LOWER KUSKOKWIM SCHOOL DISTRICT EMPLOYEE HEALTHCARE PLAN

PLAN DOCUMENT
AND
EMPLOYEE BENEFIT BOOKLET

RESTATED MARCH 1, 2020

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1 INTRODUCTION

Lower Kuskokwim School District (the "Employer" or "Company") is pleased to offer you this benefit plan. It is a valuable and important part of your overall compensation package.

This booklet describes your medical and prescription drug benefits, dental benefits, vision benefits and serves as the Summary Plan Description (SPD) and Plan document for the LOWER KUSKOKWIM SCHOOL DISTRICT EMPLOYEE HEALTHCARE PLAN ("the Plan").

This document sets forth the provisions of the Plan that provide for payment or reimbursement of Plan benefits. It is written to comply with disclosure requirements under the Employee Retirement Income Security Act ("ERISA") of 1974, as amended.

We encourage you to read this booklet and become familiar with your benefits. You may also wish to share this information with your enrolled family members.

This Plan and SPD replace all previous booklets you may have in your files. Be sure to keep this booklet in a safe and convenient place for future reference.

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at: Lower Kuskokwim School District, PO Box 305 Bethel, AK, 99559, 907-543-4820.

You may also contact the Employee Benefits Security Administration, U. S. Department of Labor at 1-866-444-3272, or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered plans.

2 ADOPTION OF THE PLAN DOCUMENT

2.1 Adoption

Plan Sponsor hereby adopts this Plan Document as the written description of its employee welfare benefit plan (the "Plan"). This Plan Document replaces any prior statement or the health care coverages of the Plan and is effective on the date shown below.

2.2 Purpose of the Plan

The purpose of the Plan is to provide certain benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents. The benefits provided by the Plan include:

- Medical Coverage
- Prescription Drug Coverage
- Dental Coverage
- Vision Coverage
- Hearing Coverage

2.3 Intent to Comply with ERISA

It is intended that the Plan Document will serve to describe the nature, funding and benefits of the Plan. It is also intended that the Plan will conform to the requirements found in the Employee Retirement Income Security Act of 1974 (ERISA), as amended from time to time, as that act applies to employee welfare benefit plans. If any portion of the Plan does now, or in the future, conflict with ERISA or Federal regulations, such regulations will govern.

2.4 Conformity with Law

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

2.5 Participating Employers

Employers participating in this Plan are as stated in the section entitled General Plan Information.

The Plan Sponsor may act for and on behalf of any and all of the Participating Employers in all matters pertaining to the Plan, and every act, agreement, or notice by the Plan Sponsor will be binding on all such Employers.

2.6 Acceptance of the Plan Document

IN WITNESS WHEREOF, the Plan Sponsor has caused this instrument be executed, effective as of March 1, 2020.

Table 2.1: Signature of Adoption of Plan Document

Lower Kuskokwim School District	
By: [signature]	Title: Business Manager
Date: 7-15-20	

3 UTILIZATION MANAGEMENT PROGRAM

Benefits provided by the Plan under the Medical Schedule of Benefits are subject to compliance with the requirements of the Utilization Management Program as described below and in any packet of information distributed by the Utilization Management Organization. These requirements are designed to encourage Covered Persons to obtain quality medical care while utilizing the most cost-efficient sources.

The Utilization Management Organization that is assisting in cost management for the Plan is:

Hines & Associates 1-800-559-5257

3.1 Compliance Procedures for Hospital Admission

Prior to any scheduled Hospital admission, the Covered Person or his attending Physician must phone the Utilization Management Organization and follow with the filing of any necessary forms.

In the case of an emergency hospitalization (admission for treatment of a condition which, if treated on an Outpatient basis, could lead to disability or death), patient, doctor, or a family member, must phone the Utilization Management Organization within 48 hours of admission or on the first business day following a weekend or holiday admission.

3.2 Penalty for Non-Compliance

If the preauthorization requirements are not completed for a Hospital admission, a ***$250 reduction in benefits*** will be applied.

Any additional share of expenses, which becomes the Covered Person's responsibility for failure to comply with these requirements will not be considered eligible medical expenses and thus will not apply to any Deductible, Coinsurance or out-of-pocket maximums of the Plan.

3.3 Utilization Review

Utilization review is a program designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

- Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:
    - Inpatient Hospitalizations
    - Chemical Dependency Treatment
    - Skilled Nursing Facility Stays
    - Home Health Care
    - Hospice Care
    - Organ and/or Tissue Transplant Services
- Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;
- Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

- Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

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

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

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced by $250.

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

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

3.4 Special Notices

It is the Employee or Covered Person's responsibility to make certain that the compliance procedures of this program are completed. To minimize the risk of reduced benefits, an Employee should contact the review organization to make certain that the Hospital or attending Physician has initiated the necessary processes.

Also, prior authorization is not a guarantee of coverage. The Utilization Management Program is designed ONLY to determine whether or not a proposed course of treatment is Medically Necessary and appropriate. Benefits under the Plan will depend upon the person's eligibility for coverage and the Plan's limitations and exclusions.

