatient and Outpatient Professional Fees and All Other Services	90% after Deductible	
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
Outpatient Surgical Facility		
Providence Alaska Medical Center and Participating Provider Facilities	90% after Deductible	
Non-Participating Provider Facility	70% after Deductible	
Services Outside Participating Provider Network Area	80% after Deductible	
Physical Therapy	90% after Deductible	
Physician's Services		
Inpatient/Outpatient Services/Office Visits	90% after Deductible	
Pre-Admission Testing (Outpatient)	100%; Deductible waived	
Preventive Services and Routine Care		
Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)	100%; Deductible waived	
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above such as office visits, lab tests, x-rays, routine testing, vaccinations or inoculations, well child care, annual pap smears, annual mammograms, colon exams, and PSA testing)	90% after Deductible	
Second Surgical Opinion	100%; Deductible waived	
Skilled Nursing Facility and Rehabilitation Facility	100%; Deductible waived	
Combined Calendar Year Maximum Benefit	90 days	
Surgical Procedures through BridgeHealth	100% Deductible waived*	
* 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.		

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Transplants	90% after Deductible (Aetna IOE program)*	Not Covered
Transportation	100%; Deductible waived	
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including transportation and lodging maximums.		
All Other Eligible Medical Expenses	90% after Deductible	

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – CERTIFIED PLAN

BENEFIT DESCRIPTION	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
NOTE: The Covered Person will be reimbursed the amount that would have been paid to a Participating Provider less the applicable Deductible and Coinsurance if Prescription Drugs are obtained from a Non-Participating Provider.		
CALENDAR YEAR DEDUCTIBLE: (combined with major medical Deductible) Single Family	 $50 $150	 $200 $500
CALENDAR YEAR OUT-OF-POCKET MAXIMUM: (combined with major medical Out-of-Pocket) Per Individual Per Family	 $1,500 $3,000	 $4,000 $8,000
Retail Pharmacy: 90-day supply Generic	90% after Deductible	
Brand Name	90% after Deductible	
Specialty Drugs	90% after Deductible	
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	100% (Deductible waived, Plan pays 100%)	
Mail Order Pharmacy: 90-day supply		
Generic	90% after Deductible	
Brand Name	90% after Deductible	
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	100% (Deductible waived, Plan pays 100%)	

NOTE: Coverage for preventive contraceptives and contraceptive devices is only available for women of child bearing age and limited to contraceptives that are considered Generic Drugs unless no equivalent Generic Drug is available and the Brand Name Drug is otherwise covered under the Prescription Drug Card Program. If the Covered Person chooses a Brand Name Drug rather than the Generic equivalent when there is a Generic equivalent available and the Physician has allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic Drug and the Brand Name Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a paper copy, please contact the Plan Administrator.

MEDICAL SCHEDULE OF BENEFITS – CLASSIFIED PLAN

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
OVERALL CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE (combined with Prescription Drug Card benefits)		
Single	$50	$100
Family	$150	$300
CALENDAR YEAR DEDUCTIBLE (EFFECTIVE JANUARY 1, 2017) (combined with Prescription Drug Card benefits)		
Single	$50	$150
Family	$150	$300
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible and Coinsurance - combined with Prescription Drug Card benefits)		
Per Individual	$750	$2,000
Per Family	$1,500	$4,000
Penalty If you fail to obtain precertification or fail to notify the Medical Management Program Administrator within the time periods described under Medical Management, Covered Expenses will be reduced by 50% per occurrence and this penalty amount will not accumulate toward any Out-of-Pocket Maximum limit.		
MEDICAL BENEFITS		
Allergy Services (all)	90% after Deductible	
Air Ambulance/Commercial Airlines	90% after Deductible	
Ambulance Services		
Ground	90% after Deductible	
Air (other than through Guardian Flight)	90% after Deductible	
Air (provided by Guardian Flight)*	90% after Deductible of allowable rate listed below:	
One way transport (fixed wing or rotary)	225% of the Medicare/CMS Rural rate**	
Fixed wing air mileage per statue mile	600% of the Medicare/CMS Rural rate**	
Rotary wing air mileage, per statue mile	200% of the Medicare/CMS Rural rate**	
*NOTE: If the provider is Guardian Flight, allowable charges will be payable at the Medicare/CMS Rural Rate set forth above shall be used as the Usual and Customary level and no discount will be given.		
**NOTE: Amounts paid by the Covered Person in excess of the Medicare/CMS Rural rate do not accrue toward the Plan Year Out-of-Pocket Maximum Expense.		
Audiocare (hearing exams and hearing aids)	80%; Deductible waived	
Maximum Benefit	One pair of hearing aids every 3 year period	
Birthing Center	100%; Deductible waived	
Chemotherapy (Outpatient)	90% after Deductible	

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Chiropractic Care/Spinal Manipulation	90% after Deductible	
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	90% after Deductible	
Durable Medical Equipment (DME)	90% after Deductible	
Emergency Services/Emergency Room Services (includes x-ray and lab)	90% after Deductible	
Home Health Care	90% after Deductible	
Calendar Year Maximum Benefit	100 visits; one visit per day	
Hospice Care		
Inpatient and Outpatient	100%; Deductible waived	
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient		
Providence Alaska Medical Center and Participating Provider Facilities	90% after Deductible	
Non-Participating Provider Facility	70% after Deductible	
Services Outside Participating Provider Network Area	80% after Deductible	
Room and Board Allowance*	*Semi-Private Room rate	
Room and Board Allowance – Long-Term Acute Care Facility	First 60 days at 50% and the next 30 days 25% of the semi-private rate of the last Hospital confined	
Intensive Care Unit	3 times semi-private room rate	
Miscellaneous Service and Supplies (includes x-ray and lab)		
Providence Alaska Medical Center and Participating Provider Facilities	90% after Deductible	
Non-Participating Provider Facility	70% after Deductible	
Services Outside Participating Provider Network Area	80% after Deductible	
Outpatient		
Providence Alaska Medical Center and Participating Provider Facilities	90% after Deductible	
Non-Participating Provider Facility	70% after Deductible	
Services Outside Participating Provider Network Area	80% after Deductible	
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Maternity (Professional Fees)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100% Deductible waived	
Lactation Consultations	100% Deductible waived	
All Other Prenatal, Delivery and Postnatal Care	90% after Deductible	
* See Preventive Services under Eligible Medical Expenses for limitations.		
Mental Disorders and Substance Use Disorders		
Inpatient and Outpatient Facility Charges		
Providence Alaska Medical Center and Participating Provider Facilities	90% after Deductible	
Non-Participating Provider Facility	70% after Deductible	
Services Outside Participating Provider Network Area	80% after Deductible	
Inpatient and Outpatient Professional Fees and All Other Services	90% after Deductible	
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
Outpatient Surgical Facility		
Providence Alaska Medical Center and Participating Provider Facilities	90% after Deductible	
Non-Participating Provider Facility	70% after Deductible	
Services Outside Participating Provider Network Area	80% after Deductible	
Physical Therapy	90% after Deductible	
Physician's Services		
Inpatient/Outpatient Services/Office Visits	90% after Deductible	
Pre-Admission Testing (Outpatient)	100%; Deductible waived	
Preventive Services and Routine Care		
Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)	100%; Deductible waived	
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above such as office visits, lab tests, x-rays, routine testing, vaccinations or inoculations, well child care, annual pap smears, annual mammograms, colon exams, and PSA testing)	90% after Deductible	
Second Surgical Opinion	100%; Deductible waived	

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Skilled Nursing Facility and Rehabilitation Facility	100%; Deductible waived	
Combined Calendar Year Maximum Benefit	90 days	
Surgical Procedures through BridgeHealth	100% Deductible waived*	
* 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.		
Transplants	90% after Deductible (Aetna IOE program)*	Not Covered
Transportation	100%; Deductible waived	
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including transportation and lodging maximums.		
All Other Eligible Medical Expenses	90% after Deductible	

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – CLASSIFIED PLAN

BENEFIT DESCRIPTION	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
NOTE: The Covered Person will be reimbursed the amount that would have been paid to a Participating Provider less the applicable Deductible and Coinsurance if Prescription Drugs are obtained from a Non-Participating Provider.		
CALENDAR YEAR DEDUCTIBLE: (combined with major medical Deductible)		
Single	$50	$100
Family	$150	$300
CALENDAR YEAR DEDUCTIBLE (EFFECTIVE JANUARY 1, 2017): (combined with major medical Deductible)		
Single	$50	$150
Family	$150	$300
CALENDAR YEAR OUT-OF-POCKET MAXIMUM: (combined with major medical Out-of-Pocket)		
Per Individual	$1,500	$2,000
Per Family	$3,000	$4,000
Retail Pharmacy: 90-day supply		
Generic	90% after Deductible	
Brand Name	90% after Deductible	
Specialty Drugs	90% after Deductible	
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	100% (Deductible waived, Plan pays 100%)	
Mail Order Pharmacy: 90-day supply		
Generic	90% after Deductible	
Brand Name	90% after Deductible	
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	100% (Deductible waived, Plan pays 100%)	

NOTE: Coverage for preventive contraceptives and contraceptive devices is only available for women of child bearing age and limited to contraceptives that are considered Generic Drugs unless no equivalent Generic Drug is available and the Brand Name Drug is otherwise covered under the Prescription Drug Card Program. If the Covered Person chooses a Brand Name Drug rather than the Generic equivalent when there is a Generic equivalent available and the Physician has allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic Drug and the Brand Name Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a paper copy, please contact the Plan Administrator.

DENTAL SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	BENEFIT
PRE-DETERMINATION LIMIT	$500
DEDUCTIBLE	None
CLASSES A, B AND C EXPENSES COMBINED CALENDAR YEAR MAXIMUM BENEFIT	$1,000 per Covered Person
DENTAL BENEFITS	
Class A-Preventive Services	70%/80%/90%/100%
Class B-Basic Services	70%/80%/90%/100%
Class C-Major Services	50%

The plan pays 70% of Class A-Preventive and Class B-Basic Services until the end of the Plan Year (7/1-6/30) in which coverage became effective, 80% during the next full Plan Year, 90% during the third and 100% thereafter. You must have an exam each year in order to move to the higher percentage figure. If you do not have the exam in any one year or if you do not follow the treatment recommended by your Dentist, your percentage will drop back 10% but in no event will it be less than 70%.

The Calendar Year Maximum Benefit does not apply to dependents under age 18.

VISION SCHEDULE OF BENEFITS

BENEFIT DESCRIPTION	BENEFIT
Deductible	None
Eye Exam, One Exam per Calendar Year	90%
Lenses and Contacts, One Pair per Calendar Year Disposable contacts will be payable up to the maximum benefit for contacts, but will not be subject to the “one pair of lenses” maximum. A Covered Person may only have benefits for glasses or contacts but not both in a Calendar Year.	90%
Specialty Contacts Medically Necessary contacts when glasses are not an option.	90%; up to $400 per Lifetime
Frames, One Pair per 2 Calendar Years	90%; up to $45

NOTE: The vision maximums for contacts and frames do not apply to dependents under age 18.

ELIGIBILITY FOR PARTICIPATION

Employee Eligibility
A Borough or Certified Employee of the Employer who regularly works 15 or more Hours of Service per week and a resident of the United States will be eligible to enroll for coverage under this Plan as of his/her first date of employment. Participation in the Plan will begin as of the first day of the month coinciding with or immediately following his or her first date of employment, provided all required election and enrollment forms are properly submitted to the Plan Administrator.

A Classified Employee of the Employer who regularly works 15 or more Hours of Service per week and a resident of the United States will be eligible to enroll for coverage under this Plan once he/she completes a waiting period of 30 days from the date he or she completes at least one Hour of Service with the Employer. Participation in the Plan will begin as of the first day of the month following completion of the waiting period provided all required election and enrollment forms are properly submitted to the Plan Administrator.

Also considered an eligible Employee is an Elected Official or School Board Member. An Elected Official or School Board Member is not required to work a certain number of hours. Coverage for Elected Officials or School Board Members will be the date they are elected into office or the Board of Directors. No waiting period will be applied to Elected Officials or School Board Members.

You are not eligible to participate in the Plan if you are a temporary, leased or Seasonal Employee, an independent contractor, or a person performing services pursuant to a contract under which you are designated an independent contractor (regardless of whether you might later be deemed a common law employee by a court or governmental agency), or a person covered by a collective bargaining agreement that does not provide for participation in this Plan.

Dependent Eligibility
Your Dependents are eligible for participation in this Plan; provided he/she is:

(1) Your Spouse.

(2) Your same-sex Domestic Partner.

(3) Your Child until the end of the month in which he/she attains age 26

(4) Your Child age 26 or older, who is unable to be self supporting by reason of mental or physical handicap and is incapacitated, provided the child suffered such incapacity prior to end of the month in which he/she attained age 26. Your Child must be primarily dependent upon you for support, reside with you for more than one-half of the Calendar Year. The Plan Sponsor may require subsequent proof of your Child's disability and dependency, including a Physician's statement certifying your Child's physical or mental incapacity.

(5) A child for whom you are required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO). Procedures for determining a QMCSO may be obtained from the Plan Administrator at no cost.

(6) Your Child age 26 or older; unmarried; a registered student in full-time attendance at a University or similar institution of learning; chiefly dependent on you for support, and for whom you are entitled to an income tax exemption. Before paying a claim the Plan may require proof that the child is a full-time student and/or a tax exemption is claimed by you.

The below terms have the following meanings:

"Child" means your natural born son, daughter, stepson, stepdaughter, legally adopted child (or a child placed with you in anticipation of adoption), Eligible Foster Child or a child for whom you are the Legal Guardian. Coverage for an Eligible Foster Child or a child for whom you are the Legal Guardian will remain in effect until such child no longer meets the age requirements of an eligible Dependent under the terms of the Plan, regardless of whether or not such child has attained age 18 (or any other applicable age of emancipation of minors). The term "Child" shall include a natural child of your covered minor dependent or a child of your Domestic Partner, provided such child is unmarried, lives with you for more than one half of the Calendar Year and relies on you for more than one half of his or her support.

"Child placed with you in anticipation of adoption" means a child that you intend to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by you of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

"Domestic Partner" means the person of your same gender named in the Affidavit of Domestic Partnership that you have submitted to and has been approved by the Employer. The Plan Administrator reserves the right to require such evidence as it deems necessary that a Domestic Partner satisfies the above eligibility requirements.

“Eligible Foster Child” shall mean an individual who is placed with you by an authorized placement agency.

“Legal Guardian” means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of an individual that is placed with such person by judgment, decree, or other order of any court of competent jurisdiction.

“Spouse” means any person who is lawfully married to you under any state law. Specifically excluded from this definition is a spouse by reason of common law marriage, whether or not permitted in your State. The Plan Administrator may require documentation proving a legal marital relationship.

“Full-Time Student,” means a Dependent Child who is enrolled in and regularly attending an educational institution such as an accredited post-secondary school, an accredited college or university for the minimum number of credit hours required by that institution in order to maintain full-time student status. During the final semester prior to graduation, the number of hours required to graduate will be allowed and considered as full time.

Other examples of post-secondary education institutions include an accredited business school, trade school, nursing school, mortuary school, cosmetology school, community or junior college or other similar accredited educational institution that offers a full-time curriculum. The institution must be accredited in order to qualify the Dependent Child for Full-Time Student status.

(1) A full-time student will remain covered during any regular scheduled break in the educational institution’s full-time curriculum (such as spring or summer break), as long as the Dependent Child was a Full-Time Student the quarter/semester before the break and is a Full-Time Student again the quarter/semester following the break. If the Dependent Child is not enrolled as a Full-Time Student in the next regular term or at any time drops below the minimum number of credit hours during a semester to maintain Full-Time Student status, coverage under the Plan will terminate retroactively to the last day of the attended school term at the beginning of the next regular term in which he/she is not enrolled.

(2) If a Dependent Child loses coverage under the Plan because he lost his/her status as a Full-Time Student, he will again become eligible for coverage under the Plan provided such child has been a Full-Time Student for 12 months or longer, on the date he/she once again enrolls as a Full-Time Student.

(3) A Dependent Child who does not have coverage under this Plan and who subsequently enrolls and begins attending classes as a Full-Time Student will also be eligible for coverage provided such Dependent Child has been a Full-Time Student for 12 months or longer. The date such child begins attending full-time classes will be considered the date you acquire an eligible Dependent for Plan enrollment purposes. The Plan may require a completed application for the Dependent’s coverage within a specified time frame.

Your Employer, in its sole discretion, may request at anytime (but not more frequently than annually) proof of Full-Time Student status. Failure to provide proof within 31 days of such request will result in termination of coverage under this provision.

The Plan Administrator, in its sole discretion, shall have the right to require documentation necessary to establish an individual’s status as an eligible Dependent.

When You and Your Spouse are Both Covered Employees
When both you and your Spouse are covered Employees, the Plan will allow you and your Spouse to be covered under this Plan as both Employee and Dependent. Eligible Dependent children of 2 covered Employees may be enrolled as Dependents of both Employees, whether the Employees are married or unmarried. This Plan will coordinate benefits following the guidelines as described in the "Coordination of Benefits" section of the Plan.

Court Ordered Coverage for a Child
Federal law requires the Plan, under certain circumstances, to provide coverage for your children. The details of these requirements are summarized below.

The Plan Administrator shall enroll for immediate coverage under this Plan any Child, who is the subject of a "qualified medical child support order" ("QMCSO"). If you are ordered to provide such coverage for a Child and you are not enrolled in the Plan at the time the Plan Administrator receives a QMCSO, the Plan Administrator shall also enroll you for immediate coverage under this Plan. Coverage under the Plan will be effective as of the later of the date specified in the order or the date the Plan Administrator determines that the order is a QMCSO. Any required contribution for coverage pursuant to this section will be deducted from your pay in accordance with the Employer's payroll schedule and policies.

A QMCSO is defined as a child support decree or order issued by a court (or a state administrative agency that has the force and effect of law under applicable state law) that obligates you to support or provide health care coverage to your child and includes certain information concerning such coverage. The Plan Administrator will determine whether any child support order it receives constitutes a QMCSO. Except for QMCSO's, no child is eligible for Plan coverage, even if you are required to provide coverage for that child under the terms of a separation agreement or court order, unless the child is an eligible Child under this Plan. Procedures for determining a QMCSO may be obtained, free of charge, by contacting the Plan Administrator.

Timely Enrollment
Once you are eligible to participate in the Plan, you must enroll for coverage by completing all election and enrollment forms and submitting them to the Plan Administrator within 31 days after satisfaction of the eligibility requirements. If you are required to contribute towards the cost of coverage you must complete and submit a payroll deduction authorization for the Plan Administrator to deduct the required contribution from your pay. In addition, as part of the enrollment requirements, you will be required to provide your social security number, as well as the social security numbers of your Dependents. The Plan Administrator may request this information at any time for continued eligibility under the Plan. Failure to provide the required social security numbers may result in loss of eligibility or loss of continued eligibility under the Plan.

If you decline enrollment for you and/or your Dependents, you must provide a written statement to the Plan Administrator indicating that the reason you are declining enrollment is due to other health coverage. If you lose such other health coverage, it may constitute a Special Enrollment Event (described below) that gives you and/or your Dependents a right to enroll in the Plan mid-year due to such loss of coverage. However, if you failed to submit such written statement when initially eligible, you will lose your right to this special mid-year enrollment opportunity.

If you fail to complete and submit the appropriate election and enrollment forms within the 31-day period described above, you will not be eligible to enroll in the Plan until the next open enrollment period or unless you experience a Special Enrollment Event or a Status Change Event.

Open Enrollment Period
You and your Dependents may enroll for coverage during the Plan's Open Enrollment Period (August 1 through September 30 each year) designated by the Plan Sponsor and communicated to you prior to such open enrollment period. During this time you will be permitted to make changes to any existing benefit elections. Benefit elections made during the open enrollment period will be effective as of October 1st and will remain in effect until the next Open Enrollment Period unless you experience or your Dependent experiences a Special Enrollment Event or Status Change Event.

Late Enrollment
If you did not enroll during your original 31-day eligibility period you will be considered a Late Enrollee and will not be allowed to enroll for coverage until the next Open Enrollment period determined by the Employer, unless a Special Enrollment Event occurs.

Special Enrollment Event
A special enrollment event occurs when you or your Dependents suffer a loss of other health care coverage, when you become eligible for a state premium assistance subsidy, or acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption. In these circumstances, you and/or your eligible Dependents will be considered Special Enrollees.

Each special enrollment event is more fully described below:

(1) **Loss of Other Coverage (other than under Medicaid or SCHIP).** If you declined enrollment for yourself or your Dependents (including your Spouse) because you or your Dependents had other health coverage (including coverage under a group health plan sponsored by a governmental or educational institution, a medical care program of the Indian Health Service or of a tribal organization), you may enroll for coverage for yourself and/or your Dependents under this Plan if the other health coverage is lost as a result of one of the following; provided, however, you submitted a written statement to the Plan Administrator when you and/or your Dependents were initially eligible stating that other health coverage was the reason for declining enrollment under this Plan:

(a) The other health coverage was under COBRA and the maximum continuation period available under COBRA has been exhausted;

(b) Loss of eligibility under the other health coverage for reasons other than non-payment of the required contribution or premium, making a fraudulent claim, or intentional misrepresentation of a material fact in connection with the other plan; or

(c) Employer contributions cease for the other health coverage.

If you are already enrolled in a benefit option available under the Plan and your Dependent lost his or her other health coverage, you may enroll in a different benefit option available under the Plan due to the special enrollment event of your Dependent.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 31 days after the date the other health coverage was lost. Coverage under the Plan will become effective on the first day of the month coinciding with or immediately following the date you submit the appropriate election and enrollment forms to the Plan Administrator.

(2) **Loss of Coverage under Medicaid or SCHIP or Eligibility for a State Premium Assistance Subsidy.** If you or your Dependents did not enroll in the Plan when initially eligible because you and/or your Dependents were covered under Medicaid or a State sponsored Children's Health Insurance Program (SCHIP) and your coverage terminates because you or your Dependents are no longer eligible for Medicaid or SCHIP or you or your Dependents become eligible for a State premium assistance subsidy under Medicaid or CHIP, you may enroll for coverage under this Plan for yourself and your Dependents after Medicaid or CHIP coverage terminates or after you or your Dependents' eligibility for a State assistance subsidy under Medicaid or CHIP is determined.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 60 days after coverage under Medicaid or CHIP terminates or within 60 days after eligibility for a State premium assistance subsidy under Medicaid or CHIP is determined. Coverage under the Plan will become effective on the first day of the month coinciding with or immediately following the date you submit the appropriate election and enrollment forms to the Plan Administrator. Coverage under the Plan will become effective on the first day of the month coinciding with or immediately following the date you submit the appropriate election and enrollment forms to the Plan Administrator.

(3) **Acquisition of a New Dependent.** If you acquire a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll for coverage under this Plan for yourself and your Dependents. You must submit the appropriate election and enrollment forms to the Plan Administrator within 31 days after the date you acquire such Dependent.

(a) Coverage becomes effective for a Dependent Child who is born after the date your coverage becomes effective as of such child's date of birth, provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 31 days after the child's birth. Failure to enroll in the Plan within this 31-day period will result in no coverage under the Plan beyond this 31-day period.

(b) Coverage for a newly acquired Dependent due to adoption (or placement with you in anticipation of adoption will be effective as of the date of adoption (or placement in anticipation of adoption); provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 31 days after adoption or placement in anticipation of adoption, as applicable. Failure to enroll in the Plan within the 31-day period described above will result in no coverage under the Plan beyond this 31-day period.

(c) Coverage for a newly acquired Dependent due to marriage will be effective on the date of marriage; provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 31 days after your date of marriage. Failure to enroll in the Plan within the 31-day period described above will result in no coverage under the Plan.

