# Basic Benefits

## July 2017

# PLAN CONTACTS

**Board of Trustees**

Dennis Moen – Chair

| | |
|---|---|
| Jordan Adams | Kristina Roche |
| William Meers | Mike Welander |

**Other Plan Contacts**

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| ***Claims Administrator***<br>Eligibility questions;<br>Medical and dental claims;<br>Travel Preauthorization;<br>COBRA/HIPAA | Zenith American Solutions<br>PO Box 91013<br>Seattle, WA 98111-9103<br>Eligibility Customer Service: (800) 557-8701 Option 2, then 2 or ZA-SPO-PE71@zenith-american.com<br><br>Claims Customer Service: (800) 557-8701 Option 2 then 1 or local71customerservice@zenith-american.com<br>COBRA Customer Service: (800) 757-0071 Option 1<br>FSA/HRA Customer Service: (800) 757-0071 Option 2 or Flex@zenith-american.com<br><br>Or, log on to Zenith's participant's website at www.zenith-american.com |
| ***Precertification***<br>Precertification of Inpatient Hospital Stays and Certain Medical Procedures and Case Management | Aetna<br><br>When precertification is required, your doctor is responsible for calling the precertification number on your ID card. |
| ***Prescription Drug Benefits***<br>Retail, specialty and mail order prescription drug information | CVS Caremark<br>(866) 818-6911<br>www.caremark.com |

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| ***Vision Benefits***<br>For vision claims | Vision Service Plan (VSP)<br>PO Box 997105<br>Sacramento, CA 95899<br>(800) 877-7195<br>www.vsp.com |
| ***Aetna***<br>Nationwide PPO Network | www.Aetna.com<br>Log in to search for providers or go to<br>Aetna.com/docfind and select<br>"Aetna Choice POS II (Open Access)" network |
| ***Disease Management*** | Optum (formerly Alere)<br>(855) 738-1764<br>www.pe71alerehealth.com |
| ***Bridge Health***<br>Surgery Travel Service | Bridge Health<br>(844) 249-8108<br>Email: alaskacoalition@bridgehealth.com<br>Group Code: PE71L |
| ***Renalogic***<br>*Dialysis support services* | Renalogic<br>(844) 841-5065<br>www.renalogic.com/PE71TRUST |
| ***Teladoc***<br>Telehealth services | Teladoc<br>(800) 835-2362 (Tela-doc)<br>www.teladoc.com |
| ***Coalition Health Center*** | (907) 264-1370 in Anchorage<br>(907) 450-3300 in Fairbanks<br>www.coalitionhealthcenter.com |
| ***Local Trust Office***<br>General questions | Public Employees Local 71 Trust Fund<br>2510 Arctic Blvd.<br>Anchorage, AK 99503<br>(800) 446-3671( Option 7 ) or<br>276-7611 Option 7 in Anchorage |

# IMPORTANT PLAN PROVISIONS

## PREFERRED PROVIDER ORGANIZATION

Please see page 25 for more information on the Plan's preferred providers.

**WITHIN THE MUNICIPALITY OF ANCHORAGE** – Alaska Regional Hospital, Surgery Center of Anchorage, Geneva Woods Birth Center, Alaska Hand Rehabilitation, Ascension Physical Therapy, and Chugach Physical Therapy are the PPO providers. The Plan's reimbursement will be reduced if you use another provider for services that are available at Alaska Regional, Surgery Center of Anchorage, Alaska Hand Rehabilitation, Ascension Physical Therapy or Chugach Physical Therapy.

**OUTSIDE OF THE MUNICIPALITY OF ANCHORAGE** – You are encouraged to use Mat-Su Regional Hospital or providers in the Aetna network to save money for yourself and the plan.

## PRECERTIFICATION AND PREAUTHORIZATION

The Plan requires precertification of all inpatient Hospital stays and certain medical procedures. See pages 20-21 for more information.

If you must travel to obtain services not available locally, your travel may be covered by the Plan, **but you must obtain preauthorization before you travel**. See page 39 for more information.

## PLAN ADMINISTRATION

The Board of Trustees 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 Board of Trustees shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan member's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Board of Trustees will be final and binding on all interested parties.

The Board of Trustees has the discretionary authority to decide whether a charge is Usual and Reasonable or Usual Customary and Reasonable. Benefits under this Plan shall be paid only if the Board of Trustees decides in its discretion that a Plan member is entitled to them.

# PATIENT AUDITOR PROGRAM

**Your Medical Bill…it's worth a second look!**

It's a fact of life, medical bills are sometimes wrong. Those mistakes can add up to substantial amounts of lost money for the Trust Fund. While there's no one reason why mistakes happen, there are some billing problems common to some hospitals. If, for some reason, tests are never performed or the medication is never given, the billing records may not be updated. Keypunching errors are another common billing mistake. A misplaced decimal point can cost thousands of dollars.

What can you do? Be sure to ask your medical provider to send you an ITEMIZED BILL. Make sure the service dates are correct. Double check charges for tests and medicines. If you find errors or have questions about any charges, call the provider's billing office and ask them to review your records. In other words, if you find an overcharge, don't forget to obtain a corrected bill.

To encourage you to check your medical bills, **the Plan will reward you with 50% of your overcharged amount, up to a maximum reward of $400** if you find an undetected error on a medical bill that has been audited and paid by the claim payer.

For example, if you find an $800 overcharge undetected by the claim payer, once the Plan receives the overpayment back, you will get $400 from the Plan. A second look can help control the cost of your health coverage and possibly put some dollars back in your pocket.

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# WHO IS COVERED

## ELIGIBILITY

### Employees

Generally, Employees with 30 or more hours of service per week shall be eligible for coverage. Eligibility is attained the first of the month following a waiting period of 60 calendar days. Please refer to the collective bargaining agreement for more information.

If you do not elect coverage, you will be enrolled in the Yellow Family plan as default. You may change your election during the annual open enrollment period or if you experience a Qualifying Event.

### Dependents

You must complete paper or online enrollment forms and provide the required documentation if you wish to cover dependents.

Only the following are eligible for dependents' coverage:

- Your legal spouse (you may be separated, but not divorced)
- Children from birth up to age 26, if they are either:
  - Your natural children or legally adopted children, or
  - Stepchildren, foster children placed through a state foster child program, or children for whom you are the legal, court-appointed guardian.

When both parents of a child are covered under the Plan as employees, the child can be covered as a dependent of both parents.

Coverage is mandatory for a child under age 18, unless the child has other coverage.

<u>Foster Child</u>

A foster child is:

- A child you are raising as your own;
- A child who lives in your home;
- A child who is chiefly dependent on you for support; or
- A child for whom you have taken full legal parental responsibility and control as evidenced by a court order, during the term of that order. (Evidence of your assumption of legal responsibility for the child must be submitted with updated enrollment forms to the Plan.)

A foster child is not:

- A child temporarily living in your home;
- A child placed with you in your home by a social service agency which retains control of the child; or
- A child whose natural parent is in a position to exercise or share parental responsibility and control.

Adopted Child

A child placed with you for adoption will be covered from the earlier of:

- The date of adoption; or
- The date the child is placed in your home.

Placed for adoption means assumption and retention by the employee of a legal obligation for total or partial support of such child in anticipation of adoption of the child.

Dependents Not Eligible for Coverage

The following are not eligible for dependents' coverage:

- Your divorced spouse;
- A child who has been legally adopted by another person (custody ends on the date custody is assumed by the adoptive parents);
- A child for whom the court ordered guardianship or foster order placing him or her in your custody has expired; or
- A child who has attained the limiting age of 26.

Handicapped Child

Coverage for a mentally or physically handicapped child who reaches age 19 while covered under the Plan may be continued past the child's 26th birthday if the child:

- Is chiefly dependent on you for support; and
- Is not capable of self-sustaining employment.

The coverage will continue only if you give the Plan proof of the child's handicap:

- No later than 31 days after the child's 19th birthday; and
- Thereafter as we may require, but not more often than once every 2 years.

## WHEN YOUR COVERAGE BEGINS

### New Employees

You will become covered on the first day of the month which coincides with or follows the day you complete 30 calendar days of employment, provided you are actively at work on that day. If you are not actively at work on that day, your coverage will begin on the first day of the month which coincides with or follows the day you return to active work.

**Rehired Employees**

If you were previously covered, and you are rehired within 7 calendar days of the date your coverage terminated, your coverage begins on the day you return. If you were previously covered, and you are rehired more than 7 calendar days after your coverage terminated, you are considered a new employee and coverage for you and your dependent begins as described above.

**Employees Returning from Leave Without Pay or Layoff**

You will become covered on the day you return to work, provided you are actively at work on that day.

Active at Work Provision

Any requirement regarding eligibility, or that an otherwise eligible person be actively at work before coverage may begin or remain in force is not applicable to Health Coverage if the eligibility for the coverage or the absence is due to a Health Status-Related Factor.

**Health Status-Related Factor** means any of the following:

Health Status;

- Medical Condition (including both physical and mental Sickness);
- Claims experience;
- Receipt of health care;
- Medical history;
- Evidence of insurability (including conditions arising out of acts of domestic violence);
- Disability; or
- Genetic information.

However, if on the day your coverage is to begin:

- You are on a regular paid day of vacation; or
- Such day is a regular non-working day;

You will still be considered actively at work if you were available for work on the last preceding regular work day.

If, on the day your coverage is to begin you do not report to work, you will be considered actively at work if you are available for work on that day.

**Dependents**

If you want to cover your eligible dependents, you must complete paper or online enrollment forms and provide dependent documentation to the Plan before any dependent claims will be paid.

If you do not have a dependent until after you are covered, you must submit an updated enrollment form and also provide the required dependent documentation no later than 60 days from the date you acquire the dependent. If you do not submit the required forms and documentation within the 60-day timeframe, your dependent will not be eligible for coverage, and your next opportunity to enroll your dependent will be at Open Enrollment or at the time you experience another Qualifying Event.

Provided you submit the required forms and documentation timely, the dependent is eligible for coverage on the date you acquire the dependent, and will be covered on that date if you are enrolled in a plan that covers dependents. However, if you are enrolled in an employee-only plan, your plan change to a family plan will be effective on the first day of the month after you enroll online or the Plan receives the required enrollment forms and requested documentation.

Your newborn or newly adopted child will be automatically covered for 31 days, regardless of your plan election. If you are covered under an employee only plan option, you must notify the Plan of the birth or adoption and elect a family plan option within 60 days of the date of the child's birth or adoption, unless your newly acquired dependent has other health coverage. If you change your plan election, the change will be effective retroactive to the date of the birth or adoption. Coverage beyond the first 31 days will be continued only if an updated Enrollment Form and the required documents are sent to the Plan within 60 days of the birth or adoption of the new dependent.

<u>Medical Child Support Order</u>

If your child is not covered because you did not enroll your child for dependent coverage, the child will be enrolled after the Plan:

- Receives a final medical child support order which requires enrollment; and
- Determines that the order is qualified.

Our Procedures for Determining if a Medical Child Support Order is Qualified:

When we receive a proposed or final medical child support order, we will notify you and each child named in the order, at the addresses shown in the order, that we have received it. We will then review the order to decide if it meets the definition of a Qualified Medical Child Support Order. Within 30 days after we receive the order (or within a reasonable time thereafter), we will give a written notice of our decision to you and each child named in the order. We will also send our notices to each attorney or other representative who may be named in the order or in other correspondence filed with the Plan. If we decide that the order is not qualified, our notice will provide the specific reasons for our decision and the opportunity to correct the order or appeal our decision by contacting us within 30 days. If we decide that the order is qualified, our notice will provide instructions for enrolling each child named in the order. The Plan provisions that apply for other eligible dependents (such as the exceptions for when dependents' coverage begins and the rules for determining when dependents' coverage ends) will also apply for each child named in the order. We must receive a certified copy of the entire Qualified Medical Child Support Order before enrollment can occur. Also, if the cost of each child's coverage is to be deducted from your pay, the Plan must receive proper authorization in the order or otherwise.

As part of our authority to interpret the Plan, we have the discretion and final authority to decide if an order meets or does not meet the definition of a Qualified Medical Child Support order so as to require the enrollment of your child as an eligible dependent. Our reasonable decision will be binding and conclusive on all persons. If, as a result of an order, benefits are paid to reimburse medical expenses paid by a child or the child's custodial parent or legal guardian, these benefits will be paid to the child's custodial parent or legal guardian.

Medical Child Support Order is defined by Section 609 of ERISA. In general, a Qualified Medical Child Support Order means any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which:

- Either:
    - Relates to medical benefits under the Plan and provides for your child's support or health benefits coverage pursuant to a state domestic relations law (including a community property law); or
    - Enforces a law relating to medical child support described in Section 1908 of the Social Security Act;
- Creates or recognizes the existence of your child's right to be enrolled and receive medical benefits under the Plan;

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

## CHANGES TO YOUR COVERAGE

If you experience a Qualifying Event and wish to change your plan selections, please contact the Plan. You will be required to submit new enrollment forms and proof of the qualifying event within 60 days of the event, or you must wait until the next open enrollment or another Qualifying Event to make a change. Changes will be effective on the first day of the month after the Plan receives your revised forms and proof of the Qualifying Event. All changes must be consistent with the Qualifying Event.

**Eligible Qualifying Events**

- Marriage;
- Birth or adoption of a child;
- Child's 18th birthday;
- Divorce or legal separation;
- Death of a dependent;
- Dependent ceases to be an eligible dependent or becomes eligible;
- Loss, gain, or significant change in other coverage;
- Declaration of an open enrollment period by the Board of Trustees; and
- Changing from full-time to part-time status or vice versa.

Reminder: If you are enrolled in Employee Only coverage and any family member loses other coverage, you must notify the Plan in writing within 60 days.

## ENROLLMENT ELECTION REVIEW PROCEDURE

If you disagree with the implementation of your new hire, Qualifying Event, or Open Enrollment election, you must follow the enrollment appeal process below. This process is the sole and exclusive remedy available to you. In addition, you must follow the enrollment appeal process within the time periods designated or you will lose your right to appeal the matter.

Enrollment election appeals must be submitted in writing to the Public Employees Local 71 Trust Fund, c/o Trust Administrator, Zenith American Solutions, 201 Queen Ave. N. #100, Seattle, WA 98109, within 45 days after the first payroll deduction resulting from the enrollment election or default election. You or your representative may submit pertinent issues and comments in writing and provide evidence supporting your position that you were improperly enrolled.

The Board of Trustees or a committee of Trustees will consider your appeal at the next scheduled Board meeting, provided that the written appeal is received by the Plan at least 20 business days prior to the Board meeting. An appeal received after that date will be heard at the subsequent Board meeting.

The Board of Trustees has the sole and exclusive authority to make decisions regarding new hire, Qualifying Event and Open Enrollment election appeals, and the Board's decisions will be considered final and binding.

## WHEN COVERAGE ENDS

### Employees and Dependents

Coverage will end at midnight on the earliest of:

- The day the Plan ends;
- The day any premium for coverage is due and unpaid;
- The day before you enter the Armed Forces on active duty (except for temporary active duty of 2 weeks or less);
- The last day of the month in which you are no longer eligible under the Plan;
- For a dependent, the day employee coverage ends;
- For a dependent, the last day of the month the dependent is no longer eligible.

### Employees on Leave Without Pay or Layoff

Coverage ends at the end of the month in which you were last in pay status. For example, if you worked or were on paid leave status on

January 15 and then placed on leave without pay or layoff, coverage ends on January 31.

**Continuation of Coverage**

Refer to the How to Continue Health Coverage section found on page 73 of this booklet for a description of circumstances for which coverage may be continued for you or your dependents.

# SCHEDULE OF BENEFITS

## YELLOW AND BLUE PLANS

The Yellow and Blue Plans offer medical, hearing, dental, and vision benefits for members and their eligible dependents.

The Blue Plan is a lower deductible plan. The Yellow Plan is a higher deductible plan that allows access to a Health Reimbursement Account (HRA).