4 CASE MANAGEMENT

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

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

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or nursing home care;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case Management occurs in the following situations:

- the catastrophic Injury or Sickness must have occurred while the patient was covered and the Injury or Sickness must have been covered under the Plan.
- An alternate benefit will be beneficial to both the patient and the Plan

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

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

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

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

5 MEDICAL SCHEDULE OF BENEFITS

5.1 Plan Maximums

The maximum payable for all eligible medical expenses for each Covered Person will not exceed, in the aggregate, the Maximum Plan Benefit shown below which applies to all periods a person is covered under the Plan. Any lesser Maximum Benefits and Maximum Allowances are also applicable to all periods a person is covered under the Plan. Other maximums may apply to specific periods, conditions or types or levels of care and are as specified.

Table 5.1: Plan Benefit Maximums	
Home Health Care Limit of 1 visit per day Calendar Year Maximum Allowance	 100 Visits
Skilled Nursing Facility Calendar Year Maximum Benefit	 90 Days

5.2 Choice of Providers

Covered Persons have a choice of obtaining health care services and supplies from providers participating in the Preferred Provider Organization (PPO providers) or any other covered provider of their choice (non-PPO providers). The participating Preferred Provider Organization is First Choice Health Network.

PPO Providers - PPO providers have agreed to provide services to Covered Persons at reduced rates. Therefore, to encourage the use of PPO providers whenever possible, the Plan will generally provide a better benefit for their services. The benefit enhancements are described in the further sections of this schedule.

This Plan contains a Preferred Provider Organization (PPO) for hospital facilities. The Plan has entered into an agreement with certain hospitals, which are called Preferred Providers. Because these Preferred Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees. Covered Persons should refer to the provider directory on line at the PPO's website, www.fchn.com or call (800) 231-6935.

Non-PPO Providers - Non-PPO providers are those covered providers who are not participating in the Preferred Provider Organization. Benefit levels for such providers are generally less than PPO benefit levels to encourage Covered Persons to use PPO providers whenever possible.

5.3 Exceptions

Under the following circumstances, the higher in-network payment will be made for certain non-network services:

- If a covered person is referred to a Non-Preferred Provider facility by a Preferred Provider facility, or
- If a covered person requires immediate treatment for an Emergency Medical Condition (as defined by this Plan).

5.4 Participating Provider Organization – Out of Area Services

This Plan has an agreement with Valenz Health for facility services rendered outside of Alaska. When care or services are needed while traveling or residing outside of the First Choice Network area, these services will be covered at the in-network rate if received from a Valenz facility. To

find a Participating Facility, the Covered Person can contact Integrity Administrators at (800) 562-9383 or www.valenzhealth.com.

5.5 Calendar Year Deductible

A Deductible is an amount, which a Covered Person must contribute toward payment of eligible medical expenses. These deductibles are:

Table 5.2: Calendar Year Deductible	
PPO and NON-Providers (combined)	
Individual	$150
Family	$300

Family Maximum - To limit your family's out of pocket expenses, the maximum deductible for you and all your covered dependents is stated above. No more than one deductible per individual will be applied to the family deductible.

Deductible Carryover – Eligible expenses incurred in the last three (3) months of a calendar year and applied toward that year's deductible can be carried forward and applied toward the person's deductible for the next calendar year.

5.6 Coinsurance and Co-Pay Schedule

Coinsurance - Coinsurance is the percentage of eligible medical expenses that the Plan will pay after any required Deductible has been satisfied. The Coinsurances are as shown to the right of each type of service identified below.

Table 5.3: Maximum Out-of-Pocket Per Calendar Year		
Preferred Facility, Professional and Other Covered Services		
	Certified Teachers	Certified Administrators and Classified Employees
Individual	$250	$500
Family	$750	$1,500
Non- Preferred Facility		
No maximum out-of-pocket, all services remain at steerage coinsurance level. Non-PPO facility expenses do not apply to the out-of-pocket maximum.		

This schedule is designed to be used in conjunction with the section entitled Eligible Medical Expenses. Therefore, where a covered service or supply is NOT listed below, the Coinsurance is that shown under "All Other Eligible Medical Expenses."

The Plan will pay the designated percentage of covered charges. For professional services and Preferred Provider Facilities, the Plan will pay 100% of contractually covered charges when the out-of-pocket maximum is reached, for the remainder of the calendar year, unless stated otherwise.

The following expenses do not apply to the out-of-pocket maximum:

- Any excluded charges;
- Expenses over usual and customary when utilizing a Non-PPO provider;
- Expenses reduced due to non-compliance of cost containment features of the plan.
- Deductible amounts

- Facility services furnished outside of the PPO Network, including Non-PPO facilities' copayments and coinsurance, (except for care of an Emergency Medical Condition at a Non-PPO hospital emergency room)
- Copayments
- Expenses covered at 100% by the Plan,
- Dental, vision and hearing services

5.7 Co-Pay

A co-pay is an amount the Covered Person must pay to the PPO provider at the time the service/supply is rendered. The balance of the Eligible Expense will be paid by the Plan.

5.8 Detailed Medical Schedule of Benefits

Below is a list of medical benefits covered by your plan. Also, please see Eligible Medical Expenses in Section 7.