Status Change Event

Generally your election under the Plan will remain in effect for the entire Plan Year unless you experience a Special Enrollment Event (described above) or a Status Change Event. If a Status Change Event occurs you may make a new election under the Plan; provided your new election is consistent with the Status Change Event. A Status Change Event includes the following:

(1) A change in your legal marital status, including divorce, legal separation or annulment;

(2) The death of your Spouse or Dependent Child;

(3) Termination or commencement of employment by you, your Spouse or your Dependent Child that results in the gain or loss of eligibility under the Plan or another employer-sponsored employee benefit plan;

(4) A reduction or increase in your hours of employment, or those of your Spouse or your Dependent Child, including a switch from part-time to full-time, or commencement or return from an unpaid leave of absence, resulting in the gain or loss of eligibility under the Plan or another employer-sponsored employee benefit plan;

(5) A change due to your Dependent Child satisfying or ceasing to satisfy the requirements for Dependents under the Plan;

(6) A change in the place of residence or work of you, your Spouse or your Dependent Child;

(7) Entitlement to or loss of entitlement to Medicare or Medicaid by you, your Spouse or your Dependent Child;

(8) Receipt of a Qualified Medical Child Support Order ("QMCSO") which requires that you provide the child named in the Order with health care coverage under the Plan. If the required coverage is different from your current coverage under the Plan, you may change your election accordingly;

(9) A change due to you, your Spouse or your Dependent Child gaining coverage under another employer's plan;

(10) A significant increase in the cost of your coverage under the Plan during the Plan Year. If the cost of your coverage under the Plan significantly increases during the Plan Year, you may choose one of the following options: (a) maintain existing coverage and agree to pay the increased cost; (b) revoke your existing election and elect similar coverage under another Plan option (if any); or (c) drop coverage under the Plan, but only if there is no similar option available under the Plan;

(11) Addition or significant improvement of a Plan option. If the Plan adds a new option or significantly improves an existing option, you may revoke your existing election and elect coverage under the new option. Any eligible Employee, regardless of whether or not he/she elected coverage under the Plan previously, may elect coverage under any new option or significantly improved option for himself or herself and any eligible Dependents;

(12) Significant Curtailment of Coverage without Loss. If your coverage under the Plan is significantly curtailed without a loss of coverage (for example, a significant increase is the Out-of-Pocket maximum you are required to pay), you may revoke your existing election under the Plan and elect coverage under a similar Plan option, if any. If no similar option is available, then you must maintain your existing election until the end of the current Plan Year;

(13) Significant Curtailment of Coverage with Loss. If your coverage under the Plan is significantly curtailed with a loss of coverage (for example, elimination of a benefit option under the Plan), then you may either revoke your existing election under the Plan and elect coverage under a similar Plan option (if any) or drop your existing coverage, provided there is no similar Plan option available; and

(14) Change in Election under another Employer Plan. You may make an election change that is on account of and corresponds with a change made under another employer-sponsored plan (including another plan maintained by the Employer or a plan maintained by the employer of your Spouse or Dependent Child); provided the election change satisfied the regulations under Code Section 125 regarding permitted election changes, or the election is for a period of coverage under the plan maintained by the other employer which does not correspond to the Plan Year of this Plan.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 31 days after the Status Change Event. Coverage under the Plan will become effective on the first day of the month coinciding with or immediately following the date you submit the appropriate election and enrollment forms to the Plan Administrator.

TERMINATION OF COVERAGE

Termination of Employee Coverage
Coverage under the Plan will terminate on the earliest of the following dates:

(1) The date the Plan terminates, in whole or in part;

(2) If you fail to make any contribution when it is due, the beginning of the period for which a required contribution has not been paid;

(3) The date you report to active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained below;

(4) The end of the month in which you cease to be eligible for coverage under the Plan;

(5) The end of the month in which you terminate employment or cease to be included in an eligible class of Employees;

(6) The date Loss of Residence occurs;

(7) The date you (or any person seeking coverage on your behalf) performs an act, practice or omission that constitutes fraud; and

(8) The date you (or any person seeking coverage on your behalf) makes an intentional misrepresentation of a material fact.

Termination of Dependent Coverage
Coverage under the Plan will terminate on the earliest of the following dates:

(1) The date the Plan terminates, in whole or in part;

(2) The date the Plan discontinues coverage for Dependents;

(3) The date your Dependent becomes eligible as an Employee under the Plan;

(4) The date coverage terminates for the parent-Employee;

(5) If you and/or your Dependents fail to make any contribution when it is due, the beginning of the period for which a required contribution has not been paid;

(6) The end of the month the Dependent Spouse reports to active military service;

(7) The end of the month on which a Dependent ceases to be a Dependent as defined by the Plan;

(8) The date your Dependent (or any person seeking coverage on behalf of your Dependent) performs an act, practice or omission that constitutes fraud; and

(9) The date your Dependent (or any person seeking coverage on behalf of your Dependent) makes an intentional misrepresentation of a material fact.

Retroactive Termination of Coverage
Except in cases where you and/or your covered Dependents fail to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan unless you and/or your covered Dependents (or a person seeking coverage on behalf of you and/or your covered Dependents) 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 30 days advance written notice to you or your covered Dependent who is 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.

Rehire Provision
After you become covered under the Plan, if your employment ends and you are rehired by the Employer within 3 months after your termination date, your coverage will take effect on the date you complete at least one hour of service with the Employer. The waiting period will be waived.

Continuation of Plan Coverage due to Disability or Approved Leave of Absence
Medical, dental and vision coverage will be continued by your Employer for you and your Dependents in the event of your disability due to Illness. Coverage will continue as follows:

(1) In the event of Disability due to Illness, your coverage will continue for up to 12 months, provided the required contributions are paid by you or the Employer.

Coverage under this provision will continue in accordance with the same terms and conditions of an active Employee and any period of continued coverage under this section will not reduce the maximum time for which you may elect to continue coverage under COBRA. Please refer to the COBRA Continuation Coverage section of the Plan.

Continuation of Coverage under the Family and Medical Leave Act (FMLA)
The Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA), as amended and as promulgated in regulations issued by the Department of Labor.

During any leave taken under the FMLA, you may maintain coverage under the Plan on the same conditions as coverage would have been provided if you had been continuously employed during the leave period. Failure to make required payments within 30 days of the due date established by your Employer will result in the termination of coverage for you and/or your eligible Dependents.

If you fail to return to work after the FMLA leave, the Employer may have the right to recover its contributions toward the cost of coverage during the FMLA leave.

If coverage under the Plan terminates during the FMLA leave, coverage will be reinstated for you and your covered Dependents if you return to work at the end of the FMLA leave.

Continuation of Coverage under State Family and Medical Leave Laws
To the extent this Plan is required to comply with a State family and medical leave law that is more generous than the FMLA, continuation of coverage under this Plan will be provided in accordance with such State family and medical leave law, as well as under FMLA.

Continuation of Coverage under USERRA
You may elect to continue Plan coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) if you are absent from work due to military service in the Uniformed Services (as defined under USERRA). You may elect to continue coverage for yourself and any of your Dependents that were covered under the Plan at the time of your leave. Your eligible Dependents do not have an independent right to elect coverage under USERRA; therefore unless you elect to continue coverage on their behalf, your eligible Dependents will not be permitted to continue coverage under USERRA separately.

To elect coverage under USERRA, you must submit your election to continue coverage under USERRA, on a form prescribed by the Plan Administrator to the Plan Administrator within 60 days after the date of your leave. Coverage under the Plan will become effective as of the date of your leave and will continue for the lesser of (a) 24 months (beginning on the date your absence begins); or (b) the period of time beginning on the date your absence begins and ending on the day after the date you return to employment with the Employer or fail to apply for or return to employment with the Employer within the time limit applicable under USERRA.

If your leave is 31 days or more, you will be required to pay up to 102% of the full contribution under the Plan. If your leave is 30 days or less, you will not be required to pay more than the amount (if any) you would have paid had you remained an active Employee of the Employer. The Plan Administrator will notify you of the procedures for making payments under this Plan.

Continuation coverage provided under USERRA counts towards the maximum coverage period under COBRA continuation coverage.

An Employee returning from USERRA-covered military leave who participated in the Plan immediately before going on USERRA leave has the right to resume coverage under the Plan upon return from USERRA leave, as long as the Employee resumes employment within the time limit that applies under USERRA. No waiting period will apply to an Employee returning from USERRA leave (within the applicable time period) unless the waiting period would have applied to the Employee if the Employee had remained continuously employed during the period of military leave.

SURVIVOR BENEFIT

Survivor Benefit for Employees
In the event of death of an Employee, coverage will continue for the Spouse and any eligible Dependents until the earlier of the following:

(1) The date such Spouse becomes eligible for Medicare or any other employer-sponsored group health plan.

(2) The date the Dependent fails to satisfy the eligibility requirements for coverage under the Plan.

(3) 90 days following the date of the Employee's death.

If any of your surviving Dependents elect COBRA Continuation Coverage in lieu of Plan coverage available under this survivor benefit, they will not be eligible to enroll in the Plan at a later time. If however, they elect to continue Plan coverage under this survivor benefit in lieu of COBRA Continuation Coverage, the coverage available under this survivor benefit will run concurrent with COBRA (I.e. reduce COBRA by 90 days).

ELIGIBLE MEDICAL EXPENSES

Eligible expenses shall be the charges actually made for services provided to the Covered Person and will be considered eligible only if the expenses are:

(1) Routine care or preventive services provided such services are ordered and performed by a Physician and not otherwise excluded under the Plan; or

(2) Due to Illness or Injury; provided such services are ordered and performed by a Physician, Medically Necessary and not otherwise excluded under the Plan.

The following is a list of Covered Expenses:

(1) **Allergy Services:** Allergy testing, serum and injections. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(2) **Ambulance Services:** Professional ground ambulance service to transport the Covered Person to the nearest Hospital equipped to treat the specific Illness or Injury in an emergency situation; or

(a) To another Hospital in the area when the first Hospital did not have services required and/or facilities to treat the Covered Person; or

(b) To and from a Hospital during a period of Hospital confinement to another facility for special services which are not available at the first Hospital; or

(c) From the Hospital to the individual's home, or to a convalescent facility when there is documentation the Covered Person required ambulance transportation.

Air Ambulance/Commercial Airline

Round trip transportation by commercial airline or professional air ambulance from the place where Illness or Injury occurred, to nearest Hospital where treatment can be obtained, is covered subject to the following limitations (this includes dental services):

(a) The Illness or Injury must be a life-endangering situation requiring immediate transfer to a Hospital that has special facilities for treating the condition; or

(b) Surgery is needed that cannot be performed locally; or

(c) A condition exists which cannot be treated locally. In that case, transportation benefits in any one Calendar Year will be limited to one visit and one follow-up visit which is pre-authorized as a condition requiring therapeutic treatment which cannot be provided locally.

The patient's Physician must provide written certification and detailed medical documentation of the existing condition in advance of the trip, if the air transportation is required for a surgery or a condition which exists which cannot be treated locally.

If the patient is a child under 18 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 the attendance.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(3) **Ambulatory Surgery Center:** Services and supplies provided by an Ambulatory Surgery Center. Eligible expenses will be payable as shown in the Medical Schedule of Benefits under Outpatient Surgical Facility.

(4) **Anesthetics:** Anesthetics and their professional administration.

(5) **Audiocare:** Hearing exams and hearing aids. A hearing examination is required in order for the hearing aids to be a covered expense under this Plan. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(6) **Blood and Blood Derivatives:** Blood, blood plasma, or blood components not donated or replaced.

(7) **Cardiac Rehabilitation:** Cardiac rehabilitation services which are rendered: (a) under the supervision of a Physician; and (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery, or any other medical condition if medically appropriate; and (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a medical care facility.

(8) **Chemotherapy:** Services and supplies related to chemotherapy. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(9) **Chiropractic Care/Spinal Manipulation:** Skeletal adjustments, manipulation, or other treatment in connection with the correction by manual or mechanical means of structural imbalance or subluxation in the human body, including x-rays. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(10) **Circumcision:** Services and supplies related to circumcision. Circumcision performed while Hospital confined following birth will be considered as a newborn expense.

(11) **Contraceptives:** Contraceptive procedures and medicines other than those considered preventive services, including, but not limited to: orals, patches, injections, diaphragms, intrauterine devices (IUD), implants and any related office visit. Some contraceptives may be available under the Prescription Drug Card Program. The Plan does not cover contraceptive supplies or devices available without a Physician's prescription or contraceptives provided over-the-counter (unless the expense qualifies as a preventive service). Preventive services are covered as required by the Women's Health Care Act.

(12) **Cosmetic Procedures/Reconstructive Surgery:**

(a) The Plan covers reconstructive services and surgery, including but not limited to treatment of covered newborn children's congenital defects and birth abnormalities, when the reconstruction meets one of the following primary purposes:

(i) When the primary purpose is to restore large skin defects due to a port wine stain.
(ii) When the primary purpose is to relieve severe physical pain caused by an abnormal body structure.
(iii) When the primary purpose is to treat a functional impairment caused by an abnormal body structure; or restore the Covered Person's normal appearance, regardless of whether a functional impairment exists;
(iv) when the abnormality results from a documented Illness that occurred within the preceding 12 months.

Subsequent procedures integral or linked to the covered reconstruction that cannot be performed within the 12-month period due to medical considerations, may be covered after the 12-month period if documented planning for these procedures takes place within 12 months of the Illness.

"Functional impairment" means an impairment that interferes with normal bodily function. For the purpose of this provision, interference with psychological function or well-being is not considered to be a functional impairment.

(b) Charges for reconstructive breast Surgery following a mastectomy will be eligible as follows:

(i) Reconstruction of the breast on which the mastectomy has been performed;
(ii) Surgery and reconstruction of the other breast to produce symmetrical appearance; and
(iii) Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas.

The manner in which breast reconstruction is performed will be determined in consultation with the attending Physician and the Covered Person.

(13) **Dental Care:** Dental services and x-rays rendered by Dentist or dental surgeon for:

(a) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

(b) Emergency repair due to Injury to sound natural teeth within 6 months of the Accident, including the replacement of sound natural teeth.

(c) Surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

(d) Excision of benign bony growths of the jaw and hard palate.

(e) External incision and drainage of cellulitis.

(f) Incision of sensory sinuses, salivary glands or ducts.

(g) Removal of impacted teeth.

General anesthesia and Hospital expenses are covered for eligible dental care services that would require the service be performed in a Hospital to monitor the patient due to a serious underlying medical condition, such as heart condition, blood disorder, etc., or is necessary due to accidental Injury to sound natural teeth.

(14) **Diabetic Education:** The following diabetic education and self-management programs as established by the American Diabetes Association for individuals with diabetes: diabetes outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered, or licensed healthcare professional working in a program consistent with the national standards of diabetes self-management education.

(15) **Diabetic Supplies:** All Physician-prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes.

(16) **Diagnostic Testing, X-ray and Laboratory Services:** Diagnostic testing, x-ray, and laboratory services, including services of a professional radiologist or pathologist. Dental x-rays are not eligible expenses, except as specified under Dental Care. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(17) **Durable Medical Equipment:** The rental of oxygen, wheelchairs, walkers, special Hospital beds, iron lungs, and other Durable Medical Equipment will be payable as shown in the Medical Schedule of Benefits subject to the following:

(a) The equipment must be prescribed by a Physician and Medically Necessary; and

(b) The equipment will be provided on a rental basis; however such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item (oxygen equipment is not limited to the purchase price); and

(c) Benefits will be limited to standard models as determined by the Plan; and

(d) The Plan will pay benefits for only one of the following unless Medically Necessary due to growth of the Covered Person or if changes to the Covered Person's medical condition requires a different product, as determined by the Plan: a manual wheelchair, motorized wheelchair or motorized scooter; and

(e) If the equipment is purchased, benefits will be payable for subsequent repairs, excluding batteries, necessary to restore the equipment to a serviceable condition. If such equipment cannot be restored to a serviceable condition, replacement will be considered eligible subject to prior approval by the Plan. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered; and

(f) Expenses for the rental or purchase of any type of air conditioner, air purifier, or any other device or appliance will not be considered eligible.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(18) **Emergency Services:** The Plan will pay the greater of the following amounts for Emergency Services received from Non-Participating Providers (as required by law):

(a) The amount negotiated with Participating Providers for Emergency Services provided, excluding any Copay or Coinsurance that would be imposed if the service had been received from a Participating Provider. If there is more than one amount negotiated with Participating Providers for the Emergency Services provided the amount paid shall be the median of the negotiated amounts, excluding any Copay or Coinsurance that would be imposed if the service had been received from a Participating Provider; or

(b) The amount for the Emergency Services calculated using the same method the Plan generally uses to determine payments for services provided by a Non-Participating Provider (such as Usual and Customary Charge), excluding any Copay or Coinsurance that would be imposed if the service had been received from a Participating Provider; or

(c) The amount that would be paid under Medicare (Part A or Part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the Emergency Services, excluding any Copay or Coinsurance that would be imposed if the service had been received from a Participating Provider.

This includes care received outside of the United States, required to stabilize the Covered Person's condition for return to the United States.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits

(19) **Enteral Nutrition**: Medical foods that are specially formulated for enteral feedings or oral consumption. Coverage includes medically approved formulas prescribed by a Physician for the treatment of phenylketonuria (PKU).

The Plan covers enteral nutrition and supplies required for enteral feedings when *all* of the following conditions are met:

(a) It is necessary to sustain life or health;

(b) It is used in the treatment of, or in association with, a demonstrable disease, condition or disorder;

(c) It requires ongoing evaluation and management by a Physician; and

(d) It is the sole source of nutrition or a significant percentage of the daily caloric intake.

Coverage does not include:

(a) Regular grocery products that meet the nutritional needs of the patient (e.g., over-the-counter infant formulas such as Similac, Nutramigen and Enfamil); or

(b) Medical food products: (1) prescribed without a diagnosis requiring such foods; (2) used for convenience purposes; (3) that have no proven therapeutic benefit without an underlying disease, condition or disorder; (4) used as a substitute for acceptable standard dietary intervention; or (6) used exclusively for nutritional supplementation.

(20) **Foot Care:** Treatment for the following foot conditions: (a) weak, unstable or flat feet; (b) bunions, when an open cutting operation is performed; (c) non-routine treatment of corns or calluses; (d) toenails when at least part of the nail root is removed; (e) any Medically Necessary Surgical Procedure required for a foot condition. In addition, orthopedic shoes when an integral part of a leg brace will also be covered, as well as the initial purchase, fitting and repair of custom-fitted foot orthotics when determined to be Medically Necessary by the attending Physician are covered by the Plan.

(21) **Genetic Testing:** Diagnostic testing of Genetic Information and counseling when Medically Necessary. Genetic testing is covered in addition to and to the extent it is not otherwise included for coverage under the preventive services section of the Plan.

(22) **Hemodialysis/Peritoneal Dialysis:** Treatment of a kidney disorder by hemodialysis or peritoneal dialysis as an Inpatient in a Hospital or other facility, or for expenses in an outpatient facility or in the Covered Person's home, including the training of one attendant to perform kidney dialysis at home. The attendant may be a family member. When home care replaces Inpatient or outpatient dialysis treatments, the Plan will pay for rental of dialysis equipment and expendable medical supplies for use in the Covered Person's home as shown under the Durable Medical Equipment benefit.

(23) **Home Health Care:** Services provided by a Home Health Care Agency to a Covered Person in the home. The following are considered eligible home health care services:

(a) Home nursing care;

(b) Services of a home health aide or licensed practical nurse (L.P.N.), under the supervision of a registered nurse (R. N.);

(c) Visits provided by a medical social worker (MSW)

(d) Physical therapy if provided by the Home Health Care Agency;

(e) Medical supplies, drugs and medications prescribed by a Physician;

(f) Laboratory services; and

(g) Nutritional counseling by a licensed dietician.

For the purpose of determining the benefits for home health care available to a Covered Person, each visit by a member of a Home Health Care Agency shall be considered as one home health care visit and each 4 hours of home health aide services shall be considered as one home health care visit.

The Covered Person must be restricted from leaving his/her home due to a medical condition.

In no event will the services of a Close Relative, transportation services, housekeeping services, and meals, etc., be considered an eligible expense.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(24) **Hospice Care:** Hospice care on either an inpatient or outpatient basis for a terminally ill person rendered under a Hospice treatment plan. The Hospice treatment plan must certify that the person is terminally ill with a life expectancy of 6 months or less.

Covered services include:

(a) Room and board charges by the Hospice.

(b) Other Medically Necessary services and supplies.

(c) Nursing care by or under the supervision of a registered nurse (R.N.).

(d) Home health care services furnished in the patient's home by a Home Health Care Agency for the following:

(i) health aide services consisting primarily of caring for the patient (excluding housekeeping, meals, etc.); and

(ii) physical therapy.

(e) Counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family.

(f) Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family within 6 months after the patient's death. For the purposes of bereavement counseling, the term "Patient's Immediate Family" means the patient's spouse, parents of a Dependent Child, and/or Dependent children who are covered under the Plan.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(25) **Hospital Services or Long-Term Acute Care Facility/Hospital:**

(a) Inpatient

Room and board, including all regular daily services in a Hospital or Long-Term Acute Care Facility/Hospital will be payable as shown in the Medical Schedule of Benefits. Care provided in an Intensive Care Unit (including cardiac care (CCU) and burn units) will be payable as shown in the Medical Schedule of Benefits.

Miscellaneous services and supplies, including any additional Medically Necessary nursing services furnished while being treated on an Inpatient basis.

After the Covered Person's condition is stabilized, the Covered Person or his/her Authorized Representative will be presented with the options described below. The Inpatient Hospital and Physician's charges incurred after the Covered Person's condition is stabilized, are determined based on the network status of the Hospital. If the Covered Person elects to be transferred to a network Hospital after stabilization in a non-network Hospital or in an out-of area Hospital, then the benefits will be paid at the network Hospital payment percentage shown in the Medical Schedule of Benefits. Any transportation costs associated with this transfer will be paid at the network level.

If the Covered Person elects to continue to stay in a non-network Hospital and receives treatment after stabilization of the Emergency Medical Condition, then the benefits will be payable at the non-network Hospital payment percentage shown in the Medical Schedule of Benefits.

If the Covered Person elects to continue to stay in an out-of area Hospital, then benefits will be payable at the services outside the network area level shown in the Medical Schedule of Benefits.

(b) Outpatient

Services and supplies furnished while being treated on an outpatient basis will be payable as shown in the Medical Schedule of Benefits.

(26) **Infertility Testing:** Diagnosis and testing of infertility (the inability to conceive). However, treatment, drugs or procedures for the promotion of conception will not be considered eligible (e.g., in vitro fertilization, GIFT, artificial insemination, etc.).

(27) **Lenses:** Initial pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye or for aphakic patients. Soft lenses or sclera shells intended for use as corneal bandages.

(28) **Maternity:** Expenses Incurred by all Covered Persons for:

(a) Pregnancy.

(b) Preventive prenatal and breastfeeding support as identified under the preventive services section below.

(c) Services provided by a Birthing Center.

(d) Amniocentesis testing and ultrasounds.

(e) Elective induced abortions.

Hospital stays in connection with childbirth for either the mother or newborn may not be limited to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother. The Covered Person or provider is not required to precertify the maternity admission, unless the stay extends past the applicable 48 or 96 hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth.

If a newborn remains hospitalized beyond the time frames specified above, the confinement must be precertified or a penalty may be applied.

(29) **Medical and Surgical Supplies:** Casts, splints, trusses, braces, crutches, orthotics, dressings, and other Medically Necessary supplies ordered by a Physician.

(30) **Mental Disorders:** Covered charges for care, supplies and treatment of a Mental Disorder including, but not limited to treatment for autism, ADD and ADHD. This benefit includes telephonic and video counseling services for Covered Persons when Medically Necessary when existing treatment has been established. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(31) **Morbid Obesity:** Charges for the care and treatment of Morbid Obesity (surgical and non-surgical treatment).

