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**PLAN DOCUMENT AND  
SUMMARY PLAN DESCRIPTION  
FOR**

**NEA - ALASKA HEALTH PLAN**

**JUNEAU EDUCATION ASSOCIATION**

**EFFECTIVE: JULY 1, 1996**

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## INTRODUCTION

This document is a description of the NEA - Alaska Health Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Member and designated Dependents when the Member and such Dependents satisfy all the eligibility requirements of the Plan.

NEA-Alaska fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, the rights of Covered Persons are limited to covered charges incurred before termination.

This document summarizes the Plan rights and benefits for covered Members and their Dependents and is divided into the following parts:

**Eligibility, Funding, Effective Date and Termination.** Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

**Schedule of Benefits.** Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

**Benefit Descriptions.** Explains when the benefit applies and the types of charges covered.

**Cost Management Services.** Explains the methods used to curb unnecessary and excessive charges.

**Defined Terms.** Defines those Plan terms that have a specific meaning.

**Plan Exclusions.** Shows what charges are **not** covered.

**Claim Provisions.** Explains the rules for filing claims and the claim appeal process.

**Coordination of Benefits.** Shows the Plan payment order when a person is covered under more than one plan.

**Third Party Recovery Provision.** Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

**COBRA Continuation Options.** Explains when a person's coverage under the Plan ceases and the continuation options which are available.

**ERISA Information.** Explains the Plan's structure and the Participants' rights under the Plan.

## **ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS**

### **ELIGIBILITY**

#### **Eligible Classes of Members.**

All Active Members of NEA-Alaska.

**Eligibility Requirements for Member Coverage.** A person is eligible for Member coverage when he or she:

- (1) is an Active Full-Time Employee or an Active permanent certified Employee working on a half-time contract.
- (2) is in a class eligible for coverage.
- (3) completes the employment Waiting Period of 30 consecutive days as an Active Employee. A "Waiting Period" is the time between the first day of employment and the first day of coverage under the Plan. The Waiting Period is counted in the Pre-Existing Conditions exclusion time.

#### **Eligible Classes of Dependents.**

A Dependent is any one of the following persons:

- (1) A covered Member's Spouse and unmarried children from birth to the limiting age of 19 years. The Dependent children must be primarily dependent upon the covered Member for support and maintenance. However, a Dependent child will continue to be covered after age 19 provided the child is a full-time student at a school listed in the Oryx Press publication, *Accredited Institutions of Post-Secondary Education*, or is in the full-time service of a religious or charitable organization for which the child receives no compensation, and is primarily dependent upon the covered Employee for support and maintenance, is unmarried and under the limiting age of 25. When the child reaches either limiting age, coverage will end on the last day of the child's birthday month.

A covered Dependent who ceases to be a full-time student solely by reason of having completed a term of instruction shall continue to be a covered Dependent during the three months following the month during which the said instruction term ended. In the event the covered Dependent shall not have resumed the status of full-time student within three months following his or her completion of a school term, coverage will cease as of the last day of the third month following the month during which the last school term was completed. The exception to this would be that upon graduation, coverage would cease per normal dependent termination provision.

The term "Spouse" shall mean the person recognized as the covered Member's husband or wife under the laws of the state where the covered Member lives. The Plan Administrator may require documentation proving a legal marital relationship.

The term "children" shall include natural children living in the same household as the Member, adopted children or children placed with a covered Member in anticipation of adoption. Step-children who reside in the Member's household may also be included as long as a natural parent remains married to the Member and also resides in the Member's household.

If a covered Member is the Legal Guardian of an unmarried child or children, these children may be enrolled in this Plan as covered Dependents.

The phrase "child placed with a covered Member in anticipation of adoption" refers to a child whom the Member intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Member 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.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan with no Pre-Existing Conditions provisions applied.

The phrase "primarily dependent upon" shall mean dependent upon the covered Member for support and maintenance as defined by the Internal Revenue Code and the covered Member must declare the child as an income tax deduction. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

- (2) A covered Dependent child who is Totally Disabled, incapable of self-sustaining employment by reason of mental retardation or physical handicap, primarily dependent upon the covered Member for support and maintenance, unmarried and covered under the Plan when reaching the limiting age. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Member's home, but who are not eligible as defined; a divorced former Spouse of the Member.

If a person covered under this Plan changes status from Member to Dependent or Dependent to Member, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

**Eligibility Requirements for Dependent Coverage.** A family member of a Member will become eligible for Dependent coverage on the first day that the Member is eligible for Member coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

## **FUNDING**

### **Cost of the Plan.**

The School District shares the cost of Member and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

## **PRE-EXISTING CONDITIONS**

**NOTE:** The length of the Pre-Existing Conditions Limitation may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan.

An eligible person may request a certificate of Creditable Coverage from his or her prior plan and the Employer will assist any eligible person in obtaining a certificate of Creditable Coverage from a prior plan.

If, after Creditable Coverage has been taken into account, there will still be a Pre-Existing Conditions Limitation imposed on an individual, that individual will be so notified.

Covered charges incurred under Medical Benefits for Pre-Existing Conditions of a Late Enrollee are not payable unless incurred 18 consecutive months after the person's Enrollment Date. This time may be offset if the person has Creditable Coverage from his or her previous plan.

A **Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six months of the person's Enrollment Date under this Plan. Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to pregnancy, to a newborn child who is covered under this Plan within 31 days of birth, or to a child who is adopted or placed for adoption before attaining age 18 and who, as of the last day of the 31-day period beginning on the date of the adoption or placement for adoption, is covered under this Plan. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption.

The prohibition on Pre-Existing Condition exclusion for newborn, adopted, or pre-adopted children does not apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any Creditable Coverage.

## **ENROLLMENT**

**Enrollment Requirements.** A Member must enroll for coverage by filling out and signing an enrollment application. The covered Member is required to enroll for Dependent coverage also.

### **Enrollment Requirements for Newborn Children.**

A newborn child of a covered Member who has Dependent coverage is not automatically enrolled in this Plan. Charges for covered nursery care will be applied toward the Plan of the newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollments" following this section, there will be no payment from the Plan and the covered parent will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

For coverage of Sickness or Injury, including Medically Necessary care and treatment of congenital defects, birth abnormalities or complications resulting from prematurity, the newborn child is required to be enrolled, he or she must be enrolled as a Dependent under this Plan within 90 days of the child's birth in order for non-routine coverage to take effect from the birth.

If the child is required to be enrolled and is not enrolled within 90 days of birth, the enrollment will be considered a Late Enrollment.

## **TIMELY OR LATE ENROLLMENT**

- (1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.
- (2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage will be effective the first of the month after enrollment.

## **SPECIAL ENROLLMENT PERIODS**

The enrollment date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

- (1) Individuals losing other coverage.** A Member or Dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:
  - (a)** The Member or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
  - (b)** If required by the Plan Administrator, the Member stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
  - (c)** The coverage of the Member or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions towards the coverage were terminated.
  - (d)** The Member or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above.