**Medical Benefits**

| | **Blue Plan** | | **Yellow Plan** | |
|---|---|---|---|---|
| Plan Year Deductible | PPO<br>$600 Individual<br>$1,200 Family | Non-PPO<br>$1,200 Individual<br>$2,400 Family | PPO<br>$2,500 Individual<br>$5,000 Family | Non-PPO<br>$5,000 Individual<br>$10,000 Family |
| Plan's Reimbursement<br><br>(applies to all Allowable Expenses, unless otherwise noted) | PPO<br>80%<br>of the Allowable Expense until the Out-of-Pocket Limit is reached; 100% of the Allowable Expense thereafter, for the remainder of the Plan Year | Non-PPO<br>60% | PPO<br>70%<br>of the Allowable Expense until the Out-of-Pocket Limit is reached; 100% of the Allowable Expense thereafter, for the remainder of the Plan Year | Non-PPO<br>50% |
| Out-of-Pocket Limit<br>(does not include the deductible) | PPO<br>$2,000 Individual<br>$4,000 Family | Non-PPO<br>$4,000 Individual<br>$8,000 Family | PPO<br>$2,350 Individual<br>$4,700 Family | Non-PPO<br>$4,700 Individual<br>$9,400 Family |
| Penalty for Non-precertification | $400 Hospital Inpatient Only | | $400 Hospital Inpatient Only | |

| | **Blue Plan** | **Yellow Plan** |
|---|---|---|
| Pre-admission Testing Benefit | 100% of the Allowable Expense | 100% of the Allowable Expense |
| Mental/Nervous | Inpatient: 80% (60% non-PPO) of the Allowable Expense, maximum of to 30 days per Plan year<br>Outpatient: 80% (60% non-PPO) of the Allowable Expense, maximum of 30 visits per Plan Year | Inpatient: 70% (50% non-PPO) of the Allowable Expense, maximum of 30 days per Plan Year<br>Outpatient: 70% (50% non-PPO)of the Allowable Expense, maximum of 30 visits per Plan Year |
| Alcohol/Drug Abuse Treatment | Inpatient: Up to 30 days per Plan Year<br>Outpatient: 80% (60% non-PPO) of the Allowable Expense, maximum of 30 visits per Plan Year | Inpatient: Up to 30 days per Plan Year<br>Outpatient: 70% (50% non-PPO) of the Allowable Expense, maximum of 30 visits per Plan Year |
| Hearing/Audio Services | Maximum of $3,000 every 3 consecutive years, not subject to the deductible | Maximum of $3,000 every 3 consecutive years, not subject to the deductible |
| Routine Wellness Exams and Preventive Services | 100% of the Allowable Expense, not subject to the deductible | 100% of the Allowable Expense, not subject to the deductible |
| Services at the Coalition Health Center | $0 copay, not subject to the deductible | $0 copay, not subject to the deductible |
| Teladoc | $0 copay, not subject to the deductible | $0 copay, not subject to the deductible |
| Bridge Health | 100% of the Allowable Expense, not subject to the deductible | 100% of the Allowable Expense, not subject to the deductible |

| | Blue Plan | Yellow Plan |
|---|---|---|
| Skilled Nursing Facility | 100% of the Allowable Expense, subject to the deductible | 100% of the Allowable Expense, subject to the deductible |
| Home Health Care | 80% (60% non-PPO) of the Allowable Expense, maximum of 120 visits per Plan Year | 70% (50%) non-PPO) of the Allowable Expense, maximum of 120 visits per Plan Year |
| Treatment of Spinal Disorders and Acupuncture | 80 % (60% non-PPO) of the Allowable Expense, maximum of 16 visits per Plan Year for spinal disorder and acupuncture treatment combined | 70% (50% non-PPO) of the Allowable Expense, maximum of 16 visits per Plan Year for spinal disorder and acupuncture treatment combined |
| Outpatient Dialysis Treatment | 80% of the Usual and Reasonable Charge for Outpatient Dialysis Treatment | 70% of the Usual and Reasonable Charge for Outpatient Dialysis Treatment |

The Plan Year Deductible is the amount you pay for Allowable Expenses each year before the Plan starts to pay benefits. In the event of a common accident involving 2 or more family members, only 1 deductible is required.

The Out-of Pocket Limit is the maximum amount you pay for Allowable Expenses in a Plan Year, not including your deductible.

The Blue Plan pays 80% of most Allowable Expenses (60% Non PPO). You usually pay 20% of PPO Allowable Expenses and 40% of Non PPO Allowable Expenses. When your PPO Out-of-Pocket expenses total $2,000 for one person or $4,000 for the family or Non PPO Out-of-Pocket expenses total $4,000 for the individual and $8,000 for the family, the Plan pays 100% of most Allowable Expenses for the rest of the Plan Year. Certain expenses are not credited to the Out-of-Pocket Limit and the Plan will not pay these expenses at 100% after the Out-of-Pocket Limit is reached.

The Yellow Plan pays 70% of most PPO Allowable Expenses and 50% of most Non PPO Allowable Expenses. You usually pay 30% for PPO Allowable Expenses and 50% of Non PPO Allowable Expenses. When your PPO Out-of-Pocket expenses total $2,350 for one person or $4,700 for the family, or Non PPO Out-of-Pocket expenses total $4,700 for the individual and $9,400 for the family the Plan pays 100% of most Allowable Expenses for the rest

of the Plan Year. Certain expenses are not credited to the Out-of-Pocket limit and the Plan will not pay these expenses at 100% after the Out-of-Pocket limit is reached.

**Prescription Drug Benefits**

| | **Blue and Yellow Plans** |
|---|---|
| Plan's Reimbursement | **Generic Drugs:** Plan pays 90%; you pay 10% up to $50 per prescription<br>**Brand-name formulary:** Plan pays 70%; you pay 30%<br>**Brand-name Non-formulary:** Plan pays 50%; you pay 50%<br>**Specialty medications**: Plan pays 90%; you pay 10% up to $200 per prescription<br>**Mail Service Program:** Maintenance medications taken regularly can be purchased through the Mail Service Program.<br>• Up to a 90-day supply of a maintenance medication may be purchased<br>• There is no charge for standard delivery of maintenance medication through the Mail Service Program<br>• The Plan will pay a higher reimbursement rate of 80% of formulary brand-name medications purchased through the Mail Service Program |
| Prescription Drug (Rx) Out-of-Pocket Limit | $1,500 per person<br>$3,000 per family |

The Prescription Drug Out-of-Pocket Limit is the maximum amount you pay for Allowable Expenses for prescription drugs in a Plan Year. It is separate from the Out-of-Pocket Limit for medical expenses. Generic medications are covered at 90%. The plan pays 70% of most Allowable Expenses for most Brand name prescription drugs. You usually pay 30%. When your Out-of-Pocket expenses total $1,500 for one person, the Plan pays 100% of most Allowable Expenses for the rest of the Plan Year.

If you choose to purchase a Brand name medication when a generic equivalent is available, you will pay a $50 penalty in addition to your 30% copayment. The penalty does not apply to your Out-of-Pocket Limit.

Non-network pharmacy prescriptions will not apply to your Out-of-Pocket Limit and the Plan will not pay these expenses at 100% after the Out-of-Pocket Limit is reached. If you obtain a prescription in an area with no network providers nearby (within a 25-mile radius from where the prescription is obtained), you must pay for the prescription yourself and then you may submit the claim to the Claims Administrator to be processed under the medical plan.

Certain medications may require prior authorizations, and quantity limitations may apply to some medications.

**Specialty Step-Therapy:** The plan requires participation in a step therapy program for specialty prescriptions. If you are filling a specialty prescription for the first time, you must try a preferred medication before trying other alternatives. If you choose a non-preferred specialty drug without first trying the preferred medication, you may be responsible for the full cost of the non-preferred brand medication.

**Advanced Control Formulary:** Effective October 1, 2017, the plan will participate in CVS Caremark's Advanced Control Formulary program, with exclusions. This program determines if your medication is covered, considered Formulary or Non-Formulary and subsequently your associated member coinsurance.

Some medications may be excluded from coverage. You are encouraged to review the Advanced Control Formulary list prior to filling your prescriptions and talk to your doctor about alternatives if your medication is not on the Formulary list to avoid a higher member coinsurance. If you are currently taking an excluded medication, Caremark will notify you by mail and provide alternative medicines to discuss with your doctor.

**Dental Benefits**

| | **Blue and Yellow Plans** |
|---|---|
| Plan Year Deductible | $50 Individual<br>$100 Family |
| Preventive | Plan pays 100% of the Allowable Expense (no deductible) |
| Restorative | Plan pays 85% of the Allowable Expense |
| Prosthetic | Plan pays 50% of the Allowable Expense |
| Orthodontic (for dependent children only) | Plan pays 50% of the Allowable Expense, up to $500 per Plan Year, up to $1,000 maximum while covered under the Plan; not subject to the deductible |
| Plan Year Maximum Benefit | $2,000 per person |

**Vision Benefits**

| | **Blue and Yellow Plans** | |
|---|---|---|
| Deductible (applies to lenses and frames only) | $25 Individual | |
| Frequency of Service | | |
| Exam | Every 12 months | |
| Lenses | Every 12 months | |
| Frames | Every 24 months | |
| Contacts* | Every 12 months | |
| Reimbursement | PPO | Non-PPO |
| Exam | 100% | $50 |
| Lenses | | |
| Single Vision | 100% | $50 |
| Lined Bifocal | 100% | $75 |
| Lined Trifocal | 100% | $100 |
| Frame | $160 | $70 |
| Contacts* | $170 | $170 |
| Lasik Vision Services | Plan pays flat fee of $275<br>You may choose this instead of the exam/lenses/frames/contacts allowance | |

*If you choose contacts instead of glasses.

## COBRA LOW OPTION PLAN

| Benefit | Low Option Individual | Low Option Family |
|---|---|---|
| Plan Year Deductible | $600 Individual | $600 Individual<br>$1,200 Family |
| Plan's Reimbursement<br>(applies to all Allowable Expenses, unless otherwise noted) | 80% (60% non-PPO) of the Allowable Expense until the Out-of-Pocket Limit is reached; 100% of the Allowable Expense thereafter, for the remainder of the Plan Year | |
| Out-of-Pocket Limit (does not include the deductible) | $4,500 Individual PPO / $9,000 Individual non-PPO | $4,500 Individual PPO / $9,000 Individual non-PPO<br>$12,700 Family PPO / $25,400 Family non-PPO |
| Pre-admission Testing Benefit | 100% of the Allowable Expense | |
| Prescription Drug | Subject to Deductible; then paid at 80% until Out-of-Pocket Maximum is reached; then paid at 100% | |
| Mental/Nervous | Inpatient: 80% (60% non-PPO) of the Allowable Expense, maximum of 30 days per Plan Year<br>Outpatient: 80% (60% non-PPO) of the Allowable Expense, maximum of 30 visits per Plan Year | |
| Alcohol/Drug Abuse Treatment | Inpatient: 80% (60% non-PPO) of the Allowable Expense, maximum of 30 days per Plan Year<br>Outpatient: 80% (60% non-PPO) of the Allowable Expense, maximum of 30 visits per Plan Year | |
| Routine Wellness Exams and Preventive Services | 100% of the Allowable Expense, not subject to the deductible | |

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|---|---|
| Services at the Coalition Health Center | $0 copay, not subject to the deductible |
| Teladoc | $0 copay, not subject to the deductible |
| Bridge Health | 100% of the Allowable Expense, not subject to the deductible |
| Home Health Care | 80% (60% non-PPO) of the Allowable Expense, maximum of 120 visits per Plan Year |
| Treatment of Spinal Disorders and Acupuncture | 80% (60% non-PPO) of Allowable Expense, maximum of 16 visits per Plan Year for spinal disorder and acupuncture treatment combined |
| Outpatient Dialysis Treatment | 80% (60% non-PPO) of the Usual and Reasonable Charge for Outpatient Dialysis Treatment |

The COBRA Low Option Plan does not offer hearing, dental and vision benefits.

The Plan Year is July 1 through June 30.

For a definition of Allowable Expense, see page 98.

For information regarding the PPO Provisions, see page 25.

## HEALTH REIMBURSEMENT ACCOUNT (HRA)

The Yellow Plan includes an HRA. The HRA is a feature which works with the Yellow Plan to help you manage your health care costs. The HRA provides funds to pay some of the costs you have to pay under this plan.

Please Note: The Trust owns and funds the HRA. Funds in the HRA are used to pay eligible charges as claims are processed through the health plan.

HRA Amounts: When HRA coverage starts, HRA funds are set aside for each employee. HRA funds can be used for all family members. The Trust provides $1,000 per employee and $1,500 per family to help pay for Out-of-Pocket costs for yourself and any family members, including deductibles, copays and coinsurance, as well as eligible expenses allowed under the Health Care Flexible Spending Account (FSA). If you are enrolled in both the HRA and a Health Care FSA, the Health Care FSA shall pay first.

Rollover of Funds: Unused funds in your HRA at the end of the Plan Year are rolled over to the following Plan Year. If you select a different Plan or are no longer eligible for Health Trust benefits, any remaining funds in your HRA are forfeited.

| | **Blue Plan** | **Yellow Plan** |
|---|---|---|
| Health Reimbursement Account (HRA) | No HRA Provided | The Trust provides a $1,000 per employee and $1,500 per family contribution to the HRA to help pay out-of-pocket expenses |

# UTILIZATION MANAGEMENT PROVISIONS

In order to provide cost effective health coverage, the Plan contains the following Utilization Management Provisions:

- Hospital Confinement Review
- Medical Procedure Review
- Case Management
- Disease Management
- Preadmission Testing Benefits

**Note: We encourage you to read these provisions thoroughly. In some cases, the Plan provides more favorable benefits if you follow the Utilization Management Provisions. In some instances, less favorable benefits are provided if the Utilization Management Provisions are not used.**

## HOSPITAL CONFINEMENT REVIEW (PRECERTIFICATION)

The Plan requires review of all Hospital and Treatment Center Confinements. Generally, your provider will initiate precertification and provide the necessary information to Aetna. **However, it is your responsibility to ensure precertification is obtained.** If your Hospital Confinement is not reviewed according to these procedures, your benefits will be reduced.

**Effect on Benefits**

1. Reviewed and Certified: Allowable Expenses for Hospital Confinements which are certified by Aetna (or by the participant's primary health plan) as Medically Necessary will be considered according to Plan provisions.
2. Not Reviewed: If the Hospital Confinement is not reviewed timely (see Rules for a Hospital Review, below), any benefits payable for that period of Hospital Confinement will be reduced by $400. No benefits will be payable unless the services are Medically Necessary and all other Plan requirements are satisfied.
3. Reviewed and Not Certified: If the Hospital Confinement is reviewed timely, but inpatient care is not certified as Medically Necessary:
    a. Benefits for Hospital room and board will not be payable; and
    b. Expenses for other covered Hospital services will be considered according to Plan provisions.

When benefits are reduced in accordance with 2 or 3 above, the:

- $400 reduction for unreviewed Confinements; or
- Hospital expenses for services which are not Medically Necessary;

will not be used to satisfy your deductible or Out-of-Pocket Limit.

**Certification does not automatically mean benefits are payable.** No benefits will be payable for services which are not Medically Necessary or are not covered by the Plan. PPO provisions may apply.

**Rules for a Hospital Review**

1. For a Non-emergency Admission. Your Physician or the inpatient facility must notify Aetna by phone *prior to* the scheduled Hospital admission. Aetna will send the Physician and/or the Hospital written notice of certification or non-certification of the Hospital admission.
2. For an Emergency Admission. The attending Physician or the inpatient facility must notify Aetna by phone *no later than the second business day following admission*. Aetna will send the Physician and/or the Hospital written notice of certification or non-certification of the Hospital admission.
3. For Continued Confinement. If your Physician is considering lengthening your Hospital stay past the period which was originally certified, you, your Physician or the Hospital must call Aetna to request certification of the additional days.

**Exception**

These provisions will not apply when Medicare or another health plan has primary responsibility for the patient's claims.

## MEDICAL PROCEDURE REVIEW PROGRAM (PRECERTIFICATION)

Certain outpatient services must be precertified. Please visit www.aetna.com/healthcare-professionals/assets/documents/2017-precert-list.pdf for a list of procedures which require precertification.

**Effect on Benefits**

1. Reviewed and Certified: Allowable Expenses for medical procedures which are certified by Aetna (or by the participant's primary health plan) as Medically Necessary will be considered according to Plan provisions.
2. Reviewed and Not Certified: If the medical procedure is not certified as Medically Necessary, benefits for all Hospital, surgical, medical and other related services will not be payable.

Expenses for services which are not Medically Necessary will not be used to satisfy your deductible or Out-of-Pocket Limit.

**Certification does not automatically mean benefits are payable.** No benefits will be payable for services which are not Medically Necessary or are not covered by the Plan. PPO provisions may apply.

**Rules for Medical Procedure Review**

1. For a Non-emergency Medical Procedure. Your Physician must notify Aetna by phone *prior to* the scheduled procedure. Aetna will send the Physician written notice of certification or non-certification of the procedure.
2. For an Emergency Medical Procedure. Your attending Physician must notify Aetna by phone *no later than the second business day following the day the procedure was performed*. Aetna will send the Physician written notice of certification or non-certification of the procedure.

**Exception**

These provisions will not apply when Medicare or another health plan has primary responsibility for the patient's claims.

## CASE MANAGEMENT PROGRAM

If you have injuries or illness that may extend for some time, the Plan provides for services through case management. For example, if you are facing an extended period of care or treatment and these services may be accomplished in a skilled nursing facility, or in your home, the case management program may be helpful in facilitating and coordinating this care. This can be beneficial to you because these settings may offer cost savings as well as other advantages to you and your family.

When reviewing claims for the case management program, the case management provider always works with you, your family, and your Physician so you receive close, personal attention.

Through case management, the case management provider can consider recommendations involving expenses usually not covered for reimbursement. This includes suggestions to use alternative medical management techniques or procedures, or suggestions for cost-effective use of existing Plan provisions such as home health care and convalescent facilities. In order to be considered for payment under the Plan, the alternative care must result in savings without detracting from the quality of care. All parties must approve alternate care before it is provided.

Case management is voluntary. There is no penalty for not participating in case management or for leaving the program during its course.

Aetna provides these services for the Trust, and may contact you if you are a candidate for the program. If you have questions regarding case management and its possible application to you, call the Plan.

## DISEASE MANAGEMENT PROGRAMS

Optum Health

The Plan provides additional assistance for covered persons who are diagnosed with one of the following chronic conditions through Optum:

- Diabetes
- Asthma
- Coronary Artery Disease (CAD)
- Heart Failure
- Chronic Obstructive Pulmonary Disease (COPD)

Renalogic

If you are diagnosed with Chronic Kidney Disease (CKD), Renalogic's CKD program focuses on preventing the progression of the disease, managing comorbid conditions, and if necessary, helps to control the cost of dialysis. The nurse coaches are registered nurses with a specialty in CKD and teach patients how to manage their condition, change healthcare related behaviors and provide emotional support.

The Optum Health and Renalogic programs are free, voluntary and confidential. You receive information about your condition and one-on-one support and advice from an experienced medical professional to help you manage your condition.

Optum Health and Renalogic provide these services for the Trust and may contact you if you are a candidate for the program. If you have questions regarding disease management and its possible application to you, call the Plan.

## PREADMISSION TESTING BENEFITS

If you or your dependent receives preadmission tests, the Plan will pay the Allowable Expenses according to the Schedule of Benefits.