(32) **Off-Label Drug Use**: Expenses related to Off-Label Drug Use may be considered eligible expenses when all of the following additional criteria have been satisfied:

(a) The drug is not excluded under the Plan; and

(b) The drug has been approved by the FDA; and

(c) It can be demonstrated to the Plan's satisfaction that the Off-Label Drug Use is appropriate and generally accepted for the condition being treated; and

(d) If the drug is used for the treatment of cancer, The American Hospital Formulary Service Drug Information, or The Compendia-Based Drug Bulletin, recognize it as an appropriate treatment for that form of cancer.

(33) **Outpatient Pre-Admission Testing:** Outpatient pre-admission testing performed prior to a scheduled Inpatient hospitalization or Surgery. Eligible expenses will be payable as shown in the Medical Schedule of Benefits

(34) **Physical Therapy:** Physical therapy rendered by a qualified Physician or a licensed physical therapist under the recommendation of a Physician. Eligible expenses will be payable as shown in the Medical Schedule of Benefits. Therapy must be in accord with a Physician's exact orders as to the type, frequency and duration of therapy and for conditions with the expectation of significant improvement within 2 months.

Covered therapy includes exercise, heat, cold, electricity, ultrasound and massage to improve circulation, strengthen muscles, encourage return of motion and train patients to perform the activities of daily living.

Massage is covered only when it is part of a covered course of physical therapy and is provided by or under the direct supervision of a physical therapist.

(35) **Physician Services:** Services of a Physician for medical care or Surgery.

Services performed in a Physician's office on the same day for the same or related diagnosis, regardless if a Physician is seen or not, will be payable as shown in the Medical Schedule of Benefits. Services include, but are not limited to: examinations, x-ray and laboratory tests (including the reading or processing of the tests), supplies, injections, cast application, and minor Surgery.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(36) **Preventive Services and Routine Care:** The following preventive services and routine care are paid as shown in the Medical Schedule of Benefits:

(a) Preventive Services

(i) Evidence-Based Preventive Services

Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (the "Task Force") with respect to the individual involved, except that with respect to breast cancer screening, mammography and prevention of breast cancer, the recommendations of the Task Force issued in 2002 will be considered the current recommendations until further guidance is issued by the Task Force or the Health Resources and Services Administration.

(ii) Routine Vaccines

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

(iii) Prevention for Children

With Respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

(iv) Prevention for Women

With respect to women, such additional preventive care and screenings, not otherwise addressed by the Task Force, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration and published on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services). Those guidelines generally include the following:

(A) Well-woman visits. Well-woman preventive care visits annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The inclusion of a well-woman visit is not meant to limit the coverage for any other preventive service described elsewhere in this Plan document that might be administered as part of the well-woman visit.

Coverage for prenatal care is limited to pregnancy-related Physician office visits including the initial and subsequent history and physical exams of the pregnant woman. In the event a provider bills a "maternity global rate", the portion of the claim that will be considered for prenatal visits and therefore, preventive care, is 40% of the "maternity global rate". As a result, 60% of the "maternity global rate" will be considered for delivery and postnatal care and the normal cost-sharing provisions would apply. Items not considered preventive (and therefore subject to normal cost-sharing provisions) include inpatient admissions, high risk specialist units, ultrasounds, amniocentesis, fetal stress tests, delivery including anesthesia and certain pregnancy diagnostic lab tests.

(B) Screening for gestational diabetes. A maximum of 5 screenings for gestational diabetes shall be covered in pregnant women.

(C) Human papillomavirus (HPV) testing. High-risk HPV DNA testing in women with normal cytology results. Screening is limited to women age 30 or older and is limited to 1 screening every 3 Calendar Years.

(D) Counseling annually for sexually transmitted infections (including for the human immunodeficiency virus (HIV)) and screening annually for HIV for all sexually active women. Limited to 2 counseling sessions per Calendar Year.

(E) Screening and counseling annually for interpersonal and domestic violence.

(F) Contraceptive methods and counseling, as prescribed by your Physician. All FDA approved contraceptive methods (see Preventive Drugs section below), sterilization procedures and patient education and counseling for women with reproductive capacity. Contraceptive counseling is limited to 2 visits per 12-month period.

For purposes of the above, the sterilization procedures to be considered preventive include sterilization implant (Essure) and surgical sterilization (Sterilization) either abdominally, vaginally or laparoscopically. Eligible charges for a sterilization procedure and all ancillary services will be covered when sterilization is the primary purpose of the services provided and/or if it is performed as a standalone procedure and billed as such. However, complications arising following a sterilization procedure are not covered as preventive services. Covered Expenses do not include charges for a sterilization procedure to the extent the procedure was not billed separately by the provider or because it was not the primary purpose of the procedure. To the extent sterilization is part of another procedure and/or is not a separate line on the bill, the sterilization procedure is not a Covered Expense under the Preventive Services benefit.

(G) Breastfeeding support, supplies and counseling in conjunction with each birth, including the following:

(1) Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postnatal period (60 days from baby's date of birth). Lactation consultation is limited to 6 cumulative visits per 12-month period.

(2) Breastfeeding equipment will be covered, subject to the following:

(i) Rental of a Hospital grade electric pump while the baby is Hospital confined; and

(ii) Purchase of a standard (non-Hospital grade) electric breast pump or manual breast pump if requested during pregnancy or during the duration of breastfeeding, provided the Covered Person has not received either a standard electric breast pump or a manual breast pump within the last 3 Calendar Years and provided the Covered Person remained continuously enrolled in the Plan following the birth of the Child.

(3) For women using a breast pump from a prior pregnancy, one new set of breast pump supplies will be covered at 100% with each subsequent pregnancy for initiation or continuation of breastfeeding.

For a detailed listing of women's preventive services, please visit the U.S. Department of Health and Human Services website at: http://www.hrsa.gov/womensguidelines. For a paper copy, please contact the Plan Administrator. To the extent the above does not cover any preventive service required to be covered under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services), the above shall be deemed to be amended to cover such preventive services to the extent required by such guidelines.

(v) Preventive Drugs means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a paper copy, please contact the Plan Administrator.

For a detailed listing of preventive services, please visit the U.S. Department of Health and Human Services website at: https://www.healthcare.gov/what-are-my-preventive-care-benefits. For a paper copy, please contact the Plan Administrator. To the extent the above does not cover any preventive service required to be covered by the U.S. Department of Health and Human Services (HHS) the above shall be deemed to be amended to cover such preventive service to the extent required by the HHS.

(b) Routine Care

Routine care including, but not limited to, the office visit, lab tests, x-rays, routine testing, vaccinations or inoculations, well child care, annual pap smears, annual mammograms, colon exams and PSA testing. If a diagnosis is indicated after a routine exam, the exam will still be payable under the routine care benefit, however, all charges related to the diagnosis (except the initial exam) will be payable as any other Illness.

The above routine care items are covered in addition to and to the extent they are not otherwise included for coverage under the Preventive Services section of the Plan.

(37) **Private Duty Nursing:** Private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to the following extent:

(a) Inpatient Nursing Care. Charges are covered only when care is Medically Necessary and not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit. Inpatient Private Duty Nursing must be supported by a certification from the attending Physician.

(b) Outpatient Nursing Care. Charges are covered only when care is Medically Necessary and not Custodial in nature. Charges covered for Outpatient nursing care billed by a Home Health Care Agency are shown above under Home Health Care Services and Supplies. Outpatient private duty nursing care not billed by a Home Health Care Agency must be supported by a certification and a treatment plan from the attending Physician.

(38) **Prosthetic Devices:** Artificial limbs, eyes, or other prosthetic devices when necessary due to an Illness or Injury. This benefit includes any necessary repairs to restore the prosthesis to a serviceable condition. If such prosthesis cannot be restored to a serviceable condition, replacement will be considered eligible, subject to prior approval by the Plan. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered.

(39) **Pulmonary Therapy:** Pulmonary therapy under the recommendation of a Physician.

(40) **Qualified Clinical Trial Expenses:** Expenses that are, except as excluded below, healthcare items and services for the treatment of cancer or any other life threatening condition for a qualifying individual enrolled in a Qualified Clinical Trial that are otherwise consistent with the terms of the Plan and would be covered if the Covered Person did not participate in the Qualified Clinical Trial.

For purposes of this section, a “life threatening condition” means any condition or disease from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and a “qualifying individual” means any Covered Person who is eligible to participate in a Qualified Clinical Trial according to the trial protocol for treatment of cancer or any other life threatening condition that makes his or her participation in the program appropriate, as determined based on either (i) a conclusion of a referring health care professional or (ii) medical and scientific information provided by the Covered Person.

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

(a) Costs associated with managing the research associated with the Qualified Clinical Trial; or

(b) Costs that would not be covered for non-Experimental and/or Investigational treatments; or

(c) Any item or service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

(41) **Radiation Therapy:** Radium and radioactive isotope therapy treatment.

(42) **Reconstructive Surgery:** See Cosmetic Procedures/Reconstructive Surgery.

(43) **Rehabilitation Facility:** Inpatient care provided in a Rehabilitation Facility will be payable as shown in the Medical Schedule of Benefits, provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Skilled Nursing Facility confinement; and (c) is not for Custodial Care.

See the Skilled Nursing Facility benefit for services and supplies provided for confinements in a Skilled Nursing Facility.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(44) **Routine Newborn Care:** Routine newborn care including Hospital nursery expenses and routine pediatric care while confined following birth will be considered as part of the newborn's expense.

If the newborn is ill, suffers an Injury, or requires care other than routine care, benefits will be provided on the same basis as any other eligible expense.

(45) **Second Surgical Opinion:** Voluntary second surgical opinions for elective, non-emergency Surgery when recommended for a Covered Person.

If the second opinion conflicts with the first opinion, the Covered Person may obtain a third opinion, although this is not required. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Note: The BridgeHealth Surgery Benefit program can be used as a second surgical opinion.

(46) **Skilled Nursing Facility:** The Plan covers semi-private care, including room and board, in a licensed Skilled Nursing Facility. Care must be such that it requires the skills of technical or professional personnel, is needed on a daily basis and cannot be provided in the patient’s home or on an outpatient basis. Care must be required for a medical condition which is expected to improve significantly in a reasonable period of time and the Covered Person must continue to show functional improvement.

See the Rehabilitation Facility benefit for services and supplies provided for confinements in a Rehabilitation Facility.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(47) **Speech Therapy (Inpatient):** Inpatient restorative or rehabilitative speech therapy rendered by a qualified Physician or a licensed speech therapist under the recommendation of a Physician, necessary because of loss or impairment due to an Illness, Injury or Surgery. Outpatient speech therapy will not be considered eligible.

(48) **Sterilization:** Elective sterilization procedures (this does not include reversal of sterilization). Elective sterilization procedures are covered in addition to and to the extent they are not otherwise included for coverage under the preventive services section of the Plan.

(49) **Substance Use Disorders:** Charges for care, supplies and treatment of a Substance Use Disorder. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(50) **Temporomandibular Joint Dysfunction (TMJ):** Surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) and craniofacial muscle disorders. Treatment includes conditions of structures linking the jawbone and skull and complex muscles, nerves, and other tissues related to the temporomandibular joint. Treatment shall include, but is not limited to: orthodontics; physical therapy; and any appliance that is attached to or rests on the teeth.

(51) **Urgent Care Facility:** Services and supplies provided by an Urgent Care Facility.

AETNA INSTITUTE OF EXCELLENCE (IOE) PROGRAM

The Institute of Excellence (IOE) is a facility that contracted with Aetna to furnish particular services and supplies to you in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE.

Transplant Expenses
Once it has been determined that you or one of your eligible Dependents may require an organ transplant, you or your Physician must call the Medical Management Program Administrator to discuss coordination of your transplant care. Aetna will coordinate all transplant services. In addition, you must follow any precertification requirements. Organ means solid organ; stem cell; bone marrow and tissue.

Benefits may vary if an IOE facility or a non-IOE facility is used. In addition, some expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure you require. A transplant will be covered at the Participating Provider level only if performed in a facility that has been designated as an IOE facility or that is an Aetna Participating Provider facility that has a single case rate agreement between an Aetna Participating Provider and Aetna for the type of transplant in question. Any treatment or service related to transplants that are provided by a facility that is not specified as an IOE network facility or that is not an Aetna Participating Provider facility that has a single case rate agreement between an Aetna Participating Provider and Aetna, even if the facility is considered a Participating Provider for other types of services, will be covered at the Non-Participating Provider level. Please read each section below carefully.

Covered Transplant Expenses
Covered transplant expenses include the following:

(1) Charges for activating the donor search process with national registries.

(2) Compatibility testing of prospective organ donors that are immediate family member. For purposes of this section an “immediate” family member is defined as a first-degree biological relative. These are your biological parent, sibling or child.

(3) Inpatient and outpatient expenses directly related to a transplant.

(4) Charges made by a Physician or a transplant team.

(5) Charges made by a Hospital, outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.

(6) Related supplies and services provided by the IOE facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

Covered transplant services are typically Incurred during the 4 phases of transplant care described below. Expenses Incurred for one transplant during these 4 phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date the patient is discharged from the Hospital or outpatient facility for the admission or visits related to the transplant, whichever is later.

The 4 phases of one transplant occurrence and a summary of covered transplant expense during each phase are as follows:

(1) Pre-transplant evaluation/screening. Pre-transplant evaluation screening includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility’s transplant program.

(2) Pre-transplant candidacy screening. Pre-transplant candidacy screening includes Human Leukocyte Antigen (HLA) typing/compatibility testing of prospective organ donors that are immediate family members.

(3) Transplant event. A transplant event includes Inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your Inpatient stay or outpatient visits, including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your Inpatient stay or outpatient visits; cadaveric and live donor procurement.

(4) Follow-up care. Follow-up care includes all covered transplant expenses; home health care services; home infusion services and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

One Transplant Occurrence
The following are considered one transplant occurrence:

(1) Heart.

(2) Lung.

(3) Heart/Lung.

(4) Simultaneous Pancreas Kidney (SPK).

(5) Pancreas.

(6) Kidney.

(7) Liver.

(8) Intestine.

(9) Bone marrow/stem cell transplant.

(10) Multiple organs replaced during one transplant surgery.

(11) Tandem transplants (stem cell).

(12) Sequential transplants.

(13) Re-transplant of same organ type within 180 days of first transplant.

(14) Any other single organ transplant, unless otherwise excluded under the Plan.

More Than One Transplant Occurrence
The following are considered more than one transplant occurrence:

(1) Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant).

(2) Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant).

(3) Re-transplant after 180 days of the first transplant.

(4) Pancreas transplant following a kidney transplant.

(5) A transplant necessitated by an additional organ failure during the original transplant surgery/process.

(6) More than one transplant when not performed as part of a planned tandem or sequential transplant (i.e. a liver transplant with subsequent heart transplant).

Limitations
Transplant coverage does not include charges for the following:

(1) Outpatient drugs, including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence.

(2) Services and supplies furnished to a donor when recipient is not a Covered Person.

(3) Home infusion therapy after the transplant occurrence.

(4) Harvesting or storage of organs without the expectation of immediate transplant for an existing Illness.

(5) Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing Illness.

(6) Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the Plan.

Travel and Lodging Expenses
Travel and lodging expenses will be covered under the Plan subject to the conditions described below.

(1) Distance requirement. The IOE facility must be more than 100 miles away from the patient's residence.

(2) Travel allowances. Travel is reimbursed between the patient's home and the facility for round trip (air, train or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking and toll cost will be reimbursed per IRS guidelines.

(3) Lodging allowances. Reimbursement of expenses Incurred by the patient and any companion for hotel lodging away from home is reimbursed up to the maximum shown in the Medical Schedule of Benefits.

(4) Overall maximum. Travel and lodging reimbursement is limited to the maximum shown in the Medical Schedule of Benefits for any 1 transplant or procedure type, including tandem transplants. This is a combined maximum for the patient, companion and donor.

(5) Companions. One companion is permitted per adult and 2 parents or guardians are permitted per Child.

BRIDGEHEALTH SURGERY BENEFIT™

The Plan provides you and your eligible Dependents with an option to receive certain surgical procedures through the BridgeHealth Surgery Benefit™ when a treating physician recommends certain Covered Expenses and you or your eligible Dependent elects to receive treatment at certain medical providers participating in the BridgeHealth network ("BridgeHealth Providers"). The BridgeHealth Surgery Benefit™ is only available to you and your eligible Dependents if coverage under this Plan is primary. If you and/or your eligible Dependents have other health coverage that causes this Plan to pay secondary you and/or your Dependents may not be eligible for benefits under the BridgeHealth Surgery Benefit™.

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.bridgehealth.com or toll-free at 1-800-680-1366. 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 transportation for the patient and one companion between the patient'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 patient and companion. All transportation and lodging must be reserved and scheduled through BridgeHealth Medical, Inc.

(2) Meals and incidentals include a daily allowance calculated for the number of days the patient and companion are at the destination and is intended to cover incidental and "out-of-pocket" expenses Incurred by the patient 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 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 accommodations have been made. The Plan will also cover any Emergency Medical Condition required as a result of any medical procedures or health services received by the Covered Person under the BridgeHealth Surgery Benefit™, 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™.

ALTERNATE BENEFITS

In addition to the benefits specified, the Plan may elect to offer benefits for services furnished by any provider pursuant to a Plan-approved alternate treatment plan, in which case those charges Incurred for services provided to a Covered Person under an alternate treatment plan to its end, will be more cost effective than those charges to be Incurred for services to be provided under the current treatment plan to its end.

The Plan shall provide such alternate benefits at its sole discretion and only when and for so long as it determines that alternate treatment plan is Medically Necessary and cost effective. If the Plan elects to provide alternate treatment plan benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for such Covered Person in any other instance or for other Covered Persons under this Plan in any other instance, nor shall it be construed as a waiver of the Plan Administrator's rights to administer this Plan thereafter in strict accordance with its express terms.

GENERAL EXCLUSIONS AND LIMITATIONS

No payment will be eligible under any portion of this Plan for expenses Incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person, or from future benefits, and any such payment does not waive the written exclusions, limitations or other terms of the Plan.

(1) **Chelation Therapy:** Expenses for chelation therapy will not be considered eligible, unless due to heavy metal poisoning.

(2) **Close Relative:** Expenses for services, care or supplies provided by a Close Relative will not be considered eligible.

(3) **Computerized Speech Devices:** Expenses for computerized speech devices or other adaptive equipment that is not primarily restorative in nature will not be considered eligible.

(4) **Convenience Items:** Expenses for personal hygiene and convenience items will not be considered eligible. Expenses for luxury medical equipment when standard equipment is appropriate for the patient's condition (e.g. motorized wheelchairs or other vehicles, bionic or computerized artificial limbs)

(5) **Cosmetic Procedures:** Expenses for any cosmetic treatment as defined in the Plan, will not be considered eligible, except as specified under Eligible Medical Expenses. This exclusion does not apply to expenses relating to breast reconstruction after mastectomy.

(6) **Counseling:** Expenses for religious, marital, bereavement or relationship counseling will not be considered eligible, except as specified under Eligible Medical Expenses.

(7) **Custodial Care:** Expenses for Custodial Care will not be considered eligible, except as specified under the Home Health Care and Hospice Care benefits.

(8) **Dental Care:** Expenses Incurred in connection with dental care, treatment, x-rays, general anesthesia or Hospital expenses will not be considered eligible, except as specified under Eligible Medical Expenses.

(9) **Exercise Programs:** Exercise programs for treatment of any condition will not be considered eligible, except for Physician-supervised cardiac rehabilitation and occupational or physical therapy covered by the Plan.

(10) **Experimental and/or Investigational:** Expenses for any Experimental and/or Investigational treatment, or for any Hospital confinement or treatment that results from Experimental and/or Investigational treatment will not be considered eligible, except for Off-Label Drug Use or when such expenses are considered Qualified Clinical Trial Expenses.

(11) **Gene Therapy**: Expenses related to gene therapies, xenographs or cloning will not be considered eligible.

(12) **Governmental Agency:** Expenses for services and supplies which are provided by any governmental agency for which the Covered Person is not liable for payment will not be considered eligible. In the case of a state-sponsored medical assistance program, benefits payable under this Plan will be primary. Benefits payable under this Plan will also be primary for any Covered Person eligible under TRICARE (the government sponsored program for military dependents).

(13) **Home Delivery:** Expenses for home delivery will not be considered eligible. Pre and postnatal care are Covered Expenses, but obstetrical services and medical expenses related to home delivery are not covered.

(14) **Infertility:** Expenses for confinement, treatment, or services related to infertility (the inability to conceive) or the promotion of conception will not be considered eligible, except diagnosis and testing of infertility as specified under Eligible Medical Expenses.

Nothing in this section is intended to exclude coverage for any infertility counseling or treatment required to be covered (if any) as a preventive service under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines).

(15) **Massage Therapy:** Expenses for massage therapy will not be considered eligible, except when it is part of a covered course of physical therapy and is provided by or under the direct supervision of a physical therapist.

(16) **Medically Necessary:** Expenses which are determined not to be Medically Necessary will not be considered eligible.

(17) **No Legal Obligation:** Any portion of an expense which you are not obligated to pay under your Plan, or which is reimbursable to you under: (a) another group health benefit program; (b) a government supported medical research program; (c) Medicare; (d) any coordination of benefits or non-duplication of benefits provision of your Plan; (e) Worker's Compensation; or (f) any other source, will not be considered eligible.

(18) **Not Performed Under the Direction of a Physician:** Expenses for services and supplies which are not prescribed or performed by or under the direction of a Physician will not be considered eligible.

(19) **Not Recommended by a Physician:** Expenses by a Hospital or covered residential treatment center if hospitalization is not recommended or approved by a legally qualified Physician will not be considered eligible.

(20) **Nutritional Supplements:** Expenses for nutritional supplements or other enteral supplementation will not be considered eligible, except as specified under Eligible Medical Expenses. Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

(21) **Obesity:** Surgical and non-surgical care and treatment of obesity including weight loss or dietary control, whether or not it is in any case a part of a treatment plan for another Illness, will not be considered eligible, except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan. This exclusion does not apply to treatment of Morbid Obesity as specified under Eligible Medical Expenses.

(22) **Occupational Therapy:** Expenses for outpatient occupational therapy will not be considered eligible.

(23) **Operated by the Government:** Expenses for treatment at a facility owned or operated by the government will not be considered eligible, unless the Covered Person is legally obligated to pay. This does not apply to Covered Expenses rendered by a Hospital owned or operated by the United States Veteran's Administration when services are provided to a Covered Person for a non-service related Illness or Injury.

(24) **Orthognathic Surgery:** Expenses for osteotomy, orthognathic Surgery, maxillofacial orthopedics or related treatment for deformities caused by anything other than cancer or trauma will not be considered eligible.

(25) **Over-the-Counter (OTC) Medication:** Expenses for any over-the-counter medication will not be considered eligible. Expenses for drugs and medicines not requiring a prescription by a licensed Physician and not dispensed by a licensed pharmacist will not be considered eligible, except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(26) **Plan Maximums:** Charges in excess of Plan maximums will not be considered eligible.

(27) **Prior to Effective Date:** Expenses which are Incurred prior to the effective date of your coverage under the Plan will not be considered eligible.

(28) **Refractive Errors:** Expenses for radial keratotomy, Lasik Surgery or any Surgical Procedure to correct refractive errors of the eye will not be considered eligible.

(29) **Riot/Revolt:** Expenses resulting from a Covered Person's participation in a riot or revolt will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or domestic violence.

(30) **Sex Transformation:** Expenses in connection with sex transformation will not be considered eligible.

(31) **Smoking Cessation:** Expenses for smoking cessation programs, including smoking deterrents will not be considered eligible, unless otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(32) **Speech Therapy:** Expenses for outpatient speech therapy will not be considered eligible.

(33) **Stand-by Physician:** Expenses for technical medical assistance or stand-by Physician services will not be considered eligible, except for interventional cardiology procedures (such as angioplasty) and C-sections.

(34) **Sterilization:** Expenses for the reversal of elective sterilization will not be considered eligible.