Table 5.4: Medical Schedule of Benefits			
FACILITY BENEFITS $200 per admission copayment for all Non-PPO inpatient services and Non-PPO outpatient surgical facility charges			
Eligible Medical Expenses	**PPO Provider**	**Alaska Non-PPO Provider**	**Non-Alaska Non-PPO Provider**
Birthing Center	100% deductible waived	100% deductible waived	100% deductible waived
Chemical Dependency – Inpatient	90% after deductible	$200 co-pay then 60% after deductible[1]	70% after deductible[1]
Chemical Dependency – Partial Hospitalization - two days count as one day.	90% after deductible	$200 co-pay then 60% after deductible[1]	70% after deductible[1]
Chemotherapy	90% after deductible	60% after deductible[1]	70% after deductible[1]
Emergency Room – emergency medical condition as defined by the plan.	90% after deductible	90% after deductible	90% after deductible
Emergency Room – non-emergency medical condition	90% after deductible	60% after deductible[1]	70% after deductible[1]
Inpatient Services	90% after deductible	$200 co-pay then 60% after deductible[1]	70% after deductible[1]
Mental Health – Inpatient	90% after deductible	$200 co-pay then 60% after deductible[1]	70% after deductible[1]
Mental Health – Partial Hospitalization – two days count as one day.	90% after deductible	$200 co-pay then 60% after deductible[1]	70% after deductible[1]

[1]Coinsurance does not apply to the out-of-pocket maximum.

Outpatient Diagnostic Lab & X-ray	90% after deductible	60% after deductible[1]	70% after deductible[1]
Outpatient Surgical Facility	90% after deductible	$200 co-pay then 60% after deductible[1]	70% after deductible[1]
Pre-Admission Testing	100% deductible waived	100% deductible waived	100% deductible waived
Radiation Therapy	90% after deductible	60% after deductible[1]	70% after deductible[1]
Sleep Disorder Diagnosis and Treatment – medical necessity must be established	90% after deductible	60% after deductible[1]	70% after deductible[1]

Professional Service Benefits	
Covered Services	**All Providers**
Acupuncture (by a MD or DO in lieu of general anesthesia)	90% after deductible
Allergy Treatment	90% after deductible
Ambulance Service	90% after deductible
Blood or Blood Components	90% after deductible
Cardiac Rehabilitation	90% after deductible
Chemical Dependency (professional fees)	90% after deductible
Chemotherapy	90% after deductible
Chiropractic Care	90% after deductible
Dialysis	90% after deductible
Durable Medical Equipment	90% after deductible
Emergency Services (professional fees)	90% after deductible
Family Planning	See Preventive Care
Hearing/Audio Care (one per 36 months)	80% deductible waived
Home Health Care (one visit per day up to 100 visits per calendar year)	100% deductible waived
Hospice Care Services	90% deductible waived
Immunizations	See Preventive Care
Injections	90% after deductible
Laboratory Services	90% after deductible
Maternity Services (dependent children are not eligible for this benefit)	90% after deductible
Mental Health Services (professional fees)	90% after deductible
Occupational Therapy	90% after deductible
Organ and Tissue Transplants (professional fees)	90% after deductible
Physical Therapy	90% after deductible
Physician Services	
Consultations	90% after deductible
Office Visits	90% after deductible
Inpatient Visit	90% after deductible
Physician Surgical Services	
Inpatient	90% after deductible
Outpatient	90% after deductible
Physician's Office	90% after deductible
Anesthesia Services	90% after deductible

Assistant Surgeon - when medically necessary	90% after deductible
Preadmission Testing (within 7 days of admission)	90% after deductible
Prescription Drugs (*MUST BE PURCHASED THROUGH PRESCRIPTION DRUG CARD*)	
Pharmacy (120-day supply – one co-pay per month)	
Generic Drugs	$10 co-pay per month
Preferred Brand Drugs	$20 co-pay per month
Non-Preferred Brand Drugs	$40 co-pay per month
Mail Order (120-day supply)	
Generic Drugs	$0 co-pay
Preferred Brand Drugs	$0 co-pay
Non-Preferred Brand Drugs	$0 co-pay
Preventive Care (see full description of Preventive Care Benefits under Eligible Medical Expenses)	100% deductible waived
Prosthetics	90% after deductible
Radiology Services	90% after deductible
Radiation Therapy Services	90% after deductible
Second Surgical Opinion	90% after deductible
Skilled Nursing Facility (90 days per calendar year)	100% deductible waived
Sleep Disorder (professional fee) Medical necessity must be established	90% after deductible
Speech Therapy	90% after deductible
Supplies and Special Equipment	90% after deductible
Urgent Care	90% after deductible
Well Child (through age 17)	See Preventive Care
Well Newborn Care	See Preventive Care
Women's Health Care	See Preventive Care
Other Eligible Medical Expenses	90% after deductible

***PRIOR TO ANY HOSPITAL CONFINEMENT OR WITHIN 72 HOURS OF AN EMERGENCY ADMISSION, PLEASE CALL HINES & ASSOCIATES AT (800) 559-5257 FOR HOSPITAL PRECERTIFICATION. FAILURE TO COMPLY WILL AFFECT BENEFITS.**

NOTE: THIS SCHEDULE IS A SUMMARY ONLY. PLEASE REFER TO THE ELIGIBLE MEDICAL EXPENSES AND LIMITATIONS AND EXCLUSIONS SECTIONS FOR MORE COMPLETE INFORMATION.

6 PRESCRIPTION DRUG COVERAGE

6.1 Prescription Drugs

Prescription Drug benefits are provided by Integrated Prescription Management (IPM). This means that it is mandatory that you present your benefit ID card and pay co-payments at your local participating IPM pharmacy. Co-payments are not reimbursed by the Plan. Maintenance medications can be filled once locally. After the initial fill, it is mandatory that you utilize mail order services.