### Conditions

Benefits will only be payable under the Preadmission Testing Benefit if:

- Your Physician determines that Hospital Confinement is required, before the tests are performed;
- The tests would be covered if performed during Hospital Confinement;
- The tests are performed:
  - On an outpatient basis;
  - Within 7 days of admission as an inpatient; and
  - In connection with a covered Hospital Confinement; and
- The Hospital where the covered person is confined:
  - Accepts the preadmission testing in lieu of tests which would have been performed during Hospital Confinement; and
  - Does not repeat the tests upon admission, unless your medical record shows both:
    - ✓ The results of the preadmission tests; and
    - ✓ That repeated tests are Medically Necessary.

## ADVANCE MEDICAL PRE-TREATMENT ESTIMATE

In order to determine what is covered before beginning any inpatient or outpatient medical procedure expected to cost $1,000 or more, you may ask your Physician to file a Medical Pre-Treatment Estimate Form. You may obtain this form from the Claims Administrator. On this form, your Physician will describe the proposed course of treatment and the expected charges. You should submit the completed Medical Pre-Treatment Estimate Form to the Claims Administrator. The Claims Administrator will review the information provided and advise you and your Physician of the estimated benefits payable. Note this process is optional, and should not be confused with the mandatory Precertification requirements outlined on page 21.

# PREFERRED PROVIDER ORGANIZATION (PPO) PROVISIONS

When you or your dependents require health care, you may choose any Physician, Hospital or other health care provider you wish. If you use the services of a preferred provider, however, you may receive a discounted rate for services and Plan benefits may be more favorable. Regardless of the provider you choose, benefits will be subject to all terms, conditions, and limitations of the Plan. The Plan does not supervise, control, or guarantee the health care services of any provider (Preferred or Non-Preferred).

## HOSPITAL AND PHYSICAL THERAPY PPO WITHIN THE MUNICIPALITY OF ANCHORAGE

Alaska Regional Hospital is the preferred Hospital within the Municipality of Anchorage for both inpatient and outpatient services. Surgery Center of Anchorage is a preferred facility and may be used as an alternative to Alaska Regional Hospital. Geneva Woods Birth Center is a preferred facility for participants who prefer an alternative birth experience. Alaska Hand Rehabilitation, Ascension Physical Therapy, and Chugach Physical Therapy are the preferred providers within the Municipality of Anchorage for physical therapy services. Through the Health Care Cost Management Corporation, Public Employees Local 71 Trust Fund is able to get substantial discounts at these providers, which reduces overall health costs for our members while maintaining high standards of care. It is important that you use the preferred providers within the Municipality of Anchorage. **If you use a non-preferred provider for physical therapy or inpatient or outpatient Hospital services within the Municipality of Anchorage, you will be subject to a lower reimbursement percentage, as well as increased deductibles and out-of-pocket limits.**

If you use a provider for in- or outpatient services within the Municipality of Anchorage other than Alaska Regional Hospital, Surgery Center of Anchorage, Geneva Woods Birth Center, Alaska Hand Rehabilitation, Ascension Physical Therapy or Chugach Physical Therapy, your Allowable Expenses will be the amount that would have been charged by Alaska Regional or Chugach Physical Therapy. For non-PPO services within the Municipality of Anchorage, the Allowable Expense for inpatient Hospital services will be limited to the Contracted Rate at the preferred provider Hospital. The Allowable Expenses for outpatient Hospital charges at a non-PPO provider within the Municipality of Anchorage will be the case rate at the preferred provider Hospital, if any, or 50% of the billed charges. Any amount charged in excess of the Allowable Expense will be your

responsibility and will not apply to your annual Out-of-Pocket Limit. See the example below for a comparison.

**Example**

The following example assumes the charges at a non-PPO Hospital are greater than the charges at the PPO. The most important number is your "out-of-pocket expense."

***Example: Claims Comparison of a Blue Plan PPO vs. non-PPO Claim within the Municipality of Anchorage***

| | PPO | | Non PPO |
|---|---|---|---|
| AK Regional Hospital Bill | $15,000 | Non PPO Hospital Bill | $30,000 |
| Less Non-covered Expense | -$0 | Less Non-covered Expense | -$15,000 |
| Equals Covered Expense | $15,000 | Equals Covered Expense at PPO Hospital | $15,000 |
| Less Deductible | -$600 | Less Non-PPO Deductible | -$1,200 |
| Equals | $14,400 | Equals | $13,800 |
| Multiplied by % Payable<br>80% to maximum out-of-pocket<br>100% of remainder | | Multiplied by % Payable<br>60% to maximum out-of-pocket<br>100% of remainder | |
| Equals Total Payment Made | $12,400 | Equals Total Payment Made | $9,800 |
| Your Out-of-Pocket Expense<br>(Total Hospital bill less payment made by the Plan) | $2,600 | Your Out-of-Pocket Expense<br>(Total Hospital bill less payment made by the Plan) | $20,200 |

**Exceptions**

No penalty will be assessed for emergency services at a non PPO emergency facility; however the patient must be transferred to a preferred provider as soon as medically possible. Services incurred after the patient is able to be transferred will be subject to non-PPO reimbursement. No penalty will be assessed for services unavailable at a PPO or for services performed in your doctor's office, with your doctor's

staff, using your doctor's equipment. Penalties for services at a non-PPO provider apply only within the Municipality of Anchorage.

## MAT-SU REGIONAL HOSPITAL

Mat-Su Regional Hospital is a preferred provider facility in the Matanuska-Susitna Borough. The Plan receives discounted rates at this facility. Plan benefits are the same whether you use a preferred provider or a non-preferred provider in the Matanuska Susitna Borough, however, by utilizing preferred providers, you and the Trust enjoy the benefit of discounted fees.

## NATIONWIDE AETNA PPO

Aetna is the nationwide Preferred Provider Organization (PPO) network for your Plan. The network includes Hospitals, Physicians, and specialty providers nationwide so you have a wide selection of network providers available. ***By utilizing the Aetna network, you will save yourself and the Trust money.*** If you choose a non-PPO facility in Alaska or a non-PPO provider of any kind outside Alaska, the non-PPO provisions will apply. To find a provider in the Aetna network, go to www.aetna.com.

Tip: Because Aetna providers charge discounted rates, you and the Trust Fund will save money when you choose an Aetna provider both in Alaska and outside of Alaska (although you will not pay a penalty if you don't choose an Aetna provider within Alaska).

### Exceptions

No penalty will be assessed for emergency services at a non PPO emergency facility; however the patient must be transferred to a preferred provider as soon as medically possible. Services incurred after the patient is able to be transferred will be subject to non-PPO reimbursement.

Please note: The Aetna PPO network is separate from and in addition to the Alaska Regional Hospital, Geneva Woods Birth Center, Alaska Hand Rehabilitation, Ascension Physical Therapy and Chugach Physical Therapy preferred provider arrangements within the Municipality of Anchorage. Within the Municipality of Anchorage, the Plan's reimbursement will be reduced if a provider other than Alaska Regional Hospital, Geneva Woods Birth Center, Alaska Hand Rehabilitation, Ascension Physical Therapy or Chugach Physical Therapy is used for services available through these providers, even if the provider is in the Aetna network.

PPO provisions may not apply to dialysis claims. Please see the Outpatient Dialysis Treatment –provisions for more information.

## COALITION HEALTH CENTER

When you receive health care at the Coalition Health Center, you do not have to pay a copay or meet the annual deductible for those services.

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

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

## BRIDGE HEALTH

PE 71 partners with BridgeHealth to ensure you receive high quality care when you need non-emergency surgery, and to help you avoid high medical costs. BridgeHealth's network of doctors, hospitals and surgery centers are top-rated for quality – fewer complications, lower infection rates and better outcomes. Covered procedures include: cardiac, orthopedic, spine, women's health and general surgery.

This program is available to all PE 71 health plan participants only if this health plan is primary for the participant. Bridge Health is not available if this health plan is your secondary insurance.

How it works:

- BridgeHealth helps you select a provider with high quality ratings for your type of procedure, and handles all the administrative work, approvals, billing and scheduling.
- The Health Plan pays 100% of your surgical costs; there is no deductible, copay or coinsurance.
- If travel is required, the Health Plan pays for first-class airfare, lodging and meals for you and a companion.

If your doctor recommends surgery, call BridgeHealth to explore your provider options.

- Your group code is PE71L
- Phone: 844-249-8108 (toll-free)
- Email: Alaskacoalition@bridgehealth.com
- Online: bridgehealth.com

# COVERED MEDICAL EXPENSES

The Plan provides extensive and valuable benefits for you and your eligible dependents. Benefits are available for Medically Necessary services and supplies needed to diagnose, care for, or treat a medical condition. The service or supply must be widely accepted professionally in the United States as effective, appropriate and essential, based upon recognized standards of the health care specialty involved.

Services that are NOT considered Medically Necessary are:

- Services rendered by a provider but not requiring the technical skills of the provider;
- Services and supplies furnished mainly for the personal comfort or convenience of the patient, care provider or family member;
- Services and supplies furnished solely because the individual is an inpatient on a day on which the physical or mental condition could safely and adequately be diagnosed or treated while not confined; or
- Any part of the cost for services or supplies exceeding that of any other service or supply that would have been sufficient to safely and adequately diagnose or treat the patient.

## PHYSICIAN'S SERVICES

The Plan pays for covered medical treatment and surgery performed by a qualified Physician.

## HOSPITALIZATION

Remember to precertify any Hospital admission. The lack of Hospital Confinement review may result in a reduction of your benefits. See pages 20-22 for more information.

The Plan covers Hospital room and board charges only while you are necessarily confined as a registered bed patient and under the care of a Physician. Coverage includes room, board, general duty nursing, intensive care and other services regularly rendered by the Hospital to its occupants, but does not include private duty or special nursing services rendered outside of an intensive care unit. You must pay the difference in charges between a private room and a semiprivate room, unless the Plan determines a private room is Medically Necessary.

The Plan also provides for Hospital services and supplies, those charges made by a Hospital on its own behalf for necessary medical services and supplies actually administered during Hospital Confinement other than for

room and board, intensive care unit, private duty nursing, or physicians' services. Services of a personal nature, including radio, television, and guest trays are not included.

## HOME HEALTH CARE

The Plan pays for the charges of a Home Health Care Agency for services and supplies furnished to you at home for care in accordance with a home health care plan.

A home health care plan provides for the treatment of disease or Injury in a place of confinement other than a Hospital or skilled nursing facility. The attending Physician must prescribe care and treatment in writing. Treatment may include:

- Part-time or intermittent nursing care by a registered graduate nurse (RN) or by a licensed practical nurse (LPN);
- Part-time or intermittent home health aide services which consist primarily of caring for the patient;
- Physical, occupational, or speech therapy;
- Medical supplies, drugs and medicines prescribed by a Physician if they would have been covered if the patient had been confined in a Hospital or skilled nursing facility; and
- Laboratory services provided by or on behalf of a Home Health Care Agency if they would have been covered had the patient been confined in a Hospital or skilled nursing facility.

Up to 120 home health care visits to your home are covered in any one Plan Year. Visits by a registered graduate nurse (RN) or licensed practical nurse (LPN) to provide skilled nursing care, visits from therapists to provide physical, occupational, or speech therapy, and up to 4 hours of assistance by a home health aide are considered as one visit.

Non-covered home health care expenses are:

- Services or supplies not included in the home health care plan;
- Services of a person who ordinarily resides in your home, or is a member of your family or the family of your spouse;
- Services of any social worker; and
- Transportation services.

## HOSPICE CARE

The Plan will provide benefits for Hospice Care for a participant with a life expectancy of 6-months or less.

Covered Hospice expenses are limited to:

- Room and Board for confinement in a Hospice
- Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an injury or sickness
- Medical supplies, drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition
- Physician services and/or nursing care by a Registered Nurse, licensed Practical Nurse or a Licensed Vocational Nurse
- Home health aide services
- Home help furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide
- Medical social service provided by a licensed dietician
- Respite care

The attending physician must submit a written hospice care program to the Claims Administrator every 30 days. Hospice Care ceases if the terminal illness enters remission.

Unless specified above, charges for the following will not be covered:

- Daily room and board charges over the semi-private room rate
- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling. This includes estate planning and the drafting of a will.
- Homemaker or caretaker services. There are services which are not solely related to your care. These include, but are not limited to sitter or companion services for either you or other family members: transportation; maintenance of the house.

## SKILLED NURSING CARE

The Plan pays for charges by a registered nurse (RN), licensed practical nurse (LPN), or nursing agency for skilled care.

Covered services are:

- Visiting nursing care of an RN or LPN of not more than 2 hours to perform specific skilled nursing tasks; and

Private duty nursing by an RN or LPN if your condition requires skilled nursing services and visiting nursing care is inadequate. Non-covered services are:

- Nursing care that does not require the skills of an RN; and
- Care given in a health care facility that could safely and adequately be furnished by the facility's general staff if the facility were fully staffed.

## SKILLED NURSING FACILITY

The Plan pays covered expenses according to the Schedule of Benefits, after the deductible, for charges of a skilled nursing facility while you are confined for recovery from a disease or Injury. A skilled nursing facility is a licensed institution providing the following on an inpatient basis for persons convalescing from disease or Injury:

- 24-hour professional nursing care by a registered nurse (RN) or a licensed practical nurse (LPN), if directed by a full-time RN;
- Physical restoration services to help a patient meet a goal of self-care in daily living activities;
- Full-time supervision by a Physician or RN;
- A complete medical record on each patient; and
- A utilization review plan;

It is not an institution for rest, the aged, drug or alcohol abuse treatment or recovery, mentally retarded, or care of mental disorders. Specifically covered are:

- Room and board, including charges for services, such as general nursing care in connection with room occupancy, except charges for daily room and board in a private room exceeding the facility's semiprivate room rate;
- Use of special treatment rooms, x-ray and laboratory examinations; physical, occupational or speech therapy; oxygen and other gas therapy; and other medical services that a skilled nursing facility customarily provides, except private duty or other special nursing services or Physician's services; and
- Medical supplies.

## OUTPATIENT AMBULATORY SURGICAL FACILITY

The Plan pays covered expenses according to the Schedule of Benefits for same day ambulatory surgery if you are an outpatient. The surgery must take place in a freestanding surgical facility or outpatient department of a Hospital.

## NURSE MIDWIFE SERVICES

The Plan pays for covered services during pregnancy, childbirth, and the period following childbirth if performed by a state certified nurse midwife or registered midwife acting within the authorized scope of practice.

## PRESCRIPTION DRUG BENEFITS

When you or your dependents require drugs and medicine requiring a Physician's written prescription, you may choose any pharmacist you wish. However, for the best price, you are encouraged to use a pharmacy within the pharmacy network.

### Retail Prescriptions

The Plan uses the CVS Caremark retail pharmacy network. You may obtain up to a 90-day supply of medication at one time at a retail pharmacy. However, you are still encouraged to use the mail order program because mail order offers the best price on maintenance medications.

Prescriptions for specialty medications are limited to a 30-day supply at a time, whether you purchase them through a retail or mail order pharmacy.

If you visit a participating network pharmacy and present your prescription drug card, your claim will be processed when your prescription is dispensed and you will only be responsible for your coinsurance.

If you don't use your prescription drug card or if you purchase your prescription from a non-network pharmacy, you must pay for the prescription yourself and you may submit a claim to CVS Caremark. Non-network pharmacy prescriptions will not apply to your copay maximum. The Allowable Expense for the prescription will be the participating network pharmacy rate.

If you obtain a prescription in an area with no network providers nearby (within a 25-mile radius from where the prescription is obtained), you must pay for the prescription yourself and then you may submit the claim to the Claims Administrator to be processed under the medical benefit.

For a list of participating network pharmacies, please contact the Plan. Regardless of the provider you choose, benefits will be subject to all Plan terms, conditions, and limitations. The Plan does not supervise, control, or guarantee the services of any prescription drug provider.

**Mail Order Prescriptions**

The Plan uses CVS Caremark for mail order prescriptions. Mail order is a convenient and cost effective option if you take the same medication on a regular basis.

If your Physician is prescribing a medication you will be taking over an extended period of time (more than 30 days), have your Physician write one prescription for your immediate needs (30 days or less) to be filled locally and the second for you to submit to the mail order provider.

Contact the Plan for a mail order form.

**Types of Drugs Covered**

- Brand name prescription drugs;
- Generic prescription drugs;
- Insulin; and Diabetic supplies:
    - Needles and syringes;
    - Lancets; and
    - Test tablets, sticks, tapes and strips.

Prescription drugs are medical substances which cannot be dispensed in the United States without a prescription.

A generic prescription drug is:

- Produced and sold under the chemical name or shortened version;
- Approved by the US Food and Drug Administration as safe and effective;
- Produced after the original patent expires;
- Produced by a company different from the one that first patented the chemical formulation; and
- Priced less than the product produced by the company that first patented the formulation.

**Specialty Medications**

Specialty medications are complex, high cost medications. To help facilitate the safe and effective use of these drugs, the Plan requires prior

authorization and limits the quantity purchased at one time to a 30-day supply. For a list of specialty medications, go to:

www.cvscaremarkspecialtyrx.com.

**Specialty Step-Therapy:** The plan requires participation in a step therapy program for specialty prescriptions. If you are filling a specialty prescription for the first time, you must try a preferred medication before trying other alternatives. If you choose a non-preferred specialty drug without first trying the preferred medication, you may be responsible for the full cost of the non-preferred brand medication.

## RADIATION, X-RAYS AND LABORATORY TESTS

The Plan covers radium treatments, diagnostic x-rays, lab tests, radioactive isotope treatments and TENS therapy and analysis if you have specific symptoms, whether in- or outpatient.

## REHABILITATIVE CARE

The Plan covers inpatient or outpatient rehabilitative care designed to restore and improve bodily functions lost due to Injury and illness. Such care is considered Medically Necessary only if significant improvement in bodily function is occurring and is expected to continue. The Plan also covers care (excluding speech therapy) aimed at slowing deterioration of body functions caused by neurological disease.