(35) **Surrogate:** Expenses relating to a surrogate pregnancy of any person who is not covered under this Plan, including but not limited to pre-pregnancy, conception, pre-natal, childbirth and post-natal expenses, will not be considered eligible.

(36) **Transcutaneous Electrical Nerve Stimulation:** Expenses for Transcutaneous Electrical Nerve Stimulation (TENS) units will not be considered eligible.

(37) **Usual and Customary Charge:** Expenses in excess of the Usual and Customary Charge will not be considered eligible even if the Covered Person has reached the Out-of-Pocket Maximum.

(38) **Vision Therapy:** Expenses for vision therapy or orthoptic treatment will not be considered eligible.

(39) **Wage or Profit:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for wage or profit (including self-employment) will not be considered eligible.

(40) **War:** Expenses incurred for any Illness or Injury due to, or aggravated by, war or an act of war, whether declared or undeclared will not be considered eligible.

(41) **Worker’s Compensation:** Expenses that are payable or reimbursable under any Worker's Compensation law or similar legislation will not be considered eligible.

Expenses for Injuries or Illness which were eligible for payment under Worker's Compensation or similar law and have reached the maximum reimbursement paid under Worker's Compensation or similar law will not be eligible for payment under this Plan.

PRESCRIPTION DRUG CARD PROGRAM

Eligible expenses include Prescription Drugs and medicines prescribed in writing by a Physician and dispensed by a licensed pharmacist, which are deemed necessary for treatment of an Illness or Injury including but not limited to: insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician, diabetic supplies, and contraceptives (regardless of intended use). Please note Prescription Drugs are subject to the cost-sharing provisions described in the Prescription Drug Schedule of Benefits unless the Prescription Drug qualifies as a Preventive Drug (as described below).

When your prescription is filled at a retail pharmacy, the maximum amount or quantity of Prescription Drugs covered per Copay is a 90-day supply.

When using the mail order program, the maximum amount or quantity of Prescription Drugs covered per Copay is a 90-day supply.

Expenses for injectables that are not covered under the Prescription Drug Card Program and are Medically Necessary for the treatment of a covered Illness or Injury will be payable under this Plan subject to any applicable major medical Deductibles and Coinsurance as well as any coverage limitations and exclusions applicable to the major medical component of the Plan. Please refer to the Eligible Medical Expenses and the General Limitations and Exclusions section of the Plan.

Note: Coverage, limitations and exclusions for Prescription Drugs will be determined through the Prescription Drug Card Program elected by the Plan Sponsor and will not be subject to any limitations and exclusions under the major medical component of the Plan (except for injectables that are not covered under the Prescription Drug Card Program). For a complete listing of Prescription Drugs available under the Prescription Drug Card Program, as well as any exclusions or limitations that may apply, please contact the Prescription Drug Card Program Manager identified in the General Information section of this Plan and listed on the back of your Employee identification card.

Dispense As Written
Coverage for preventive contraceptives and contraceptive devices is only available for women of child bearing age and limited to contraceptives that are considered Generic Drugs unless no equivalent Generic Drug is available and the Brand Name Drug is otherwise covered under the Prescription Drug Card Program. If the Covered Person chooses a Brand Name Drug rather than the Generic equivalent when there is a Generic equivalent available and the Physician has allowed a Generic Drug to be dispensed, the Covered Person will also be responsible for the cost difference between the Generic Drug and the Brand Name Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Brand Name Drug: Means a trade name medication.

Generic Drug: A Prescription Drug, which has the equivalency of the Brand Name Drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Prescription Drug: Any of the following: (a) a Food and Drug Administration-approved drug or medicine, which, under federal law, is required to bear the legend, “Caution: federal law prohibits dispensing without prescription”; (b) injectable insulin; or (c) hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a paper copy, please contact the Plan Administrator.

DENTAL EXPENSES

If a Covered Person incurs expenses for a service on the list of "Eligible Dental Expenses," such charges are covered to the extent that they meet all of the following conditions:

(1) Constitute Dentally Necessary treatment.

(2) Are Incurred while covered under this Plan.

The Plan will pay for such eligible expenses as shown in the Schedule of Dental Benefits.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted.

Pre-Determination of Benefits
When the total cost of eligible dental expenses is expected to exceed the Pre-Determination Limit as shown in the Dental Schedule of Benefits, the Dentist's treatment plan should be sent to the Third Party Administrator before the first date of treatment. Based on the treatment plan, the Third Party Administrator will estimate the amount of the benefit available if treatment is performed and inform the Dentist of the determination. The treatment plan should:

(1) Show the Dentist's proposed course of treatment;

(2) Show the total charge for the treatment;

(3) Include x-rays, study models and any other data requested by the Third Party Administrator; and

(4) Show how long the treatment will take.

(5) Include x-rays, study models and any other data requested by the Third Party Administrator; and

(6) Show how long the treatment will take.

Pre-determination is not necessary when eligible dental expenses are Incurred for emergency dental care or accidental dental Injuries.

Pre-treatment review is not a guarantee of the benefits that will be payable. It tells the Covered Person and the Dentist, in advance, what is payable for the eligible dental services named in the treatment plan. But payment is conditioned on:

(1) The work being done as proposed and while the Covered Person is covered under this Plan; and

(2) The payment limit provisions listed in the Dental Schedule of Benefits and all of the other terms of this Plan.

Alternative Treatment
The Plan has an "alternate treatment" clause that limits the Plan's payment to the most cost effective treatment of a dental condition that provides a professionally acceptable result as determined by national standards of dental practice. If a Covered Person chooses a more expensive treatment according to accepted standards of dental practice to correct a dental condition, the Plan's payment will be based on the treatment that provides professionally satisfactory results at the most cost-effective level.

Eligible Dental Expenses
Class A-Preventive Services:

(1) Routine oral examinations are limited to twice each Calendar Year (no more than once per 5 month period).

(2) Prophylaxis (cleaning, scaling, and polishing) is limited to twice each Calendar Year (no more than once per 5 month period).

(3) X-rays as follows:

(a) Bitewing x-rays are limited to twice each Calendar Year (no more than once in any 5 month period).

(b) Full mouth and panoramic x-rays are limited to once in any 24 month period, unless special need is shown.

(4) Topical application of fluoride solution for Dependent children under age 21.

Class B-Basic Services:

(1) Extractions and alveolectomy at the time of the tooth extraction.

(2) Amalgam, silicate, acrylic, and composite fillings.

(3) Sealants.

(4) Space maintainers for a Covered Person age 14 and under for missing primary teeth.

(5) Dental surgery.

(6) X-ray and lab services required for dental procedures.

(7) General anesthesia required for dental surgery.

(8) Care and relief of dental pain.

(9) Drugs that require a Dentist's written prescription, including medication given at the Dentist's office.

(10) Consultations required by the attending Dentist.

(11) Relines and rebases to existing dentures.

(12) Endodontic and periodontic care.

(13) Harmful Habit appliances for a Covered Person age 14 and under.

Class C-Major Services:

(14) Crowns, inlays and onlays,

(15) Fixed bridge restorations.

(16) Removable partial or complete dentures.

(17) Repairs to existing dentures

(18) Initial placement of full or partial dentures or bridgework, including abutments.

(19) Replacement of existing full or partial dentures, bridgework or crowns; or the addition of teeth, inlays, onlays, crowns or gold restorations to these appliances only if:

(a) The existing appliance cannot be repaired or restored to use; and

(b) At least 5 years have passed since the last placement; or

(c) The replacement:

(i) Replaces an existing temporary appliance; and

(ii) Is placed within 12 months after a temporary appliance was placed; or

(iii) The replacement is needed because of the pulling of additional teeth or Injury to teeth (except for chewing Injuries) and is completed within 12 months of the extraction or Injury.

If a Covered Person has a partial denture, and a natural tooth adjacent to that denture is pulled, the addition of another tooth to the Covered Person's denture is covered.

DENTAL EXCLUSIONS AND LIMITATIONS

In addition to the General Exclusions and Limitations section of this Plan, no payment will be eligible under any portion of this Plan for Dental Expenses Incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person, or from future benefits, and any such payment does not waive the written exclusions, limitations or other terms of the Plan.

(1) **Alternative Treatment**. If a Covered Person chooses a more expensive treatment according to accepted standards of dental practice to correct a dental condition, the Plan's payment will be based on the treatment which provides professionally satisfactory results at the most cost-effective level.

(2) **American Dental Association**. Expenses that do not meet the standards of dental practices accepted by the American Dental Association will not be considered eligible.

(3) **Cosmetic**. Expenses for services or supplies partially or wholly Cosmetic in nature will not be considered eligible. Expenses for dental care provided to correct any birth defect or developmental malformation which does not interfere with function.

(4) **Close Relative**. Expenses for services, care or supplies provided by a Close Relative will not be considered eligible.

(5) **Customized Dental Procedures**. Expenses for customized dental procedures will not be considered eligible.

(6) **Department Maintained by an Employer**. Expenses for services received from a Dentist or dental department maintained by an employer, labor union, etc., where the individual is eligible under any group insurance plan will not be considered eligible.

(7) **Hospital Expenses**. Expenses for Hospital expenses will not be considered eligible.

(8) **Installation or Replacement**. Expenses for installation, replacement or alteration of, or addition to, dentures and fixed bridgework will not be considered eligible, except as shown in Eligible Dental Expenses.

(9) **Not Performed By a Dentist**. Expenses for treatment by any person other than a Dentist or Physician, except charges for treatment performed under the supervision and direction of a Dentist or Physician by any person duly licensed or certified to perform such treatment under applicable professional statutes and regulations, will not be considered eligible.

(10) **Not Prescribed by a Dentist**. Expenses for services not prescribed as necessary by a Physician or Dentist will not be considered eligible.

(11) **Oral Hygiene**. Expenses for oral hygiene, dietary or plaque control programs, or other educational programs will not be considered eligible.

(12) **Orthodontic Treatment**. Expenses for Orthodontic Treatment and appliances will not be considered eligible.

(13) **Orthognathic Surgery**. Surgery to correct malposition in the bones of the jaw will not be considered eligible.

(14) **Personalization**. Expenses for personalization of dentures will not be considered eligible.

(15) **Plan Design**. Expenses excluded or limited by the Plan design as stated in this document will not be considered eligible.

(16) **Replacement**. Replacement of lost or stolen appliances will not be considered eligible.

(17) **Take Home Items**. Expenses for take home items will not be considered eligible.

(18) **Temporary**. Temporary dental service will be considered an integral part of the final dental service rather than a separate service.

(19) **Temporomandibular Joint Dysfunction (TMJ)**. Expenses Incurred for appliances or restorations in connection with Temporomandibular Joint Dysfunction (TMJ) or myofunctional therapy will not be considered eligible.

(20) **Usual and Customary Charges**. Expenses in excess of the Usual and Customary Charge will not be considered eligible.

(21) **Veneers**. Cosmetic veneers will not be considered eligible.

Integration with Medical Benefits
In the event benefits are available for the same expenses under both the medical and dental provisions of this Plan, such charges will first be considered for payment as a medical expense. The charges will be considered under the dental expenses only if the amount normally paid under the dental expenses exceeds the amount paid under the medical expenses, and only up to the excess amount.

VISION BENEFITS

Vision Care Benefits performed by a licensed Optician, Optometrist or Ophthalmologist and provided to a Covered Person will be covered as shown in the Schedule of Vision Benefits.

Eligible Expenses
The following Vision Care Benefits will be payable as shown in the Schedule of Vision Benefits:

(1) Vision examinations;

(2) Lenses and their fittings, including customization such as tinting, photograying, hardening of lenses, rolled edges and non-glare coatings;

(3) Contact lenses and their fittings; and

(4) Frames.

NOTE: Frames replaced due to loss, theft or breakage will be covered if the Covered Person has been continuously covered under the Plan for at least 36 months and the Covered Person has not used the frames benefit for at least 36 months.

Exclusions and Limitations
In addition to the General Exclusions and Limitations section of this Plan, vision expenses are not provided for:

(1) Safety glasses.

(2) Radial keratotomy, Lasik, laser and other refractive surgery.

(3) Medical or surgical treatment of the eye.

(4) Artificial eyes.

COBRA CONTINUATION COVERAGE

The right to COBRA Continuation Coverage was created by a federal law, known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you and/or your eligible Dependents when your coverage under the Plan ends because of a life event known as a "qualifying event.

Qualified Beneficiary
In general, you, your Spouse and any Dependent Child covered under the Plan on the day before a qualifying event that causes you to lose coverage under the Plan is considered a "qualified beneficiary".

In addition, any Dependent Child who is born to or placed for adoption with you during a period of COBRA continuation coverage is considered a "qualified beneficiary".

A Domestic Partner of an Employee, generally is not entitled to continue coverage under COBRA; however the Plan Sponsor has chosen to extend COBRA-like coverage to Domestic Partners and to the child of a Domestic Partner. COBRA-like coverage is identical to a continuation of coverage under COBRA offered to a Spouse and any Dependent Child of an Employee.

Each qualified beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) is offered the opportunity to make an independent election to receive COBRA continuation coverage.

Qualifying Event
If you are a covered Employee, you, your Spouse and/or Dependent Child will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

(1) Your hours of employment are reduced, or

(2) Your employment ends for any reason other than your gross misconduct.

You, your Spouse and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 18 months; provided you elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage.

You, your Spouse and Dependent Child have an independent right to elect COBRA Continuation Coverage. You and/or your Spouse may elect coverage on behalf of either one of you and parents may elect coverage on behalf of their Dependent Child.

If you are the Spouse and/or Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events:

(1) Your spouse/parent-Employee dies;

(2) Your spouse/parent-Employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or

(3) You/your parents become divorced or legally separated.

Your Spouse and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 36 months; provided such Spouse and/or Dependent Child provide notice of the qualifying event to the Employer and elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date they are given notice of their rights to elect COBRA Continuation Coverage and their obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If you are a Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose coverage under the Plan because you cease to be eligible for coverage under the Plan as a Dependent Child. You may elect to continue coverage under the Plan for up to a maximum period of 36 months; provided such Dependent Child provides notice of the qualifying event to the Employer and elects to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage and your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

Extension of 18-Month Continuation Coverage Period

If you, your Spouse or Dependent Child is determined to be disabled by the Social Security Act (SSA); you and all other qualified beneficiaries 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 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. To qualify for this extension in coverage, notification must be given to your Employer on a date that is both within 60 days after the later of (a) the date of the SSA determination; (b) the date coverage under the Plan would end due to the qualifying event; or (c) the date you are given notice of your obligation to provide such notice and before the end of the initial 18-month period of coverage. If you are later determined not disabled by SSA, you must notify your Employer within 30 days following the later of (a) the date of the SSA determination; or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and any Dependent Child in your family may be entitled to receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. To qualify for this extension in coverage, notification must be given to your Employer within 60 days after the later of (a) the date coverage under the Plan would end due to the qualifying event or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled "Notice Requirement" for the requirements of such notice.

Notice Requirement

The notice must be postmarked (if mailed), or received by the COBRA 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 you are electing COBRA continuation coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan, or if you are eligible for an extension of COBRA continuation coverage, such coverage will end on the last day of the initial 18-month COBRA continuation coverage period.

For qualifying events such as divorce or legal separation of the Employee and Spouse or a Dependent Child's loss of eligibility under the Plan, the notice must contain the following information:

(1) Name and address of the covered Employee or former Employee;

(2) Name and address of your Spouse, former Spouse and any Dependent Children;

(3) Description of the qualifying event; and

(4) Date of the qualifying event.

In addition to the information above, if you, your Spouse or any Dependent Child is determined by SSA to be disabled within 60 days after your COBRA continuation coverage begins, the notice must also contain the following information:

(1) Name of person deemed disabled;

(2) Date of disability determination; and

(3) Copy of SSA determination letter.

If you cannot provide a copy of the decree of divorce or the SSA's determination 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 you do 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 COBRA Administrator may request additional information. If the individual fails to provide such information within the time period specified in the request, the notice may be rejected.

In addition to accepting a letter with the information described above, the Plan Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, a covered Employee or a covered Spouse may obtain a copy by requesting it from the Plan Administrator at the address provided in this notice.

Notice must be sent to the COBRA Administrator at:

Northwest Arctic Borough School District
P.O. Box 51
Kotzebue, AK 99752
1-907-442-3472

Termination of COBRA Continuation Coverage
COBRA continuation coverage automatically ends 18, 29 or 36 months (whichever is applicable) after the date of the qualifying event; however coverage may end before the end of the maximum period on the earliest of the following events:

(1) The date the Plan Sponsor ceases to provide any group health plan coverage;

(2) The date on which the qualified beneficiary fails to pay the required contribution;

(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); 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.

Payment for COBRA Continuation Coverage
Once COBRA continuation coverage is elected, you 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. The amount you are required to pay for COBRA continuation coverage is 102% of the actual cost of coverage you elect, unless you qualify for the 11-month period of extended coverage due to disability (as specified above). In the event of disability, you will be required to pay 150% of the actual cost of coverage you elect for the 11-month extension period.

Additional Information
Additional information about the Plan and COBRA continuation coverage is available from the Plan Administrator, who is identified on the General Information page of this Plan.

Current Addresses
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members.

CLAIM PROCEDURES

You will receive an Employee identification card which will contain important information, including claim filing directions and contact information. The Employee identification card will show your Participating Provider Network and the Medical Management Administrator.

At the time you receive treatment, show the Employee identification 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, Inc.
P.O. 853921
Richardson, TX 75085-3921
(800) 925-2272

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 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 written claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

Timely Filing
All claims must be filed with the Third Party Administrator within 15 months following the date services were Incurred. Claims filed after this time period will be denied.

In the event the Plan is the Covered Person’s secondary payor, claims must be received by the Third Party Administrator within 15 months of the date charges for the service were Incurred or within 15 months of the date the primary carrier processed the claim, whichever is greater.

Procedures for all Claims
The Plan's claim procedures are intended to reflect the Department of Labor's claims procedures regulations and should be interpreted accordingly. In the event of any conflict between this Plan and those Regulations, those Regulations will control. In addition, any changes in those Regulations shall be deemed to amend this Plan automatically, effective as of the date of those changes.

To receive benefits under the Plan, the claimant (i.e. you and your covered Dependents) must follow the procedures outlined in this section. There are 4 different types of claims: (1) Urgent Care Claims; (2) Concurrent Care Claims; (3) Pre-Service Claims; and (4) Post-Service Claims. The procedures for each type of claim are more fully described below:

(1) **Urgent Care Claims.** If your claim is considered an urgent care claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless you fail to provide sufficient information to determine whether or to what extent, benefits are covered or payable under the Plan. If you fail to provide sufficient information for the Plan to decide your claim, the Plan Administrator will notify you as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by you. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator will notify you of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the claimant to provide the specified additional information.

A claim for benefits is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. In determining if the initial claim for benefits should be treated as an urgent care claim, the Plan will defer to a determination, if any, by an attending provider that the claim should be treated as an urgent care claim, if that determination is timely provided to the Plan.

(2) **Concurrent Care Claims.** If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Plan Administrator will notify you of the adverse determination at a time sufficiently in advance of the reduction or termination to allow you, the claimant, to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by you to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies and the Plan Administrator will notify you of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

(3) **Pre-Service Claims.** For a pre-service claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to matters beyond the control of the Plan, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time to notify you of the Plan's benefit determination for up to 15 days provided that the Plan Administrator notifies you within 15 days after the Plan receives the claim, of those special circumstances and of when the Plan Administrator expects to make its decision. However, if such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

(4) **Post-Service Claims.** For a post-service claim, the Plan Administrator will notify you of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time for notifying you of the Plan's benefit determination on a one-time basis for up to 15 days provided that the Plan Administrator notifies you within 30 days after the Plan receives the claim, of those special circumstances and of the date by which the reviewer expects to make a decision. However, if such a decision is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a post-service claim if it is a request for payment for services or other benefits that you have already received (or any other claim for health benefits that is not a pre-service claim or an urgent care claim).

Manner and Content of Notice of Initial Adverse Determination
If the Plan Administrator denies a claim, it must provide to you in writing or by electronic communication:

(1) An explanation of the specific reasons for the denial;

(2) A reference to the Plan provision or insurance contract provision upon which the denial is based;

(3) A description of any additional information or material that you must provide in order to perfect the claim;

(4) An explanation of why the additional material or information is necessary;

(5) Notice that you have the right to request a review of the claim denial and information on the steps to be taken if you wish to request a review of the claim denial along with the time limits applicable to a request for review;

(6) A statement describing your right to request an external review (or, if applicable, to request a second level appeal) or, if applicable, to bring an action for judicial review;

(7) A copy of any rule, guideline, protocol or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon your request and without charge); and

(8) If the adverse determination is based on the Plan's Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment applying the exclusion or limit to your medical circumstances or (b) a statement that the same will be provided upon your request and without charge.

Any notice of adverse determination also will include the following information:

(1) Information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);

(2) As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and

(5) A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

For an adverse determination concerning an urgent care claim, the information described in this Section may be provided to you orally within the permitted time frame provided that a written or electronic notification in accordance with this section is furnished to you no later than 3 days after the oral notification.

Internal Review of Initially Denied Claims
If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the procedures described below:

You have 180 days after you receive notice of an initial adverse determination within which to request a review of the adverse determination. For a request for a second level appeal, you have 60 days after you receive notice of an adverse determination at the first level of appeal to request a second level appeal of the adverse determination.

If you request a review of an adverse determination within the applicable time period, the review will meet the following requirements:

(1) The Plan will provide a review that does not afford deference to the adverse determination that is being appealed and that is conducted by an appropriate named fiduciary of the Plan who did not make the adverse determination that is the subject of the appeal and who is not a subordinate of the individual who made that adverse determination.

(2) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental and/or Investigational or not Medically Necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence will be an individual who is neither an individual who was consulted in connection with the adverse determination that is the subject of the appeal, nor a subordinate of any such individual.

(3) The Plan will identify any medical or vocational experts whose advice is obtained on behalf of the Plan in connection with the Plan's review of an adverse determination, without regard to whether the advice is relied upon in making the adverse determination on review.

(4) For a requested review of an adverse determination involving an urgent care claim, the review process will meet the expedited deadlines described below. Your request for such an expedited review may be submitted orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly expeditious method.

(5) The reviewer will afford you an opportunity to review and receive, without charge, all relevant documents, information and records relating to the claim and to submit issues and comments relating to the claim in writing to the Plan. The reviewer will take into account all comments, documents, records and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(6) You will be provided, free of charge, any new or additional evidence or rationale considered, relied upon or generated by the Plan in connection with the claim. Such evidence or rationale will be provided as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of its determination on review to give you a reasonable opportunity to respond prior to such determination.

(7) The Plan will ensure that all claims are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.

(8) The Plan will provide you with continued coverage pending the outcome of an internal appeal.

All requests for review of initially denied claims (including all relevant information) must be submitted to the following address:

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

Deadline for Internal Review of Initially Denied Claims

(1) Urgent Care Claims. The Plan provides for 2 levels of appeal for urgent care claims. For each level of appeal, the reviewer will notify you of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 36 hours after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

(2) Pre-Service Claims. The Plan provides for 2 levels of appeal for a pre-service claim. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 15 days after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

(3) Post-Service Claims. The Plan provides for 2 levels of appeal for a post-service claim. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

Manner and Content of Notice of Decision on Internal Review of Initially Denied Claims
Upon completion of its review of an initial adverse determination (or a first-level appeal adverse determination), the reviewer will give you, in writing or by electronic notification, a notice of its benefit determination. For an adverse determination, the notice will include:

(1) A description of the Plan's decision;

(2) The specific reasons for the decision;

(3) The relevant Plan provisions or insurance contract provisions on which its decision is based;

(4) A statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of, all documents, records and other information in the Plan's files which is relevant to your claim for benefits;

(5) A statement describing your right to request an external review (or, if applicable, to request a second level appeal),or, if applicable, to bring an action for judicial review;

(6) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge to you upon request;

(7) If the adverse determination on review is based on a Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances or (b) a statement that such an explanation will be provided without charge upon request.