If the Member or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

- (2) Dependent beneficiaries.** If:
  - (a)** The Member is a participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
  - (b)** A person becomes a Dependent of the Member through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Member) may be enrolled under this Plan as a covered Dependent of the covered Member. In the case of the birth or adoption of a child, the Spouse of the covered Member may be enrolled as a Dependent of the covered Member if the Spouse is otherwise eligible for coverage.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

- (a) in the case of marriage, as of the date of marriage;
- (b) in the case of a Dependent's birth, as of the date of birth; or
- (c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

## **EFFECTIVE DATE**

**Effective Date of Member Coverage.** A Member will be covered under this Plan as of the first day the Member satisfies all of the following:

- (1) The Eligibility Requirement.
- (2) The Active Employee Requirement.
- (3) The Enrollment Requirements of the Plan.

### **Active Employee Requirement.**

A Member must be an Active Employee (as defined by this Plan) for this coverage to take effect.

**Effective Date of Dependent Coverage.** A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Member is covered under the Plan; and all Enrollment Requirements are met.

## **TERMINATION OF COVERAGE**

**When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of coverage under this Plan. Please contact the Plan Administrator for further details.**

**When Member Coverage Terminates.** Member coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Member may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options):

- (1) The date the Plan is terminated.
- (2) The last day of the calendar month in which the covered Member ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Member. (See the COBRA Continuation Options.)
- (3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

**Continuation During Family and Medical Leave.** Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Member had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Member and his or her covered Dependents if the Member returns to work in accordance with the terms of the FMLA leave. Coverage

will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations and other Waiting Periods will not be imposed unless they were in effect for the Member and/or his or her Dependents when Plan coverage terminated.

**Rehiring a Terminated Member.** A terminated Member who is rehired within a six month period immediately following the date of such termination, shall become eligible reinstatement of coverage on the date he resumes employment and shall not be subject to any waiting periods in the Plan.

**Members on Military Leave.** Members going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Members and their Dependents covered under the Plan before leaving for military service.

- (1) The maximum period of coverage of a person under such an election shall be the lesser of:
  - (a) The 18 month period beginning on the date on which the person's absence begins; or
  - (b) The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.
- (2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Member's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

**When Dependent Coverage Terminates.** A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options):

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The date that the Member's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Options.)
- (3) The date a covered Spouse loses coverage due to loss of dependency status. (See the COBRA Continuation Options.)
- (4) On the last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan. (See the COBRA Continuation Options.)
- (5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

**SCHEDULE OF BENEFITS  
FOR THE  
JUNEAU EDUCATION ASSOCIATION**

**MEDICAL BENEFITS**

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator’s determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

**This is a traditional medical benefits plan. Covered Persons may choose any Physician or Hospital without the reimbursement levels of the Plan being affected, however, NEA-Alaska Health Plan has negotiated significant fee reductions for covered Hospital services at Providence Alaska Medical Center and Charter NorthStar Hospital in Anchorage. These facilities are Preferred Hospitals for covered Hospital services. When inpatient Hospital services are provided in Anchorage, it is required that the Covered Person use one of the above referenced facilities or the plan benefit percentage will be reduced to 60%. Non-Preferred Hospital co-insurance will not apply to the Out-of-Pocket maximum and are never paid at 100%. If the Covered Person’s Physician does not have privileges at a Preferred Hospital, or if the Hospital the Covered Person wishes to use is more than 30 miles from a Preferred Hospital in Anchorage, the Hospital where the Physician has privileges and renders treatment will be treated as if it were a Preferred Hospital for purposes of determining deductibles and coinsurance. Hospitals approved as “Centers of Excellence” for transplant benefits by the Network designated by the Plan will be considered as Preferred.**

**The charges for the following do not apply to the 100% benefit limit and are never paid at 100%: Deductibles, non-preferred prescription benefits, prescription copayments under this Plan, hearing aid benefit charges and mental disorder treatment charges.**

**Note: All inpatient services must be precertified. See the Cost Management section in this booklet for details.**

**The attending Physician does not have to obtain precertification from the plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.**

**Deductibles payable by Plan Participants**

Deductibles are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services. Each January 1st, a new deductible amount is required. However, covered expenses incurred in, and applied toward the deductible in October, November and December will be applied to the deductible in the next Calendar Year as well as the current Calendar Year. The deductible will not apply to the out-of-pocket maximum.

**Deductibles, per Calendar Year**

Per Covered Person .....	\$50
Per Family Unit .....	\$150

**Maximum out-of-pocket payments, per Calendar Year**

The Plan will pay the percentage of covered charges designated until the following amounts of out-of-pocket payments are reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the Calendar Year unless stated otherwise.

Per Covered Person, ..... \$264.75

**Maximum Benefit Amounts**

Lifetime, while covered ..... \$2,000,000

**SUPPLEMENTARY ACCIDENT CHARGE BENEFIT**

Maximum benefit per accident..... first \$500, payable at 100%, deductible waived

**FOLLOWING ARE OTHER MAXIMUMS ON INDIVIDUAL BENEFITS.**

**Hospital Services --**

Room and Board Daily limit ..... the average semiprivate room rate

Intensive Care Unit Daily limit ..... Hospital's ICU Charge

Reimbursement rate ..... 85% after deductible

**Pre-Admission Testing --**

Reimbursement rate ..... 85% after deductible

**Skilled Nursing Facility --**

Daily limit ..... the facility's average semiprivate room rate

Reimbursement rate ..... 85% after deductible

Calendar Year maximum ..... \$5,000

**Home Health Care --**

Reimbursement rate ..... 85% after deductible

**Physician Services --**

**Inpatient**

Reimbursement rate ..... 85% after deductible

**Office visit**

Reimbursement rate ..... 85% after deductible

**Surgical services**

Reimbursement rate .....	85% after deductible
<b>Hospice Care --</b>	
Reimbursement rate .....	85% after deductible
<b>Ambulance Service --</b>	
Reimbursement rate .....	85% after deductible
<b>Temporomandibular Joint (TMJ) and Myofascial Pain Dysfunction (MPD)--</b>	
Reimbursement rate .....	85% after deductible
<b>Wig after chemotherapy--</b>	
Reimbursement rate .....	85% after deductible
<b>Speech Therapy (See limitations under the Plan Exclusions) --</b>	
Reimbursement rate .....	85% after deductible
<b>Occupational Therapy--</b>	
Reimbursement rate .....	85% after deductible
<b>Physical Therapy --</b>	
Reimbursement rate .....	85% after deductible
Calendar Year maximum .....	\$1,000
<b>Inpatient Rehabilitation Therapy --</b>	
Reimbursement rate .....	85% after deductible
Lifetime maximum .....	\$100,000
<b>Durable Medical Equipment --</b>	
Reimbursement rate .....	85% after deductible
<b>Prosthetics--</b>	
Reimbursement rate .....	85% after deductible
<b>Orthotics (See limitations under Plan Exclusions)--</b>	
Reimbursement rate .....	85% after deductible

**Mental Disorders Treatment Limits--**

Inpatient Reimbursement rate ..... 50% after deductible  
Outpatient Reimbursement rate..... 50% after deductible

Calendar Year maximum

Inpatient ..... 15 days  
Outpatient..... 40 visits

**Substance Abuse Treatment Limits --**

Inpatient Reimbursement rate ..... 85% after deductible  
Outpatient Reimbursement rate..... 85% after deductible

24 month maximum

Inpatient and Outpatient..... \$11,500

Lifetime maximum

Inpatient and Outpatient..... \$23,000

**Spinal Manipulation/Chiropractic Services --**

Reimbursement rate ..... 85% after deductible

**Organ Transplant Coverage Limits --**

Covered Transplant Procedures:

Organ and tissue transplants are covered except those which are classified as "Experimental and/or Investigational."