6.2 Generic Substitution

Over 400 commonly prescribed drug products are now available in a generic form at an average cost of 50% less than the brand name products. This Plan encourages the use of generic prescription drugs. By law, generic and brand name drugs must meet the same standards of safety, purity, strength and effectiveness. Brand name drugs are often two to three times more expensive than generic drugs. Use of generics with this benefit will save money for both the covered person and the Plan. We encourage the covered person to ask his or her physician to prescribe a generic whenever possible.

6.3 Retail Prescription Program

This Plan provides benefits for prescriptions purchased at an IPM retail pharmacy.

Covered charges include drugs requiring the written prescription of a licensed physician; such drugs must be necessary for the treatment of an illness or injury, including insulin and syringes and allergy serums.

Any drugs purchased locally would be considered a "Retail Benefit". These drugs would be subject to the supply limitation and co-pay provisions outlined below.

6.4 Mail Order Prescription Program

This Plan participates in the IPM Mail Order Program through Walgreen's Pharmacy. The Mail Order Pharmacy Benefit is provided to assist covered persons in obtaining their maintenance medications (ongoing medications) at a lesser cost by delivering the medications via the U.S. Mail system directly to their mailing address.

Any drugs purchased through the IPM system would be considered "Mail Order" and subject to the supply limitation and $0.00 cost co-pay provisions outlined below.

Any drug that is first attempted to be purchased through the IPM system and is not available for any reason but is available through another licensed pharmaceutical service, would still be considered "Mail Order" and subject to the supply limitations and $0.00 cost co-pay provision outlined below.

IPM can be reached at 1-877-860-8844 or on its website: www.rxipm.com

6.5 Dispensing Limitations

Payment will be limited to no more than a 120-day advance supply or 360 unit/doses, whichever is greater.

6.6 DAW

DAW means that the pharmacist will dispense a prescription to the member based on the doctor's orders. The pharmacist will dispense the prescription in an amount prescribed in the written order by the doctor for up to 120 days.

6.7 Co-Pay Schedule

Retail Benefits
Day Supply Limits: 120-**day** supply

Members may obtain a 4-month supply of medication at an IPM local pharmacy but will pay 1 co-pay for each month.

Retail Member Co-Pays

Non-Preferred Brand	$40 Co-pay
Preferred Brand	$20 Co-pay
Generic	$10 Co-pay

Mail Order Benefits
Day Supply Limits: 120-day supply
It is mandatory that members order maintenance medication through mail order. However, the initial maintenance prescription may be filled at IPM local pharmacy with retail co-pay