Any notice of adverse determination will include the following information:

(1) Information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);

(2) As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and

(5) A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

Calculation of Time Periods
For purposes of the time periods described in the Plan's claim procedures, the period of time during which a benefit determination is required to be made begins at the time a claim (or a request for review of a denied claim) is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to your failure to submit all information necessary for a claim for non-urgent care benefits, the period for making the determination is "frozen" from the date the notification requesting the additional information is sent to you until the date you respond or, if earlier, until 45 days from the date you receive (or were reasonably expected to receive) the notice requesting additional information.

Adverse Determination
For purposes of the Plan's claim procedures, an "adverse determination" is a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Plan and including a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental and/or Investigational or not Medically Necessary or appropriate. Adverse determination also includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission.

Plan's Failure to Follow Procedures
If the Plan fails to follow the claim procedures described above, you will be deemed to have exhausted the Plan internal claim procedures and you will be entitled to pursue any available remedy (including any available external review process) under State or Federal law on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

However, the Plan will not be treated as failing to follow its claim procedures and you will not be deemed to have exhausted the Plan's administrative remedies merely because of a failure by the Plan that would be considered (based on applicable regulations) a "*de minimis* violation" that does not cause and is not likely to cause prejudice or harm to you as long as the Plan can demonstrate that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and you. You may request a written explanation of any violation by the Plan of these procedures. If you request such an explanation, the Plan will provide it within 10 days and, if applicable, the explanation will include a specific description of the Plan's reasons for asserting that the violation does not cause the Plan's internal claim procedures to be exhausted. If a court or external review rejects your request for an immediate review (based on a claim that you should be deemed to have exhausted the Plan's internal claim procedures), because the court or external reviewer determines that the "*de minimis* violation" exception applies, the Plan will provide to you a notice of your right to resubmit your internal appeal with a reasonable time (no longer than 10 days) after the court or external reviewer makes such a determination. Any applicable time limit for you to re-file your claim will begin to run when you receive that notice from the Plan.

External Review of Denied Claims
If you have exhausted the Plan's internal appeal process (or if you are eligible to request an external review for any other reason under the above procedures), you may request an external review of the Plan's final adverse determination for certain health benefit claims.

The Plan will provide for an external review process in accordance with applicable State law (if any). If no external review process exists under applicable State law or, effective after December 31, 2011, if the State law external review process does not meet certain minimum standards of the NAIC Uniform Health Carrier External Review Model Act (or the temporary "NAIC-similar" standards described in Department of Labor Technical Release 2011-02), the Plan will provide for an external review process that meets Federal law requirements. Governmental plans that are not eligible to participate in a qualifying State process must elect to participate in a federal process administered by HHS or in the federal external review process that applies to ERISA-governed, self-funded Plans. If the Plan elects to participate in the federal external review process that applies to an ERISA self-funded plan, the external review procedures described below will apply.

Note that the Federal external review process (including the expedited external review process described later in these procedures) is <u>not</u> available for review of all internal adverse determinations. Specifically, Federal external review is not available for review of an internal adverse determination that is based on a determination that a claimant fails to meet the eligibility requirements under the terms of the Plan. Also, for any claim for which an external review request is not initiated before September 20, 2011, the Federal external review process is available only for:

(1) An adverse determination that involves medical judgment (including, but not limited to determinations based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the Plan's determination that a treatment is Experimental and/or Investigational), as determined by the external reviewer; and

(2) A rescission of coverage.

For any adverse determination for which external review is available, the Federal external review requirements are as follows:

(1) You have 4 months following the date you receive notice of the Plan's final internal adverse determination within which to request an external review. The request for an external review must be submitted to the following address:

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

(2) Within 5 business days following the date the Plan receives your external review request the Plan will complete a preliminary review. The Plan will notify you in writing within one business day after it completes the preliminary review whether the claim is eligible for the external review process:

(a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will provide contact information for the U.S. Department of Health and Human Services Health Insurance Assistance Team (HIAT).

(b) If the request is not complete, the notice will describe information or materials needed to make the request complete. If the request is not complete and additional information or materials are needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 4-month deadline described in (1) above to provide the necessary additional information or materials.

(3) Following the Plan's preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) (as soon as administratively feasible) to make a determination on the request for external review. Within 5 business days following assignment of the IRO, the Plan will forward to the IRO all information and materials relevant to the final internal adverse determination.

(4) The assigned IRO will notify you in writing (within a reasonable period of time) of the request's eligibility and acceptance for external review. The notice will include a statement regarding your right to submit any additional information, within 10 business days from the date of receipt of the notice, for the IRO to consider as part of the external review process. Any such additional information received by the IRO will be forwarded on and shared with the Plan. The Plan, based upon any new information received, may reconsider its final internal adverse determination. Reconsideration by the Plan will not delay the external review process. If the Plan does not reconsider its final internal adverse benefits determination, the IRO will continue to proceed with the external review process.

(5) Within 45 days after the IRO receives the external review request from the Plan, the IRO must provide written notice of its external review determination to you and the Plan. The IRO's notice is required to contain the following:

(a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;

(b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;

(d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(e) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to you;

(f) A statement that judicial review may be available to you; and

(g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Expedited External Review
You may request an expedited external review if you have received:

(1) An initial internal adverse determination if the adverse determination involves a medical condition for which the time frame for completion of an expedited internal appeal under the Plan's internal claim procedures would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

(2) A final internal adverse determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or if the final internal adverse determination concerns an admission, availability of care, continued stay or health care item or service for which you received emergency services but have not been discharged from a facility.

The following requirements apply to an expedited external review:

(1) Immediately following the date the Plan receives the external review request the Plan will complete a preliminary review. The Plan will notify you in writing immediately after completion of the preliminary review whether the request is eligible for the external review process.

(a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will include contact information for the Employee Benefits Security Administration.

(b) If the request is not complete, the notice will describe any information or materials needed to make the request complete. If the request is not complete and additional information or materials is needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 4-month deadline described in (1) above to provide the necessary additional information or materials.

(2) Following the Plan’s preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) to make a determination on the request for external review. The Plan will promptly forward to the IRO, by any available expeditious method (e.g. telephone, facsimile, etc.), all information and materials relevant to the final internal adverse determination.

(3) The IRO must provide notice to the claimant and the Plan (either in writing or orally) as expeditiously as the claimant’s medical condition or circumstance require and no later than 72 hours after it receives the expedited external review request from the Plan. If notice is not provided in writing, the IRO must provide written notice to you and the Plan as confirmation of the decision within 48 hours after the date of the notice. The IRO’s notice is required to contain the following information:

(a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;

(b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;

(d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(e) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to you;

(f) A statement that judicial review may be available to you; and

(g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Effect of External Review Determination
A determination on external review is binding on the Plan and the claimant, except to the extent that other remedies are available under applicable State or Federal law. However, a decision by the external reviewer does not preclude the Plan from making payment or providing benefits on a claim at any time, including after a decision that denies the claim. When an external review decision requires the Plan to provide benefits or payment on a claim, the Plan will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether the Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

State Insurance Laws
Nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable State law.

Statute of Limitations for Plan Claims
Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 3 years after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

Appointment of Authorized Representative
A Covered Person is permitted to appoint an authorized representative to act on his or her 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 Third Party 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 Illness or Injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Plan Administrator may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition to coverage.

COORDINATION OF BENEFITS

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

Excess Insurance
If at the time of injury, sickness, disease or disability there is available, or potentially available, any coverage (including, but not limited to, coverage resulting from a judgment at law or settlements), the benefits under the Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible:

(1) Any primary payer besides the Plan;

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(3) Any policy of insurance from any insurance company or guarantor of a third-party;

(4) Worker's compensation or other liability insurance company; or

(5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Vehicle Limitation
When medical payments are available (or, under applicable law should be available) under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification. If medical payments would have been available under a vehicle insurance policy if minimum legally required levels of coverage had been in effect, but the minimum level of coverage was not in effect, the Plan shall pay excess benefits only, determined as if the minimum legally required level of coverage had been in effect at the applicable time.

Allowable Expenses
"Allowable expenses" shall mean any Medically Necessary, Usual 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 in the amount that would be payable in accordance with the terms of the Plan shall 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.

Other Plan
"Other Plan" means any of the following plans, other than this Plan, providing benefits or services for medical or dental care or treatment:

(1) Group, blanket, or franchise insurance coverage;

(2) Any group Hospital service prepayment, group medical or dental service prepayment, group practice or other group prepayment coverage;

(3) Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, school insurance, or Employee benefit organization plans;

(4) Coverage under Medicare and any other governmental program that the Covered Person is liable for payment, except state-sponsored medical assistance programs and TRICARE, in which case this Plan pays primary;

(5) Coverage under any Health Maintenance Organization (HMO); or

(6) Any mandatory automobile insurance (such as no-fault) providing benefits under a medical expense reimbursement provision for health care services because of Injuries arising out of a motor vehicle accident, and any other medical and liability benefits received under any automobile policy.

Application to Benefit Determinations
The plan that pays first according to the rules in the section entitled “Order of Benefit Determination” will pay as if there were no other plan involved. When this Plan is secondary, this Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses.

Order of Benefit Determination
For the purposes of the section entitled “Application to Benefit Determinations,” the rules establishing the order of benefit determination are listed below. The Plan will consider these rules in the order in which they are listed and will apply the first rule that satisfies the circumstances of the claim.

(1) A plan without a coordinating provision will always be the primary plan;

(2) The plan covering the person directly rather than as an Employee's dependent is primary and the other plans are secondary.

(3) Active/laid-off or Retirees: The plan which covers a person as an active Employee (or as that Employee’s dependent) determines its benefits before the Plan which covers a person as a laid-off or retired employee (or as that Employee’s dependent). If the Plan which covers that person has not adopted this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

(4) Dependent children of parents not separated or divorced, or unmarried parents living together: the plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. However, if the other plan does not have this rule but instead has a rule based upon the gender of the parent, and if as a result the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

(5) Dependent children of separated or divorced parents, or unmarried parents not living together: When parents are separated or divorced or unmarried and not living together, neither the male/female nor the birthday rules apply. Instead:

(a) The plan of the parent with custody pays first;

(b) The plan of the spouse of the parent with custody (the step-parent) pays next;

(c) The plan of the parent without custody pays next; and

(d) The plan of the spouse of the non-custodial parent pays last.

Notwithstanding the above provisions, if there is a court decree that would otherwise establish financial responsibility for the child’s health care expenses, the benefits of the plan that covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan that covers the child as a dependent child.

(6) If a person whose coverage is provided under a right of continuation pursuant to state or federal law (e.g., COBRA) is also covered under another plan, the plan covering the person as an Employee, member, subscriber, or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

Right to Receive and Release Necessary Information
For the purpose of determining the applicability of and implementing the terms of this coordination of benefits provision or any provision of similar purpose of any other plan, this Plan may, without notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan is deemed to consent to the release and receipt of such information and agrees to furnish to the Plan such information as may be necessary to implement this provision.

Facility of Payment
Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid 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.

Right of Recovery
Whenever payments have been made by this Plan with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right to recover such payments, to the extent of such excess, in accordance with the Recovery of Payments provision of this Plan.

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, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. This Plan may also inadvertently pay benefits that are later found to be greater than the maximum allowable charge. In this case, this Plan may recover the amount of the overpayment from the person or entity to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. 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.

A Covered Person, 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 or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have discretion in deciding whether to obtain 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 any other Injury or Illness) 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 any other Injury or Illness) 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 or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, 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, most recent edition of the ICD 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.

Further, a Covered Person and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns ("Plan Participants") shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), provider error(s), or damages arising from another party's act or omission for which the Plan has not already been reimbursed.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

(1) In error;

(2) Pursuant to a misstatement contained in a proof of loss or a fraudulent act;

(3) Pursuant to a misstatement made to obtain coverage under this Plan within 2 years after the date such coverage commences;

(4) With respect to an ineligible person;

(5) In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Subrogation, Third Party Recovery and Reimbursement provisions; or

(6) Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Covered Person if such payment is made with respect to the Covered Person.

If the Plan seeks to recoup funds from a provider, due to a claim being made in error, a claim being fraudulent on the part of the provider, and/or the claim that is the result of the provider's misstatement, said provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

Medicaid Coverage
You or your Dependent'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 you or your Dependent. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of such 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 with Medicaid
In all cases, benefits available through a state or federal Medicaid program will be secondary or subsequent to the benefits of this Plan.

Coordination of Benefits with Medicare
When Medicare is the primary payor, the Plan will base its payment upon benefits allowable by Medicare.

Rules for Choosing Medicare or Plan Coverage
In accordance with federal law, the following rules apply in situations in which an individual has a choice of electing either Medicare or Plan coverage as their primary health care coverage:

(1) The Working Aged Rule: When you or your Spouse become eligible for Medicare due to the attainment of age 65, you or your spouse may still be eligible for benefits provided under the Plan. To qualify for Plan benefits, you must be age 65 or over and still an Employee who is eligible for Plan coverage. Your Spouse qualifies for these benefits if he or she is age 65 or over and you are an eligible Employee who is employed by the Employer. Under these circumstances, you or your Spouse have the option of choosing either Plan benefits or Medicare benefits as primary coverage.

If you and your Spouse choose this Plan as primary coverage, the Plan will pay the portion of your Incurred expenses that are normally covered by the Plan. All or part of the remaining amount, if any, may be paid by Medicare if the expenses are covered expenses under Medicare and the portion of the expenses covered by Medicare exceeds the portion covered by the Plan. If the expenses are not covered by the Plan but are Medicare-covered expenses, then Medicare will process its payment of the expenses as if you do not have Plan coverage.

When Plan benefits are elected as primary coverage, the start of Medicare Part B coverage for the aged person may be deferred, without penalty, for up to 8 full months after such person's Plan coverage terminates. Your local Social Security office can provide you with more detailed information on how this deferral works.

If you choose Medicare benefits as primary coverage, you, your Spouse and any Dependent Child will no longer be eligible for Plan coverage. If your Spouse chooses Medicare coverage as primary coverage, your Spouse will no longer be eligible for Plan coverage but you and any eligible Dependent Child may still continue coverage under the Plan.

(2) The Disability Rule: If you are or your covered Dependent is eligible for Medicare by reason of disability due to a condition other than end-stage renal disease, you or your Dependent have the option of choosing the benefits provided under the Plan or Medicare as primary health coverage for the period that you are an Employee who is eligible for Plan coverage. When Plan coverage is elected as primary coverage, the start of Medicare Part B coverage may be deferred, without penalty, for up to 8 full months after such person's Plan coverage terminates. Your local Social Security office can provide you with more detailed information on how this deferral works.

(3) End-Stage Renal Disease Rule: If you become or your covered Dependent becomes eligible for Medicare due to end-stage renal disease ("ESRD"), you or your Dependent may have the option of choosing benefits provided under the Plan or Medicare as primary health coverage for a period not to exceed 30 months generally beginning the first day of the month of eligibility or entitlement to Medicare due to ESRD. Because an ESRD patient can have up to a 3-month wait to obtain Medicare coverage, the Plan's primary payment responsibility may vary up to 3 months. If the basis of your entitlement to Medicare changes from ESRD to age or disability, the Plan's primary payment responsibility may terminate on the month before the month in which the change is effective and the rules set forth above, if applicable, will apply. Your Employer can provide you with more detailed information on how this rule works.

Medicare and COBRA

For most COBRA beneficiaries, Medicare rules state that Medicare will be primary to COBRA continuation coverage, and this would apply to this Plan’s Continuation of Benefits (COBRA) coverage.

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT

Payment Condition

(1) The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an Injury, Illness, disease, or disability is caused in whole or in part by, or results from the acts or omissions of you and/or your Dependents, plan beneficiaries, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person") or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions (collectively "coverage").

(2) The Covered Person, his or her attorney, and/or Legal Guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts.

(3) In the event a Covered Person settles, recovers, or is reimbursed by any coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

(4) If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may elect to seek reimbursement, at its discretion.

Subrogation

(1) As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to assign to the Plan the right to subrogate any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan's discretion.

(2) If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Covered Person may have against any coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

(3) The Plan may, at its discretion, in its own name or in the name of the Covered Person, commence a proceeding or pursue a claim against any party or coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

(4) If the Covered Person fails to file a claim or pursue damages against:

(a) The responsible party, its insurer, or any other source on behalf of that party;

(b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(c) Any policy of insurance from any insurance company or guarantor of a third party;

(d) Workers' compensation or other liability insurance company; or,

(e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Persons and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

(1) The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable subrogation lien. The obligation exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

(2) No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

(3) The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

(4) These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.

(5) This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, disease or disability.

Excess Insurance

If at the time of Injury, Illness, disease, or disability, there is available, or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage, except as provided for under the Plan's "Coordination of Benefits" section. The Plan's benefits shall be excess to:

(1) The responsible party, its insurer, or any other source on behalf of that party;

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(3) Any policy of insurance from any insurance company or guarantor of a third party;

(4) Workers' compensation or other liability insurance company or

(5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person, and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person, such that the death of the Covered Person, or filing of bankruptcy by the Covered Person, will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death
In the event that the Covered Person dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any coverage, the Plan's subrogation and reimbursement rights shall still apply.

Obligations
(1) It is the Covered Persons' obligation at all times, both prior to and after payment of medical benefits by the Plan:

(a) To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;

(b) To provide the Plan with pertinent information regarding the Illness, disease, disability, or Injury, including Accident reports, settlement information and any other requested additional information;

(c) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

(d) To do nothing to prejudice the Plan's rights of subrogation and reimbursement;

(e) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and

(f) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan beneficiary may have against any responsible party or coverage.

(2) If the Covered Person and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.

(3) The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Persons' cooperation or adherence to these terms.

Offset
Failure by the Covered Person and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Covered Person satisfies his or her obligation.

Minor Status
(1) In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

(2) If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation
The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability
In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Notwithstanding anything contained herein to the contrary, to the extent this Plan is not governed by ERISA, the Plan's right to subrogation and reimbursement may be subject to applicable State subrogation laws.

DEFINITIONS

In this section you will find the definitions for the capitalized words found throughout this Plan. There may be additional words or terms that have a meaning that pertains to a specific section, and those definitions will be found in that section; provided, however that any such capitalized word shall have such meaning when used in any other section. These 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 this Plan for that information.

Accident means a non-occupational sudden and unforeseen event, definite as to time and place, or a deliberate act resulting in unforeseen consequences.

Ambulatory Surgical Center means a free-standing surgical center, which is not part of a Hospital and which: (1) has an organized medical staff of Physicians; (2) has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; (3) has continuous Physician's services and registered graduate nursing (R.N.) services whenever a patient is in the facility; (4) is licensed by the jurisdiction in which it is located and (5) does not provide for overnight accommodations.

Assistant Surgeon means a Physician who actively assists the Physician in charge of a case in performing a Surgical Procedure. Depending on the type of Surgery to be performed, an operating surgeon may have one or 2 Assistant Surgeons. The technical aspects of the Surgery involved dictate the need for an Assistant Surgeon.

Birthing Center means a place licensed as such by an agency of the state. If the state does not have any licensing requirements, it must meet all of the following tests: (1) is primarily engaged in providing birthing services for low risk pregnancies; (2) is operated under the supervision of a Physician; (3) has at least one registered nurse (R.N.) certified as a nurse midwife in attendance at all times; (4) has a written agreement with a licensed ambulance for that service to provide immediate transportation of the Covered Person to a Hospital as defined herein if an emergency arises; and (5) has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.

Calendar Year means January 1 – December 31.

Close Relative means a Covered Person's spouse, parent (including step-parents), sibling, child, grandparent, or in-law.

Concurrent Review means the Medical Management Program Administrator will review all Inpatient admissions for a patient's length of stay. The review is based on clinical information received by the Medical Management Program Administrator from the provider or facility.

Congenital Anomaly means a physical developmental defect that is present at birth.

Cosmetic means any procedure which is primarily directed at improving an individual's appearance and does not meaningfully promote the proper function of the body or prevent or treat Illness or disease.

Covered Expense means:

(1) An item or service listed in the Plan as an eligible medical expense for which the Plan provides coverage.

(2) For prescription drug expenses, any prescription drugs or medicines eligible for coverage under the Prescription Drug Card Program.

(3) For dental expenses, an item or service listed in the Plan as an eligible dental expense for which the Plan provides coverage.

(4) For vision expenses, an item or service listed in the Plan as an eligible vision expense for which the Plan provides coverage.

Covered Person means, individually, a covered Employee and each of his or her Dependents who are covered under the Plan.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as may be amended from time to time.

Coinsurance has the same meaning as set forth in the section of this Plan entitled “General Overview of the Plan”.

Copay has the same meaning as set forth in the section of this Plan entitled “General Overview of the Plan”.

Custodial Care means care or confinement provided primarily for the maintenance of the Covered Person, essentially designed to assist the Covered Person, whether or not totally disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

Dentist means an individual who is duly licensed to practice dentistry or to perform oral Surgery in the state where the service is performed and is operating within the scope of such license. A Physician will be considered a Dentist when performing any covered dental services allowed within such license.

Dentally Necessary means services or supplies, which are determined by the Plan Administrator to be:

(1) Appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the dental condition, Injury or Illness;

(2) Provided for the diagnosis or direct care and treatment of the dental condition, Injury or Illness;

(3) Within standards of good dental practice within the organized dental community;

(4) Not primarily for the convenience of the Covered Person, the Covered Person’s Dentist or another provider; and

(5) The most appropriate supply or level of service which can safely be provided.

Dependent is a Covered Person, other than the Employee**,** who is covered by the Plan pursuant to the terms and conditions set forth in the "Eligibility for Participation" section of the Plan.

Domestic Partner means the person of your same gender named in the Affidavit of Domestic Partnership that you have submitted to and has been approved by the Employer. The Plan Administrator reserves the right to require such evidence as it deems necessary that a Domestic Partner satisfies the above eligibility requirements.

Durable Medical Equipment means equipment that:

(1) Can withstand repeated use;

(2) Is primarily and customarily used to serve a medical purpose;

(3) Generally is not useful to a person in the absence of an Illness or Injury; and

(4) Is appropriate for use in the home.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(2) Serious impairment to bodily functions; or

(3) Serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition:

(1) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

(2) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) to Stabilize the individual.

Employee is defined in the "Eligibility for Participation" section of the Plan.

Employer means the Plan Sponsor and each Participating Employer, as applicable**.**

Endodontic Treatment means procedures for the prevention and treatment of diseases of the dental pulp, pulp chamber, root canal and surrounding periapical structures.

ERISA means the Employee Retirement Income Security Act of 1974, as may be amended from time to time. ***NOTE: This is not an ERISA plan.***

Experimental/Investigational: For the purpose of determining eligible expenses under this Plan, a treatment (other than covered Off-Label Drug Use) will be considered by us to be Experimental and/or Investigational if:

(1) The treatment is governed by the United States Food and Drug Administration ("FDA") and the FDA has not approved the treatment for the particular condition at the time the treatment is provided; or

(2) The treatment is provided as part of an ongoing Phase I, II, or III clinical trials as defined by the National Institute of Health, National Cancer Institute or the FDA; or

(3) There is documentation in published U.S. peer-reviewed medical literature that states that further research, studies, or clinical trials are necessary to determine the safety, toxicity or efficacy of the treatment.

Experimental and/or Investigational treatment includes any treatment or Hospital confinement that arises from, relates to, or is provided in connection with, the Experimental and/or Investigational treatment whether or not the treatment or Hospital confinement, on their own, are considered standard of care or Medically Necessary or appropriate.

FMLA means the Family and Medical Leave Act of 1993, as may be amended from time to time.

Genetic Information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes. Genetic Information will not be taken into account for purposes of (1) determining eligibility for benefits under the Plan (including initial enrollment and continued eligibility) and (2) establishing contribution or premium accounts for coverage under the Plan.

Harmful Habit means the acquired habit of thumb sucking, tongue thrusting or bruxism, which causes damage to the teeth and/or periodontal support.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be amended from time to time.