Reimbursement rate ..... 85% after deductible  
Donor coverage maximum..... covered under the Transplant lifetime Maximum

Plan covers a Covered Person's charges as a donor only when the recipient is also a Covered Person.

**Well Newborn Nursery Care Limits--**

Reimbursement rate ..... 85% after deductible

**Preventive Care--**

Reimbursement rate ..... 85% after deductible

Coverage is limited to reimbursement for the following routine services: mammogram, routine pap smear screening and prostate screening, including Physician charges.

**Hearing Aid Benefit--**

Reimbursement rate ..... 80% after deductible

Maximum Benefit each three consecutive years ..... \$800

**All Other Eligible Charges--**

Reimbursement rate ..... 85% after deductible

**PRESCRIPTION DRUG BENEFIT**

**Pharmacy Option – 30 day supply**

Copayment, per Prescription

For name brand drugs ..... \$15

For Generic drugs ..... \$5

**Mail Order Prescription Drug Option – 90 day supply**

Copayment, per Prescription

For name brand drugs ..... \$22.50

For Generic drugs ..... \$7.50

**VISION SERVICE PLAN BENEFITS**

NEA – Alaska Health Plan has contracted with Vision Service Plan to provide vision care services for you and your dependents. An outline of the benefits is provided below. See the Human Resources Department for further benefit details.

BENEFITS:	Examination Lenses Frame	Once a Calendar Year starting January Once a Calendar Year starting January Every other calendar year
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COPAYMENT*: <i>*Copayment applies to in and out of network services.</i>	Examination Materials	\$20.00 \$20.00
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	<b>Services from a VSP Participating Provider</b>	<b>Services from a Non-Participating Provider</b>
Examination	Paid-in-Full (After co-payment)	Up to \$40.00 (After co-payment)
Single Vision Lenses	Paid-in-Full (After co-payment)	Up to \$40.00 (After co-payment)
Bifocal Lenses	Paid-in-Full (After co-payment)	Up to \$60.00 (After co-payment)
Trifocal Lenses	Paid-in-Full (After co-payment)	Up to \$80.00 (After co-payment)
Lenticular Lenses	Paid-in-Full (After co-payment)	Up to \$125.00 (After co-payment)
Frame	A wide selection of attractive Frames are covered in full	Up to \$45.00 (After co-payment)
Contact Lenses (Instead of spectacle lenses and frame)		
Necessary	Paid-in-Full (After co-payment)	Up to \$210.00 (After co-payment)
Elective	Up to \$105.00 (After co-payment)	Up to \$105.00 (After co-payment)

**THIS IS ONLY A SUMMARY**

**VISION SERVICE PLAN CUSTOMER SERVICE (800) 877-7195**  
**Web site at <http://www.vsp.com>**

**DENTAL BENEFITS**

**Dental Percentage Payable**

Class A Services- Preventive .....	100%
Class B Services- Basic .....	80%
Class C Services- Major .....	50%
Calendar Year maximum for Class A, B and C Services per person.....	\$2,000
Class D Services- Orthodontia .....	50%
Lifetime maximum for Class D Services.....	\$2,000

## MEDICAL BENEFITS

Medical Benefits apply when covered charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

### DEDUCTIBLE

**Deductible Amount.** This is an amount of covered charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

**Deductible Three Month Carryover.** Covered expenses incurred in, and applied toward the deductible in October, November and December will be applied toward the deductible in the next Calendar Year.

**Family Unit Limit.** When the dollar amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

**Deductible For A Common Accident.** This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident.

These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Calendar Year in which the accident occurred will be required for them as a unit.

### BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the covered charges of a Covered Person that are in excess of the deductible. Payment will be made at the rate shown under Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

### OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% for the rest of the Calendar Year.

### MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all covered charges incurred by a Covered Person.

### COVERED CHARGES

Covered charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

- (1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be paid at 80% of the average private room rate.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

- (2) **Coverage of Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Member or covered Spouse.

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

***CARELINK PRIORITY MATERNITY CARE***

*Priority Maternity Care is an educational and empowerment program for eligible female Members and dependent spouses.*

*This program provides a means to positively affect a pregnancy and the health of the baby.*

*A CareLink registered nurse will set up a confidential, personal telephone interview to identify medical history and lifestyles that could have an impact on the outcomes of the pregnancy.*

*A CareLink registered nurse is available to assist and coordinate high risk aspects of maternity care. This includes providing information such as access to educational programs and community resources designed to meet the needs identified by the patient or physician.*

***Priority Maternity Care Notification: The Covered Person needs to notify CareLink during the first trimester of their pregnancy.***

***The Covered Person will receive a \$100 credit against out-of-pocket deductible or co-insurance costs related to pregnancy and childbirth from the NEA-Alaska Health Plan Trust after satisfying all requirements.***

There is no coverage of Pregnancy for a Dependent child.

- (3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

- (a) the patient is confined as a bed patient in the facility;
- (b) the confinement starts within 5 days of a Hospital confinement of at least 14 days;
- (c) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
- (d) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered charges for a Covered Person's care in these facilities is limited to the covered daily charge limit shown in the Schedule of Benefits.

- (4) **Physician Care.** The professional services of a Physician for surgical or medical services.

- (a) Charges for **multiple surgical procedures** will be a covered expense subject to the following provisions:

- (i) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered “incidental” and no benefits will be provided for such procedures;
  - (ii) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon’s primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Reasonable percentage allowed for that procedure; and
  - (iii) If an assistant surgeon is required, the assistant surgeon’s covered charge will not exceed 25% of the surgeon’s Usual and Reasonable allowance.
- (5) **Private Duty Nursing Care.** The 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 this extent:
  - (a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.
  - (b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.
- (6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

- (7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

- (8) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:
  - (a) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

- (b) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
- (c) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.
- (d) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.
- (e) Initial **contact lenses** or glasses required following cataract surgery.
- (f) **Contraceptives** and any related physician expenses.
- (g) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.
- (h) Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome and Myofascial Pain Dysfunction.**
- (i) **Laboratory studies.**
- (j) **Massage Therapy.** Massage therapy will be considered an eligible expense when services are provided by a massage therapist working under the direction of a Physician and services are billed through the Physician's office.
- (k) Treatment of **Mental Disorders and Substance Abuse.** Covered charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits.

Physician's visits are limited to one treatment per day.