Mail Order Member Co-Pays

Non-Preferred Brand	$0 Co-pay
Preferred Brand	$0 Co-pay
Generic	$0 Co-pay

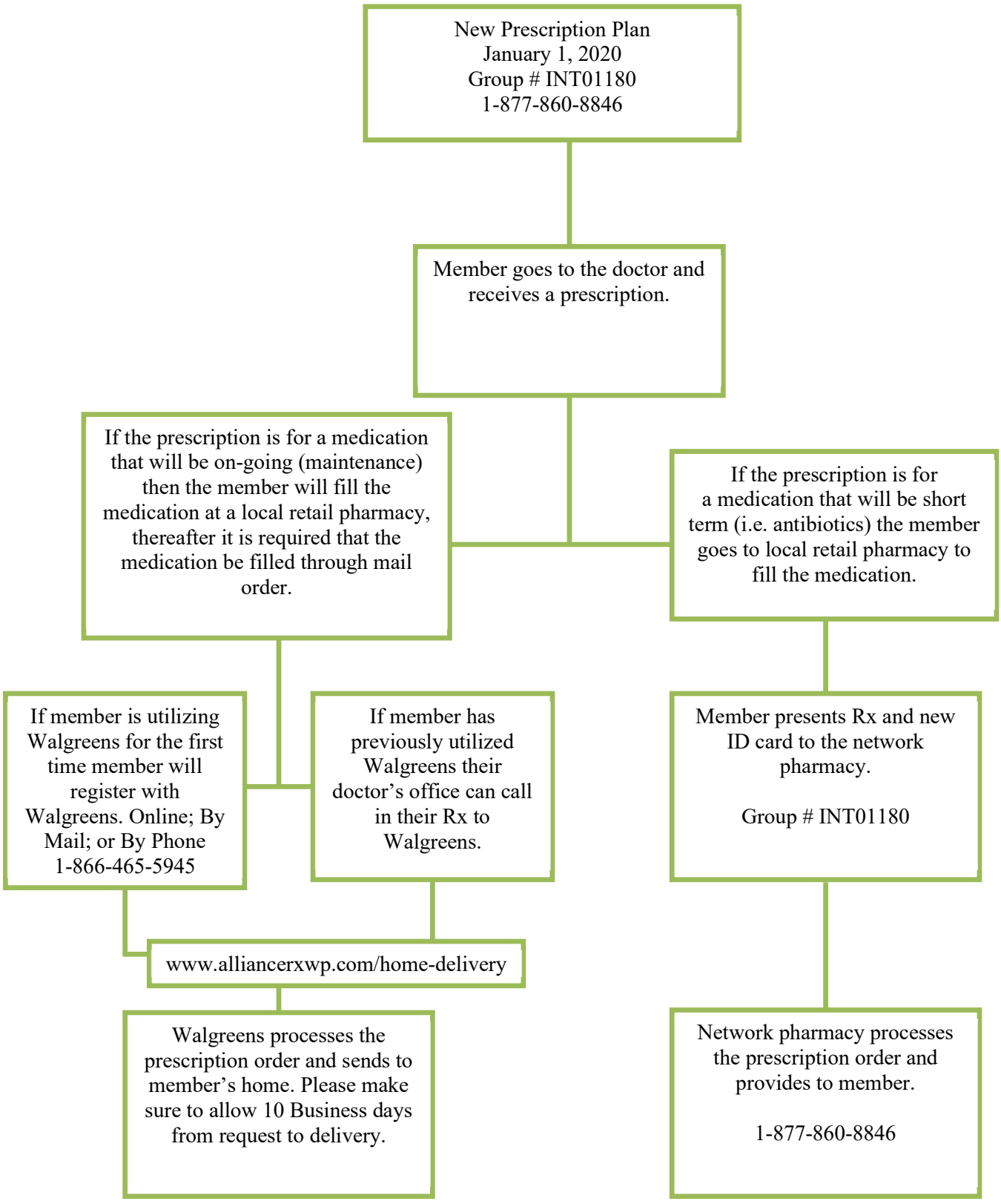
6.8 Over the Counter Medications

The Plan will also offer coverage for Prilosec OTC. For members that choose to utilize Prilosec OTC, they will only pay a generic copayment.

6.9 Medicare Part D Creditable Coverage

If you are Medicare-eligible, you should be aware that Medicare offers prescription drug coverage (known as Medicare Part D). You are not required to choose this coverage. The Plan will continue to provide your prescription drug coverage if you become eligible for Medicare. If you enroll in coverage under this Plan and under Medicare Part D, you will be paying more for additional insurance that you may not need as Medicare Part D will not supplement your coverage under this Plan. There is no coordination between the plans.

Prescription drug coverage under this Plan is, on average, at least as good as Medicare prescription drug coverage; therefore, there is no advantage to signing up for Medicare Part D coverage. The government refers to this as "creditable coverage". Since the Plan's coverage is considered to be creditable, you will not be subject to penalties or restrictions if you later choose to enroll in a Medicare prescription drug plan.


New Prescription Plan
January 1, 2020
Group # INT01180
1-877-860-8846
Member goes to the doctor and receives a prescription.
If the prescription is for a medication that will be on-going (maintenance) then the member will fill the medication at a local retail pharmacy, thereafter it is required that the medication be filled through mail order.
If the prescription is for a medication that will be short term (i.e. antibiotics) the member goes to local retail pharmacy to fill the medication.
If member is utilizing Walgreens for the first time member will register with Walgreens. Online; By Mail; or By Phone 1-866-465-5945
If member has previously utilized Walgreens their doctor's office can call in their Rx to Walgreens.
Member presents Rx and new ID card to the network pharmacy.
Group # INT01180
www.alliancerxwp.com/home-delivery
Walgreens processes the prescription order and sends to member's home. Please make sure to allow 10 Business days from request to delivery.
Network pharmacy processes the prescription order and provides to member.
1-877-860-8846

7 ELIGIBLE MEDICAL EXPENSES

This section is a listing of those medical services, supplies and conditions that are covered by the Plan. This section must be read in conjunction with the Medical Schedule(s) of Benefits to understand how Plan benefits are determined (application of Deductible requirements and Coinsurance percentages, etc.).

Except as otherwise noted below or in the Medical Schedule of Benefits, eligible medical expenses are the Usual, Customary and Reasonable charges for services listed below and which are incurred by a Covered Person subject to the Definitions, Limitations and Exclusions and all other provisions of the Plan Document. In general, services and supplies must be approved by a Physician and must be Medically Necessary for the care and treatment of a covered Sickness, Accidental Injury, Pregnancy or other covered health care condition.

For benefit purposes medical expenses will be deemed incurred on the latest of the following dates:

- The date a purchase is contracted: or
- The date delivery is made: or
- The actual date a service is rendered.

7.1 Acupuncture

Charges for acupuncture by a physician (MD or DO) when performed in lieu of general anesthesia.

7.2 Allergy Testing and Treatment

Allergy testing, treatment, injections and serum.

7.3 Ambulance/Travel Service

- Professional ground or air ambulance, if medically necessary; or
- Round trip transportation by a commercial airline or professional air ambulance from the place where an illness or injury occurred to the nearest hospital where professional treatment can be obtained, subject to the following limitations:
    - The illness or injury must be a life endangering situation that requires immediate transfer to a hospital that has special facilities for treating the condition;
    - Surgery is needed that cannot be performed locally; or
    - A condition exists which cannot be treated locally. In such case, transportation benefits for any one illness or condition in any one calendar year must be certified in writing from a physician and will be limited to:
        - One visit and one follow-up visit for required therapeutic treatment which cannot be provided locally; or
        - One pre- or post-surgical visit and one trip for the actual surgical procedure which cannot be provided locally.
- If air transportation is required, the physician must provide written certification and detailed medical documentation of the existing condition in advance of the trip. The Plan will determine how much of the transportation charges, if any, are eligible for coverage under the Plan.

- If the patient is a child under 17 years of age, the transportation charges of a parent or legal guardian accompanying the child will be allowed, if the attending physician certifies the need for such attendance.

- Transportation charges for a physician and/or registered nurse may be covered, only when deemed medically necessary.

- Travel benefits apply only to the conditions covered by the medical Plan. Dental care and vision care do not qualify for travel benefits.