Home Health Care Agency means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions, it: (1) is duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services; (2) qualifies as a Home Health Care Agency under Medicare; (3) meets the standards of the area-wide healthcare planning agency; (4) provides skilled nursing services and other services on a visiting basis in the patient's home; (5) is responsible for administering a home health care program; and (6) supervises the delivery of a home health care program where the services are prescribed and approved in writing by the patient's attending Physician.

Hour(s) of Service mean each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer (or a related Employer) and each hour for which an Employee is paid, or entitled to payment by the Employer (or a related Employer) for a period of time during which no duties are performed due to vacation, holiday, Illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence, but excluding Hours of Service to the extent that the compensation for those services constitutes income from sources outside the United States or performed as (1) a bona fide volunteer (as defined in Treas. Reg. Section 54.4980H-1(a)(7)) or (2) part of a Federal or State work study program. For purposes of this definition, a related Employer is any entity that must be treated as part of the same "applicable large employer" as the Employer for purposes of Code Section 4980H, as determined at the time that the applicable Hour of Service is performed or credited.

For Employees paid on an hourly basis, an Employer must calculate actual Hours of Service from records of hours worked and hours for which payment is made or due (the "actual method"). For Employees paid on a non-hourly basis, the Employer must calculate Hours of Service based on the actual method or, provided doing so does not substantially understate the Employee's hours, using an equivalency method where the Employee is credited with either: (1) 8 Hours of Service for each day for which the Employee would be required to be credited with one Hour of Service; or (2) 40 Hours of Service for each week for which the Employee would be required to be credited with at least one Hour of Service.

Hospice means an agency that provides counseling and incidental medical services and may provide room and board to terminally ill individuals and which meets all of the following requirements: (1) has obtained any required state or governmental Certificate of Need approval; (2) provides 24-hour-a-day, 7 days-a-week service; (3) is under the direct supervision of a duly qualified Physician; (4) has a nurse coordinator who is a registered nurse (R.N.) with 4 years of full-time clinical experience, at least 2 of which involved caring for terminally ill patients; (5) has a social-service coordinator who is licensed in the jurisdiction in which it is located; (6) is an agency that has as its primary purpose the provision of hospice services; (7) has a full-time administrator; (8) maintains written records of services provided to the patient; (9) the employees are bonded, and it provides malpractice and malplacement insurance; (10) is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law; (11) provides nursing care by a registered nurse (R.N.), a licensed practical nurse (L.P.N.), a licensed physical therapist, certified occupational therapist, American Speech Language and Hearing Association certified speech therapist, or a certified respiratory therapist; and (12) provides a home health aide acting under the direct supervision of one of the above persons while performing services specifically ordered by a Physician.

Hospital means a facility which: (1) is licensed as a Hospital where licensing is required; (2) is open at all times; (3) is operated mainly to diagnose and treat Illnesses or Injuries on an Inpatient basis; (4) has a staff of one or more Physicians on call at all times; (5) has 24-hour-a-day nursing services by registered nurses (R.N.'s); and (6) has organized facilities for major Surgery.

However, an institution specializing in the care and treatment of Mental Disorders or Substance Use Disorders which would qualify as a Hospital, except that it lacks organized facilities on its premises for major Surgery, shall be deemed a Hospital.

In no event shall "Hospital" include an institution which is primarily a rest home, a nursing home, a clinic, a Skilled Nursing Facility, a convalescent home or a similar institution.

Illness means a non-occupational bodily disorder, disease, physical sickness, Pregnancy (including childbirth and miscarriage), Mental Disorder, or Substance Use Disorder.

Incurred means 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, Covered 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 means 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 means any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for room and board is made by the Hospital.

Intensive Care Unit means a separate, clearly designated service area, which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit", or an "acute care unit." It has: (1) facilities for special nursing care not available in regular rooms and wards of the Hospital; (2) special life saving equipment which is immediately available at all times; (3) at least 2 beds for the accommodation of the critically ill; and (4) at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee is an eligible Employee or eligible Dependent that does not elect coverage under this Plan during their original 31 –day eligibility period. A Special Enrollee is not considered a Late Enrollee.

Leave of Absence means a Leave of Absence of an Employee that has been approved by the Employer, as provided for in the Employer's rules, policies, procedures and practices.

Legal Guardian is defined in the "Eligibility for Participation" section of the Plan.

Lifetime Maximum means the maximum benefit payable during an individual's lifetime while covered under this Plan. Benefits are available only when an individual is eligible for coverage under this Plan. The Plan may provide for a Lifetime Maximum benefit for specific types of medical treatment. Any Lifetime Maximum will be shown in the applicable Schedule of Benefits or the applicable covered expenses section of the Plan.

Long-Term Acute Care Facility/Hospital (LTACH) means a facility that provides specialized acute care for medically complex patients who are critically ill; have multi-system complications and/or failures and require hospitalization in a facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour-a-day, 7 days a week basis. The severity of the LTACH patient's condition requires a Hospital stay that provides: (1) interactive Physician direction with daily on-site assessment; (2) significant ancillary services as dictated by complex, acute medical needs - such as full service and laboratory, radiology, respiratory care services, etc.; (3) a patient-centered outcome-focused, interdisciplinary approach requiring a Physician-directed professional team that includes intensive case management to move the patient efficiently through the continuum of care; (4) clinically competent care providers with advanced assessment and intervention skills; (5) education for the patient and family to manage their present and future healthcare needs.

Loss of Residence is defined as being outside the United States for more than 60 days. However, an Employee will continue to be eligible for the benefits provided under this Plan if he or she is temporarily outside of the United States: on vacation; to study; or to conduct business for your Employer; for a period of up to, but not exceeding, 60 continuous days.

Maintenance Therapy means medical and non-medical health-related services that do not seek to cure, or that are provided during periods when the medical condition of the patient is not changing, or does not require continued administration by medical personnel.

Medically Necessary/Medical Necessity: For the purpose of determining eligible expenses under this Plan, a Medically Necessary and appropriate treatment is one that meets all of the following criteria:

(1) It is recommended and provided by a licensed Physician, Dentist or other medical practitioner who is practicing within the scope of his or her license; and

(2) It is generally accepted as the standard of medical practice and care for the diagnosis and treatment of the particular condition; and

(3) It is approved by the FDA, if applicable.

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

Mental Disorder means 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 the U.S. Department of Health and Human Services.

Morbid Obesity Morbid obesity is defined as (1) a body mass index (BMI) of 40 or greater or (2) a BMI of 35 or greater in conjunction with a severe co-morbidity, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy, or musculoskeletal dysfunction.

Non-Participating Provider means a health care practitioner or health care facility that has not contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

Off-Label Drug Use: The use of a drug for a purpose other than that for which it was approved by the FDA.

Orthodontic Treatment means the corrective movement of teeth to treat a handicapping malocclusion of the mouth.

Participating Provider means a health care practitioner or health care facility that has contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

Physician means a legally licensed Physician who is acting within the scope of their license, and any other licensed practitioner required to be recognized for benefit payment purposes under the laws of the state in which they practice and who is acting within the scope of their license. The definition of Physician includes, but is not limited to: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Chiropractor, Licensed Consulting Psychologist, Licensed Psychologist, Licensed Clinical Social Worker, Occupational Therapist, Optometrist, Ophthalmologist, Physical Therapist, Podiatrist, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Speech Therapist, Speech Pathologist, and Licensed Midwife. An Employee of a Physician who provides services under the direction and supervision of such Physician will also be deemed to be an eligible provider under the Plan.

Plan means the Northwest Arctic Borough School District Non-Grandfathered Health Care Plan.

Plan Administrator means the Plan Sponsor. The Plan Sponsor may delegate fiduciary and other responsibilities to the Plan Administrator.

Plan Sponsor means Northwest Arctic Borough School District or any successor thereto.

Plan Year means the period from December 1 - November 30 each year.

Prescription Drug means any of the following: (a) a Food and Drug Administration-approved drug or medicine, which, under federal law, is required to bear the legend, “Caution: federal law prohibits dispensing without prescription,” (b) injectable insulin; or (c) hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

Qualified Clinical Trial means a Phase I, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening condition and is described in (1), (2) or (3) below:

(1) The study or investigation is approved or funded (which may include funding though in-kind contributions) by one or more of the following:

   (a) The National Institutes of Health;

   (b) The Centers for Disease Control and Prevention;

   (c) The Agency for Health Care Research and Quality;

   (d) The Centers for Medicare & Medicaid Services;

   (e) A cooperative group or center of one of the entities described in (a) through (d) above;

   (f) A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants; or

   (g) The Department of Veteran Affairs; the Department of Defense or the Department of Energy, if (i) the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and (ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(2) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

(3) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Reconstructive Surgery means Surgery that is incidental to an Injury, Illness, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify such Surgery as Cosmetic when a physical impairment exists, and the Surgery restores or improves function. Additionally, the fact that a Covered Person may suffer psychological consequences, or socially avoidant behavior as a result of an Injury, Illness, or Congenital Anomaly does not classify Surgery to relieve such consequences or behavior as Reconstructive Surgery.

Rehabilitation Facility means a facility must meet all of the following requirements: (1) must be for the treatment of acute Injury or Illness; (2) is licensed as an acute Rehabilitation Facility; (3) the care is under the direct supervision of a Physician; (4) services are Medically Necessary; (5) services are specific to an active written treatment plan; (6) the patient's condition requires skilled nursing care and interventions which cannot be achieved or managed at a lower level of care; (7) 24 hour nursing services are available; and (8) the confinement is not for Custodial Care or maintenance care.

Seasonal Employee means an Employee who is hired into a position that recurs annually at about the same time each year for which the customary annual employment is 6 months or less.

Security Standards mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

Semi-Private Room means a Hospital room shared by 2 or more patients.

Skilled Nursing Facility is a facility that meets all of the following requirements:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, developmentally disabled, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

This term also applies to charges Incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Special Enrollee is as an eligible Employee or eligible Dependent that does not elect coverage under this Plan during their original 31-day eligibility period and who later enrolls in the Plan due to a Special Enrollment Event.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment for the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility; or with respect to an Emergency Medical Condition of a pregnant woman who is having contractions and (1) there is inadequate time to effect a safe transfer to another Hospital before delivery or (2) transfer may pose a threat to the health or safety of the woman or her unborn child to deliver (including the placenta).

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

Surgery or **Surgical Procedure** means any of the following:

(1) The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;

(2) The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;

(3) The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;

(4) The induction of artificial pneumothorax and the injection of sclerosing solutions;

(5) Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;

(6) Obstetrical delivery and dilation and curettage; or

(7) Biopsy.

Third Party Administrator means Meritain Health, Inc., P.O. Box 27267, Minneapolis, MN 55427-0267.

Urgent Care Facility means a facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a registered nurse, and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. For the purpose of this Plan, a facility meeting these requirements will be considered to be an Urgent Care Facility, by whatever actual name it may be called; however, an after-hours clinic shall be excluded from the terms of this definition.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as may be amended from time to time.

Usual and Customary Charge (U&C) means, with respect to Non-Participating Providers, charges made for medical or dental services or supplies essential to the care of the individual will be subject to a Usual and Customary determination. Usual and Customary allowances are based on what is usually and customarily accepted as payment for the same service within a geographical area. In determining whether charges are Usual and Customary, consideration will be given to the nature and severity of the condition and any medical or dental complications or unusual circumstances which require additional time, skill or experience. Limitations for Usual and Customary Charges are not applicable to Participating Providers.

PLAN ADMINISTRATION

Delegation of Responsibility
The Plan Sponsor is a named fiduciary of the Plan with full discretionary authority for the control and management of the operation and administration of the Plan. The Plan Sponsor may delegate fiduciary and other responsibilities to any individual or entity. Any person to whom any responsibility is delegated may serve in more than one fiduciary capacity with respect to the Plan and may be a participant in the Plan.

Authority to Make Decisions
The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other ministerial services. 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 otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator will 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 will 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, care and treatments are Experimental and/or Investigational), to decide disputes which may arise relative to you and/or your Dependent's rights, and to decide questions of Plan interpretation and those of fact and law 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 you and/or your Dependent (as applicable) is entitled to them.

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; or, alternatively, to appoint a qualified administrator to carry out these functions on the Plan Administrator's behalf;

(7) To keep and maintain the Plan documents and all other records pertaining to the Plan;

(8) To appoint and supervise a Third Party Administrator to pay claims;

(9) To perform all necessary reporting as required by Federal or State law;

(10) To establish and communicate procedures to determine whether a child support order or decree 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.

Amendment or Termination of Plan
The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part.

The Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate by operation of law, as a result of changes in law which are required to affect provisions in the Plan.

Any such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents.

If the Plan is terminated, the rights of Covered Persons are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

MISCELLANEOUS INFORMATION

Assignment of Benefits
No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order ("QMCSO") which provides for coverage under the Plan for an alternate recipient, in the manner described in the Plan's QMCSO procedures.

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 you and/or your Dependents 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.

Conformity with Applicable Laws
This Plan shall be deemed automatically to 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 that are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of Plan. It is intended that the Plan will conform to the requirements of any applicable federal or state law.

Cost of the Plan
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, including, but not limited to, payment of Plan expenses from the Employer's general assets. The amount of contribution (if any) for your coverage or coverage for your Dependents will be determined from time to time by the Plan Sponsor, in its sole discretion.

Interpretation of this Document
The use of masculine pronouns in this Plan shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this Plan are used for convenience of reference only. You and your Dependents are advised not to rely on any provision because of the heading.

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

Minimum Essential Coverage
Refer to the Employer's Summary of Benefits and Coverage (SBC) for determination as to whether the Plan provides "minimum essential coverage" within the meaning of Code Section 5000A(f) and any accompanying regulations or guidance and whether it provides "minimum value" within the meaning of Code Section 36B(c)(2)(C)(ii) and any accompanying regulations or guidance (e.g. the Plan provides at least 60% actuarial value).

No Contract of Employment
This Plan and any amendments constitute the terms and provisions of coverage under this Plan. The Plan shall not be deemed to constitute a contract of any type between the Employer and any person or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time.

Release of 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 person covered for benefits under 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 applicable 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.

Worker's 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 you received or are 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 you receive from workers' compensation. The Plan will exercise its right to recover against you. 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 you 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 you file a claim 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.

HIPAA PRIVACY PRACTICES

The following is a description of certain rules that apply to the Plan Sponsor regarding uses and disclosures 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:

(1) Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or

(2) Modifying, amending or terminating the Plan.

"Summary health information" is information, which may include individually identifiable health information, that summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but that 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 5-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes
Except as described under "Disclosure of Summary Health Information to the Plan Sponsor" above or under "Disclosure of Certain Enrollment Information to the Plan Sponsor" below or under the terms of an applicable individual authorization, the Plan may disclose PHI to the Plan Sponsor and may permit the disclosure of PHI by a health insurance issuer or HMO with respect to the Plan to the Plan Sponsor only if the Plan Sponsor requires the PHI to administer the Plan. The Plan Sponsor by formally adopting this Plan document certifies that it agrees to:

(1) Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;

(2) Ensure that any agents , 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;

(3) 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;

(4) 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;

(5) Make available PHI in accordance with section 164.524 of the privacy standards;

(6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards;

(7) Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards;

(8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services ("HHS"), for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards;

(9) 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

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

(a) The Plan Sponsor shall only allow certain named employees or classes of employees or other persons under control of the Plan Sponsor who have been designated to carry out plan administration functions, access to PHI. The Plan Sponsor will maintain a list of those persons and that list is incorporated into this document by this reference. The access to and use of PHI by any such individuals shall be restricted to plan administration functions that the Plan Sponsor performs for the Plan.

(b) In the event any of the individuals described in (a) 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. 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:

(1) The Plan documents have been amended to incorporate the above provisions; and

(2) The Plan Sponsor agrees to comply with such provisions.

Disclosure of Enrollment Information to the Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the privacy standards, 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 under the Plan.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage; Disclosures of Genetic Information
Except as otherwise provided below, 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.

The Plan will not use or disclose genetic information, including information about genetic testing and family medical history, for underwriting purposes. The Plan may use or disclose PHI for underwriting purposes, assuming the use or disclosure is otherwise permitted under the privacy standards and other applicable law, but any PHI that is used or disclosed for underwriting purposes will not include genetic information.

"Underwriting purposes" is defined for this purpose under federal law and generally includes any Plan rules relating to (1) eligibility for benefits under the Plan (including changes in deductibles or other cost-sharing requirements in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Plan (including discounts or payments or differences in premiums based on activities such as completing a health risk assessment or participating in a wellness program); and (3) other activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits. However, "underwriting purposes" does not include rules relating to the determination of whether a particular expense or claim is medically appropriate.

HIPAA SECURITY PRACTICES

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

In accordance with HIPAA's standards for security (the "security standards"), 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 and maintain 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 any business associate or 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.

(4) Report to the Plan any Security Incident of which it becomes aware.

(5) 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.

Any terms not otherwise defined in this section shall have the meanings set forth in the security standards.

GENERAL PLAN INFORMATION

Name of Plan:	Northwest Arctic Borough School District Non-Grandfathered Health Care Plan
Plan Sponsor:	Northwest Arctic Borough School District P.O. Box 51 Kotzebue, AK 99752 1-907-442-3472
Plan Administrator: **(Named Fiduciary)**	Northwest Arctic Borough School District P.O. Box 51 Kotzebue, AK 99752 1-907-442-3472
Plan Sponsor EIN:	92-0056820
Plan Year:	December 1 - November 30
Plan Type:	Welfare benefit plan providing medical, dental, vision and prescription drug benefits.
Plan Funding:	All benefits are paid from the general assets of the Employer.
Third Party Administrator:	Meritain Health, Inc. P.O. Box 27267 Minneapolis, MN 55427-0267 866-808-2609
COBRA Administrator:	Northwest Arctic Borough School District P.O. Box 51 Kotzebue, AK 99752 1-907-442-3472
Medical Management Program Administrator:	Medical Rehabilitation Consultants 111 West Cataldo, Suite 200 Spokane, WA 99201-3203 1-800-827-5058
Prescription Drug Program Card Program Administrator:	Scrip World 4246 Riverboat Road, Suite 175 Salt Lake City, UT 84123 877-468-6592 www.scripworld.com
Agent for Service of Legal Process:	Northwest Arctic Borough School District P.O. Box 51 Kotzebue, AK 99752 1-907-442-3472

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

SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #1
TO THE
NORTHWEST ARCTIC BOROUGH SCHOOL DISTRICT
HEALTH CARE PLAN
GROUP NO. 12431

This Summary of Material Modification and Amendment describes changes to the Northwest Arctic Borough School District Health Care Plan effective January 1, 2016. These changes are effective as of **January 1, 2016** 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.

Northwest Arctic Borough School District (the "Plan Administrator") is amending the Northwest Arctic Borough School District Health Care Plan (the "Plan") as follows:

*The **Calendar Year Out-of Pocket Maximum** in the **Prescription Drug Schedule of Benefits – Classified Plan** is hereby deleted and replaced as follows:*

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – CLASSIFIED PLAN

BENEFIT DESCRIPTION	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
CALENDAR YEAR OUT-OF-POCKET MAXIMUM: (combined with major medical Out-of-Pocket)		
Per Individual	$750	$2,000
Per Family	$1,500	$4,000

All other provisions of this Plan shall remain unchanged.

SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #2
TO THE
NORTHWEST ARCTIC BOROUGH SCHOOL DISTRICT
HEALTH CARE PLAN
GROUP NO. 12431

This Summary of Material Modification and Amendment describes changes to the Northwest Arctic Borough School District Health Care Plan effective January 1, 2016.These changes are effective as of **January 1, 2017** 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.

Northwest Arctic Borough School District (the "Plan Sponsor") is amending the Northwest Arctic Borough School District Health Care Plan (the "Plan") as follows:

1. *The **Calendar Year Deductible** listed in the **Medical Schedule of Benefits – Certified Plan** and the **Prescription Drug Schedule of Benefits – Certified Plan** is hereby deleted and replaced as follows:*

MEDICAL SCHEDULE OF BENEFITS – CERTIFIED PLAN

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
CALENDAR YEAR DEDUCTIBLE (combined with Prescription Drug Card benefits)		
Single	$150	$200
Family	$250	$500

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – CERTIFIED PLAN

BENEFIT DESCRIPTION	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
CALENDAR YEAR DEDUCTIBLE: (combined with major medical Deductible)		
Single	$150	$200
Family	$250	$500

2. *Number **(35) - Surrogate** in the **General Exclusions and Limitations** section is hereby deleted and replaced with the following:*

GENERAL EXCLUSIONS AND LIMITATIONS

(35) **Surrogate:** Expenses relating to a surrogate pregnancy of any person who is not covered under this Plan and for any Covered Person other than the Employee and Spouse will not be considered eligible, including but not limited to pre-pregnancy, conception, prenatal, childbirth and postnatal expenses. This exclusion does not apply to preventive services for any Covered Person as described under the Eligible Medical Expenses section of the Plan.

3. *The address to which an appeal is submitted as shown under **Internal Review of Initially Denied Claims** and **External Review of Denied Claims** in the **Claim Procedures** section are hereby deleted and replaced with the following:*

CLAIM PROCEDURES

Internal Review of Initially Denied Claims

All requests for review of initially denied claims (including all relevant information) must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P. O. Box 41980
Plymouth, MN 55441-0970

External Review of Denied Claims
NOTE: This provision does not apply to dental and vision benefits.

For any adverse determination for which external review is available, the Federal external review requirements are as follows:

(1) You have 4 months following the date you receive notice of the Plan's final internal adverse determination within which to request an external review. The request for an external review must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P. O. Box 41980
Plymouth, MN 55441-0970

4. *The **Subrogation, Third-Party Recovery and Reimbursement** section of the Plan is hereby deleted and replaced as shown in **Exhibit A**.*

5. *The definition of **Usual and Customary Charge (U&C)** under the **Definitions** section is hereby deleted and replaced with the following:*

DEFINITIONS

Usual and Customary Charge (U&C) means, with respect to Non-Participating Providers, charges made for medical or dental services or supplies essential to the care of the individual that will be subject to a Usual and Customary determination. Subject to the rest of this definition, the Usual and Customary Charge means the lesser of the charge by other providers in the same geographic area or billed charges for the same or comparable service or supply. From time to time, the Plan may enter into an agreement with a Non-Participating Provider (directly or indirectly through a third party) which sets the rate the Plan will pay for a

service or supply. In these cases the Usual and Customary Charge will be the rate established in such agreement with the Non-Participating Provider.

The Plan may reduce the Usual and Customary Charge by applying reimbursement policies administered by the Plan's Third Party Administrator. These reimbursement policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

(1) The duration and complexity of a service;

(2) Whether multiple procedures are billed at the same time but no additional overhead is required;

(3) Whether an Assistant Surgeon is involved and necessary for the service;

(4) If follow up care is included;

(5) Whether there are any other characteristics that may modify or make a particular service unique; and

(6) When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

The reimbursement policies utilized are based on review of the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which are otherwise consistent with Physician or dental specialty society recommendations; and the views of Physicians and Dentists practicing in the relevant clinical areas.

All other provisions of this Plan shall remain unchanged.

EXHIBIT A

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT

Payment Condition

(1) The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, disease or disability is caused in whole or in part by, or results from the acts or omissions of you and/or your Dependents, plan beneficiaries and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other insurance or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

(2) The Covered Person, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

(3) In the event a Covered Person settles, recovers or is reimbursed by any Coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

(4) If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

Subrogation

(1) As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation or entity and to any Coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person fails to so pursue such rights or action.

(2) If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

(3) The Plan may, at its discretion, in its own name or in the name of the Covered Person, commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

(4) The Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Persons and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims if the Covered Person fails to file a claim or pursue damages against:

(a) The responsible party, its insurer or any other source on behalf of that party;

(b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(c) Any policy of insurance from any insurance company or guarantor of a third party;

(d) Workers' Compensation or other liability insurance company; or

(e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

The Covered Person assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

(1) The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

(2) No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

(3) The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

(4) These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.