- (l) Injury to or care of **mouth, teeth and gums.** Charges for injury to or care of the mouth, teeth, gums and alveolar processes will be covered charges under Medical Benefits only if that care is for the following oral surgical procedures:

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

Emergency repair due to Injury to sound natural teeth. This repair must be made within 12 months from the date of an accident.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

- (m) **Nutritional counseling and educational services** for individuals with diabetes and asthma.
- (n) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.
- (o) **Organ transplant** limits. There is a twelve month waiting period for transplant benefits. Services and supplies provided under this benefit will not be covered during the first twelve consecutive months of the Covered Person's coverage under this Plan. However, the waiting period is waived if the transplant is needed as a direct result of a congenital anomaly of a child.

Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue.

Charges for obtaining donor organs or tissues are covered charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:

evaluation, screening and candidacy determination ;

organ procurement

removing the organ or tissue from the donor; and

transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

If the Covered Person is receiving an organ transplant at a preferred network hospital, and he normally resides more than fifty miles from the transplant facility, associated travel expenses will be paid up to a maximum benefit of \$5,000 per transplant procedure. Travel expenses include commercial transportation to and from the site of the organ transplant for the Covered Person receiving the transplant and one companion. Reasonable lodging and meal expenses incurred by the Covered Person receiving the organ transplant and one companion will be paid up to a maximum benefit of \$150 per day.

- (p) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. Replacement orthotic appliances will not be allowed unless the current appliances is not functional.
- (q) **Physical therapy** by a licensed physical therapist.
- (r) **Prescription Drugs** (as defined). Prescriptions purchased at a participating pharmacy, but not submitted to CuraScript, will be reimbursed at 100%, less any copayment listed in

the Prescription Drug Benefit in the Schedule of Benefits. Prescriptions purchased at a Non-Participating Pharmacy will be paid at 50% after deductible.

- (s) Routine **Preventive Care**. Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.
- (t) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.
- (u) **Reconstructive Surgery**. Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered covered charges.

This mammoplasty coverage will include reimbursement for:

- (i) reconstruction of the breast on which a mastectomy has been performed,
- (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- (iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

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

- (v) Charges for **Rehabilitation therapy** up to the limits stated in the Schedule of Benefits. Services must be medically necessary to restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an accidental injury, illness, or surgery.
  - (i) Inpatient Care. Services must be furnished in a specialized rehabilitative unit of a hospital and billed by the hospital or be furnished and billed by a rehabilitation facility approved by the Plan. This benefit only covers care the Covered Person received within 24 months from the onset of the injury or illness or from the date of the surgery that made rehabilitation necessary. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physiatrist (a physician specializing in rehabilitative medicine).
- (w) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.
- (x) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C., subject to medical necessity and non-maintenance care.
- (y) **Sterilization** procedures.
- (z) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.
- (a1) **Transportation**. This Plan will provide benefits for round trip transportation by commercial airline from the place where the Illness or Injury occurred to the nearest Hospital where professional treatment can be obtained, subject to the following limitations:
  - (i) The Illness or Injury must be life endangering situation that requires immediate transfer to a Hospital that has special facilities for treating the condition; or

- (ii) Surgery or a condition exists which cannot be performed locally. In that case, transportation benefits in any one calendar year will be limited to:

One visit which is pre-authorized as a condition requiring therapeutic treatment which cannot be provided locally; or

One visit for the actual surgical procedure which cannot be provided locally.

If the Covered Person requires transportation as stated above, the Physician must provide written certification and detailed medical documentation of the existing condition in advance of the trip. The Plan Administrator will then determine how much of the transportation charges, if any, are eligible for coverage under the Plan.

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.

Travel benefits apply only to the conditions covered under this Plan. They do not apply to dental care benefits, unless approved by the Plan Administrator. Benefits will not be given for diagnostic or second opinion diagnosis.

- (a2) Coverage of **Well Newborn Nursery/Physician Care.**

**Charges for Routine Nursery Care.** Routine well newborn nursery care is room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the birth and the newborn child is an eligible Dependent and is neither injured nor ill.

The benefit is limited to Usual and Reasonable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn child.

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

**Charges for Routine Physician Care.** The benefit is limited to the Usual and Reasonable Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

- (a3) Charges associated with the initial purchase of a **wig after chemotherapy.**

- (a4) Diagnostic **x-rays.**

## **SUPPLEMENTARY ACCIDENT CHARGE BENEFITS**

This benefit applies when an accident charge is incurred for care and treatment of a Covered Person's Injury and:

- (1) the Injury is sustained while the person is covered for these benefits; and
- (2) the charge is for a service delivered within 90 days of the date of the accident; and
- (3) to the extent that the charge is not payable under any other benefits under the Plan (other than Medical Benefits).

## **BENEFIT PAYMENT**

Benefits will be paid as described in the Schedule of Benefits.

## **ACCIDENT CHARGE**

An accident charge is a Usual and Reasonable Charge incurred for the following:

- (1) Physician services.
- (2) Hospital care and treatment.
- (3) Diagnostic x-rays and lab tests.
- (4) Local professional ambulance service.
- (5) Surgical dressings, splints and casts and other devices used in the reduction of fractures and dislocations.
- (6) Nursing service.
- (7) Anesthesia.
- (8) Covered Prescription Drugs.
- (9) Use of a Physician's office or clinic operating room.

## HEARING AID BENEFIT

Benefits include eligible charges for:

- (1) An otologic (ear) examination by a Physician licensed by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.);
- (2) An audiologic (hearing) examination and hearing evaluation by a certified or licensed audiologist including a follow-up consultation;
- (3) The hearing aid (monaural or binaural) must be prescribed as a result of the examination;
- (4) Ear molds;
- (5) The hearing instrument;
- (6) The initial batteries, cords and other necessary equipment;
- (7) A follow-up consultation within thirty (30) days following delivery of the hearing aid;
- (8) Rental charges for the use of a hearing aid instrument for a period up to but not exceeding 30 days in the event the Covered Person elects to return the hearing aid before actual purchase.

Physician certification and the examination charge for the examination must be submitted with the claim.

A certification from the Physician will not be necessary if the Covered Person purchases a replacement hearing aid covered by this benefit so long as the hearing aid being replaced was provided while covered by this benefit.

In addition to other limitations and exclusions elsewhere in this document, the following supplies and services are not covered by this benefit:

- (1) Replacement of a hearing aid for any reason more often than once in a three-year period;
- (2) Batteries or other ancillary equipment other than that obtained upon purchase of the hearing aid;
- (3) Repairs, servicing or alteration of hearing aid equipment;
- (4) A hearing aid which exceeds the specifications prescribed for correcting any hearing loss;
- (5) Hearing aid charges in excess of benefit limitation;
- (6) A hearing aid examination when no hearing aid is obtained.

## COST MANAGEMENT SERVICES

### Cost Management Services Phone Number

CareLink  
(866) 894-1505

The patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 7 days in advance of services being rendered or within two business days after an emergency.