Rehabilitative care includes:

- Physical therapy and occupational therapy;
- Massage therapy;
- Acupuncture (subject to a combined visit limit with Treatment of Spinal Disorders);
- Speech therapy if existing speech function (the ability to express thoughts, speak words, and form sentences) has been lost and the speech therapy is expected to restore the level of speech the individual had attained before the onset of the disease or Injury; and
- Rehabilitative counseling or other help needed to return the patient to activities of daily living but excluding maintenance care or educational, vocational or social adjustment services.

Rehabilitative care must be part of a formal written program of services consistent with your condition. Your Physician or therapist must submit a statement to the claim payer outlining the goals of therapy, type of program and frequency and duration of therapy.

## ANESTHETIC

The Plan covers the cost of anesthetic and its administration. This includes injections of muscle relaxants, local anesthesia and steroids. When billed by a Hospital or Physician, the services of an anesthetist are covered.

## PREGNANCY

Pregnancy and childbirth are covered like any other medical condition while you are covered under the Plan.

If you or your dependent are confined to a Hospital as a resident inpatient for childbirth, the Plan will pay benefits in the same manner and subject to the same conditions and limitations as any other Sickness, but in no event will benefits be less than:

- 48 hours following a vaginal delivery; or
- 96 hours following a cesarean section;

for the mother and the newborn infant(s), unless the attending Physician, in consultation with the mother, recommends an earlier discharge.

Miscarriage and other pregnancy problems are covered only if you are eligible at the time they occur. If you are totally disabled as a result of a pregnancy problem and your coverage ends, you may be eligible for extended benefits. See the "Disabled Employees or Dependents" section on page 81. You may also be eligible for COBRA Continuation Coverage described under the section of this booklet entitled, "How to Continue Health Coverage" beginning on page 73.

## BENEFITS FOLLOWING MASTECTOMY

After a mastectomy for which benefits are paid by this Plan, the Plan will cover:

- The cost and fitting of external breast prostheses, to restore and achieve symmetry for the patient, but not more than 2 prostheses in any Plan Year for each breast;
- Inpatient or outpatient chemotherapy; and
- Reconstructive breast surgery on the diseased breast or on the nondiseased breast to achieve symmetry.

## TRANSPLANT BENEFITS

The Plan will cover Medically Necessary charges incurred for the care and treatment due to an organ or tissue transplant, which are not considered Experimental or Investigational, subject to the following criteria:

- The transplant must be performed to replace an organ or tissue.
- If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or donated marrow (allogenic). Coverage will also be provided for search charges to identify an unrelated match, and treatment and storage costs of the marrow, up to the time of reinfusion.
- Charges incurred for follow-up care, including immunosuppressant therapy.

**Organ procurement limits**

Charges for obtaining donor organs or tissues are covered under the Plan only when the recipient is a covered person. When the donor has medical coverage, his or her plan will pay first. The donor 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 process.
- Removing the organ or tissue from the donor; and
- Transportation of the organ or tissue from within the United States or Canada to the facility where the transplant is to be performed.

Note: Expenses related to the purchase of any organ will not be covered.

## SUPPLIES

When Medically Necessary, the Plan covers supplies prescribed by a Physician, including:

- Drugs and medicines requiring a Physician's written prescription;
- Artificial limbs and eyes;
- Bandages and surgical dressings;
- Orthopedic shoes, once per year;
- Purchase or rental (up to purchase price) of automatic repositioning appliances, eyes, casts, splints, trusses, braces, crutches and other similar durable medical or mechanical equipment. Durable medical and mechanical equipment is that which bears repeated use. It primarily and customarily serves a medical purpose, is of little use to a healthy or uninjured person, and must be ordered or prescribed by a Physician.
- Rental (up to purchase price) or purchase of a wheelchair or hospital-type bed;

- Rental or purchase of mechanical equipment required for respiratory treatment;
- Blood transfusions, including the cost of blood and blood derivatives;
- Oxygen or rental of equipment for which benefits are paid under this Plan; and
- Cranial prosthesis required as a result of medical treatment causing the loss of hair. Benefits for a cranial prosthesis are limited to $500 per person while covered under the Plan.

At its option, the Plan may purchase rather than rent medical equipment.

## TRANSPORTATION BENEFITS

### Emergency

If you have an emergency condition requiring immediate transfer to a Hospital with special facilities for treating your condition, your transportation expense will be covered by the Plan, as described in this section.

### Non-Emergency

Non-emergency transportation is covered only if you have a condition which cannot be treated locally (except as provided for orthopedic surgery) and the travel has been preauthorized. Travel preauthorization must be obtained for each visit (including initial and follow-up visits).

Transportation benefits during any Plan Year for a condition that cannot be treated locally are limited to:

- One visit and one follow-up visit for a condition requiring therapeutic treatment or surgery;
- One visit for prenatal or postnatal maternity care and one visit for the actual maternity delivery;
- One pre- or post-surgical visit and one visit for the surgical procedure; and
- One visit for each allergic condition.

If you require preoperative testing and surgery more than 100 miles from your home, food and lodging expenses outside of the Hospital are covered during the preoperative testing period, but only if you receive preauthorization. Please see the preauthorization procedures below.

### Payment of Transportation Benefits

The Plan will pay the following benefits for emergency and preauthorized non-emergency travel expenses:

- Ambulance costs within the United States. This includes transportation to the nearest Hospital by professional ambulance. A professional ambulance is a land or air vehicle specially equipped to transport injured or sick people to a destination capable of caring for them upon arrival. Specially equipped means that the vehicle contains the appropriate stretcher, oxygen and other medical equipment necessary for patient care en route. A medical technician trained in lifesaving services accompanies the transported patients.
- Round-trip transportation, not exceeding the cost of coach class commercial air transportation, from the site of the illness or Injury to the nearest professional treatment. If you use ground transportation and the one-way distance exceeds 100 miles, the Plan pays your documented travel expenses while en route for fares and mileage for the most direct route. If you obtain services in a location other than the site of the nearest professional treatment, the maximum Allowable Expense will be the cost of travel to the site of the nearest professional treatment, as determined by the Plan. Allowable Expenses for ground transportation mileage are calculated at the current IRS allowance for mileage when traveling medical care.
- The Plan pays your documented expenses for food and lodging required during the Medically Necessary travel period. The maximum Allowable Expense for food and lodging is $120 per day, or $50 per day without overnight lodging. If a parent or legal guardian accompanies a child under age 18, the Plan will pay up to an additional $50 per day. To obtain your food and lodging reimbursement, you must complete a "Travel Expense Voucher" and provide with it along with itemized food and lodging receipts. You may obtain the Travel Expense Voucher from the Claims Administrator.

If the patient is a child under 18 years of age or an incapacitated adult, a parent, legal guardian or other attendant's transportation charges are allowed, but must be preauthorized as described above. When authorized by the claim payer, transportation charges for a Physician or registered nurse are also covered.

**Travel Incentive for Orthopedic Surgery**

In many cases, it may be less expensive to receive treatment outside Alaska. The Trust will pay the travel costs for you and for a companion to accompany you if you obtain orthopedic surgery services outside Alaska and you use a participating PPO surgeon and participating PPO facility. This travel incentive will include:

- Travel for one pre-surgical visit, one post-surgical visit, and for the surgery itself. The visits and the surgery must be medically necessary.

Travel must be preauthorized. Preauthorization must be obtained each time you travel.

- Round trip transportation, not exceeding the cost of coach class commercial air transportation to the site of treatment for the patient and a companion.
- Food and lodging expenses:
    - When the patient is not an inpatient, the Plan will pay food and lodging expenses not to exceed $120 per day, or $50 per day without overnight lodging. The Plan will pay up to an additional $50 per day for the companion.
    - During any period of inpatient hospitalization, no food and lodging expenses will be paid for the patient, but the Plan will cover up to $120 per day for food and lodging for the companion, or $50 per day without lodging

You must preauthorize the travel in order to receive the incentive.

**Procedures for Preauthorization of Transportation Benefits**

All non-emergency travel **must** be preauthorized. No Plan benefits can be paid without prior travel authorization. Preauthorization must be obtained each time you travel. Contact the Claims Administrator for more information about travel preauthorization and to obtain a travel preauthorization form. The Plan may need to obtain additional information from your Physician. Once a decision has been made regarding coverage of your travel expenses, you will receive written confirmation. Travel benefits are subject to all Plan provisions, limitations and exclusions.

**Travel Exclusions**

Travel costs are payable for medical services only. No travel costs will be paid for dental or vision services.

Travel costs will not include:

- Rental cars
- Parking
- Gasoline
- Gratuities
- Alcohol

### Additional Travel Options

Refer to the Bridge Health section of this document for details on travel benefits through the Bridge Health program.

## SERVICES OBTAINED OUTSIDE THE US

The Plan provides coverage for treatment of an emergency medical condition while traveling outside the US.

The Plan will cover non-emergency and elective hospital services outside the US only if the hospital is accredited by the Joint Commission International. You can view a list of accredited facilities on the JCI website at http://jointcommissioninternational.org/JCI-Accredited-Organizations.

All other plan provisions continue to apply, including but not limited to Plan exclusions for experimental and investigational services and all internal benefit limitations.

## ALCOHOLISM AND DRUG ABUSE BENEFITS

If you or your dependent, while covered under the Plan, incurs expense for Treatment of Alcoholism or Drug Abuse, benefits will be paid in the same manner as any other Sickness, but not to exceed the benefit maximums outlined in the Schedule of Benefits.

The maximum payable for any future benefits will be reduced by the amount of benefits that have been paid.

**Alcoholism or Drug Abuse** means an illness characterized by:

- A physical and/or psychological dependency on alcohol or controlled substances; or
- Habitual lack of self control in using alcohol or controlled substances to the extent that the covered person's health is substantially impaired or social or economic function is substantially disrupted.

An approved treatment facility is one that is licensed by the state in which it is located, for treatment of Alcoholism or Drug Abuse.

**Treatment** means inpatient or outpatient medical care at an approved treatment facility including, but not limited to:

- Detoxification;
- Medical or psychiatric evaluation;
- Activity or family therapy;

- Counseling; or
- Prescription drugs and supplies.

**Exceptions**

Benefits will not be paid for:

- Any expense for which benefits are paid under any other provision of the Plan; or
- Anything excluded under the General Exclusions and Limitations starting on page 51.

## MENTAL AND NERVOUS DISORDERS

The Plan pays benefits for Mental and Nervous Disorders according to the Schedule of Benefits. The Plan covers both inpatient and outpatient treatment.

Benefits are not provided for adolescent behavior problems; learning disabilities; marital, family, sexual, or other counseling or training; Custodial Care; services after a court-ordered admission; or services which are not Medically Necessary.

**Exception**

The expense incurred for outpatient Mental and Nervous will not be used to satisfy the Out-of-Pocket Limit and will not be paid at 100% after the Out-of-Pocket Limit is reached.

## TREATMENT OF SPINAL DISORDERS

This benefit applies to specific services to diagnose and treat:

- Misalignment or dislocation of the spine; and
- Strained muscles or ligaments related to the spinal disorder.

The services subject to the limit shown in the Schedule of Benefits are:

- Office visits;
- Examinations;
- Consultations; and
- Regional manipulations.

The limit applies regardless of whether the services are performed by an MD, chiropractor, osteopath, physical therapist, massage therapist, or other provider.

The limit does not apply if you are confined as an inpatient in a Hospital.

The limit applies to treatment of spinal disorders and acupuncture treatment combined.

## CLINICAL TRIALS

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

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

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

An " Approved Clinical Trial" is defined as a Phase I,II,III or IV clinical trial for the prevention, detection or treatment of cancer or other life-threatening condition or disease (or other condition described in ACA such as federally funded trials, trials conducted under an investigational new drug application reviewed by the FDA or drug trials exempt from having an investigational new drug application). A life-threatening condition is any disease from which the likelihood of death is probable unless the course of the disease is interrupted.

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

## MEDICAL TREATMENT OF MOUTH, JAWS AND TEETH

The plan covers medical conditions of the teeth, jaw and jaw joints as well as supporting tissues including bones, muscles and nerves. Medical services include:

- Hospital care to perform dental services if required due to an underlying medical condition;
- Surgery needed to treat wounds, cysts or tumors or to alter the jaw, jaw joint or bite relationships when appliance therapy alone cannot provide functional improvement;
- Nonsurgical treatment of infections or diseases not related to the teeth, supporting bones or gums;
- Dental implants if necessary due to disease or accident but only if dentures or bridges are inappropriate or ineffective. (False teeth for use with the implants are covered only under the Dental Plan as a Class III Prosthetic Service.);
- Services needed to treat accidental fractures or dislocations of the jaw or Injury to natural teeth. The teeth must have been damaged or lost other than in the course of biting or chewing and must have been free of decay or in good repair. Benefits will be first provided under the Dental Plan and then under the Medical Plan;
- Diagnosis, appliance therapy, nonsurgical treatment, and surgery by a cutting procedure which alters the jaw joints or bite relationship for temporomandibular joint disorder or similar disorder of the joint.

Myofunctional therapy is not covered. This includes muscle training or in-mouth appliances to correct or control harmful habits.

## ERECTILE DYSFUNCTION TREATMENT

The plan covers medication to treat erectile dysfunction, subject to prior authorization and quantity limits. The plan also coverage surgery to treat erectile dysfunction following treatment for prostate cancer.

## PHENYLKETONURIA (PKU) TREATMENT BENEFITS

If you or your dependent requires formulas necessary for the treatment of phenylketonuria (PKU), the Plan will pay the Allowable Expense incurred in the same manner and subject to the same conditions and limitations as for any other covered service.

## ROUTINE WELLNESS EXAMS AND PREVENTIVE SERVICES

The Plan covers preventive care, including:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (Task Force) with respect to the individual involved.

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

The complete list of recommendations and guidelines that must be covered by plans is located at:

http://www.HealthCare.gov.

Generally, covered preventive care includes:

- Routine wellness or physical exams
- Mammograms
- Pap smears
- Prostate Specific Antigen (PSA) tests
- Diabetes education
- Colorectal cancer screening, and
- Immunizations.

Recommended services may be subject to age, gender, and family history.

## OUTPATIENT DIALYSIS TREATMENT

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

- The Dialysis Program has been established for the following reasons:
  - the concentration of dialysis providers in the market in which Plan members reside may allow such providers to exercise control over prices for dialysis-related products and services,
  - the potential for discrimination by dialysis providers against the Plan because it is a non-governmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Plan members,
  - evidence of (i) significant inflation of the prices charged to Plan members by dialysis providers, (ii) the use of revenues from claims paid on behalf of Plan members to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of the Plan and other non-governmental and non-commercial plans by the dialysis providers as profit centers, and
  - the fiduciary obligation to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to Plan members, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the Plan members' interests, such as subsidies for other plans and discriminatory profit-taking.
- The components of the Dialysis Program are as follows:
  - Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, Plan members for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims").
  - Claims Affected. The Dialysis Program shall apply to all dialysis-related claims received by the Plan on or after July 1, 2013, regardless when the expenses related to such claim were incurred or when the initial claim for such products or services was received by the Plan with respect to the Plan member.
  - Mandated Cost Review. All dialysis-related claims will be subject to cost review by the Plan to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the Plan shall consider factors including:
    1. Market concentration: The Plan shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise

control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.

2. Discrimination in charges: The Plan shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.

- In the event that the Plan's charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been a material factors resulting in an increase of the charges for outpatient dialysis products and/or services for the dialysis-related claims under review, the Plan may, in its sole discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, the Plan may subject the claims and all future claims for outpatient dialysis goods and services from the same provider with respect to the Plan member, to the following payment limitations, under the following conditions:

    1. Where the Plan deems it appropriate in order to minimize disruption and administrative burdens for the Plan member, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.

    2. Where the provider is or has been a participating provider under a Preferred Provider Organization (PPO) available to the Plan's members, upon the Plan's determination that payment limitations should be implemented, the rate payable to such provider shall be subject to the limitations of this Section.

    3. Maximum Benefit. The maximum Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.

    4. Usual and Reasonable Charge. With respect to dialysis-related claims, the Plan shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or

supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

5. Additional Information related to Value of Dialysis-Related Services and Supplies. The Plan member, or where the right to Plan benefits has been properly assigned to the provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Plan, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Plan based upon credible information from identified sources. The Plan may, but is not required to, review additional information from third-party sources in making this determination.
6. All charges must be billed by a provider in accordance with generally accepted industry standards.

- Provider Agreements. Where appropriate, and a willing appropriate provider acceptable to the Plan member is available, the Plan may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this Section of the Plan and clearly state that such agreement is intended to supersede this Section.

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

- A provider that accepts the payment from the Plan will be deemed to consent and agree that (i) such payment shall be for the full amount due for the provision of services and supplies to a Plan member and (ii) it shall not "balance bill" a Plan member for any amount billed but not paid by the Plan.

## AUDIO SERVICES

The Plan pays the Allowable Expenses according to the Schedule of Benefits.

The Plan covers:

- An ontological (ear) examination by a Physician or surgeon;
- An audiological (hearing) examination and evaluation by a certified or licensed audiologist, including a follow-up consultation;
- A hearing aid (monaural or binaural) prescribed as a result of the examination. This includes ear molds, hearing aid instrument, initial batteries, cords, and other necessary supplementary equipment as well as warranty and follow-up consultation within 30 days following delivery of the hearing aid; and
- Repairs, servicing or alteration of hearing aid equipment.

You must provide written certification from the examining Physician, which explains you are suffering from a hearing loss that may be lessened by the use of a hearing aid.

**Non-Covered Audio Services**

The Plan does not pay for:

- Replacement of a hearing aid, for any reason, more than once in a 3 Plan year period;
- Batteries or other supplementary equipment other than those obtained upon purchase of a hearing aid;
- A hearing aid exceeding the specifications prescribed for correction of hearing loss;
- Expenses incurred after coverage ends, unless you order a hearing aid before the termination of coverage and receive it within 90 days of the coverage end date; and
- Audio related services otherwise covered under the Medical Plan.