(5) This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, Disease or disability.

Covered Person is a Trustee Over Plan Assets

(1) Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or Accident. By virtue of this status, the Covered Person understands that he/she is required to:

(a) Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;

(b) Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;

(c) In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,

(d) Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

(2) To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

(3) No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

If at the time of Injury, Illness, disease or disability, there is available or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage, except as otherwise provided for under the Plan's "Coordination of Benefits" section.

The Plan's benefits shall be excess to any of the following:

(1) The responsible party, its insurer or any other source on behalf of that party;

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(3) Any policy of insurance from any insurance company or guarantor of a third party;

(4) Workers' Compensation or other liability insurance company; or

(5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person, such that the death of the Covered Person or filing of bankruptcy by the Covered Person, will not affect the Plan's equitable lien, the funds over which the Plan has a lien or the Plan's right to subrogation and reimbursement.

Wrongful Death
In the event that the Covered Person dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

Obligations
(1) It is the Covered Person's obligation at all times, both prior to and after payment of medical benefits by the Plan:

(a) To cooperate with the Plan or any representatives of the Plan, in protecting its rights, including discovery, attending depositions and cooperating in trial to preserve the Plan's rights;

(b) To provide the Plan with pertinent information regarding the Illness, disease, disability or Injury, including Accident reports, settlement information and any other requested additional information;

(c) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

(d) To do nothing to prejudice the Plan's rights of subrogation and reimbursement;

(e) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;

(f) To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;

(g) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or coverage;

(h) To instruct his/her attorney to ensure that the Plan or its authorized representative is included as a payee on any settlement draft;

(i) In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and

(j) To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

(2) If the Covered Person and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.

(3) The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Persons' cooperation or adherence to these terms.

Offset
If timely repayment is not made, or the Covered Person and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

Minor Status

(1) In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

(2) If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Sponsor retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision and to administer the Plan's subrogation and reimbursement rights.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Notwithstanding anything contained herein to the contrary, to the extent this Plan is not governed by ERISA, the Plan's right to subrogation and reimbursement may be subject to applicable State subrogation laws.

SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #3
TO THE
NORTHWEST ARCTIC BOROUGH SCHOOL DISTRICT
HEALTH CARE PLAN
GROUP NO. 12431

This Summary of Material Modification and Amendment describes changes to the Northwest Arctic Borough School District Health Care Plan effective January 1, 2016.These changes are effective as of **January 1, 2018** 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.

Northwest Arctic Borough School District (the "Plan Sponsor") is amending the Northwest Arctic Borough School District Health Care Plan (the "Plan") as follows:

1. *The **Claim Procedures** section of the Plan is hereby deleted and replaced as shown in **Exhibit A.***

2. ***Third Party Administrator** under the **Definitions** section is hereby deleted and replaced with the following:*

DEFINITIONS

Third Party Administrator means Meritain Health, Inc., P.O. Box 27810, Minneapolis, MN 55427-0810.

*3. The **Third Party Administrator** section under **General Plan Information** are hereby deleted and replaced with the following:*

GENERAL PLAN INFORMATION

Third Party Administrator	Meritain Health, Inc. P.O. Box 27810 Minneapolis, MN 55427-0810 (866) 808-2609

EXHIBIT A

CLAIM PROCEDURES

You will receive an Employee identification card which will contain important information, including claim filing directions and contact information. The Employee identification card will show your Participating Provider Network and the Medical Management Administrator.

At the time you receive treatment, show the Employee identification card to your provider of service. In most cases, your provider will file your claim for you. You may file the claim yourself by sending it to the address listed on the Employee identification card. Other general information or inquiries should be sent to:

Meritain Health, Inc.
P.O. Box 27810
Minneapolis, MN 55427-0810
(800) 925-2272

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 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 written claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

Timely Filing
All claims must be filed with the Third Party Administrator within 15 months following the date services were Incurred. Claims filed after this time period will be denied.

In the event the Plan is the Covered Person’s secondary payor, claims must be received by the Third Party Administrator within 15 months of the date charges for the service were Incurred or within 15 months of the date the primary carrier processed the claim, whichever is greater.

Procedures for all Claims
The Plan's claim procedures are intended to reflect the Department of Labor's claims procedures regulations and should be interpreted accordingly. In the event of any conflict between this Plan and those Regulations, those Regulations will control. In addition, any changes in those Regulations shall be deemed to amend this Plan automatically, effective as of the date of those changes.

To receive benefits under the Plan, the claimant (i.e. you and your covered Dependents) must follow the procedures outlined in this section. There are 4 different types of claims: (1) Urgent Care Claims; (2) Concurrent Care Claims;

(3) Pre-Service Claims; and (4) Post-Service Claims. The procedures for each type of claim are more fully described below:

(1) **Urgent Care Claims.** If your claim is considered an urgent care claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless you fail to provide sufficient information to determine whether or to what extent, benefits are covered or payable under the Plan. If you fail to provide sufficient information for the Plan to decide your claim, the Plan Administrator will notify you as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by you. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator will notify you of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the claimant to provide the specified additional information.

A claim for benefits is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. In determining if the initial claim for benefits should be treated as an urgent care claim, the Plan will defer to a determination, if any, by an attending provider that the claim should be treated as an urgent care claim, if that determination is timely provided to the Plan.

(2) **Concurrent Care Claims.** If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Plan Administrator will notify you of the adverse determination at a time sufficiently in advance of the reduction or termination to allow you, the claimant, to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by you to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies and the Plan Administrator will notify you of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

(3) **Pre-Service Claims.** For a pre-service claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to matters beyond the control of the Plan, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time to notify you of the Plan's benefit determination for up to 15 days provided that the Plan Administrator notifies you within 15 days after the Plan receives the claim, of those special circumstances and of when the Plan Administrator expects to make its decision. However, if such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

(4) **Post-Service Claims.** For a post-service claim, the Plan Administrator will notify you of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time for notifying you of the Plan's benefit determination on a one-time basis for up to 15 days provided that the Plan Administrator notifies you within 30 days after the Plan receives the claim, of those special circumstances and of the date by which the reviewer expects to make a decision. However, if such a decision is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a post-service claim if it is a request for payment for services or other benefits that you have already received (or any other claim for health benefits that is not a pre-service claim or an urgent care claim).

Manner and Content of Notice of Initial Adverse Determination
If the Plan Administrator denies a claim, it must provide to you in writing or by electronic communication:

(1) An explanation of the specific reasons for the denial;

(2) A reference to the Plan provision or insurance contract provision upon which the denial is based;

(3) A description of any additional information or material that you must provide in order to perfect the claim;

(4) An explanation of why the additional material or information is necessary;

(5) Notice that you have the right to request a review of the claim denial and information on the steps to be taken if you wish to request a review of the claim denial along with the time limits applicable to a request for review;

(6) A statement describing your right to request an external review (or, if applicable, to request a second level appeal) or, if applicable, to bring an action for judicial review;

(7) A copy of any rule, guideline, protocol or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon your request and without charge); and

(8) If the adverse determination is based on the Plan's Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment applying the exclusion or limit to your medical circumstances or (b) a statement that the same will be provided upon your request and without charge.

Any notice of adverse determination also will include the following information:

(1) Information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);

(2) As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and

(5) A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

For an adverse determination concerning an urgent care claim, the information described in this Section may be provided to you orally within the permitted time frame provided that a written or electronic notification in accordance with this section is furnished to you no later than 3 days after the oral notification.

Internal Review of Initial Adverse Benefit Determination
If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the procedures described below.

You have 180 days after you receive notice of an initial adverse determination within which to request a review of the adverse determination. For a request for a second level appeal, you have 60 days after you receive notice of an adverse determination at the first level of appeal to request a second level appeal of the adverse determination.

If you request a review of an adverse determination within the applicable time period, the review will meet the following requirements:

(1) The Plan will provide a review that does not afford deference to the adverse determination that is being appealed and that is conducted by an appropriate named fiduciary of the Plan who did not make the adverse determination that is the subject of the appeal and who is not a subordinate of the individual who made that adverse determination.

(2) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental and/or Investigational or not Medically Necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence will be an individual who is neither an individual who was consulted in connection with the adverse determination that is the subject of the appeal, nor a subordinate of any such individual.

(3) The Plan will identify any medical or vocational experts whose advice is obtained on behalf of the Plan in connection with the Plan's review of an adverse determination, without regard to whether the advice is relied upon in making the adverse determination on review.

(4) For a requested review of an adverse determination involving an urgent care claim, the review process will meet the expedited deadlines described below. Your request for such an expedited review may be submitted orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly expeditious method.

(5) The reviewer will afford you an opportunity to review and receive, without charge, all relevant documents, information and records relating to the claim and to submit issues and comments relating to the claim in writing to the Plan. The reviewer will take into account all comments, documents, records and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(6) You will be provided, free of charge, any new or additional evidence or rationale considered, relied upon or generated by the Plan in connection with the claim. Such evidence or rationale will be provided as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of its determination on review to give you a reasonable opportunity to respond prior to such determination.

(7) The Plan will ensure that all claims are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.

(8) The Plan will provide you with continued coverage pending the outcome of an internal appeal.

All requests for review of initial adverse benefit determinations (including all relevant information) must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P. O. Box 41980
Plymouth, MN 55441-0970

Deadline for Internal Review of Initial Adverse Benefit Determinations

(1) Urgent Care Claims. The Plan provides for 2 levels of appeal for urgent care claims. For each level of appeal, the reviewer will notify you of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 36 hours after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

(2) Pre-Service Claims. The Plan provides for 2 levels of appeal for a pre-service claim. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 15 days after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

(3) Post-Service Claims. The Plan provides for 2 levels of appeal for a post-service claim. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

Manner and Content of Notice of Decision on Internal Review of Initial Adverse Benefit Determinations
Upon completion of its review of an initial adverse determination (or a first-level appeal adverse determination), the reviewer will give you, in writing or by electronic notification, a notice of its benefit determination. For an adverse determination, the notice will include:

(1) A description of the Plan's decision;

(2) The specific reasons for the decision;

(3) The relevant Plan provisions or insurance contract provisions on which its decision is based;

(4) A statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of, all documents, records and other information in the Plan's files which is relevant to your claim for benefits;

(5) A statement describing your right to request an external review (or, if applicable, to request a second level appeal),or, if applicable, to bring an action for judicial review;

(6) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge to you upon request;

(7) If the adverse determination on review is based on a Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances or (b) a statement that such an explanation will be provided without charge upon request.

Any notice of adverse determination will include the following information:

(1) Information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);

(2) As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;

(3) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(4) Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and

(5) A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

Calculation of Time Periods
For purposes of the time periods described in the Plan's claim procedures, the period of time during which a benefit determination is required to be made begins at the time a claim (or a request for review of an adverse benefit determination) is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to your failure to submit all information necessary for a claim for non-urgent care benefits, the period for making the determination is "frozen" from the date the notification requesting the additional information is sent to you until the date you respond or, if earlier, until 45 days from the date you receive (or were reasonably expected to receive) the notice requesting additional information.

Adverse Determination
For purposes of the Plan's claim procedures, an "adverse determination" is a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Plan and including a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental and/or Investigational or not Medically Necessary or appropriate. Adverse determination also includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission.

Plan's Failure to Follow Procedures
If the Plan fails to follow the claim procedures described above, you will be deemed to have exhausted the Plan internal claim procedures and you will be entitled to pursue any available remedy (including any available external review process) under state or federal law on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

However, the Plan will not be treated as failing to follow its claim procedures and you will not be deemed to have exhausted the Plan's administrative remedies merely because of a failure by the Plan that would be considered (based on applicable regulations) a "*de minimis* violation" that does not cause and is not likely to cause prejudice or harm to you as long as the Plan can demonstrate that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and you. You may request a written explanation of any violation by the Plan of these procedures. If you request such an explanation, the Plan will provide it within 10 days and, if applicable, the explanation will include a specific description of the Plan's reasons for asserting that the violation does not cause the Plan's internal claim procedures to be exhausted. If a court or external review rejects your request for an immediate review (based on a claim that you should be deemed to have exhausted the Plan's internal claim procedures), because the court or external reviewer determines that the "*de minimis* violation" exception applies, the Plan will provide to you a notice of your right to resubmit your internal appeal with a reasonable time (no longer than 10 days) after the court or external reviewer makes such a determination. Any applicable time limit for you to re-file your claim will begin to run when you receive that notice from the Plan.

External Review of Adverse Benefit Determinations
If you have exhausted the Plan's internal appeal process (or if you are eligible to request an external review for any other reason under the above procedures), you may request an external review of the Plan's final adverse determination for certain health benefit claims.

The Plan will provide for an external review process in accordance with applicable state law (if any). If no external review process exists under applicable state law or if the state law external review process does not meet certain minimum standards of the NAIC Uniform Health Carrier External Review Model Act (or the temporary "NAIC-similar" standards described in Department of Labor Technical Release 2011-02), the Plan will provide for an external review process that meets federal law requirements. Governmental plans that are not eligible to participate in a qualifying state process must elect to participate in a federal process administered by HHS or in the federal external review process that applies to ERISA-governed, self-funded Plans. If the Plan elects to participate in the federal external review process that applies to an ERISA self-funded plan, the external review procedures described below will apply.

Note that the federal external review process (including the expedited external review process described later in these procedures) is <u>not</u> available for review of all internal adverse determinations. Specifically, federal external review is not available for review of an internal adverse determination that is based on a determination that a claimant fails to meet the eligibility requirements under the terms of the Plan. Also, the federal external review process is available only for:

(1) An adverse determination that involves medical judgment (including, but not limited to determinations based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the Plan's determination that a treatment is Experimental or Investigational), as determined by the external reviewer; and

(2) A rescission of coverage.

For any adverse determination for which external review is available, the federal external review requirements are as follows:

(1) You have 4 months following the date you receive notice of the Plan's final internal adverse determination within which to request an external review. The request for an external review must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P. O. Box 41980
Plymouth, MN 55441-0970

(2) Within 5 business days following the date the Plan receives your external review request the Plan will complete a preliminary review. The Plan will notify you in writing within one business day after it completes the preliminary review whether the claim is eligible for the external review process:

(a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will provide contact information for the U.S. Department of Health and Human Services Health Insurance Assistance Team (HIAT).

(b) If the request is not complete, the notice will describe information or materials needed to make the request complete. If the request is not complete and additional information or materials are needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 4-month deadline described in (1) above to provide the necessary additional information or materials.

(3) Following the Plan's preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) (as soon as administratively feasible) to make a determination on the request for external review. Within 5 business days following assignment of the IRO, the Plan will forward to the IRO all information and materials relevant to the final internal adverse determination.

(4) The assigned IRO will notify you in writing (within a reasonable period of time) of the request's eligibility and acceptance for external review. The notice will include a statement regarding your right to submit any additional information, within 10 business days from the date of receipt of the notice, for the IRO to consider as part of the external review process. Any such additional information received by the IRO will be forwarded on and shared with the Plan. The Plan, based upon any new information received, may reconsider its final internal adverse determination. Reconsideration by the Plan will not delay the external review process. If the Plan does not reconsider its final internal adverse benefits determination, the IRO will continue to proceed with the external review process.

(5) Within 45 days after the IRO receives the external review request from the Plan, the IRO must provide written notice of its external review determination to you and the Plan. The IRO's notice is required to contain the following:

(a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;

(b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;

(d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(e) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to you;

(f) A statement that judicial review may be available to you; and

(g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Expedited External Review
You may request an expedited external review if you have received:

(1) An initial internal adverse determination if the adverse determination involves a medical condition for which the time frame for completion of an expedited internal appeal under the Plan's internal claim procedures would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

(2) A final internal adverse determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or if the final internal adverse determination concerns an admission, availability of care, continued stay or health care item or service for which you received Emergency Services but have not been discharged from a facility.

The following requirements apply to an expedited external review:

(1) Immediately following the date the Plan receives the external review request the Plan will complete a preliminary review. The Plan will notify you in writing immediately after completion of the preliminary review whether the request is eligible for the external review process.

(a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will include contact information for the Employee Benefits Security Administration.

(b) If the request is not complete, the notice will describe any information or materials needed to make the request complete. If the request is not complete and additional information or materials is needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 4-month deadline described in (1) above to provide the necessary additional information or materials.

(2) Following the Plan’s preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) to make a determination on the request for external review. The Plan will promptly forward to the IRO, by any available expeditious method (e.g. telephone, facsimile, etc.), all information and materials relevant to the final internal adverse determination.

(3) The IRO must provide notice to the claimant and the Plan (either in writing or orally) as expeditiously as the claimant’s medical condition or circumstance require and no later than 72 hours after it receives the expedited external review request from the Plan. If notice is not provided in writing, the IRO must provide written notice to you and the Plan as confirmation of the decision within 48 hours after the date of the notice. The IRO’s notice is required to contain the following information:

(a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;

(b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;

(d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(e) A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to you;

(f) A statement that judicial review may be available to you; and

(g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Effect of External Review Determination
A determination on external review is binding on the Plan and the claimant, except to the extent that other remedies are available under applicable state or federal law. However, a decision by the external reviewer does not preclude the Plan from making payment or providing benefits on a claim at any time, including after a decision that denies the claim. When an external review decision requires the Plan to provide benefits or payment on a claim, the Plan will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether the Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

State Insurance Laws
Nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable state law.

Statute of Limitations for Plan Claims
Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 3 years after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

Appointment of Authorized Representative
A Covered Person is permitted to appoint an authorized representative to act on his or her 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 Third Party 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 Illness or Injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Plan Administrator may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition for coverage.

SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #4
TO THE
NORTHWEST ARCTIC BOROUGH SCHOOL DISTRICT
HEALTH CARE PLAN
GROUP NO. 12431

This Summary of Material Modification and Amendment describes changes to the Northwest Arctic Borough School District Health Care Plan effective January 1, 2016.These changes are effective as of **December 1, 2018** 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.

Northwest Arctic Borough School District (the "Plan Sponsor") is amending the Northwest Arctic Borough School District Health Care Plan (the "Plan") as follows:

1. *The name of the Plan on **Cover Page** is hereby deleted and replaced as follows:*

Northwest Arctic Borough School District
Health Plan

2. *The first paragraph under the **Establishment of the Plan** is hereby deleted and replaced as follows:*

   Northwest Arctic Borough School District (the "Employer" or the "Plan Sponsor") has adopted this amended and restated Plan Document and Summary Plan Description effective as of January 1, 2016, for Northwest Arctic Borough School District Health Plan hereinafter referred to as the "Plan" or "Summary Plan Description"), as set forth herein for the exclusive benefit of its Employees and their eligible Dependents. The Plan was originally adopted by the Employer effective as of January 1, 2014.

3. *The subheading **Non-Participating Provider Exceptions** under the **General Overview Of The Plan** is hereby deleted and replaced with the following:*

GENERAL OVERVIEW OF THE PLAN

Non-Participating Provider Exceptions
Covered services rendered by a Non-Participating Provider will be paid at the Participating Provider level subject to the Usual and Customary provision of the Plan (except for treatment of an Emergency Medical Condition) when a:

(1) Covered Person has no choice of a Participating Provider.

(2) Covered Person has an Emergency Medical Condition requiring immediate care.

(3) Covered Person receives services by a Non-Participating Provider (e.g. anesthesiologists, radiologists, pathologists, etc.) who is under agreement with a Network facility.

(4) Participating Provider submits a specimen to a Non-Participating Provider laboratory.

(5) Covered Person receives services from a Network surgeon who uses a non-Network Assistant Surgeon.

(6) Participating Provider is not available within a 50-mile radius of the Covered Person's residence.

(7) Referral is made by a Participating Provider to receive services from a Non-Participating Provider.

Not all providers based in Network Hospitals or medical facilities are Participating Providers. It is important when you enter a Hospital or medical facility that you request that ALL Physician services be performed by Participating Providers. By doing this, you will always receive the greater Participating Provider level of benefits.

4. *The **Medical Schedule of Benefits - Classified Plan** is hereby deleted and replaced as shown in **Exhibit A.***

5. *The **Prescription Drug Schedule of Benefits – Classified Plan** is hereby deleted and replaced as shown in **Exhibit B.***

6. ***Plan** under **Definitions** is hereby deleted and replaced with the following:*

DEFINITONS

Plan means the Northwest Arctic Borough School District Health Plan

7. *The **Name of the Plan** and **Third Party Administrator** section under **General Plan Information** is hereby deleted and replaced with the following:*

GENERAL PLAN INFORMATION

Name of Plan:	Northwest Arctic Borough School District Health Plan
Third Party Administrator:	Meritain Health, Inc. P.O. Box 853921 Richardson, TX 75085-3921 (866) 808-2609

All other provisions of this Plan shall remain unchanged.