- Travel pre-authorization will not be given for diagnostic purposes or second opinion diagnosis. Post-authorization may be given after a review of the medical documentation of such procedures.

- An "Air Travel Pre-Authorization Supplement Form" is required in all instances that do not involve a genuine life endangering emergency. A sample of this form can be found at the end of this document, and photocopied as needed.

7.4 Ambulatory Surgical Center
See Definitions

7.5 Anesthesia
Charges for the cost and administration of anesthetic by a Physician or registered nurse anesthetist (R.N.A.).

7.6 Birthing Center
See Definitions

7.7 Blood or Blood Components
Blood and blood components (if not replaced by or for the patient), including blood processing and administration services.

7.8 Cardiac Rehabilitation
Services deemed Medical Necessary which are rendered:
- under the supervision of a Physician;
- in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery;
- initiated within 12 weeks after other treatment for the medical condition ends; and
- in a Medical Care Facility as defined by this Plan.

7.9 Chemical Dependency
- Charges for chemical dependency, subject to the maximums shown on the Summary of Medical Benefits. Covered expenses include:

    - Inpatient services rendered by a licensed general hospital, or a freestanding inpatient facility, while the covered person is confined as an inpatient in the hospital or facility;

    - Outpatient services rendered in an outpatient setting in a licensed general hospital, a physician's, psychologist's office or an alcoholism or drug treatment center;

    - Covered services rendered by a physician or psychologist, also includes MSW and MA as defined under physician section; and

- Services received as an inpatient or outpatient also include medical and psychiatric evaluations, inpatient room and board (including detoxification), group and individual psychotherapy, behavior therapy, recreation therapy and family therapy for the patient and the covered person's family.

7.10 Chemotherapy
The use of chemical agents in the treatment or control of disease.

7.11 Chiropractic Services
Charges for chiropractic treatment, furnished by a chiropractor practicing within the scope of his or her license as defined by state law.

7.12 Cornea Transplant
Cornea transplants and all related covered services, when incurred by a covered enrollee who is the recipient of the transplant. This benefit includes organ and tissue procurement from a donor consisting of removal, surgical storage, and transportation costs incurred which are directly related to the donation of an organ used in a covered transplant procedure. Benefits are not provided for travel expenses or services, chemotherapy, supplies, drugs and aftercare for or relating to artificial or non-human organ implant or transplants.

7.13 Cosmetic Surgery
Charges for cosmetic surgery, under only the following circumstances:

- Treatment within 24 months of an accidental bodily injury, provided that treatment begins within 90 days of the accident;
- Reconstructive surgery which is incidental to, or follows an injury or illness, provided that the surgery is not performed mainly to improve the mental or emotional state of the patient;
- The surgical correction of a congenital anomaly in a child which impairs bodily function; or
- Reconstructive breast surgery following a mastectomy. See **Reconstructive Breast Surgery** in this section for more information.

7.14 Diabetic Instruction
Charges for medically necessary diabetic instruction, provided by a hospital on an outpatient basis.

7.15 Diabetic Supplies
Insulin, needles and Clinitest for the treatment of diagnosed diabetes mellitus.

7.16 Diagnostic Laboratory and X-ray Services
Diagnostic laboratory and x-ray expense, including charges for mammograms, electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, amniocentesis, or similar diagnostic tests generally approved by Physicians throughout the United States.

For pre-admission testing prior to hospital admission see Pre-Admission Testing in this section.

7.17 Dialysis Services
Dialysis services, including training, when provided and billed for by a Hospital, freestanding dialysis center or other appropriate Covered Provider.

7.18 Durable Medical Equipment
Charges for rental of durable basic (i.e., non-luxury) medical equipment (but not to exceed the

purchase price) or purchase of such equipment where only purchase is permitted or where purchase is more cost effective due to a long-term need for the equipment. Such equipment must be prescribed by a Physician and required for therapeutic use in treatment of an active Sickness or Accidental Injury.

"Durable medical equipment" includes such items as braces, crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, oxygen, iron lung and dialysis equipment, etc., which: (1) can withstand repeated use, (2) are primarily and customarily used to serve a medical purpose, (3) generally are not useful to a person in the absence of Sickness or Accidental Injury, and (4) are appropriate for use in the home.

7.19 Emergency Services

Services and supplies by a physician and/or hospital to treat injuries caused by an accident and to treat sudden and acute medical conditions that could not have been reasonably anticipated and requires immediate medical care.

7.20 Extended Care Facility

See Skilled Nursing Facility in this section.

7.21 Family Planning Services

See Preventive Care in this section.

7.22 Gynecological Exams

See Preventive Care in this section.

7.23 Hearing/Audio Therapy

Charges for treatment and services rendered by a registered hearing therapist under the supervision of a physician in an institution whose primary purpose is to provide medical care for an illness or injury.

7.24 Home Health Care

Services and supplies as listed herein, which are furnished by a Home Health Care Agency to a Covered Person who is under the care of a Physician and which are furnished in accordance with a home health care plan. The home health care plan must be established and periodically reviewed by the attending Physician who must not have any ownership interest or contract with the home health care provider. Also, the attending Physician must certify that the proper treatment of the Sickness or Accidental Injury would require confinement as a resident Inpatient in a Hospital or Skilled Nursing Facility in the absence of the services and supplies provided as part of the home health care plan. Home health care must commence within seven (7) days following a covered Hospital confinement.