# NON-COVERED MEDICAL EXPENSES

## GENERAL EXCLUSIONS AND LIMITATIONS

The Plan will not cover:

- Any Injury or Sickness which arises out of or in the course of any employment with any employer or for which the covered person is entitled to benefits under any workers' compensation or occupational disease law, or receives any settlement from a workers' compensation carrier;
- Any injury, accident, or illness for which there is a right of recovery against a third-party, unless the covered person complies with the Third Party Reimbursement and/or Subrogation requirements on page 95
- Any expense which is in excess of the Allowable Expense;
- Services or supplies which are not Medically Necessary;
- Any expense incurred after coverage ends (except as specifically provided under any extended benefits provision of the Plan);
- Any loss, expense or charge resulting from the covered person's participation in a riot or in the commission of a felony;
- Any expense or charge which the covered person does not have to pay;
- Custodial Care, except as provided under Hospice Care;
- Developmental Care;
- Cosmetic or Reconstructive Surgery, except for:
    - Expenses resulting from Injury for which a third-party or liability insurer is liable;
    - reconstructive breast surgery necessary because of a mastectomy, including all states of one reconstructive breast reduction on the nondiseased breast to make it equal in size with the diseased breast following reconstructive surgery on the diseased breast;
    - for congenital anomalies when the patient has been covered under the Plan since birth;
- Adolescent behavior problems; learning disabilities; marital, family, sexual or other counseling or training; Custodial Care; services after a court-ordered admission;

- Appetite control, food addictions, eating disorders (except for documented cases of bulimia or anorexia that meet standard diagnostic criteria as determined by the Plan, and present significant symptomatic medical problems) or any treatment of obesity (except for surgery to treat morbid obesity);
- Dental work, dental surgery or Oral Surgery (unless specifically provided; see page 54), including:
  - Treatment or replacement of any tooth or tooth structure, alveolar process, abscess or disease of the periodontal or gingival tissue; or
  - Surgery or splinting to adjust dental occlusion;
- Treatment of jaw joint disorders (unless specifically provided);
- Sex transformation or any treatment related to sexual dysfunction, unless specifically provided for erectile dysfunction;
- Promotion of fertility including, but not limited to:
  - Fertility tests;
  - Reversal of surgical sterilization; and
  - Any attempt to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization, and embryo transfer or any similar treatment or method;
- Chelation therapy except for acute arsenic, gold, mercury or lead poisoning;
- Services or supplies not provided in accord with generally accepted professional standards on a national basis;
- Services or supplies which:
  - Are considered Experimental or Investigational drugs, devices, treatments or procedures; or
  - Result from or relate to the application of such Experimental or Investigational drugs, devices, treatments or procedures;
- Any expense or charge which is primarily for the covered person's education, training or development of skills needed to cope with any Injury or Sickness, except as provided for diabetes education under Preventive Services or as required by the Affordable Care Act;
- Services or supplies which are provided or paid for by the federal government or its agencies, except for:
  - The Veterans Administration, when services are provided to a veteran for a disability which is not service-connected;

  - Military Hospital or facility, when services are provided to a retiree (or dependent of a retiree) from the armed services;
  - A group health plan established by a government for its own civilian employees and their dependents; or
  - Medicaid, if required by a Medicaid assignment of benefits;
- Any loss, expense or charge which results from an act of declared or undeclared war or armed aggression;
- Any loss, expense, or charge:
  - Which is incurred while the covered person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country; and
  - For which any governmental body or its agencies are liable;
- Treatment of mental, neuropsychiatric and personality disorders, except as provided in the "Mental and Nervous Disorders" section;
- Eye refractions/visual analysis therapy or training relating to muscular imbalance of the eye (orthoptics) or the fitting of eye glasses;
- The fitting of hearing aids, except as described under the "Audio Benefits" section;
- Services or supplies not specifically listed as a covered benefit under the Plan; and
- Any expense or charge which is primarily for the covered person's convenience or comfort or that of the covered person's family, caretaker, Physician, or other medical provider.

# DENTAL BENEFITS

The Plan provides benefits for preventive dental services and treatment of dental conditions. See the Schedule of Benefits for information about the Plan's deductibles, reimbursement percentages and benefit maximums.

## COVERED DENTAL SERVICES

### Class I Services – Preventive

The Dental Plan covers the following Class I services rendered by a Dentist (DDS or DMD):

- Oral examinations;
- Dental x-rays required for the diagnosis of a specific condition;
- Routine dental x-rays, but not more than one full mouth or series per year;
- Topical fluoride application (painting the surface of the teeth with a fluoride solution);
- Prophylaxis, including cleaning, scaling, and polishing, but not more than twice in a Plan Year; and
- Dental sealants applied to the first and second molars, but only:
    - For your dependent who is less than age 19; and
    - When the teeth have not been treated with sealants for at least 4 years.

### Class II – Restorative

The Dental Plan covers the following Class II services:

- Fillings of silver amalgam, silicate and plastic restoration;
- Repair of dentures and bridges;
- Palliative (alleviation of pain) emergency treatment;
- Extractions (removal of teeth);
- Endodontics (treatment of disease of the tooth pulp) including pulpotomy, pulp capping and root canal treatment;
- Space maintainers;
- Oral Surgery, including surgical extractions;
- Apicoectomy (surgical removal of a root tip); and
- Periodontic services (treatment of the supporting tooth structures).

**Class III – Prosthetic**

The Dental Plan covers the following Class III services:

- Inlays and onlays;
- Crowns;
- Bridges, fixed and removable;
- Dentures, full and partial; and
- Implants.

Note: benefits for these services are not payable until date of placement of the prosthesis and are subject to eligibility and benefit limitations on the date of placement.

**Class IV Services – Orthodontic**

The Dental Plan provides Orthodontic care, treatment, services and supplies according to the Schedule of Benefits, for eligible dependent children only. The Plan will not pay for orthodontia performed exclusively on primary teeth.

## NON-COVERED DENTAL SERVICES

The Dental Plan does not provide benefits for:

- Any injury, accident, or illness for which there is a right of recovery against a third-party, unless the covered person complies with the Third Party Reimbursement and/or Subrogation requirements on page 96.
- Services for congenital deformities or for purposes of improving personal appearance;
- Services that the Dentist is not licensed to perform;
- Charges that are higher than would have been charged if there were no Dental Plan;
- Service for dentures, bridges, crowns or other devices started before the effective date of coverage;
- Charges made after your coverage ends, unless they are for prosthetic devices fitted and ordered while you were covered and arriving within 90 days of the coverage end date;
- Services rendered after the end of coverage, even if you are in the course of an approved treatment plan;
- Charges of more than one Dentist for the same services in the same visit;

- Appliances or restorations necessary to increase vertical dimensions or restore or correct occlusions;
- Orthodontic care, treatment, services and supplies, except as provided under Class IV services;
- A denture replacement made less than 5 years after the last one was obtained, whether or not it was covered under this Plan;
- Replacement costs of a lost or stolen denture if this benefit has been used within the last 5 years;
- Special techniques or personalized restoration for the construction of a denture beyond the standard procedure charges;
- Services or techniques that are in excess of the alternate course of treatment guidelines; and
- Anything excluded under the Non-Covered Medical Expenses.

The Plan may, at its discretion, make benefit payments directly to either the Dentist or other provider furnishing the service, the employee, or both.

To determine whether dental needs and treatment are within Plan limitations and exclusions, the Plan reserves the right to review your dental records, including x-rays, photographs and models. With respect to your dental services, the Plan, at its expense, also has the right to request that you obtain an oral examination by a Dentist of its choice.

## DENTAL PRE-TREATMENT ESTIMATE

In order to determine what will be covered before beginning dental treatment for which charges are expected to exceed $500, you may ask your Dentist to file a description of the proposed course of treatment and expected charges with the Claims Administrator. The Claims Administrator will review the proposal and advise you and your Dentist of the estimated benefits payable.

A course of treatment is a planned program of one or more services or supplies. It may be rendered by one or more providers for the treatment of a condition diagnosed by the attending Physician or Dentist as a result of an examination. It commences on the day the provider first renders the services to correct or treat such a condition.

The Plan pays for the least expensive, professionally adequate service. By receiving an advance review, you will reduce the possibility of unexpected claim denials.

As part of advance claim review and proof of loss for any claim, the Plan, at its expense, has the right to require you to obtain an oral examination. You must furnish to the Plan all diagnostic and evaluative material

required to establish your right to benefits. Evaluative material includes dental x-rays, models, charts and written reports.

In many cases, alternative services or supplies may be used to treat a dental condition. If so, benefit coverage is limited to the services and supplies customarily employed to treat the disease or Injury and recognized by the dental profession to be appropriate according to broadly accepted national standards of practice. The Plan takes into account your total oral condition.

Following are examples of coverage limited to customary services and supplies:

- Restorative:
    - Gold, baked porcelain restoration, crowns and jackets – If a tooth can be restored with amalgam or like material and you and your Dentist select another type of restoration, your benefits are limited to the appropriate charges for amalgam or similar material; and
    - Reconstruction – Covered expenses only include charges for procedures necessary to eliminate oral disease and replace missing teeth. Appliances or restorations to increase vertical dimension or restore the occlusion are considered optional and are not covered.
- Prosthodontics:
    - Partial dentures – If cast chrome or acrylic partial dentures will restore a dental arch satisfactorily and you and your Dentist choose a more elaborate precision appliance, Allowable Expenses are limited to the appropriate charges for cast chrome or acrylic;
    - Complete dentures – If, in the provision of complete denture services, you and your Dentist decide on personalized restorations or specialized techniques, as opposed to standard procedures, covered expenses are limited to appropriate charges for the standard procedures; and
    - Replacement of existing dentures – Charges for existing denture replacements are covered only if the existing dentures are not or cannot be made serviceable; otherwise, covered expenses are limited to appropriate charges for services necessary to make appliances serviceable.

# VISION BENEFITS

The Plan provides benefits for vision services. See the Schedule of Benefits for information about the Plan's deductibles, reimbursement percentages and benefit maximums.

## COVERED SERVICES

The vision plan covers charges for eye care when provided or prescribed by an ophthalmologist or optometrist. The Plan covers only those expenses which are reasonable and customary for the services provided in the area where the expenses are incurred. The Plan requires a copayment for lenses and frames. No copayment is required for exams.

You and your dependents (if dependent coverage has been selected) may use the services of a Vision Service Plan (VSP) member doctor or any other licensed ophthalmologist or optometrist.

### Exam

This Plan covers one complete examination or vision survey per person during any 12 consecutive months, according to the Schedule of Benefits.

### Conventional Lenses

Prescription lenses will be covered once during any 12 consecutive months, if a visual analysis indicates new lenses are necessary. Lenses are covered according to the Schedule of Benefits.

### Frames

New frames will be covered whenever necessary, but not more than once during any 24 consecutive months, and will be covered according to the Schedule of Benefits.

### Contact Lenses – Elective

If contact lenses are elected instead of eyeglasses, this Plan will provide a benefit. This benefit will use up your lenses and frame benefit. For example, you will not be eligible again for a frame until 24 months after the date you purchased your contacts.

### Contact Lenses – Medically Necessary

Medically necessary contact lenses may be prescribed by a VSP doctor for certain conditions. A VSP doctor must receive prior approval from VSP for medically necessary contact lenses. Upon approval from VSP, the medically necessary contact lenses will be paid according to the Schedule of Benefits. When prescribed by a non-member doctor, the

non-member doctor must get prior approval from VSP for this benefit to be paid.

A patient who has received contact lenses either Elective or Medically Necessary would again be eligible for vision benefits as follows:

- Examination and conventional lenses, after 12 months;
- Frames, after 24 months; and
- Contact lens replacement, after 12 months if a change in prescription so indicates.

**Lasik Services**

You may choose to obtain Lasik vision services in lieu of your vision allowance for one year up to a maximum amount of $275. Claims should be submitted to the Claims Administrator. Contact the Claims Administrator for more information.

## SERVICES NOT PAID UNDER VISION BENEFITS

- Any injury, accident, or illness for which there is a right of recovery against a third-party, unless the covered person complies with the Third Party Reimbursement and/or Subrogation requirements on page 95.
- Replacement of lost or broken lenses or frames which are furnished under the Plan, except at the normal intervals when services are otherwise covered;
- Glasses secured when no prescription change is warranted;
- Sunglasses, plain or prescription;
- Photosun lenses or tinted lenses, except pink shades No. 1 and 2;
- Pano (non-prescription) lenses;
- Two pairs of glasses in lieu of bifocals;
- Any excess charge for no-line bifocals (blended type), unless the doctor certifies that the no-line bifocal (blended type) is necessary and prior approval is obtained.
- Special procedures, such as orthoptics and visual training;
- Contact lenses and subnormal vision aids, except as described in this section;
- Medical or surgical treatment of the eyes. You will be notified if an examination indicates that this type of treatment is required and, if desired, a referral will be made. However, the Vision Benefit will not pay for medical or surgical treatment, whether or not a referral is

made. (See Medical Benefits section for medical and surgical coverage.);

- Services or materials which are payable under Workers' Compensation, employer liability or similar program;
- Services which are provided without cost through any government agency;
- Eye examinations required as a condition of employment, which the employer must provide by virtue of a labor agreement; and
- Eye examinations required by a government body.

# PAYMENT OF CLAIMS

## HOW TO FILE CLAIMS

Before benefits are paid, the Plan must be provided itemized documentation of incurred expenses. The Claimant must be eligible for benefits on the date the medical care or services are received, before a claim can be considered for payment. Please refer to the eligibility section in this booklet.

A provider may file a claim on behalf of a Claimant. If a Claimant files his or her own claim, he or she must complete and sign a claim form, attach the provider's itemized bill to the claim form, and submit the form to The Claims Administrator.

Note: These Claims Procedures apply to health benefits (medical, dental, prescription drug, hearing, and vision) only. Claims for benefits under the Life, AD&D, Short-Term and Long-Term Disability Policies shall be handled by the Insurer under the provisions of the applicable Policy.

### Timely Claim Filing

All claims must be submitted:

- Within 90 days after the loss occurs; or
- As soon as reasonably possible, but not later than 365 days after the date of loss, unless the claimant is not legally capable of submission within that deadline due to confinement or disability. Claims filed after the 365-day claims-bar deadline will be denied regardless of who was at fault for the missed deadline.

Benefits are based upon the Plan provisions at the time charges were incurred.

### Examination

The Plan may require that a Claimant be examined by a physician of the Plan's choice. The Plan will not require more than a reasonable number of examinations. Where not prohibited by law, the Plan may also require an autopsy, at the Plan's expense.

## NO WAIVER OF CLAIM PAID IN ERROR AND RECOVERY BY TRUST

If a claim is paid erroneously, or if payment is made because of incomplete or inaccurate information furnished to the Plan, or if payment is made in an incorrect amount due to a clerical error, payment of the claim will not constitute a waiver of applicable Plan eligibility requirements, or any Plan limitation or exclusion. The Plan may recoup the

erroneous payment from the provider, Employee, Spouse, or Dependent, or the Plan may offset future benefit payments of the Employee, or other family members by the amount of the claim paid in error. The Plan may also take appropriate legal action to recover the amount of an overpayment.

In the event an employee's contribution for coverage not paid in full, the Plan may recoup the underpayment by offsetting future benefit payments of the Employee, or other family members by the amount of the underpayment. The Plan may also take appropriate legal action to recover the amount of unpaid contributions.

## MISREPRESENTATION

An individual who knowingly presents a false or fraudulent claim for payment or knowingly misrepresents facts relating to the eligibility for benefits (including failure to timely notify the Trust of a dependents loss of eligibility) will be subject to liability for reimbursement of the claim, for audit fees, attorney fees, and cost incurred by the Plan on account of such misrepresentation, as well as potential criminal liability. Knowingly misrepresenting eligibility, failing to timely notify the plan of a dependent's loss of eligibility, or submission of fraudulent claims is considered an intentional and material misstatement of fact to the Plan and may result in retroactive termination of coverage for the participant, spouse, and dependents.

## ANTI-ALIENATION

The Trust, and benefits payable in accordance with the Plan, shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge by any person, provided that the Trustees may recognize assignments of benefits from a Covered Person to a physician, hospital, or other person or institution that has treated or cared for, or provided services or goods to, the Covered Person; and shall recognize a Qualified Medical Child Support Order (QMSCO).

## DIRECT PAYMENTS

Any benefits for services which the Claimant has assigned will be paid to the Hospital or the provider of services. If the Claimant has not assigned the benefits, the Plan, at its option, will pay the Claimant or the Hospital or the provider of services.

Any other benefits will be paid to the Claimant, except for any benefits unpaid at the time of the Claimant's death, which may be paid, at the Plan's option, to:

- The Claimant's beneficiary; or
- The Claimant's estate.

If the Claimant's beneficiary is unable to give a valid release or if benefits unpaid at the time of the Claimant's death are not more than $1,000, the Plan may pay up to $1,000 to any relative of the Claimant who the plan finds is entitled to the benefit.

Any payment made in good faith will fully discharge the Plan to the extent of payment.

## INITIAL BENEFIT DETERMINATIONS

A Claim means a request for a Plan benefit, made by a Claimant (Plan Participant or by an authorized representative of the Plan Participant) that complies with the Plan's reasonable procedures for filing benefit claims. A Claim does not include an inquiry on a Claimant's eligibility for benefits, or a request by a Claimant or his/her physician for preauthorization of benefits for medical treatment.

A Claimant may appoint an authorized representative to act on his/her behalf with respect to the Claim. Only those individuals who satisfy the Plan's requirements to be an authorized representative will be considered an authorized representative. A healthcare provider is not an authorized representative simply because of an assignment of benefits. Contact the Claims Administrator for information on the Plan's procedures for appointing an authorized representative.