### CARELINK UTILIZATION AND MEDICAL CARE MANAGEMENT SERVICES

**The final decision regarding healthcare always remains with the Covered Person and the Covered Person's physician. A Covered Person or the Attending Physician is entitled to appeal non-certification decisions made by CARELINK. This process can be initiated by written request submitted to the CARELINK manager, within 45 days after receipt of the non-certification letter.**

**No benefits are provided for care which is determined to be not Medically Necessary, whether as a result of review through the certification process, retrospective review or subsequent claim review. Further, certification is not a guarantee of benefits. All charges, even for services certified as appropriate and Medically Necessary, are subject to plan eligibility and benefit provisions (e.g. pre-existing conditions, time limitations, exclusions, etc.)**

### UTILIZATION REVIEW

Utilization review is a program designed to help assist Covered Persons in receiving necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

- (a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:
  - Acute Hospitalizations
  - Free Standing Chemical Dependency facilities
  - Free Standing Mental Health facilities
  - Free Standing Rehabilitation facilities
- (b) Retrospective review of the listed services provided on an emergency basis;
- (c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and
- (d) Planning for discharge from a Medical Care Facility or cessation of medical treatment.

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 health care provider.

If a particular course of treatment or medical service is not certified, it means that the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

**Here's how the program works.**

**Precertification.** Before a Covered Person enters a Medical Care Facility on a non-emergency basis, or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at:

CareLink (406) 245-3575 or (866) 894-1505  
Monday through Thursday, 7:00 a.m. to 7:00 p.m. (Mountain Time)  
Friday, 7:00 a.m. to 5:00 p.m. (Mountain Time)

**at least 7 days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Member
- The name, Social Security number and address of the covered Member
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact CARELINK **within two business days** after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement authorized for payment.

Hospital Observation Room stays in excess of 23 hours are considered an emergency admission for purposes of this program and must be certified as such.

**Concurrent review, discharge planning.** Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

**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 person's condition is diagnosed, he or she might need extensive services or might be able to be moved into another type of care setting--even to his or her home.

Case Management is a program whereby a case manager monitors these patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the attending Physician in order to coordinate a plan of care approved by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- individualized support to the patient;

- contacting the family to offer assistance for coordination of medical care needs;
- monitoring response to treatment;
- determining alternative care options; and
- 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. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

**Note: 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.**

#### **TELEPHONE CONSULTATION**

Registered Nurses are available by a toll free line during CARE LINK normal working hours to answer Covered Person's health-related questions. Assistance ranges from providing a better understanding of specific medical procedures, to plain English translations of medical terminology and help in locating community support services.

#### **CARELINK PRIORITY MATERNITY CARE**

Priority Maternity Care is an educational and empowerment program for eligible female Members and dependent spouses.

This program provides a means to positively affect a pregnancy and the health of the baby.

A CareLink registered nurse will set up a confidential, personal telephone interview to identify medical history and lifestyles that could have an impact on the outcomes of the pregnancy.

A CareLink registered nurse is available to assist and coordinate high risk aspects of maternity care. This includes providing information such as access to educational programs and community resources designed to meet the needs identified by the patient or physician.

**Priority Maternity Care Notification: The Covered Person needs to notify CareLink during the first trimester of their pregnancy.**

**The Covered Person will receive a \$100 credit against out-of-pocket deductible or co-insurance costs related to pregnancy and childbirth from the NEA-Alaska Health Plan Trust after satisfying all requirements.**

## DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

**Active Employee** is an Employee who is on the regular payroll of the Employer and who is scheduled to perform the duties of his or her job with the Employer on a full-time basis.

**Ambulatory Surgical Center** is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

**Baseline** shall mean the initial test results to which the results in future years will be compared in order to detect abnormalities.

**Birthing Center** means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

**Calendar Year** means January 1st through December 31st of the same year.

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**Cosmetic Dentistry** means dentally unnecessary procedures.

**Covered Person** is an Member or Dependent who is covered under this Plan.

**Creditable Coverage** includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid or Medicare.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

**Custodial Care** is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

**Dentist** is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

**Durable Medical Equipment** means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

**Employee** means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship and who is either a member of the Juneau Education Association, affiliated with NEA-Alaska, or is covered by a collective bargaining agreement negotiated by an affiliate of NEA-Alaska.

**Employer** is Juneau School District.

**Enrollment Date** is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

**ERISA** is the Employee Retirement Income Security Act of 1974, as amended.

**Experimental and/or Investigational** means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

- (1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- (2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- (3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- (4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

**Family Unit** is the covered Member and the family members who are covered as Dependents under the Plan.

**Generic Drug** means 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.

**Genetic Information** means information about genes, gene products and inherited characteristics that may derive from an 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.

**Home Health Care Agency** is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

**Home Health Care Plan** must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis and it must specify the type and extent of Home Health Care required for the treatment of the patient.

**Home Health Care Services and Supplies** include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

**Hospice Agency** is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

**Hospice Care Plan** is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

**Hospice Care Services and Supplies** are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

**Hospice Unit** is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

**Hospital** is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

**Illness** means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or Complications of Pregnancy.

**Injury** means an accidental physical Injury to the body caused by unexpected external means.

**Intensive Care Unit** is defined as 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: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

**Late Enrollee** means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

**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 a minor child.

**Lifetime** is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

**Medical Care Facility** means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

**Medical Emergency** means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

**Medically Necessary** care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical and dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

**Medicare** is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

**Member** means a person who is directly employed and compensated for services by the Employer, who meets the Eligibility requirements and who is properly enrolled in the Plan.

**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 International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

**Morbid Obesity** is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most recent Metropolitan Life Insurance Co. tables (or similar actuarial tables) for a person of the same height, age and mobility as the Covered Person.

**No-Fault Auto Insurance** is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

**Outpatient Care** is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

**Pharmacy** means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

**Physician** means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist, Acupuncturist (L.Ac.), Naturopath (N.D.), Christian Science Practitioner authorized by

the Mother Church of Christ, First Church of Christ Scientist, in Boston Massachusetts, and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

**Plan** means NEA - Alaska Health Plan, which is a benefits plan for certain Employees of the Employer and is described in this document.

**Plan Participant** is any Employee or Dependent who is covered under this Plan.

**Plan Year** is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

**Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six months of the person's Enrollment Date under this Plan. Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to pregnancy, to a newborn child who is covered under this Plan within 31 days of birth, or to a child who is adopted or placed for adoption before attaining age 18 and who, as of the last day of the 31-day period beginning on the date of the adoption or placement for adoption, is covered under this Plan. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption.

The prohibition on Pre-Existing Condition exclusion for newborn, adopted, or pre-adopted children does not apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

**Preferred Hospital** means a provider which, at the time the services are rendered, has an agreement with the Plan to furnish services to Plan Participants at negotiated fees and for which Plan Participants generally receive a higher level of reimbursement than for Non-Preferred Providers.

**Pregnancy** is childbirth and conditions associated with Pregnancy, including complications.

**Prescription Drug** means any of the following: 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"; injectable insulin; 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 a Sickness or Injury.

**Sickness** is:

For all persons but a covered Dependent daughter: Illness, disease or Pregnancy.

For a covered Dependent daughter: Illness or disease, not including Pregnancy or its complications.

**Skilled Nursing Facility** is a facility that fully meets all of these tests:

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. 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, mental retardates, 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 or any other similar nomenclature.