Covered Home Health Care Agency expenses will include visits by any of the following professionals:

- A registered graduate nurse (R.N.) or another nurse under the supervision of a registered nurse (R.N.);
- Home health aides;
- Physical, occupational, speech and respiratory therapists.

A maximum of one visit per day and one hundred (100) home health care visits will be covered in any one Calendar Year. Each visit by a nurse or by a therapist and each visit of up to four (4) hours of home health aide services will be considered as one visit.

Covered Home Health Care Agency expenses will also include medical supplies, drugs and medicines prescribed by a Physician and laboratory services, but only to the extent that such charges would have been covered if the patient had been confined in the Hospital. Covered home health care expenses will NOT include food, food supplements, home-delivered meals, and transportation or housekeeping services.

7.25 Hospice Care

The Plan will provide coverage for Hospice care of a Covered Person with a terminal prognosis (i.e., life expectancy of six months or less) who has been admitted to a formal program of Hospice care. Covered Hospice expenses are limited to:

- Room and board for confinement in a hospice;
- Ancillary services furnished by the hospice while the patient is confined therein, including rental of durable medical equipment which is used solely for treating an illness or injury;
- Medical supplies and medicines prescribed by the attending physician, but only to the extent such items are necessary for pain control and management of the condition;
- Physician services and/or nursing care by a registered nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN);
- Home health aide services;
- Home care charges for home care furnished by a hospital or home health care agency under the direction of a hospice. Custodial care will be included if it is provided during a regular visit by a registered nurse, a licensed practical nurse or a home health aide;
- Medical social services by licensed or trained social workers, psychologists or counselors;
- Nutrition services provided by a licensed dietitian;
- Respite care; and
- Bereavement counseling.

7.26 Hospital Services

- The actual room and board expenses incurred for a ward or semi-private room;
- The actual expense incurred for confinement in an intensive care unit, cardiac care unit or burn unit;
- Hospital nursery and physician expenses (including circumcision) of a healthy newborn. Healthy newborn expenses will be paid as the newborn's claim as long as the newborn is enrolled within 31 days after birth.
    - If the newborn is ill, suffers an injury, premature birth, congenital abnormality or requires care other than routine care, benefits will be provided on the same basis as for any other eligible expense, provided that application for dependent coverage is made within 31 days of the birth. Benefits will be considered under the baby's own claim.
- Miscellaneous hospital services and supplies during hospital confinement;
- Outpatient hospital services and supplies; or

- Outpatient emergency room charges.

7.27 Hospitalization for Dentistry and Dental Services Covered by the Medical Plan

- When hospitalization is required for a dental procedure because of a concurrent hazardous medical condition such as serious blood dyscrasia, unstable diabetes or severe cardiovascular disease, charges for the hospital, anesthesiologist and physician's assistant will be allowed.

- Certain medical expenses associated with dental procedures may be covered by the Medical Plan. Such dental procedures include, but are not limited to: excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth; emergency repair due to injury to sound natural teeth; surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth; excision of benign bony growths of the jaw and hard palate; external incision and drainage of cellulitis; incision of sensory sinuses, salivary glands or ducts; and removal of impacted teeth.

- Charges for the dentist's services will be covered under the Dental Plan only.

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

7.28 Immunizations

See Preventive Care in this section.

7.29 Laboratory Services

Charges for clinical and pathological laboratory examinations.

7.30 Mammography

See Preventive Care for routine mammography and see Diagnostic Services for diagnostic mammography in this section.

7.31 Maternity

- Charges for maternity care, on the same basis as any illness are covered under this Plan.

- This benefit includes elective abortion.

- This benefit includes testing for infertility, but not infertility treatment.

Note: Dependent children are not eligible for benefits under this provision, even for a complication of pregnancy.

7.32 Medical Supplies

Charges for disposable medical supplies such as casts, splints, trusses, surgical dressings, colostomy bags and related supplies, catheters, and syringes and needles for treatment of allergies and diabetes.

7.33 Mental Health Services

Charges for mental health care.

Covered expenses include:

- Inpatient benefits when rendered in a licensed general hospital; or

- Outpatient benefits only when services are rendered by a physician (MD or DO), psychiatrist (MD), psychologist (PhD), or a counselor with the degree of MSW, LCSW, MA, MFC, or LPC who is acting under the direct supervision of a physician (MD or DO) and whose expenses are billed through that physician.

7.34 Midwife

Services of a registered nurse midwife.

7.35 Newborn Care

Hospital and Physician services, including circumcision, rendered during the birth confinement to a covered well newborn child.

7.36 Occupational Therapy

Therapy, under the direction of a Doctor of Medicine (M.D.) and provided by a certified occupational therapist, utilizing arts, crafts or specific training in daily living skills, to improve and maintain a patient's ability to function.

7.37 Organ and/or Tissue Transplant

- Pre-authorization is a requirement for organ transplants. Expenses incurred in connection with any organ or tissue transplant listed in this provision will be covered subject to referral to and pre-authorization by the Plan.

- As soon as reasonably possible, but in no event more than ten days after a covered person's attending physician has indicated that he or she is a potential candidate for a transplant, the covered person or physician should contact the Contract Administrator for pre-authorization. A comprehensive treatment plan must be developed for this Plan's review, and must include such information as the diagnosis, the nature of the transplant, the setting of the procedure and any secondary medical need for the procedure, as well as a description and the estimated cost of the proposed treatment.