EXHIBIT A

MEDICAL SCHEDULE OF BENEFITS – CLASSIFIED PLAN

CLASSIFIED PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
LIFETIME MAXIMUM BENEFIT	Unlimited	
OVERALL CALENDAR YEAR MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE (combined with Prescription Drug Card benefits)		
Single	$100	$600
Family	$300	$1,800
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible and Coinsurance - combined with Prescription Drug Card benefits)		
Per Individual	$900	$3,000
Per Family	$2,000	$6,000
Penalty If you fail to obtain precertification or fail to notify the Medical Management Program Administrator within the time periods described under Medical Management, Covered Expenses will be reduced by 50% per occurrence and this penalty amount will not accumulate toward any Out-of-Pocket Maximum limit.		
MEDICAL BENEFITS		
Allergy Services (all)	90% after Deductible	70% after Deductible
Air Ambulance/Commercial Airlines	90% after Deductible	70% after Deductible
Ambulance Services		
Ground Ambulance Services	90% after Deductible	Paid at the Participating Provider level of Benefits
Air Ambulance Services	90% after Deductible	90% after Deductible of the allowable rate listed below
One way transport (fixed wing or rotary)	350% of the Medicare/CMS Rural rate*	
Fixed wing air mileage per statue mile	600% of the Medicare/CMS Rural rate*	
Rotary wing air mileage, per statue mile	200% of the Medicare/CMS Rural rate*	
*NOTE: Amounts paid by the Covered Person in excess of the Medicare/CMS Rural rate do not accrue toward the Plan Year Out-of-Pocket Maximum Expense.		
Audiocare (hearing exams and hearing aids)	90%; Deductible waived	70% after Deductible
Maximum Benefit	One pair of hearing aids every 3 year period	
Birthing Center	100%; Deductible waived	70% after Deductible
Chemotherapy (Outpatient)	90% after Deductible	70% after Deductible
Chiropractic Care/Spinal Manipulation	90% after Deductible	70% after Deductible
Diagnostic Testing, X-Ray and Lab Services (Outpatient)	90% after Deductible	70% after Deductible

CLASSIFIED PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Durable Medical Equipment (DME)	90% after Deductible	70% after Deductible
Emergency Services/Emergency Room Services (includes x-ray and lab)	90% after Deductible	Paid at the Participating Provider level of benefits
Home Health Care	90% after Deductible	70% after Deductible
Calendar Year Maximum Benefit	100 visits; one visit per day	
Hospice Care		
Inpatient and Outpatient	100%; Deductible waived	70% after Deductible
Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)		
Inpatient	90% after Deductible	70% after Deductible
Room and Board Allowance	*Semi-Private Room rate	
Room and Board Allowance – Long-Term Acute Care Facility	First 60 days at 50% and the next 30 days 25% of the semi-private rate of the last Hospital confined	
Intensive Care Unit	3 times semi-private room rate	
Miscellaneous Service and Supplies (includes x-ray and lab)	90% after Deductible	70% after Deductible
Outpatient	90% after Deductible	70% after Deductible
* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Maternity (Professional Fees)*		
Preventive Prenatal and Breastfeeding Support (other than lactation consultations)	100%; Deductible waived	70% after Deductible
Lactation Consultations	100%; Deductible waived	100% Deductible waived
All Other Prenatal, Delivery and Postnatal Care	90% after Deductible	70% after Deductible
* See Preventive Services under Eligible Medical Expenses for limitations.		
Mental Disorders and Substance Use Disorders		
Inpatient	90% after Deductible	70% after Deductible
Outpatient	90% after Deductible	70% after Deductible
NOTE: Emergency care (ambulance and Emergency Services/Room) will be paid the same as the benefits for ambulance services and Emergency Services/Room listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
Outpatient Surgical Facility	90% after Deductible	70% after Deductible
Physical Therapy	90% after Deductible	70% after Deductible
Physician's Services		
Inpatient/Outpatient Services/Office Visits	90% after Deductible	70% after Deductible
Pre-Admission Testing (Outpatient)	100%; Deductible waived	70% after Deductible
Preventive Services and Routine Care		
Preventive Services (includes the office visit and any other eligible item	100%; Deductible waived	70% after Deductible

CLASSIFIED PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
or service received at the same time, whether billed at the same time or separately)		
Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above such as office visits, lab tests, x-rays, routine testing, vaccinations or inoculations, well child care, annual pap smears, annual mammograms, colon exams, and PSA testing)	90% after Deductible	70% after Deductible
Second Surgical Opinion	100%; Deductible waived	70% after Deductible
Skilled Nursing Facility and Rehabilitation Facility	100%; Deductible waived	70% after Deductible
Combined Calendar Year Maximum Benefit	90 days	
Surgical Procedures through BridgeHealth	100% Deductible waived*	N/A
* 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.		
Transplants	90% after Deductible (Aetna IOE program)* Not Covered (All Other Network Providers)	Not Covered
Transportation	100%; Deductible waived	Not Covered
* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit, including travel and lodging maximums. Travel and lodging will be paid at 100% with no Deductible.		
NOTE: Cornea transplants performed by any provider are covered under the Plan as a separate benefit and paid the same as any other Illness.		
All Other Eligible Medical Expenses	90% after Deductible	70% after Deductible

EXHIBIT B

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – CLASSIFIED PLAN

BENEFIT DESCRIPTION	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
NOTE: The Covered Person will be reimbursed the amount that would have been paid to a Participating Provider less the applicable Deductible and Coinsurance if Prescription Drugs are obtained from a Non-Participating Provider.		
CALENDAR YEAR DEDUCTIBLE (combined with major medical Deductible)		
Single	$100	$600
Family	$300	$1,800
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible and Coinsurance -combined with major medical Out-of-Pocket)		
Per Individual	$900	$3,000
Per Family	$2,000	$6,000
Retail Pharmacy: 90-day supply		
Generic	90% after Deductible	70% after Deductible
Brand Name	90% after Deductible	70% after Deductible
Specialty Drugs	90% after Deductible	70% after Deductible
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	100% Deductible waived	70% after Deductible
Mail Order Pharmacy: 90-day supply		
Generic	90% after Deductible	70% after Deductible
Brand Name	90% after Deductible	70% after Deductible
Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)	100% Deductible waived	70% after Deductible

NOTE: Coverage for preventive contraceptives and contraceptive devices is only available for women of child bearing age and limited to contraceptives that are considered Generic Drugs unless no equivalent Generic Drug is available and the Brand Name Drug is otherwise covered under the Prescription Drug Card Program. If the Covered Person chooses a Brand Name Drug rather than the Generic equivalent when there is a Generic equivalent available and the Physician has allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic Drug and the Brand Name Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Preventive Drug means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a paper copy, please contact the Plan Administrator.

SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #5
TO THE
NORTHWEST ARCTIC BOROUGH SCHOOL DISTRICT
HEALTH CARE PLAN
GROUP NO. 12431

This Summary of Material Modification and Amendment describes changes to the Northwest Arctic Borough School District Health Care Plan effective January 1, 2016.These changes are effective as of **December 1, 2019** 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.

Northwest Arctic Borough School District (the "Plan Sponsor") is amending the Northwest Arctic Borough School District Health Care Plan (the "Plan") as follows:

1. *In the **Medical Schedule of Benefits – Classified Plan**, the **Calendar Year Deductible** and the **Calendar Year Out-of-Pocket Maximum** sections are hereby deleted and replaced as follows:*

MEDICAL SCHEDULE OF BENEFITS – CLASSIFIED PLAN

BENEFIT DESCRIPTION	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
CALENDAR YEAR DEDUCTIBLE (combined with Prescription Drug Card benefits)		
Single	$150	$600
Family	$450	$1,800
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible and Coinsurance - combined with Prescription Drug Card benefits)		
Single	$1,000	$3,000
Family	$2,750	$6,000

2. *In the **Prescription Drug Schedule of Benefits – Classified Plan**, the **Calendar Year Deductible** and the **Calendar Year Out-of-Pocket Maximum** sections are hereby deleted and replaced as follows:*

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – CLASSIFIED PLAN

BENEFIT DESCRIPTION	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
CALENDAR YEAR DEDUCTIBLE (combined with major medical Deductible)		
Single	$150	$600
Family	$450	$1,800
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible and Coinsurance - combined with major medical Out-of-Pocket)		
Single	$1,000	$3,000
Family	$2,750	$6,000

All other provisions of this Plan shall remain unchanged.

SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #6
TO THE
NORTHWEST ARCTIC BOROUGH SCHOOL DISTRICT
HEALTH PLAN
GROUP NO. 12431

This Summary of Material Modification and Amendment describes changes to the Northwest Arctic Borough School District Health Plan effective January 1, 2016. These changes are effective as of **December 1, 2019** 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.

Northwest Arctic Borough School District (the "Plan Sponsor") is amending the Northwest Arctic Borough School District Health Plan (the "Plan") as follows:

1. *The following sentence will be added to the first paragraph under the **General Overview of the Plan** section:*

GENERAL OVERVIEW OF THE PLAN

You are also not required to designate a Primary Care Physician (PCP), but the Plan encourages you to designate a PCP to help manage your care.

2. *The **CancerCare Program Coverage** is hereby added as shown in **Exhibit A**.*

3. *The **Ambulance Services** and **Physician's Services** benefits in the **Medical Schedule of Benefits - Certified Plan** are hereby deleted and replaced as follows**:***

MEDICAL SCHEDULE OF BENEFITS – CERTIFIED PLAN

CERTIFIED PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Ambulance Services		
Ground Ambulance Services	90% after Deductible	
Air (Participating Provider)	90% after Deductible	
Air (Non-Participating Provider)	90% after Deductible of the allowable rate listed below:	
One way transport (fixed wing or rotary)	350% of the Medicare/CMS Rural rate*	
Fixed wing air mileage per statue mile	600% of the Medicare/CMS Rural rate*	
Rotary wing air mileage, per statue mile	200% of the Medicare/CMS Rural rate*	
*__NOTE:__ Amounts paid by the Covered Person in excess of the Medicare/CMS Rural rate do not accrue toward the Plan Year Out-of-Pocket Maximum Expense.		

CERTIFIED PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Physician's Services		
Inpatient/Outpatient Services/Office Visits	90% after Deductible	
Teladoc	100%; Deductible waived	N/A

4. *The **Physician's Services** benefit in the **Medical Schedule of Benefits – Classified Plan** is hereby deleted and replaced as follows:*

MEDICAL SCHEDULE OF BENEFITS – CLASSIFIED PLAN

CLASSIFIED PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
Physician's Services		
Inpatient/Outpatient Services/Office Visits	90% after Deductible	70% after Deductible
Teladoc	100%; Deductible waived	N/A

5. *Item **(b)** under number **(13) - Dental Care. n**umber **(35) – Physician's Services** and number **(40) – Qualified Clinical Trial Expenses** in the **Eligible Medical Expenses** section of the Plan are hereby deleted and replaced as follows:*

ELIGIBLE MEDICAL EXPENSES

(13) **Dental Care:** Dental services and x-rays rendered by Dentist or dental surgeon for:

(b) Emergency repair due to Injury to sound natural teeth, including the emergency replacement of sound natural teeth.

(35) **Physician's Services:** Services of a Physician for medical care or Surgery.

(a) Services performed in a Physician's office on the same day for the same or related diagnosis, regardless if a Physician is seen or not, will be payable as shown in the Medical Schedule of Benefits. Services include, but are not limited to: examinations, x-ray and laboratory tests (including the reading or processing of the tests), supplies, injections, cast application, and minor Surgery.

(b) Teladoc: Teladoc provides 24/7/365 access to a national network of U.S. board-certified Physicians who can resolve many of your medical issues. Teladoc services involve the delivery of clinical medicine via real-time telecommunications such as telephone, the Internet, or other communication networks or devices that do not involve direct patient contact.

For any questions with respect to Teladoc, please contact the Plan Administrator. Coverage under this benefit does not include consults from your regular Physician; it only includes coverage for consults to the extent the Physician who is consulted participates in the Teladoc program. To speak to a Teladoc Physician, call (855) 835-2362 or visit the website at www.teladoc.com for additional information.

Teladoc benefits include:

- 24/7/365 access to a Physician online or by phone.
- Fast treatment. Teladoc Physicians respond within 22 minutes, on average
- Talk to a Teladoc Physician from anywhere: at home, work, or while traveling.
- Save money by avoiding expensive urgent care or emergency room visits.

Call Teladoc:

- When you need care now.
- If you're considering the emergency room or urgent care center for non-emergency issues.
- On vacation, on a business trip, or away from home.
- For short-term prescription refills.

Teladoc providers treat conditions such as:

- Cold and flu
- Bronchitis
- Respiratory infection
- Sinus problems
- Allergies
- Urinary tract infection
- Pediatric care
- Poison ivy
- Pink eye
- Ear infections

(40) **Qualified Clinical Trial Expenses:** Please refer to the CancerCARE Program section of the Plan for information related to Qualified Clinical Trial Expenses for cancer.

For all other Qualified Clinical Trials, eligible expenses are, except as excluded below, healthcare items and services for the treatment of cancer or any other life threatening condition for a qualifying individual enrolled in a Qualified Clinical Trial that are otherwise consistent with the terms of the Plan and would be covered if the Covered Person did not participate in the Qualified Clinical Trial.

For purposes of this section, a "life threatening condition" means any condition or disease from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and a "qualifying individual" means any Covered Person who is eligible to participate in a Qualified Clinical Trial according to the trial protocol for treatment of cancer or any other life threatening condition that makes his or her participation in the program appropriate, as determined based on either (i) a conclusion of a referring health care professional or (ii) medical and scientific information provided by the Covered Person.

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

(a) Costs associated with managing the research associated with the Qualified Clinical Trial; or

(b) Costs that would not be covered for non-Experimental and/or Investigational treatments; or

(c) Any item or service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

6. *A **Specialty Drug** definition is hereby added alphabetically under the **Prescription Drug Card Program** section as follows:*

PRESCRIPTION DRUG CARD PROGRAM

Specialty Drug means those Prescription Drugs, medicines, agents, substances and other therapeutic products that include one or more of the following particular characteristics:

(1) Address complex, chronic diseases with many associated co-morbidities (e.g., cancer, rheumatoid arthritis, hemophilia, multiple sclerosis);

(2) Require a greater amount of pharmaceutical oversight and clinical monitoring for side effect management and to limit waste;

(3) Limited pharmaceutical supply chain distribution as determined by the applicable drug's manufacturer; and/or

(4) Relative expense.

7. *The address in the beginning of the **Claim Procedures** section of the Plan is hereby deleted and replaced as follows:*

CLAIM PROCEDURES

At the time you receive treatment, show the Employee identification 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, Inc.
P.O. Box 853921
Richardson, TX 75085-3921
(800) 925-2272

8. *Definitions of **Primary Care Physician** and **Specialty Drug** are hereby added alphabetically and **Qualified Clinical Trial** and **Third Party Administrator** are hereby deleted and replaced under the **Definitions** section as follows:*

DEFINITIONS

Primary Care Physician means a licensed Physician practicing in one of the following fields: (1) family practice; (2) general practice; (3) internal medicine; (4) obstetrics and gynecology; or (5) pediatrics.

Qualified Clinical Trial: Please refer to the CancerCARE Program section of the Plan for information related to Qualified Clinical Trial Expenses for cancer.

For all others, Qualified Clinical Trial means a Phase I, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening condition and is described in (1), (2) or (3) below:

(1) The study or investigation is approved or funded (which may include funding though in-kind contributions) by one or more of the following:

(a) The National Institutes of Health;

(b) The Centers for Disease Control and Prevention;

(c) The Agency for Health Care Research and Quality;

(d) The Centers for Medicare & Medicaid Services;

(e) A cooperative group or center of one of the entities described in (a) through (d) above;

(f) A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants; or

(g) The Department of Veteran Affairs; the Department of Defense or the Department of Energy, if (i) the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and (ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(2) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

(3) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Specialty Drug is defined in the "Prescription Drug Card Program" section of the Plan.

Third Party Administrator means Meritain Health, Inc., P.O. Box 853921, Richardson, TX 75085-3921.

9. ***Telemedicine Program Administrator*** *is hereby added to the* ***General Plan Information*** *section as follows:*

GENERAL PLAN INFORMATION

Telemedicine Program Administrator:	Teladoc, Inc. 1945 Lakepointe Drive Lewisville, TX 75057 (855) 835-2362 www.teladoc.com

All other provisions of this Plan shall remain unchanged.

EXHIBIT A

CANCERCARE PROGRAM COVERAGE

The Plan provides benefit coverage for evidence-based cancer care services provided at local, regional and national cancer programs. In order to obtain the best outcomes for Covered Persons, the Plan employs INTERLINK's CancerCARE Program with specialized care coordination nurses, McKesson Clear Value Plus with Value Pathways powered by NCCN® and NCCN Clinical Practice Guidelines in Oncology®. To be eligible for maximum Plan benefits, all Covered Persons with a cancer diagnosis must as soon as reasonably possible call the CancerCARE program at (877) 640-9610 and complete registration.

CancerCARE Benefits	
Participating Providers	
Compliant Benefit	**Non-Compliant Benefit**
• Standard Plan Benefits apply as outlined within the Medical Schedule of Benefits • Certain Course of Care Certification requirements waived for services included in a confirmed Value Pathway • Covered Persons choosing not to travel to a COE Network Provider for complex care, but receiving care in concordance to a Value Pathway • Clinical Trials as defined below • Navigator or Compass Covered Persons receiving cancer care when a Value Pathway does not exist if Clear Value Participation has been achieved with NCCN Guideline® concordance or Plan-approved deviation • CancerCARE Second Opinion benefits at 100% of CancerCARE Allowable • Travel Benefits at 100%	• Standard Plan Benefits apply as outlined within the Medical Schedule of Benefits

DEFINITIONS

CancerCARE Allowable: For Inpatient and outpatient Hospital and professional services, CancerCARE Allowable means billed charges for covered services provided in compliance with the CancerCARE Program, minus non-covered services and supplies, negotiated price concessions, discounts and professional charges beyond Usual and Customary fees for such services. Once treatment is precertified by the Plan for services from a COE Network Provider, payment to the provider will be paid at the applicable benefit reimbursement percentage based on the applicable contract allowable.

For covered cancer pharmacy products and supplies, CancerCARE Allowable means pharmacy products dispensed in concordance with the NCCN Guidelines and Drugs & Biologics Compendium®, with Category 1, 2a or 2b level of evidence, which are then payable at a Plan maximum benefit of AWP plus 40% unless provided at a Participating Provider. Pharmacy and dosing instructions are included in the evidence-based NCCN Guidelines®. Non-covered cancer pharmacy products are not included in the CancerCARE Allowable.

CancerCARE Program: A comprehensive cancer management program operated by INTERLINK, which employs care coordinator nurses to monitor care and coordinate care at COE Network Providers for appropriate Covered Persons.

National Comprehensive Cancer Network (NCCN®): An alliance of the nation's most prominent hospitals that review outcome information for cancer treatments, publish evidence-based NCCN Guidelines® and update them as needed.

NCCN Guidelines®: NCCN® disease-specific, committee recommended, evidence-based treatment processes for specific cancers with integrated drugs, dosing and biologics recommendations.

Value Pathway: Optimal course of treatment created by the input of patient specific clinical facts into the McKesson Clear Value Plus application which utilizes NCCN Guidelines®. Each Value Pathway has been based on efficacy, toxicity and cost, providing value to the Covered Person and the Plan.

Risk Management Group: Covered Person groups based upon diagnosis or staging. The three groups are Explorer, Navigator and Compass. CancerCARE will notify the Covered Person to which group he/she has been assigned.

COE Network Provider: A cancer center, hospital or other institution, Physician or ancillary provider that has been designated by the CancerCARE Program to provide complex cancer care services. COE Network Providers must have their designation as a National Cancer Institute (NCI) Cancer Center or NCCN® member institution and be a member of the Aetna Network.

Pathology/DiagnosticCOE: A Network of highly specialized pathology labs identified by CancerCARE's Medical Advisory Board to affirm diagnoses for commonly misdiagnosed cancer types. Pathology/DiagnosticCOE access is arranged by the CancerCARE Triage Center based on Covered Person-reported diagnosis during the triage center registration. The Pathology/DiagnosticCOE is comprised of only COE Network Providers in the Aetna Network.

Compliant Benefit Level: A Covered Person status obtained when the Covered Person 1) has completely registered into the CancerCARE Program; 2) the treatment is deemed concordant to a Value Pathway; and 3) the provider's office has achieved Clear Value Participation. If all the above conditions have been met, and there is no Value Pathway available, treatment must be concordant with NCCN Guidelines®, or the care plan must be deemed consistent with evidence-based medicine by CancerCARE. Covered Persons that are directed by CancerCARE to receive care from a COE Network Provider shall be deemed Compliant. This status is reported by the CancerCARE Triage Center to the Plan.

Non-Compliant Benefit: If the Covered Person does not comply with the requirements of the CancerCARE Program, achieve a Compliant Benefit Level, or attend a Participating Provider, the Plan's standard benefits apply as outlined within the Medical Schedule of Benefits.

Clear Value Participation: In order to determine courses of care, testing occurs and the results of those tests (Clinical Facts) are used to determine any applicable Value Pathways. Clear Value Participation requires the provider to: 1) submit Clinical Facts to CancerCARE when care is being planned; 2) consider Value Pathways as treatment options; and 3) confirm with CancerCARE the optimal Value Pathway course of care will be utilized.

Course of Care Certification Waiver: Precertification for CancerCARE confirmed Value Pathway courses of treatment is required, but precertification for services and products included in each Value Pathway is waived if 1) the Covered Person has enrolled in the CancerCARE Program, and 2) the Covered Person has obtained a Compliant Benefit Level status. Course of Care Certification Waiver for courses of treatment shall apply to COE Network Providers if they achieve Clear Value Participation.

COE Referral: CancerCARE provides benefits and support for all cancer diagnoses, but Covered Persons with a diagnosis or condition that is considered rare, aggressive or complex will be evaluated for referral to a COE Network Provider. Such diagnoses or conditions are evaluated and determined by the CancerCARE Medical Team in consultation with a Medical Advisory Board and other relevant medical literature. These diagnoses and conditions are reviewed and revised periodically, please contact CancerCARE for details regarding what cancer diagnoses or conditions are currently considered rare, aggressive or complex.

ADDITIONAL PROVISIONS

Registration Requirement: Upon diagnosis of cancer of any type, Covered Persons shall call the CancerCARE Program at (877) 640-9610 for registration into the Program. Failure to register with the CancerCARE Program will reduce benefits to the Non-Compliant Benefit Level as outlined above.

COE Travel Benefits: The Plan provides a maximum travel and lodging benefit up to $10,000 per Covered Person per lifetime. Travel benefits will only apply for Covered Persons with cancer diagnoses or conditions as described within the COE Referral provision that have been directed to a COE Network Provider by the CancerCARE Program. The COE Network Provider location must be at least 50 miles from the Covered Person's home. Travel and lodging assistance shall be coordinated by the CancerCARE Program. While receiving care at a COE Network Provider, the Plan will reimburse lodging, meals and incidentals. The Plan covers travel costs (coach air, train or mileage at Internal Revenue Service "IRS" Standard Mileage Rate for travel by car) for the Covered Persons plus one companion if the Covered Person is an adult (18 or older), or up to 2 companions if the Covered Person is less than 18. The benefit is subject to INTERLINK's CancerCARE Program coordination and approval guidelines.

CancerCARE Second Opinion: The Plan provides coverage for a CancerCARE Second Opinion through utilization of the COE Network Providers, which may include a review of the diagnosis, review of the treatment plan or both. Second Opinions may require travel to a COE Network Provider to qualify for benefits. A Second Opinion may consist solely of having pathology slides reviewed by a specialized lab or may include other services. Genetic testing is a covered benefit when coordinated by a CancerCARE Program Nurse.

Clinical Trial Benefits: The Plan provides Clinical Trial coverage for Routine Patient Costs consistent with applicable law. Routine Patient Costs will not be considered Experimental and/or Investigational for Covered Persons accepted into an Approved Clinical Trial (as defined by Section 2709(d) of the Public Health Services Act). Routine Patient Costs are limited to: (1) covered health services for which benefits are typically provided in the absence of a Clinical Trial; (2) covered health services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects or item of service, or the prevention of complications; and (3) covered health services needed for reasonable and necessary care arising for the provision of an investigational item or service.

Routine Patient Costs for a Clinical Trial do not include: (1) the investigational item, device, or service itself; (2) items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Covered Person; and (3) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis. These items shall be considered Experimental and/or Investigational and are excluded.

Routine Patient Costs shall be reimbursed at the Compliant Benefit level, provided that the Clinical Trial: (1) is provided at a COE Network Provider; and (2) is a Phase 1-4 Clinical Trial, that has been approved and coordinated by a CancerCARE Program Nurse. Otherwise, Routine Patient Costs shall be reimbursed per standard Plan benefits as outlined in the Medical Schedule of Benefits section.

Covered Persons will be reimbursed at the Non-Compliant Benefit level for participation at a Non-Participating Provider only if Non-Participating Provider benefits are otherwise provided by the Plan.

Covered Persons are encouraged to contact CancerCARE at (877) 640-9610 for further information on clinical trial coverage.

Questions: If there are any questions regarding coverage or a specific provision of the CancerCARE Program, please contact the Plan Administrator or the CancerCARE Program at (877) 640-9610.

SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #7
TO THE
NORTHWEST ARCTIC BOROUGH SCHOOL DISTRICT
HEALTH PLAN
GROUP NO. 12431

This Summary of Material Modification and Amendment describes changes to the Northwest Arctic Borough School District Health Plan effective January 1, 2016. These changes are effective as of **May 1, 2020** 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.

Northwest Arctic Borough School District (the "Plan Sponsor") is amending the Northwest Arctic Borough School District Health Plan (the "Plan") as follows:

1. *Under the **Medical Schedule of Benefits – Certified Plan**, the **Calendar Year Deductible** and **Calendar Year Out-of-Pocket Maximum** are hereby deleted and replaced as follows**:***

MEDICAL SCHEDULE OF BENEFITS – CERTIFIED PLAN

CERTIFIED PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
CALENDAR YEAR DEDUCTIBLE (combined with Prescription Drug Card benefits)		
Single	$500	$1,000
Family	$750	$1,750
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible and Coinsurance - combined with Prescription Drug Card benefits)		
Per Individual	$1,500	$4,000
Per Family	$3,000	$8,000

2. *Under the **Prescription Drug Schedule of Benefits – Certified Plan**, the **Calendar Year Deductible** and **Calendar Year Out-of-Pocket Maximum** are hereby deleted and replaced as follows**:***

PRESCRIPTION DRUG SCHEDULE OF BENEFITS – CERTIFIED PLAN

CERTIFIED PLAN	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)
CALENDAR YEAR DEDUCTIBLE (combined with Major Medical Deductible)		
Single	$500	$1,000
Family	$750	$1,750
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductible and Coinsurance - combined with Major Medical Out-of-Pocket)		
Per Individual	$1,500	$4,000
Per Family	$3,000	$8,000

All other provisions of this Plan shall remain unchanged.