**Spinal Manipulation/Chiropractic Care** means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

**Substance Abuse** is the condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

**Temporomandibular Joint (TMJ) syndrome** is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

**Total Disability (Totally Disabled)** means: In the case of a Dependent Child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

**Usual and Reasonable Charge** is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan will reimburse the actual charge billed if it is lesser than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

## PLAN EXCLUSIONS

**Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.**

**Note: All exclusions related to Vision are shown in the Vision Plan.**

**Note: All exclusions related to Dental are shown in the Dental Plan.**

**For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:**

- (1) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are covered.
- (2) **Counseling.** Charges for family, marital, social, sexual or lifestyle counseling.
- (3) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.
- (4) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.
- (5) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
- (6) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.
- (7) **Eye care.** Radial keratotomy or other eye surgery to correct near-sightedness. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting, except as specifically stated in the Schedule of Benefits.. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.
- (8) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease). This includes foot-support supplies, devices and shoes.
- (9) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
- (10) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy up to the limit shown in the Schedule of Benefits.
- (11) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- (12) **Illegal acts.** Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance.
- (13) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence.
- (14) **Infertility.** Care and treatment for infertility, artificial insemination or in vitro fertilization.

- (15) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (16) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- (17) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (18) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
- (19) **Not specified as covered.** Services, treatments and supplies which are not specified as covered under this Plan.
- (20) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Medically Necessary charges for Morbid Obesity will be covered.
- (21) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.
- (22) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.
- (23) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.
- (24) **Pregnancy of daughter.** Care and treatment of Pregnancy and Complications of Pregnancy for a dependent daughter only.
- (25) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
- (26) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.
- (27) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury, suicide or attempted suicide, while sane or insane.
- (28) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan or after coverage ceased under this Plan.
- (29) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
- (30) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches.
- (31) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

- (32) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except as specifically stated as a benefit of this Plan.
- (33) **War.** Any charge that is due to a declared or undeclared act of war or caused during service in the armed forces of any country.

## **PRESCRIPTION DRUG BENEFITS**

**The Pre-Existing Limitation and Coordination of Benefits Provisions will not apply to the prescriptions purchased at a participating pharmacy.**

### **PHARMACY DRUG CHARGE**

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. CuraScript is the administrator of the pharmacy drug plan.

### **COPAYMENT**

The copayment is applied to each covered pharmacy drug charge and is shown in the Schedule of Benefits. The copayment amount is not a covered charge under the Medical Plan. Any one prescription is limited a 90-day supply, however a copayment will be charged for each 30 day supply.

### **MAIL ORDER DRUG BENEFIT OPTION**

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, CuraScript, the mail order pharmacy, is able to offer Covered Persons significant savings on their prescriptions.

### **COPAYMENT**

The copayment is applied to each covered mail order prescription charge and is shown in the Schedule of Benefits. It is not a covered charge under the Medical Plan. Any one prescription is limited to a 90-day supply.

### **COVERED PRESCRIPTION DRUGS**

- (1) All drugs prescribed by a Physician that require a prescription either by federal or state law, except insulin or any other drugs not covered under this Plan.
- (2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- (3) Insulin when prescribed by a Physician.
- (4) Oral contraceptives, contraceptive devices and contraceptive injectables.
- (5) Injectable drugs.
- (6) Diabetic supplies including insulin syringes/needles, glucose sticks, urine tablets, lancets, test strips, Insulin pumps and pump supplies.
- (7) Renova, Retin A and Accutane.
- (8) Fluoride supplements.

### **LIMITS TO THIS BENEFIT**

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

- (1) Refills only up to the number of times specified by a Physician.
- (2) Refills up to one year from the date of order by a Physician.

## EXCLUDED

This benefit will not cover a charge for any of the following:

- (1) **Administration.** Any charge for the administration of a covered Prescription Drug.
- (2) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- (3) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device, except as stated as a covered expense.
- (4) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.
- (5) **FDA.** Any drug not approved by the Food and Drug Administration.
- (6) **Growth hormones.**
- (7) **Immunization.** Immunization agents or biological sera.
- (8) **Impotence.** A charge for impotence medication.
- (9) **Infertility.** A charge for infertility medication.
- (10) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".
- (11) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.
- (12) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
- (13) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
- (14) **Obesity drugs.**
- (15) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.
- (16) **Rogaine** (or similar drug) for topical application.
- (17) **Smoking cessation.** A charge for Prescription Drugs for smoking cessation (i.e., nicotine gum).
- (18) **Smoking deterrent patches.** A charge for smoking deterrent patches.
- (19) **Vitamins,** except for pre-natal vitamins.

## **DENTAL BENEFITS**

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

### **BENEFIT PAYMENT**

Each Calendar Year benefits will be paid to a Covered Person for the dental charges. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

### **MAXIMUM BENEFIT AMOUNT**

The Maximum Dental Benefit Amount is shown in the Schedule of Benefits.

### **DENTAL CHARGES**

Dental charges are the Usual and Reasonable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

## **COVERED DENTAL SERVICES**

### **Class A Services: Preventive and Diagnostic Dental Procedures**

The limits on Class A Services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

- (1) Routine oral exams. This includes the cleaning and scaling of teeth. Limit of two exams per Covered Person each Calendar Year.
- (2) Bitewing x-ray series. Limit of two per Covered Person each Calendar Year.
- (3) One full mouth x-ray every 36 consecutive month period.
- (4) Two fluoride treatments for covered Dependent children under age 20 each Calendar Year.
- (5) Space maintainers for covered Dependent children under age 20.
- (6) Emergency palliative treatment for pain.
- (7) Sealants on permanent teeth for Dependent children under age 14.
- (8) All other dental x-rays.

### **Class B Services: Basic Dental Procedures**

- (1) Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts.
- (2) Periodontics (gum treatments).

- (3) Endodontics (root canals).
- (4) Extractions. This service includes local anesthesia and routine post-operative care.
- (5) Repair and recementing bridges, crowns or inlays.
- (6) Fillings, other than gold.
- (7) General anesthetics, upon demonstration of Medical Necessity.
- (8) Antibiotic drugs.

**Class C Services:  
Major Dental Procedures**

- (1) Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.
- (2) Installation of crowns.
- (3) Installing precision attachments for removable dentures.
- (4) Installing partial, full or removable dentures to replace one or more natural teeth that were extracted while the person was covered for this benefit. This service also includes all adjustments made during a six-month period following the installation.
- (5) Addition of clasp or rest to existing partial removable dentures.
- (6) Initial installation of fixed bridgework to replace one or more natural teeth which were extracted while the person was covered for these benefits.
- (7) Rebasing or relining of removable dentures.
- (8) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if one of these tests is met:
  - (a) The replacement or addition of teeth is required because of one or more natural teeth being extracted after the person is covered under these benefits.
  - (b) The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.
  - (c) The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed.
- (9) Implants. Charges for implants, including any appliances and/or crowns and the surgical insertion or removal of implants.

**Class D Services:  
Orthodontic Treatment and Appliances**

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth.

These services are available for covered Dependent children under age 19 and include preliminary study, including x-rays, diagnostic casts and treatment plan, active treatments and retention appliance.