Claims that are properly filed with the Claims Administrator will be processed in accordance with the following guidelines:

- Pre-Service Non-Urgent Health Claims. A pre-service health claim is a properly filed claim for medical or dental benefits that must be preauthorized to receive full benefits from the Plan. Pre-service claims are only claims to the extent that preauthorized services are reviewed and determined to be Medically Necessary for the appropriate level of care requested. Pre-service determinations do not address the Claimant's eligibility or Plan coverage for specific services or treatment. **Failing to obtain preauthorization for a pre-service claim may result in reduced or denied benefits.** Pre-service claims include, but are not limited to non-emergency admission to a Hospital, or a Skilled Nursing Facility, Home Health Care or Hospice Care. A pre-service claim will generally be processed within 15 days of receipt. This period may be extended for up to 15 days if the Plan determines an extension is necessary due to matters beyond the control of the Plan, and notifies the claimant within the initial 15-day period of the circumstances requiring the extension of time and the date by which the Plan expects

to render a decision. If an extension is necessary due to the claimant's failure to submit the information necessary to process the claim, the notification of the extension will be provided to the Claimant as soon as possible, but not later than 5 days after the receipt of the claim. The notice will describe the specific necessary information needed to process the claim, and the Claimant will be provided at least 45 days from receipt of the notification to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information within the extension period described in the notice of not less than 45 days from the notice.

If services that require preauthorization have been provided and the only issue is what payment, if any, will be made, the claim will be processed as a post-service claim.

- Post-Service Health Claims. A post-service health claim is any properly filed claim for medical, dental, vision, audio, or Prescription Drug benefits that is not a pre-service claim and does not involve urgent care, where the treatment or services have already been provided. A post-service claim will generally be processed within 30 days of receipt. This period may be extended for up to 15 days if the Plan determines an extension is necessary due to matters beyond the control of the Plan, and notifies the Claimant within the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If an extension is necessary due to the Claimant's failure to submit the information necessary to process the claim, the notification of the extension will describe the necessary information, and the Claimant will be provided at least 45 days from receipt of the notification to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the Claimant responds to the request for additional information within the extension period described in the notice of not less than 45 days from the notice.
- Urgent Care Health Claims. Urgent care health claims are pre-service claims with respect to which the normal time frames for review of a claim could seriously jeopardize the life or health of the claimant, or expose the Claimant to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim. Urgent care claims may be filed, orally or in writing, by the Claimant or by the health care provider with knowledge of the Claimant's medical condition. A decision on an urgent care will

generally be made within 72 hours after receipt of a claim that is complete when submitted. Claimants will be notified within 72 hours if additional information is required to process the claim, and will be provided at least 48 hours to submit the additional information. If additional information is required to process the claim, a determination will be made within 48 hours of the earlier of the Plan's receipt of the requested information, or the end of the period afforded the Claimant to provide the additional information. A determination involving urgent care may be provided orally within the time frames in this section, with a written notification furnished not later than three days after the oral notification.

It is important to remember that, if a participant needs emergency medical care for a condition which could seriously jeopardize his/her life, there is no need to contact the Plan for prior approval. The participant should obtain such care without delay. Further, if the Plan does not require the participant to obtain approval of a medical service prior to getting treatment, then there is no Pre-Service Claim. The participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment and files the claim as a Post-Service Claim.

- Concurrent Care Claims. Concurrent care claims are pre-service claims involving an ongoing course of treatment to be provided over a period of time or for a number of treatments. Except in the case of urgent care, a claim to extend a course of treatment beyond the period of time or number of treatments previously approved, will be treated as a new claim and processed within the timeframes appropriate to the type of claim. A claim to extend a course of treatment that involves urgent care will be processed within 72 hours after receipt of the claim, provided the claim is made to the Plan at least 72 hours prior to the expiration of the prescribed period of time or number of treatments. If the claim is not made at least 72 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care. If the Plan reduces or terminates certification for a course of treatment before the end of the previously approved period or number of treatments, the Plan will notify the Claimant in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review before the benefit is reduced or terminated.

**Adverse Benefit Determinations**

If a claim is denied or partly denied, the claimant will be notified in writing and given an opportunity for review. The written denial will give the following information:

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

**If the Claimant has questions about the denial of benefits, the Claimant should contact the Claims Administrator at the address and telephone number on the Notice of Determination.**

An Adverse Benefit Determination also includes a rescission of coverage, which is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation regarding eligibility or a claim for benefits. A rescission of coverage does not include a cancellation or discontinuance of coverage that takes effect prospectively, or is a retroactive cancellation of coverage due to the Participant's failure to timely pay a required premium (including a COBRA premium).

## REMEDIES AVAILABLE SHOULD A CLAIM BE DENIED

A Claimant may appeal an adverse benefit determination. The Plan offers a two-level internal review procedure to provide a Claimant with a full and fair review of an adverse benefit determination. If a Claimant completes the two levels of internal review and is dissatisfied with the determination on internal review, the Claimant may request an External Review in accordance with the procedures that follow under the title External Review Procedure.

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

1. 180 days following the notification of an adverse benefit determination within which to appeal the determination;
2. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. A review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
4. A review that takes into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
5. In deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan

fiduciary shall consult with a health care professional who has appropriate training and expertise in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and
7. The Claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits in possession of the Administrative Office or the Claims Administrator; any internal rule, guidelines, protocol, or other similar criterion relied upon in making the adverse benefit determination; and any explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.

**Level 1 – Internal Review**

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

The first level of review will be performed by the Claims Administrator on the Plan's behalf. The appeal must be filed in writing within 180 days following the date on the written notice of an adverse benefit determination. To file an appeal in writing, the appeal must be addressed as follows:

Public Employees Local 71 Trust Fund
Zenith American Solutions
P.O. Box 91013
Seattle, WA 98111-9103

It shall be the Claimant's responsibility to submit proof that the claim for benefits is covered and payable under the provision of the Plan. Any appeal must include:

1. The name of the Claimant;
2. The Claimant's alternative Plan identification number or social security number;
3. All facts or theories supporting the claim for benefits;

4. A statement in clear and concise terms of the reason or reasons for the disagreement with the handling of the claim; and
5. Any material or information that the Claimant has which indicates that he/she is entitled to benefits under the terms of the Plan.

**Timing and Notification of Benefit Determination on Appeal**

The Claims Administrator shall notify the Claimant of the Plan's benefit determination on review within the following time frames:

- Urgent Care Claims – within a reasonable period of time appropriate to the medical circumstances, but not later than 72 hours after receipt of the claim.
- Pre-Service Non-Urgent Care Claims – within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
- Concurrent Claims – the response will be made in the appropriate time period based on the type of claim (Pre-service Non-Urgent or Post Service).
- Post-Service Claims – within a reasonable period of time, but not later than 30 days after receipt of the appeal.

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

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

The Claims Administrator shall provide the Claimant, in writing or electronically, of the Plan's adverse benefit determination on review, setting forth the same information as described in the section above entitled Adverse Benefit Determinations above.

**Level 2 – Internal Review**

The Level 2 Internal Review will be done by the Board of Trustees, as Plan Administrator. The Claimant shall have the right to request a hearing before the Board of Trustees, by submitting the request in writing to the Claims Administrator at the address noted on the notice of the Level 1 Review determination, within sixty (60) calendar days of the date of the notice. The Claimant may present his/her testimony and argument to the Trustees. The Claimant may be represented by an attorney or other authorized representative. The Board of Trustees may afford the Claimant

or his/her authorized representative the opportunity to appear in person or telephonically at the hearing. The Board of Trustees will review the information initially received and any additional information provided by the Claimant, regardless of whether such information was submitted by the Claimant or considered in the Level 1 Internal Review. The Board of Trustees will not afford deference to the initial adverse benefit determination. When deciding an appeal that is based in whole or in part on a medical judgment, the Trustees will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination will be identified to the Claimant. Any health care professional engaged for the purpose of a consultation on a claim will not be an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Trustees will review a properly filed appeal of a post-service claim at the next regularly scheduled Board of Trustee meeting following receipt of the properly submitted second level appeal, provided the second level appeal is received at least twenty (20) business days prior to such regularly scheduled Board of Trustee meeting. If the second level appeal is received within 20 business days of the next regularly scheduled Board of Trustee meeting, the appeal will be set for hearing at the next following meeting.

If the claim involves the reduction or termination of a previously approved claim for Concurrent Care or Non-Urgent Pre-Service care, the Trustees will review the second level appeal within 15 days of receipt of the properly filed second level appeal regardless of the date of the next regularly scheduled Board of Trustees meeting. The Trustees will review a properly filed second level appeal of an Urgent Care claim within 72 hours after receipt of the appeal regardless of the date of the next regularly scheduled Board of Trustee meeting. In such cases, such appeal hearing may be conducted via teleconference or email poll. All necessary information on a claim for Concurrent Care, Non-Urgent Pre-Service care, or Urgent Care may be transmitted between the Plan and the claimant by telephone, facsimile, or other available expeditious method. The Trustees may delegate the decision on an expedited appeal to a Committee of not less than three Trustees or to the Trust Claims Administrator upon prior approval of a quorum of the Board of Trustees. Such decision on a Concurrent Care, Non-Urgent Pre-Service care, or Urgent Care second level appeal will be provided to the appellant telephonically by the Administrator following the meeting, with a written

decision to follow as soon as practical, but not more than five (5) days following such decision.

The Board of Trustees will issue a decision on a Post-Service Level 2 Internal Review as soon as practical but not more than thirty (30) business days after the Level 2 Internal Review hearing.

The Claimant cannot proceed to an External Review (as described more fully below) unless the Claimant timely files for, and timely completed the Level 1 and Level 2 Internal Review process.

**External Review Procedure**

The Plan has an external review procedure that provides for a review conducted by a qualified Independent Review Organization (IRO). The Claimant may request a review by an IRO within 4 months after the date of the notice of the Plan's adverse decision regarding the Level 2 Internal Review. If there is no corresponding day 4 months after the date of the notice on the Level 2 Internal Review appeal determination notice, then the request must be filed by the 1st day of the fifth month following the date of the notice. As with the original appeal, the Claimant's request for external review must be in writing and include all of the items set forth in 1-5 of the section above entitled Level 1 – Internal Review. The Plan is entitled to charge a fee of $25 to initiate an External Review, which must be paid when the Claimant submits the Request for External Review Form to initiate the process.

For an adverse benefit determination to eligible for external review, the Claimant must complete the required forms to process an External Review. The Claimant may obtain the appropriate forms and information on the filing process by contacting the Claims Administrator.

An appeal of an adverse benefit determination that does **not** involve medical judgment or rescission of coverage may not be appealed to IRO. Rather, a Claimant has to option of filing a lawsuit within one (1) year of the final determination after exhausting Levels 1 and 2 of the internal appeal process.

**Preliminary Review**

Within 6 business days following the date of receipt of the external review request, the Claimant will be provided a written notice stating whether the request is eligible for external review and if additional information is necessary to process the request. If the request is determined to be ineligible, the notice will include the reasons for ineligibility and provide contact information for the appropriate State or federal oversight agency. If additional information is required to process the external review request, the notice will describe the information needed and you

may submit the additional information within the 4 month filing period or within 48 hours of receipt of the notification, whichever is later.

**Timing of Notice from the IRO**

The IRO will notify you in writing of your rights to submit information to the IRO and the applicable time period and procedure for submitting such information. The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will contain the reasons and rationale for the decision, including any applicable evidence-based standards used, and references to the evidence or documentation considered in reaching the decision.

**Decision of IRO Final**

The decision of the IRO is binding upon you and the Plan, except to the extent other remedies may be available under applicable law. Before filing a lawsuit against the Plan, you must exhaust all available levels of review as described in this section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one (1) year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.

# HOW TO CONTINUE HEALTH COVERAGE

## FEDERAL MARKETPLACE

### What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace occurs annually. For more information go to: https://www.healthcare.gov.

### Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

### Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

**Note:** if you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution – as well as your employee contribution to the employer-offered coverage-is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after tax basis.

### How Can I Get More Information?

For more information about your coverage offered by your employer, please check your Summary Plan Description or contact the Trust Administrator, Zenith American Solutions, 201 Queen Anne Ave. N #100, Seattle, WA 98109. Phone (800) 757-0071, option 1.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please

visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PE71 offers a plan that meets the definition of affordable coverage and minimum value to all full time employees. As a result, most employees and any family members eligible for PE71's plan are **NOT** eligible for the federal subsidies available in the Health Insurance Marketplace.

According to the Affordable Care Act and IRS regulations, as long as PE71's health plan is affordable based on your household income compared to the employee only cost of coverage, you and any family members eligible for our plan are not eligible for the federal subsidies if you purchase individual health insurance through the Marketplace.

## COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise cease. This section of the booklet generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. COBRA, and the description of COBRA coverage contained in this section, applies only to the group health plan benefits offered under the Plan, and not to any other benefits offered under the Plan or by the State of Alaska (such as life insurance, disability, or accidental death and dismemberment benefits).

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. For additional information about your rights or obligations under the Plan and under federal law, you should contact the Claims Administrator. With the exception of a special provision for participants who lose coverage because of temporary layoff (including layoff as a seasonal worker) or leave of absence without pay, the Plan provides no greater COBRA rights than what COBRA requires – nothing in this section is intended to expand your rights beyond COBRA's requirements.

### What is COBRA coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a

qualifying event occurs and any required notice of that event is properly provided to the Plan's Administrator, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternative recipients under a Qualified Medical Child Support Order may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.) Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

**Who is entitled to elect COBRA?**

If you are an employee of an employer who participates in the Plan offered through the Public Employees Local 71 Trust Fund, you will be entitled to elect COBRA coverage if you lose your group health coverage under the Plan because one of the following qualifying events occurs:

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

If you are the spouse of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events occurs:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or
- You become divorced or legally separated from your spouse.

A person enrolled as the employee's dependent child will be entitled to elect COBRA if he or she loses group health coverage under the Plan because any of the following qualifying events occurs:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct; or
- The child ceases being eligible for coverage under the Plan as a "dependent child" under the definition provided by the Plan.

**When is COBRA coverage available?**

When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify the Public Employees Local 71 Trust Fund Claims Administrator (hereafter Claims Administrator) of any of these three qualifying events. However, for other qualifying events, you must provide notice to the Claims Administrator. The events that require such notice are divorce or legal separation of the employee and spouse, or a dependent ceasing to be eligible for coverage under the Plan as a dependent child. Where notice of the qualifying event is required, a COBRA election will be available to you only if you notify the Claims Administrator in writing within sixty (60) calendar days after the later of (1) the date of the qualifying event or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. In providing this notice, you must use the form entitled "Notice of Qualifying Event (Form & Notice Procedures)," and you must follow the Notice Procedures for Notice of Qualifying Event that appear at the end of the form. If these procedures are not followed, or if the notice is not provided in writing to the Claims Administrator within the 60-day notice period, you will lose your right to elect COBRA continuation coverage. A copy of the Notice of Qualifying Event (Form & Notice Procedures) can also obtained from the Claims Administrator.

**Electing COBRA**

Each qualifying beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their dependent children. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice will lose his or her right to elect COBRA continuation coverage.

Qualified beneficiaries may be enrolled in one or more group health components of the Plan at the time of a qualifying event. If a qualified beneficiary is entitled to a COBRA election as a result of a qualifying event, he or she may elect COBRA under the group health component under which he or she was participating on the day before the qualifying event occurred. If you lose coverage because of temporary layoff (including layoff as a seasonal worker) or leave of absence without pay, you may continue your health coverage or you can elect a low option medical plan.

Qualifying beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied).

**Open Enrollment Rights and HIPAA Special Enrollment Rights**

Qualified beneficiaries who have elected COBRA will be given the same opportunity available to similarly-situated active employees to change their coverage options or to add or eliminate coverage for dependents at open enrollment. In addition, HIPAA's special enrollment rights will apply to those who have elected COBRA.

**How long does COBRA last?**

COBRA coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the covered employee's divorce or legal separation, or dependent child's losing eligibility as a dependent child, COBRA coverage can last for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for the qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last up to 36 months after the date of the Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA coverage under the Plan for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months. When the qualifying event is temporary layoff (including layoff as a seasonal worker) or leave of absence without pay, the Plan has extended the period of COBRA coverage from 18 months up to a total of 24 months.

The COBRA coverage periods described above are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage period described in this notice for several reasons:

- The Plan no longer provides group health coverage;
- The premium for the qualified beneficiary's COBRA coverage is not timely paid;
- After electing COBRA, you (employee, spouse, or dependent child) become covered under another group health plan (as an employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the other plan has applicable exclusions or limitations, then your COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12-month preexisting condition waiting period expires.) This rule applies only to the qualified beneficiary who becomes covered by another group health plan. (Note that under HIPAA, an exclusion or limitation of the other group health plan might not apply to the qualified beneficiary, depending on the length of his or her creditable coverage prior to enrolling in the other group health plan.);
- After electing COBRA, you (employee, spouse or dependent child) become entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare;
- You (employee, spouse, or dependent child) became entitled to a 29-month maximum coverage period due to disability of a qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however continuation coverage will not end until the month that begins more than 30 days after the determination.);
- Occurrence of any event (e.g. submission of a fraudulent benefit claim) that permits termination of coverage for cause with respect to covered employees or their spouses or dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of federal law.

**Extension of COBRA Coverage**

There are two ways in which the period of COBRA coverage resulting from a termination of employment or reduction of hours of employment can be extended.

Disability extension

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the Claims Administrator in

writing and in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours of employment. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours of employment resulting in the loss of coverage and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months as described above). The disability extension is available only if you notify the Claims Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction of hours of employment; and
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination or reduction of hours of employment.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours of employment in order to be entitled to a disability extension.

In providing this notice, you must use the form entitled "Notice of Disability (Form & Notice Procedures)," and you must follow the Notice Procedures for Notice of Disability that appear at the end of the form. If these procedures are not followed, or if the notice is not provided in writing to the Claims Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours of employment, then there will be no disability extension of COBRA coverage. A copy of the Notice of Disability (Form & Notice Procedures) can be obtained from the Claims Administrator.

Second qualifying event extension

If your family experiences another qualifying event while receiving COBRA coverage because of the covered employee's termination of employment or reduction in hours of employment (including COBRA coverage during a disability extension period described above), the spouse and dependent children receiving COBRA coverage can get up to an additional 18 months of COBRA coverage, for a maximum of 36 months, if notice of the second qualifying event is given in writing and timely to the Claims Administrator. This extension may be available to the

spouse and any dependent children receiving COBRA coverage if the employee or former employee dies or gets divorced or legally separated, or if the dependent child ceases to be eligible as a dependent under the terms of the Plan, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare.)

This extension due to a second qualifying event is available only if you notify the Claims Administrator in writing of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event or (2) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan). In providing this notice, you must use the form entitled "Notice of Second Qualifying Event (Form & Notice Procedures)," and you must follow the Notice Procedures for Notice of Second Qualifying Event that appear at the end of the form. If these procedures are not followed or if the notice is not provided in writing to the Claims Administrator during the 60-day notice period, then there will be no extension of COBRA coverage due to a second qualifying event. A copy of the Notice of Second Qualifying Event (Form & Notice Procedures) can be obtained from the Claims Administrator.

**More Information about Individuals Who May be Qualified Beneficiaries**

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

**Alternate Recipients**

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by the Public Employees Local 71 Trust Fund Administrator during the covered employee's period of employment with an employer who is contributing to the Public Employees Local 71 Trust Fund, is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

### If You Have Questions

Questions concerning your Plan or your COBRA rights should be addressed to the following contact or contacts. For more information about your rights under COBRA, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefit Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Note that this Plan is a non-federal governmental plan, which is exempt from ERISA; however, COBRA does apply to this Plan and the information on the DOL website is instructive, but there may be some distinctions between the provisions of COBRA applicable to governmental plans and those offered to private-sector ERISA plans.

### Keep Your Plan Informed of Address Changes and Changes in Your Family Information

To protect your family's rights, you must keep the Public Employees Local 71 Trust Fund Administrator informed of any changes in the addresses of you and your family members. In addition, you have the obligation to report to the Public Employees Local 71 Trust Fund Administrator any changes for you or your family members that would affect eligibility information. You should also keep, for your records, a copy of any information or notices you send to the Public Employees Local 71 Trust Fund Administrator and proof of mailing of such information or notices.

### Plan Contact Information

You may obtain information about the Plan on request from:

Public Employees Local 71
c/o Trust Administrator
Zenith American Solutions
201 Queen Anne Ave. N #100
Seattle, WA 98109
Telephone toll free (800) 557-8701 or 276-7611 in Anchorage

Contact information for the Plan may change from time to time.

## DISABLED EMPLOYEES OR DISABLED DEPENDENTS

Disabled employees or Disabled dependents that lose coverage may be entitled to an extension of their health benefits if Totally Disabled due to Injury, illness, or pregnancy when coverage terminates. Extended benefits for Total Disability are provided for the number of months you have been covered under the plan, to a maximum of 12 months. In such a case, only the condition which caused the Disability is covered. Coverage is provided only while the Total Disability continues. You must apply for this extension of benefits within 30 days of the date your coverage terminates.

# FAMILY AND MEDICAL LEAVE- AS FEDERALLY MANDATED

If you become eligible for a family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA) (including any amendments to such Act) your insurance coverage may be continued on the same basis as if you were an actively-at-work employee for up to 12 weeks during the 12-month period, as defined by your employer, for any of the following reasons:

1. to care for your child after the birth or placement of a child with you for adoption or foster care; so long as such leave is completed within 12 months after the birth or placement of the child;
2. to care for your spouse, child, foster child, adopted child, stepchild, or parent who has a serious health condition; or
3. for your own serious health condition.

In the event you and your spouse are both covered as members of the Plan, the continued coverage under (1) may not exceed a combined total of 12 weeks. In addition, if the leave is taken to care for a parent with a serious health condition, the continued coverage may not exceed a combined total of 12 weeks.

## CONDITIONS:

1. If, on the day your coverage is to begin, you are already on an FMLA leave of absence, you will be considered actively at work. Coverage for you and any eligible dependents will begin in accordance with the terms of the Plan. However, if your leave of absence is due to your own or any eligible dependent's serious health condition, benefits for that condition will not be payable to the extent benefits are payable under any prior group plan.
2. You are eligible to continue coverage under FMLA if:
    a. you have worked for your employer for at least one year;
    b. you have worked at least 1,250 hours over the previous 12 months;
    c. your employer employs at least 50 employees within 75 miles from your work-site; and
    d. you continue to pay any required premium for yourself and any eligible dependents in a manner determined by your employer.
3. In the event you choose not to pay any required premium during your leave, your coverage will not be continued during the leave.

You will be able to reinstate your coverage on the day you return to work, subject to any changes that may have occurred in the Plan during the time you were not covered. You and any covered dependents will not be subject to any evidence of good health requirement provided under the Plan. Any partially-satisfied waiting periods, including any limitations for a preexisting condition, which are interrupted during the period of time premium was not paid will continue to be applied once coverage is reinstated.

4. You and your dependents are subject to all conditions and limitations of the Plan during your leave, except that anything in conflict with the provisions of FMLA will be construed in accordance with the FMLA.
5. If requested by us, you or your employer must submit proof acceptable to us that your leave is in accordance with FMLA.
6. This FMLA continuation is concurrent with any other continuation option except for COBRA, if applicable. You may be eligible to elect any COBRA continuation available under the Plan following the day your FMLA continuation ends.
7. FMLA continuation ends on the earliest of:
    a. the day you return to work;
    b. the day you notify your employer that you are not returning to work;
    c. the day your coverage would otherwise end under the policy; or
    d. the day coverage has been continued for 12 weeks.

## DEFINITIONS FOR TERMS IN THIS SECTION

**Prior group plan** means the group plan providing similar benefits (whether insured or self-insured including HMO's and other prepayment plans provided by the Policyholder) in effect immediately prior to the effective date of this Plan.

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

**Serious Health Condition** is defined as stated in the FMLA.

**Important Notice**

Contact your employer for additional information regarding FMLA.

# UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS - AS FEDERALLY MANDATED

**What is USERRA?**

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) was signed into law on October 13, 1994, and clarifies and strengthens the Veterans' Reemployment Rights (VRR) Statute. USERRA's purpose is to minimize the disadvantages that may occur if you need to leave civilian employment to serve in the country's uniformed services. USERRA covers virtually every individual in the country who serves in or has served in the uniformed services, and applies to all employers in the public and private sectors, including state, local, and federal government.

As of December 10, 2004, the Veterans Benefits Improvement Act of 2004 amended USERRA, extending the period for continued health benefits coverage from 18 months to 24 months. The Trust has adopted procedures that it will follow when administering USERRA elections for continuation of health benefits coverage. (These procedures are similar to those used for COBRA continuation coverage elections.) The Trust has also adopted procedures for immediate reinstatement in the Trust's Benefit Plans for employees who return to work after uniformed service. This notice describes the new procedures.

**What is Uniformed Service under USERRA?**

Protection under USERRA is provided to anyone who is (or has been) in the "uniformed services," which is defined very broadly by the law. USERRA defines "uniformed service" as active or reserve service in the Army, Air Force, Navy, Marine Corps, and Coast Guard; service in the National Guard, Air Guard, and the Public Health Service; and any other category designated by the President during time of war.

**Who May Elect USERRA Continuation Coverage?**

To have a right under USERRA to continued health benefits coverage under the Trust's Benefit Plans, you must:

1. Be a participant in the Plan immediately prior to leaving for uniformed service;
2. Enter uniformed service as defined by USERRA;
3. Provide advance notice of the uniformed service, unless you are prevented from doing so by military necessity or it is otherwise impossible or unreasonable under the circumstances;

4. Timely complete and return the USERRA Continuation Coverage Election Form and pay the appropriate premium to the Trust Administrator; and
5. Be absent from employment for performance of uniformed service for the entire period of coverage.

**How do You Notify the Trust of Your Uniformed Service?**

If you are going to be absent from work due to uniformed service, you (or an appropriate officer of your branch of the uniformed service) must give advance notice to the Claims Administrator, unless notice is precluded by military necessity. You can contact the Claims Administrator either orally or in writing. When the Claims Administrator receives your notice of duty, that office will determine your entitlement to USERRA health benefits continuation coverage and send either a USERRA Continuation Coverage Election Form or an explanation of why you are not entitled to USERRA continuation coverage. If needed, the Claims Administrator may request appropriate records documenting the uniformed service for later evaluation of your eligibility for USERRA continuation coverage or of your rights to reemployment and restoration of benefits.

**How do You Obtain a USERRA Continuation Coverage Election Form?**

As mentioned above, if you promptly notify the Claims Administrator of your plan to enter uniformed service, you will automatically receive a USERRA Continuation Coverage Election Form if the Trust Administrator determines that you are eligible to elect continuation coverage. Also, you can contact the Claims Administrator at your convenience to request a USERRA Continuation Coverage Election Form.

**When are the USERRA Election and Payment Deadlines?**

You have 60 days after reporting for uniformed service to complete and return the USERRA Continuation Coverage Election Form provided by the Claims Administrator. The Claims Administrator's receipt of your Election Form will be determined by the postmark or hand-delivery date,

After electing USERRA continuation coverage, you have 45 days to pay the initial premium to the Claims Administrator. The date a premium payment is made is determined by the date it is postmarked or hand delivered. All premiums for subsequent months are due on the 1st day of the month to which the premium applies. If your payment is not made by the first of the month, the Claims Administrator will send notice that you have 30 days from the premium due date to pay the premium or your coverage will terminate effective with the last month for which you paid a premium. Any claims submitted during the 30-day grace period will be held until the premium is received, and any claims incurred during the

grace period will be denied if the premium is not paid by the end of the grace period. If you miss the deadline for completing and return the USERRA Continuation Coverage Election Form, or the deadline for paying any premium, you will lose your right to USERRA continuation coverage under the Plan.

**Who Pays the USERRA Continuation Coverage Premium?**

**Leave for Fewer than 31 Days:** If your uniformed service is for fewer than 31 days, your employer will pay the cost of coverage on the same basis as it did prior to the your absence for uniformed service, and you must self-pay your portion of the premium for coverage.

**Leave for More than 31 Days:** If your uniformed service is for more than 31 days, you must pay the full premium by the deadline described above. The premium for coverage for leave lasting more than 31 days will be 102% of the premium charged for active participants.

**How does USERRA Continuation Coverage Coordinate with COBRA?**

If you elect to continue coverage under USERRA, the Plan will continue coverage for 24 months beginning on the date your uniformed service begins, or the date after you fail to apply for reemployment within the time limits described below, whichever is less. Unlike COBRA continuation coverage, your entitlement to USERRA continuation coverage is not affected by your entitlement to coverage another group health plan or Medicare. If a second Qualifying Event occurs while you are in uniformed service (for example, if you die or divorce), then your spouse and/or children may be entitled to an extension of coverage under COBRA for up to a total of 36 months of continuation coverage, between your USERRA election and a subsequent COBRA election.

**How do You Get Regular Health Plan Coverage Reinstated?**

To have a right to reinstated health benefits coverage from the Trust's Benefit Plan following your absence from work for uniformed service, you must:

1. Have been on leave from a full-time, temporary, part-time, probationary, or seasonal position subject to the collective bargaining agreement between Public Employees Local 71 and a participating Employer;
2. Have been in "uniformed service" as defined by USERRA;
3. Have provided advance notice of the absence, unless military necessity prevented you from doing so or it was otherwise impossible or unreasonable under the circumstances;

4. Have not received a dishonorable or bad-conduct discharge, a discharge under other than honorable conditions, or any other disqualifying discharge;
5. Have no more than five years of cumulative uniformed service (although some limited exceptions apply)
6. Report back for work (or apply to return to work) promptly. If your uniformed service was:
    - ✓ **Less than 31 days of service**--you must report by the next workday after returning from service (allowing for 8 hours sleep and reasonable time to get home).
    - ✓ **From 31 to 180 days of service**--you must apply for reemployment within 14 days after returning from service.
    - ✓ **More than 180 days of service**--you must apply for reemployment within 90 days after returning from service.

    Note: These time limits may be extended up to 2 years if you are hospitalized or incapacitated by a service-related injury or illness.
7. If your military leave was for more than 30 days, you must provide any available documents requested by the Plan to establish that you are entitled to the protections of USERRA; and
8. Be reemployed in covered employment.

If these requirements are met, then health benefits coverage for you and your eligible spouse and/or dependents will be reinstated immediately. However, an exception applies to disabilities that the Secretary of Veteran's Affairs (the VA) determines to be connected to military service.

# COORDINATION OF BENEFITS (COB)

## DEFINITIONS FOR TERMS IN THIS SECTION

**Plan** means any of the following coverages, including policy coverage and any coverage which is declared to be "excess" to all other coverages, which provide benefit payments or services to an insured person for hospital, medical, surgical, dental, prescription drug or vision care:

- Group, blanket or franchise insurance (except student accident insurance);
- Group health care programs issued by insurers, health care services contractors, and health maintenance organizations;
- Coverage under a labor-management trustees plan, a union welfare plan, an employer organization plan or an employee benefits plan;
- Coverage under governmental programs, including Medicare or Medicaid, and any other coverage required or provided by law; and
- Other arrangements of insured or self-insured group coverage.

If any of the above coverages include group and group-type hospital indemnity coverage, Plan also means that amount of indemnity benefits which exceeds $100 a day.

**Claimant** means the covered person for whom the claim is made.

**Claim Period** means part or all of a calendar year during which the claimant is covered under the Plan.

A **Covered Expense** means any expense which is covered by at least one Plan during a Claim Period; however, any expense which is not payable by the Primary Plan because of the claimant's failure to comply with cost containment requirements (such as second surgical opinions, preadmission testing, preadmission review of Hospital Confinement, mandatory outpatient surgery, etc.) will not be considered a Covered Expense by the Secondary Plan. Where a Plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service during a Claim period will also be considered a Covered Expense.

## COORDINATION OF BENEFITS (COB)

If the claimant is covered by another Plan or Plans, the benefits under this Plan and the other Plan(s) will be coordinated. This means one Plan pays its full benefits first, then the other Plan(s) pay(s).

The Primary Plan (which is the Plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.

The Secondary Plan (which is the Plan that pays benefits after the Primary Plan) will limit the benefits it pays so that the sum of its benefit and all other benefits paid by the Primary Plan will not exceed the greater of:

- 100% of total Covered Expense; or
- The amount of benefits it would have paid had it been the Primary Plan.

The "Order of Benefit Determination" section below explains the order in which Plans must pay.

This COB provision will not apply to a claim when the Covered Expense for a Claim Period is $50 or less, but if:

- Additional expense is incurred during the Claim Period; and
- The total Covered Expense exceeds $50

then this COB provision will apply to the total amount of the claim.

## ORDER OF BENEFIT DETERMINATION

When another Plan does not have a COB provision, that plan must determine benefits first.

When another Plan does have a COB provision, the first of the following rules which applies govern:

a) If a Plan covers the claimant as an employee, member or nondependent, then that Plan will pay its benefits first.

b) If the claimant is a dependent child whose parents are not divorced or separated then the Plan of the parent whose birthday anniversary is earlier in the calendar year will pay first, except:

    1. If both parents' birthdays are on the same day, rule (d) will apply.

    2. If another Plan does not include this COB rule based on the parents' birthdays, but instead has a rule based on the gender of the parent, then that Plan's COB rule will determine the order of benefits.

c) If the claimant is a dependent child whose parents are divorced or separated, then the following rules apply:

    1. A Plan which covers a child as a dependent of a parent who by court decree must provide health coverage must pay first.

2. When there is no court decree which requires a parent to provide health coverage to a dependent child, the following rules will apply:

    a. When the parent who has custody of the child has not remarried, that parent's Plan will pay first.

    b. When the parent who has custody of the child has remarried, then benefits will be determined by that parent's Plan first, by the stepparent's Plan second, and by the Plan of the parent without custody third.

d) If none of the above rules apply, the Plan which has covered the claimant for the longer period of time will pay its benefits first, except when:

    1. One Plan covers the claimant as a laid-off or retired employee (or a dependent of such an employee); and

    2. The other Plan includes this COB rule for laid-off or retired employees (or is issued in a state which requires this COB rule by law);

    then the Plan which covers the claimant as other than a laid-off or retired employee (or a dependent of such an employee) will pay first.

Where part of a Plan coordinates benefits and a part does not, each part will be treated like a separate Plan.

## CREDIT SAVINGS

Where the Plan does not have to pay its full benefits because of COB, the savings will be credited to the claimant for the Claim Period. These savings would be applied to any unpaid Covered Expense during the Claim Period.

## HOW COB AFFECTS BENEFIT LIMITS

If COB reduced the benefits payable under more than one Plan provision, each benefit will be reduced proportionately. Only the reduced amount will be charged against any benefit limit in those Plan provisions.

## RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

In order to receive benefits, the claimant must give the Plan any information which is needed to coordinate benefits. With the claimant's

consent, the claim payer may release to or collect from any person or organization any needed information about the claimant.

## FACILITY OF PAYMENT

If benefits which this Plan should have paid are instead paid by another Plan, this Plan may reimburse the other Plan. Amounts reimbursed are Plan benefits and are treated like other Plan benefits in satisfying Plan liability.