Payments for comprehensive full-banded orthodontic treatments are made in installments.

**EXCLUSIONS**

A charge for the following is not covered:

- (1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.
- (2) **Broken appointments.** Charges for broken or missed dental appointments.
- (3) **Cosmetic.** Services or supplies which are primarily cosmetic in nature.
- (4) **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
- (5) **Excluded under Medical.** Services that are excluded under Medical Plan Exclusions.
- (6) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.
- (7) **Medical services.** Services that, to any extent, are payable under any medical expense benefits of the Plan.
- (8) **No listing.** Services which are not included in the list of covered dental services.
- (9) **Personalization.** Personalization of dentures.
- (10) **Replacement.** Replacement of lost or stolen appliances.
- (11) **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

## HOW TO SUBMIT A CLAIM

To assist the Claims Administrator in processing a claim, the Covered Person should follow the steps listed below:

- (1) If the claim is caused from an accident, obtain a claim form from the Personnel Office or the Plan Administrator.
- (2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.
- (3) Have the Physician or Dentist complete the provider's portion of the form.
- (4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:
  - Name of Plan
  - Member's name and Social Security Number
  - Name of patient
  - Name, address, telephone number of the provider of care
  - Diagnosis
  - Type of services rendered, with diagnosis and/or procedure codes
  - Date of services
  - Charges

A receipt for prescription drug must show the following:

- Name of Plan
  - Group number of Plan
  - Member's name and Social Security Number
  - Name of patient
  - The prescribing Physician
  - The prescription name
  - An itemization for each separate prescription
  - The date of purchase
- (5) Send the above to the Claims Administrator at this address:

Employee Benefit Management Services, Inc.  
PO Box 21367  
Billings, Montana 59104  
(406) 245-3575 or (800) 777-3575

## WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 90 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

- (a) it's not reasonably possible to submit the claim in that time; and
- (b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the Plan Participant with a written notice of this denial. This written notice will be provided within 90 days after receipt of the claim. The written notice will contain the following information:

- (a) the specific reason or reasons for the denial;
- (b) specific reference to those Plan provisions on which the denial is based;
- (c) a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and
- (d) appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

A Plan Participant will be notified within 90 days of receipt of the claim as to the acceptance or denial of a claim and if not notified within 90 days, the claim shall be deemed denied.

If special circumstances require an extension of time for processing the claim, the Claims Administrator shall send written notice of the extension to the Plan Participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of 90 days from the end of the initial 90-day period.

## CLAIMS REVIEW PROCEDURE

In cases where a claim for benefits payment is denied in whole or in part, the Plan Participant may appeal the denial. This appeal provision will allow the Plan Participant to:

- (a) Request from the Plan Administrator a review of any claim for benefits. Such request must include: the name of the Member, his or her Social Security number, the name of the patient and the Group Identification Number, if any.
- (b) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The request for review must be directed to the Plan Administrator or Claims Administrator within 60 days after the claim payment date or the date of the notification of denial of benefits.

A review of the denial will be made by the Plan Administrator and the Plan Administrator will provide the Plan Participant with a written response within 60 days of the date the Plan Administrator receives the Plan Participant's written request for review and if not notified, the Plan Participant may deem the claim denied. If,

because of extenuating circumstances, the Plan Administrator is unable to complete the review process within 60 days, the Plan Administrator shall notify the Plan Participant of the delay within the 60 day period and shall provide a final written response to the request for review within 120 days of the date the Plan Administrator received the Plan Participant's written request for review.

The Plan Administrator's written response to the Plan Participant shall cite the specific Plan provision(s) upon which the denial is based.

A Plan Participant must exhaust the claims appeal procedure before filing a suit for benefits.

## COORDINATION OF BENEFITS

**Coordination of the benefit plans.** Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses.

**Benefit plan.** This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs. This includes Medicare.
- (5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

**Allowable charge.** For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

**Automobile limitations.** When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

**Benefit plan payment order.** When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

- (1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:
  - (a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

Special rule. If: (i) the person covered directly is a Medicare beneficiary, and (ii) Medicare is secondary to Plan B, and (iii) Medicare is primary to Plan A (for example, if the person is retired), THEN Plan B will pay before Plan A.

- (b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
  - (c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
  - (d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
    - (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
    - (ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.
  - (e) When a child's parents are divorced or legally separated, these rules will apply:
    - (i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
    - (ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
    - (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
    - (iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
  - (f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.
- (3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid

by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

- (4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

**Claims determination period.** Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

**Right to receive or release necessary information.** To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

**Facility of payment.** This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

**Right of recovery.** This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

## THIRD PARTY RECOVERY PROVISION

### RIGHT OF SUBROGATION AND REIMBURSEMENT

**When this provision applies.** The Covered Person may incur medical or dental charges due to injuries which may be caused by the act or omission of a third party or a third party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that third party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical, dental or vision expenses automatically assigns to the Plan any rights the Covered Person may have to recover payments from any third party or insurer. This subrogation right allows the Plan to pursue any claim which the Covered Person has against any third party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the third party or insurer, but in any event, the Plan has a lien on any amount recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is reimbursed in full.

The Covered Person:

- (1) automatically assigns to the Plan his or her rights against any third party or insurer when this provision applies; and
- (2) must reimburse to the Plan the benefits paid on his or her behalf out of the recovery made from the third party or insurer.

**Amount subject to subrogation or reimbursement.** The Covered Person agrees to recognize the Plan's right to subrogation and reimbursement. These rights provide the Plan with a priority over any funds paid by a third party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses.

Notwithstanding its priority to funds, the Plan's subrogation and reimbursement rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical, dental or vision charges as well as any costs and fees associated with the enforcement of its rights under the Plan. However, the Plan's right to reimbursement still applies if the recovery received by the Covered Person is less than the medical, dental or vision charges paid by the Plan, and, as a result, the claimant is not made whole.

When a right of subrogation and reimbursement exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of subrogation and reimbursement as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to subrogate and seek reimbursement.

**Defined terms:** "Recovery" means monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injuries or Sickness whether or not said losses reflect medical or dental charges covered by the Plan.

"Subrogation" means the Plan's right to pursue the Covered Person's claims for medical or dental charges against the other person.

"Reimbursement" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

**Recovery from another plan under which the Covered Person is covered.** This right of reimbursement also applies when a Covered Person recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

## COBRA CONTINUATION OPTIONS

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), requires that most employers sponsoring a group health plan ("Plan") offer Employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

**What is COBRA continuation coverage?** COBRA continuation coverage is group health insurance coverage that an employer must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the employer's Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated nonCOBRA beneficiaries).

**Who is a Qualified Beneficiary?** In general, a Qualified Beneficiary is:

- (i) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (ii) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (iii) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director).

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a qualified beneficiary, then a Spouse or Dependent child of the individual is not considered a Qualified Beneficiary by virtue of the relationship to the individual.