## SECONDARY COVERAGE

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

## RIGHT OF RECOVERY

If payments are made under this Plan for any treatment or service or loss of income because of Injury to, or Sickness of, a covered individual caused by the act or omission of a third party, who has a lawful claim, demand or right against a third party or parties (including an insurance carrier) for indemnification, damages or other payment with respect to such Injury or Sickness, then:

- The Plan shall have the Right of Recovery to the extent of the payments made under this Plan, to have the rights of the covered individual to receive or claim such indemnification, damages or other payment. The covered individual shall execute or secure the execution of such instruments as the Trust may require to enforce its rights hereunder;
- The Plan asserts a lien in the form of a constructive trust in any amount received by the covered individual as a result of a claim for damages against a third-party for the illness, accident or injury for which the Plan has extended benefits, up to the total amount of such benefits;
- Any individual who shall receive payment from any such third party or parties because of Injury to, or Sickness of, a covered individual shall reimburse the Plan from such payment so received (but not in excess of the amount of benefits paid), less contribution by the Plan for the pro rata costs and attorney's fees expended by the covered individual in obtaining the recovery.

What this means is that if you receive a benefit payment from the Plan and a liability claim is made against a third party, benefits payable by the Plan must be included in the claim and when the claim is settled the Plan must be reimbursed for the benefits provided. For more information on the Trust's right of recovery, see the section entitled Third Party Reimbursement and/or Subrogation.

## CONTRACT LIABILITY

The full extent of liability under this Plan and benefits conferred, including recovery under any claim of breach, will be limited to the actual cost of hospital and medical services as described here and will specifically exclude any claim for general damages that includes alleged "pain, suffering or mental anguish."

# MEDICARE COORDINATION OF BENEFITS

This Medicare COB provision applies when the covered person:

a) Has health coverage under the Plan; and

b) Is eligible for insurance under Medicare, Parts A and B, whether or not the covered person has applied or is enrolled in Medicare.

The Medicare COB provision applies before any other COB provision of the Plan.

## EFFECT ON BENEFITS

1. If, in accord with the following rules, the Plan has primary responsibility for the covered person's claims, then the Plan pays benefits first.
2. If, in accord with the following rules, the Plan has secondary responsibility for the covered person's claims:
    a. First Medicare benefits are determined or paid; and
    b. Then Plan benefits are paid;

    but for services payable under both plan, the combined Medicare Benefits and Plan benefits will not exceed 100% of the expense incurred.

## RULES FOR DETERMINING ORDER OF BENEFITS

1. For You. The Plan has primary responsibility for your claims if:
    a. You are covered under the Plan because of your current active employment status with an ADEA Employer, and you are eligible for Medicare Benefits because of age; or
    b. The Plan is part of a Large Group Plan, and you are covered under the Plan because of your current active employment status, and you are eligible for Medicare Benefits because of disability.

    The Plan has secondary responsibility for your claims if you are eligible for Medicare Benefits and the above conditions do not apply.
2. For Your Dependent. The Plan has primary responsibility for your dependent's claims if:

a. You are covered under the Plan because of your current active employment status with an ADEA Employer, and your dependent spouse is eligible for Medicare because of age; or

b. The Plan is part of a Large Group Plan, and you are covered under the Plan because of your current active employment status, and your dependent is eligible for Medicare Benefits because of disability.

The Plan has secondary responsibility for your claims if your dependent is eligible for Medicare Benefits and the above conditions do not apply.

3. Exception for End Stage Renal Disease. If Medicare does not already have primary responsibility when you or your dependent becomes eligible for Medicare Benefits because of end stage renal disease:

   a. The Plan has primary responsibility for you or your dependent's claims for up to 30 months beginning with the month in which you or your dependent is first eligible for Medicare Benefits because of end stage renal disease; and

   b. The Plan has secondary responsibility after the end of this 30-month period.

## DEFINITIONS FOR TERMS IN THIS SECTION

**Medicare Benefits** means service and supplies which the covered person receives or is eligible for under Medicare, whether or not the covered person has applied for or is enrolled in Medicare.

**ADEA Employer** means an employer which:

a) Is subject to the federal Age Discrimination in Employment Act (ADEA); and

b) Has 20 or more employees each working day in 20 or more calendar weeks during the current or preceding calendar year.

**Large Group Plan** means a plan which covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year.

## IMPORTANT INFORMATION ABOUT MEDICARE

Medicare may affect Plan benefits, therefore, you may want to contact your local Social Security office for information about Medicare. This should be done before you or your spouse's 65th birthday.

# THIRD PARTY REIMBURSEMENT AND/OR SUBROGATION

This provision applies if you or your dependent is injured or becomes sick as a result of the act or omission of a third party. **The Plan does not provide benefits for an injury, accident or illness for which there is a right of recovery against a third party.** However, if you or your dependent has medical expenses as a result of an injury, accident or illness for which a third party is, or may be held responsible, the Plan, as a convenience to you or your dependent, will advance payment of such expenses on the condition that you or your dependent (if applicable) sign and return a Subrogation Agreement. The Subrogation Agreement constitutes an enforceable contract between you or your dependent (your attorney, or your dependent's attorney) and the Plan which creates a reimbursement right for the Plan and obligates you (or your dependent, as applicable) to reimburse the Plan for the full value of the benefits paid by the Plan, on a first-dollar basis, from any recovery, settlement or judgment received by you, your dependent, or legal representative from the liable third party and/or their insurer. The Subrogation Agreement also creates an assignment of any recovery, settlement or judgment in favor of the Plan up to the amount of the benefits paid by the Plan, less contribution by the Plan of a pro rata portion of the costs and attorney's fees incurred by you in obtaining the recovery.

## DEFINITIONS FOR TERMS IN THIS SECTION

**Reimbursement Rights** means the Plan's right to be reimbursed if:

- The Plan pays Plan benefits for you or your dependent because of an Injury, accident or sickness caused by a third party's act or omission; and
- You, your dependent or the legal representative recovers an amount from the third party, the third party's insurer, an uninsured motorist insurer or anyone else by reason of the third party's act or omission. This recovery may be the result of a lawsuit, a settlement or some other act. The Plan is entitled to be paid first out of any recovery, up to the amount of the Plan benefits paid, less contribution by the Plan of a pro rata portion of the costs and attorney's fees incurred by you in obtaining the recovery.

**Subrogation Rights**, as used in this provision, means the Plan's right to enforce the Plan's recovery of any Plan benefits paid for you or your dependent because of an Injury or Sickness caused by a third party's act or omission based on the contract created by the executed Subrogation Agreement.

**Third Party** means another person, corporation, partnership or organization, and/or their insurer.

## REIMBURSEMENT AND SUBROGATION RIGHTS

If you or your dependent has an Injury or Sickness caused by a third party's act or omission:

1. The Plan will pay Plan benefits for that Injury or Sickness subject to the Plan's Reimbursement and Subrogation Rights on the condition that you or your dependent, or your legal representative execute a Subrogation Agreement and the condition that you (or your dependent, as applicable):
    a. Will not take any action which would prejudice the Plan's Reimbursement or Subrogation rights; and
    b. Will cooperate in doing what is reasonably necessary to assist the Plan in enforcing the Plan's Reimbursement or Subrogation Rights, including signing an assignment, a reimbursement agreement or other document upon the Plan's written request.
2. The Plan's Reimbursement or Subrogation Rights will not be reduced because the recovery is not described as being related to medical costs or loss of income.
3. The Plan may enforce the Plan's Reimbursement or Subrogation Rights by filing a lien with the third party, the third party's insurer or another insurer, a court having jurisdiction in this matter or any other appropriate party.
4. The Plan may elect to charge any reimbursement due the Plan under this provision against any future benefits payments for you or your dependent under this Plan. This will not reduce the Plan's right to be paid first out of any recovery up to the amount of Plan benefits not yet reimbursed.
5. After reimbursement from benefits paid by the Plan, the Plan may be relieved from any obligation to pay further benefits to you or your dependents for such injuries up to the entire net amount of the balance of the settlement judgment recovered by you or your dependent for hospital, medical, dental or surgical benefits.
6. The Board of Trustees will review a request for a waiver of Subrogation Rights, in part or in whole, in the event you or your dependent is not fully compensated due to a lack of insurance or recoverable funds. The Board of Trustees has the sole and exclusive

discretion as to what circumstances would justify a waiver of any part of the Plan's Subrogation Rights.

7. The Plan will contribute to the costs and attorney's fees associated with obtaining a recovery on a pro rata basis, (e.g., the Plan will reduce its subrogation interest by 1/3 if you contracted to pay attorney's fees of 1/3 of the recovery obtained).

# DEFINITIONS

**Acupuncture** means the practice of insertion of needles into specific exterior body locations to relieve pain, to induce surgical anesthesia, or for therapeutic reasons.

**Allowable Expense** means the actual costs (billed amount) charged for Medically Necessary services to the extent that such charges are Usual, Customary and Reasonable (UCR) for the area and the type of service, or are the Usual and Reasonable Charge for Outpatient Dialysis Treatment. For Non-PPO inpatient Hospital services within the Municipality of Anchorage, the Allowable Expense will be limited to the Contracted Rate at the preferred provider Hospital. The Allowable Expense for outpatient facility charges at a non-PPO provider within the Municipality of Anchorage will be the case rate or 50% of the billed charges, if no case rate is available (except as provided by the Outpatient Dialysis Treatment provision herein). The Allowable Expense for non-PPO physical therapy services within the Municipality of Anchorage will be the Contracted Rate at Chugach Physical Therapy.

The Allowable Expense for documented multiple surgical procedures, whether related or not, is 100% of the prevailing fee for the greater procedure and 50% for each lesser procedure during the same operative session. Exceptions:

- Fractures: when reduction (or treatment) of one or more separate and distinct fractures takes place (such as an arm and a leg) 100% of the prevailing fee is allowable for each fracture.

More than one surgeon: When the skill of two or more surgeons is required and each performs separate operations, the allowance is 100% of the prevailing fee for each procedure, provided the doctors bill separately, even though the procedures are performed at the same operative session. The allowance for an assistant surgeon is 20% of the prevailing fee. Charges in excess of the Allowable Expense as determined by the Plan will not be paid by the Plan, and will not apply to your deductible or Out-of-Pocket Limit.

**Contracted Rate** means the rate negotiated with PPO providers for covered services.

**Cosmetic or Reconstructive Surgery** means any surgical procedure performed primarily:

- To improve physical appearance or to change or restore bodily form without materially correcting a bodily malfunction; or

- To prevent or treat a Mental or Nervous Disorder through a change in bodily form.

**Custodial Care** means services or supplies, regardless of where or by whom they are provided which:

- A person without medical skills or background could provide or could be trained to provide; or
- Are provided mainly to help the covered person with daily living activities, including, but not limited to:
    - Walking, getting in and/or out of bed, exercising and moving the covered person;
    - Bathing, using the toilet, administering enemas, dressing and assisting with any other physical or oral hygiene needs;
    - Assistance with eating by utensil, tube or gastronomy;
    - Homemaking, such as preparation of meals or special diets, and house cleaning;
    - Acting as a companion or sitter; or
    - Supervising the administration of medications which can usually be self-administered, including reminders of when to take such medications; or
- Provide a protective environment;
- Are part of a maintenance treatment plan or are not part of an active treatment plan intended to or reasonably expected to improve the covered person's Sickness, Injury or functional ability; or
- Are provided for the convenience of the covered person or the caregiver or are provided because the covered person's own home arrangement is not appropriate or adequate.

The Plan determines what services or supplies are Custodial Care. When a confinement in a facility or a visit to a Physician is found to be mainly for Custodial Care, some services (such as prescription drugs, x-rays and lab tests) may still be covered if Medically Necessary and otherwise covered by the Plan. All bills should be routinely submitted for consideration.

**Dentist** means a licensed dentist who performs a dental service which is payable under the Plan. A Dentist does not include a person who lives with you or is part of your family (you; your spouse; or a child, brother, sister or parent of you or your spouse).

**Developmental Care** means services or supplies, regardless of where or by whom they are provided, which:

- Are provided to a covered person who has not previously reached the level of development expected for the covered person's age in the following areas of major life activity:
    - Intellectual;
    - Physical;
    - Receptive and expressive language;
    - Learning;
    - Mobility;
    - Self-direction;
    - Capacity for independent living; or
    - Economic self-sufficiency; or
- Are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to Injury or Sickness); or
- Are educational in nature.

The Plan will determine what services or supplies are Developmental Care. When a confinement in a facility or a visit to a Physician is found to be mainly for Developmental Care, some services (such as prescription drugs, x-rays and lab tests) may still be covered if Medically Necessary and otherwise covered by the Plan. All bills should be routinely submitted for consideration.

**Experimental or Investigational means that:**

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

- Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment or diagnosis.

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

**Home Health Care Agency** is an organization:

- Providing skilled nursing and other therapeutic services in the patient's home;
- Associated with a professional policy-making group of at least one Physician and one RN supervising full-time;
- Keeping complete medical records on each patient;
- Staffed by a full-time administrator; and
- Meeting licensing standards.

**Hospital** means any of the following facilities which are licensed by the proper authority in the area in which they are located:

- A place which is licensed as a general hospital by the proper authority of the area in which it is located;
- A place which:
    - Is operated for the care and treatment of resident inpatients;
    - Has a registered graduate nurse (RN) always on duty;
    - Has a laboratory and x-ray facility; and
    - Has a place where major surgical operations are performed; or
- A facility which is accredited by the Joint Commission on the Accreditation of Healthcare Organizations, American Osteopathic Association or the Commission on Accreditation of Rehabilitative Facilities if the function of such facility is primarily of a rehabilitative nature, provided such rehabilitation is specifically for treatment of a physical disability. Such facility need not have major surgical facilities.

When treatment is needed for Mental and Nervous Disorders, Alcohol and Drug Abuse and/or Substance Abuse, Hospital can also mean a place which meets these requirements:

- Has rooms for resident inpatients;
- Is equipped to treat mental and nervous disorders, alcohol and drug abuse, and/or substance abuse;
- Has a resident Physician on duty or on call at all times;
- As a regular practice, charges the patient for the expense of confinement; and
- Is licensed by the proper authority of the area in which it is located.

A Hospital does not include a hospital or institution or part of a hospital or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home, home for the aged, halfway house or board and care facilities.

**Hospital Confinement** means a Medically Necessary Hospital stay of 24 consecutive hours or more in any single or multiple departments or parts of a Hospital for the purpose of receiving any type of medical service. These requirements apply even if the Hospital does not charge for daily room and board. How the Hospital classified the stay is irrelevant.

Any Hospital Confinement satisfying this definition will be subject to all Plan provisions relating to inpatient Hospital services or admissions, including any applicable preadmission review requirements. Hospital stays or services not satisfying this definition will be considered under the Plan provisions for outpatient services.

**Injury** means an accidental bodily Injury which requires treatment by a Physician. It must result in loss independently of Sickness and other causes.

**Mammogram** means an x-ray examination of the breast.

**Medical Emergency** means a severe condition which the Plan determines:

- results from symptoms which occur suddenly and unexpectedly; and
- requires immediate Physician's care to prevent death or serious impairment of the covered person's health.

or

- poses an imminent serious threat to the covered person or to others.

**Medically Necessary** service or supply means one which is ordered by a Physician and which the Plan determines is:

- provided for the diagnosis or direct treatment of an Injury or Sickness;

- appropriate and consistent with the symptoms and findings or diagnosis and treatment of the covered person's Injury or Sickness;
- provided in accord with generally accepted medical practice on a national basis; and
- the most appropriate supply or level of service which can be provided on a cost effective basis (including but not limited to inpatient vs. outpatient care, electric vs. manual wheelchair, surgical vs. medical or other types of care).

The fact that the covered person's Physician prescribes services or supplies does not automatically mean such services or supplies are Medically Necessary and covered by the Plan.

**Mental and Nervous Disorders / Alcohol and Drug Abuse** means any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as a Mental Disorder. Not included in this definition are conditions or diseases specifically excluded from coverage.

**Oral Surgery** means excision of partially or completely unerupted or impacted teeth.

**Physician** means any of the following licensed practitioners who perform a service payable under the Plan:

- Doctor of medicine (MD), osteopathy (DO), podiatry (DPM), chiropractic (DC), or dentistry (DDS or DMD);
- Occupational therapist or physical therapist;
- Audiologist;
- Optometrist or ophthalmologist;
- Midwife;
- Naturopath;
- Licensed doctoral clinical psychologist;
- Master's level counselor and licensed or certified social worker who is acting under the supervision of a doctor of medicine or a licensed doctoral clinical psychologist;
- Licensed marital and family therapist (LMFT);
- Christian Science Practitioner, authorized by the Mother Church, First Church of Christ Scientist, Boston, Massachusetts;
- Nurse practitioner, if licensed by the State in which is he/she is practicing, provided he/she is practicing within the scope of that license;

- Licensed physician's assistant (PA); or
- Where required to cover by law, any other licensed practitioner who:
    - is acting within the scope of his/her license; and
    - performs a service which is payable under the Plan when performed by an MD.

A Physician does not include a person who lives with you or is part of your family (you; your spouse; or a child, brother, sister, or parent of you or your spouse).

**Sickness** means a disease, disorder or condition which requires treatment by a Physician and includes childbirth, pregnancy or any related conditions.

**Total Disability, Totally Disabled or Disabled** means for health coverage, that because of an Injury or Sickness:

- you are completely and continuously unable to perform the material and substantial duties of your regular occupation and are not engaging in any work or occupation for wages or profit; or
- your dependent is:
    - whether physically or mentally unable to perform all of the usual and customary duties and activities (the " normal activities") of a person of the same age and gender who is in good health; and
    - not engaged in any work or occupation for wages or profit.

**Usual, Customary and Reasonable (UCR)** means the charge the Plan determines to be the prevailing rate charged in the geographic area in which the service is provided, or the provider's usual charge, whichever is less.

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

**You, your** means an employee or member who is covered under the Plan.