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) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

**What is a Qualifying Event?** A Qualifying Event is any of the following where Plan coverage would be terminated except for COBRA continuation:

- (i) The death of a covered Employee.
- (ii) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (iii) The divorce or legal separation of a covered Employee from the Employee's Spouse.
- (iv) A covered Employee's becoming entitled to Medicare benefits.
- (v) A Dependent child's ceasing to be a Dependent child of a covered Employee under the requirements of the Plan.
- (vi) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA law are also met.

The taking of leave under FMLA does not constitute a Qualifying Event. A Qualifying Event occurs, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the maximum coverage period is measured from this date.

**What is an election period and how long must it last?** A group health plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

**Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?** In general, the Employer or Plan Administrator must determine when a Qualifying Event has occurred. However, each covered Employee or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

- (i) A Dependent child's ceasing to be a Dependent child under the generally applicable requirements of the Plan.
- (ii) The divorce or legal separation of the covered Employee.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of: the date of the Qualifying Event, or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

**Is a waiver before the end of the election period effective to end a qualified beneficiary's election rights?**

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Employer or Plan Administrator, as applicable.

**When may a Qualified Beneficiary's COBRA continuation coverage be terminated?** During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (i) The last day of the applicable maximum coverage period.
- (ii) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (iii) The date upon which the Employer ceases to provide any group health plan (including successor plans) to any Employee.
- (iv) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (v) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (vi) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
  - (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
  - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated nonCOBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

**What is the maximum coverage periods for COBRA continuation coverage?** The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- (i) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not disability extension and 29 months after the Qualifying Event if there is a disability extension.

- (ii) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
  - (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
  - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- (iii) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the retired covered Employee ends on the date of the retired covered Employee's death. The maximum coverage period for a Qualified Beneficiary who is the Spouse, surviving Spouse or Dependent child of the retired covered Employee ends on the earlier of the date of the Qualified Beneficiary's death or the date that is 36 months after the death of the retired covered Employee.
- (iv) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- (v) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

**Under what circumstances can the maximum coverage period be expanded?** If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who were Qualified Beneficiaries in connection with both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months.

**How does a Qualified Beneficiary become entitled to a disability extension?** A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage and provides notice to the Plan Administrator of the disability determination on a date that is both within 60 days after the date the determination is issued and before the end of the original 18-month maximum coverage period that applies to the Qualifying Event.

**Can a Plan require payment for COBRA continuation coverage?** Yes. For any period of COBRA continuation coverage, a Plan can require the payment of an amount that does not exceed 102% of the applicable premium except the Plan may require the payment of an amount that does not exceed 150% of the applicable premium for any period of COBRA continuation coverage covering a disabled qualified beneficiary that would not be required to be made available in the absence of a disability extension. A group health plan can terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the Plan with respect to that qualified beneficiary.

**Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?** Yes. The Plan is also permitted to allow for payment at other intervals.

**What is Timely Payment for payment for COBRA continuation coverage?** Timely Payment means payment that is made to the Plan by the date that is 30 days after the first day of that period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the

period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situation nonCOBRA beneficiaries for the period.

Notwithstanding the above paragraph, a plan cannot require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary.

## **RESPONSIBILITIES FOR PLAN ADMINISTRATION**

**PLAN ADMINISTRATOR.** NEA - Alaska Health Plan is the benefit plan of NEA - Alaska, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by NEA - Alaska to be Plan Administrator and serve at the convenience of NEA-Alaska. If the Plan Administrator resigns, dies or is otherwise removed from the position, NEA - Alaska Health Plan shall appoint a new Plan Administrator as soon as reasonably possible.

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

Service of legal process may be made upon the Plan Administrator.

### **DUTIES OF THE PLAN ADMINISTRATOR.**

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes which may arise relative to a Plan Participant's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Administrator to pay claims.
- (7) To perform all necessary reporting as required by ERISA.
- (8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
- (9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

**PLAN ADMINISTRATOR COMPENSATION.** The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

**FIDUCIARY.** A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

**FIDUCIARY DUTIES.** A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Members and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

- (1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
- (2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

- (3) in accordance with the Plan documents to the extent that they agree with ERISA.

**THE NAMED FIDUCIARY.** A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

- (1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
- (2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

**CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY.** A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

### **FUNDING THE PLAN AND PAYMENT OF BENEFITS**

The cost of the Plan is funded as follows:

**For Member and Dependent Coverage:** Funding is derived from the funds of the Employer and contributions made by the covered Members.

The level of any Member contributions will be set by the Employer. These Member contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Member or withheld from the Member's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

### **PLAN IS NOT AN EMPLOYMENT CONTRACT**

The Plan is not to be construed as a contract for or of employment.

### **CLERICAL ERROR**

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

### **AMENDING AND TERMINATING THE PLAN**

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

NEA-Alaska intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

## **CERTAIN EMPLOYEE RIGHTS UNDER ERISA**

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If a Plan Participant's claim for a benefit is denied, in whole or in part, the Plan Participant must receive a written explanation of the reason for the denial. The Plan Participant has the right to have the Plan review and reconsider the claim. Under ERISA there are steps that the Plan Participant can take to enforce the above rights. For instance, if the Plan Participant requests materials from the Plan and does not receive them within 30 days, that person may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to \$110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, that participant may file suit in state or federal court.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), that Plan Participant should contact either the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquires, Pension and Welfare Benefits Administration, at 200 Constitution Avenue, N.W., Washington, DC 20210.

## GENERAL PLAN INFORMATION

### TYPE OF ADMINISTRATION

The Plan is a self-funded health plan and the administration is provided through a third party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Members. The Plan is not insured.

### PLAN NAME

NEA - Alaska Health Plan

**PLAN NUMBER:** 501

**TAX ID NUMBER:** 92-6027877

**PLAN EFFECTIVE DATE:** July 1, 1996

**PLAN YEAR ENDS:** June 30

### EMPLOYER INFORMATION

Juneau School District  
10014 Crazyhorse Drive  
Juneau, Alaska 99801  
907-463-1700

### PLAN ADMINISTRATOR

Executive Director  
NEA - Alaska Health Plan  
360 West Benson Blvd, Suite 100  
Anchorage, Alaska 99503  
(907) 274-7526

### NAMED FIDUCIARY

Executive Director  
NEA - Alaska Health Plan  
360 West Benson Blvd, Suite 100  
Anchorage, Alaska 99503

### AGENT FOR SERVICE OF LEGAL PROCESS

Executive Director  
NEA - Alaska Health Plan  
360 West Benson Blvd, Suite 100  
Anchorage, Alaska 99503

### CLAIMS ADMINISTRATOR

Employee Benefit Management Services, Inc.  
PO Box 21367  
Billings, Montana 59104  
(406) 245-3575

**TRUSTEE(S)**

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Mary Carter  
360 West Benson Blvd, Suite 100  
Anchorage, Alaska 99503

Joe Irvine  
360 West Benson Blvd, Suite 100  
Anchorage, Alaska 99503

Maggie Jacoby  
360 West Benson, Suite 100  
Anchorage, Alaska 99503

BY THIS AGREEMENT, NEA - Alaska Health Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for NEA - Alaska on or as of the day and year first below written.

By \_\_\_\_\_  
NEA - Alaska

Date \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_