- All potential transplant cases will be assessed for their appropriateness through Individual Case Management.

- The term "covered expenses" with respect to transplants include the UCR expenses for services and supplies which are covered under this Plan, or which are specifically identified as covered only under this provision and which are medically necessary and appropriate to the transplant. Covered expenses include:

    - Charges incurred in the evaluation, screening and candidacy determination process;

    - Charges incurred for organ transplantation;

    - Charges for organ procurement, including donor expenses not covered under the donor's plan of benefits;

    - Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving, and transporting the organ;

    - Coverage for organ procurement from a living donor will be provided for the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant, as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow up care;

- 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 treatment storage costs of the marrow up to the time of reinfusion and search charges to identify an unrelated match;

- Charges incurred for follow up care, including immuno-suppressant therapy; and

- Charges for transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual, or in the event that the recipient or the donor is a minor, two other individuals.

- Donor Expenses

  - Medical expenses of the donor will be covered under this provision to the extent that they are not covered elsewhere under this Plan or any other benefit plan covering the donor. In addition, medical expense benefits for a donor who is not a participant under this Plan are limited to a maximum of $10,000 per transplant benefit period; or

  - If the donor is a covered person under this Plan but the recipient is not, no benefits are available, however complications and unforeseen effects from a covered person's organ donation will be covered as any other illness.

7.38 Oxygen
Charges for oxygen and other gases and their administration.

7.39 Parenteral Nutrition (Intravenous Feeding)
Charge for hyperalimentation or total parenteral nutrition (TPN) for persons recovering from or preparing for surgery.

7.40 Physical Exams
See Preventive Care in section.

7.41 Physical Therapy
Professional services of a licensed physical therapist, when specifically prescribed by a Physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of bodily function.

7.42 Physician Services
Medical and surgical treatment by a Physician (M.D. or D.O.), including office, home or hospital visits, clinic care, consultations and second surgical opinions. Physician Services in the office would include; dressings, supplies, equipment, injections, anesthesia, take-home drugs, blood, blood plasma, x-rays, laboratory work, chemotherapy, dialysis, radium and radioactive isotope therapy.

7.43 Pre-Admission Testing
One (1) set of diagnostic tests performed on an Outpatient basis prior to a scheduled Hospital admission when:

- The admission to the Hospital is confirmed in writing by the attending Physician before the testing takes place;

- The tests are performed within seven (7) days before admission to the Hospital;

- The tests are ordered by the attending Physician;
- The tests are accepted by the Hospital in place of the same tests which would otherwise be done while the individual is Hospital-confined;
- The tests are not repeated in the Hospital;
- The patient is subsequently admitted to the Hospital (unless a Hospital bed is unavailable or there is a Change in the patient's health condition which precludes such admission).

7.44 Preventive Care

Preventive Care Benefits are to promote wellness, disease prevention and early detection by encouraging the Plan's Covered Persons to have regular preventive examinations to identify potential health risks and provide the opportunity for early intervention.

Services are considered Preventive Care when a Covered Person:

- Does not have symptoms or any abnormal studies indicating an abnormality at the time the service is performed;
- Has had a screening done within the age and gender guidelines recommended by the U.S. Preventive Services Task Force with the results being considered normal;
- Has a diagnostic service with normal results, after which the physician recommends future preventive care screening using the appropriate age and gender guidelines recommended by the U.S. Preventive Services Task force, or
- Has a preventive service done that results in a diagnostic service being done at the same time because it is an integral part of the preventive service (e.g. polyp removal during a preventive colonoscopy).

If a health condition is diagnosed during a preventive care exam or screening, the preventive exam or screenings still qualifies for preventive care coverage.

Services are considered Diagnostic Care, and not Preventive Care, when;

- Abnormal results on previous preventive or diagnostic screening requires further diagnostic testing or services,
- Abnormal test results found on a previous preventive or diagnostic service requires the same test to be repeated sooner than normal age and gender guideline as recommended by the U.S. Preventive Services Task Force would require, or
- Services are ordered due to current symptom(s) that require further diagnosis.

The Plan will pay for Preventive Care Services only if the service;

- Falls within the scope of a Preventive Care Service as indicated above; and
- Is identified as a covered preventive service on the US Department of Health and Human Services (HHS) list of Preventive Care services.

A list of the Preventive Care services can be found on the US Department of Health and Human Services (HHS) website at https://www.healthcare.gov/what-are-my-preventive-care-benefits. The

services listed on the HHS website are not subject to co-payment or deductible, and will be paid at 100% of the provider's rate, regardless of whether the provider is a PPO or non-PPO Provider.

7.45 Prosthetics

Charges for artificial limbs or eyes to replace a missing body part. The loss of the body part or an organ's function, must have resulted from an accidental injury, a surgery, or a congenital anomaly of a child. Repair or replacement will only be covered when required due to physiological changes.

7.46 Radiology Services

Charges for diagnostic x-ray examinations, ultrasound, nuclear medicine, mammography and magnetic imaging.

7.47 Radiation Therapy

Charges for radium and radioactive isotope therapy.

7.48 Reconstructive Breast Surgery

Reconstructive breast surgery following mastectomy, including reimbursement for reconstruction of the breast on which a mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient;

Pre-authorization from the Plan is required for repair, replacement or removal of breast prosthesis.

7.49 Rehabilitation Therapy

Covered services include multi-disciplinary inpatient and outpatient treatment furnished by a physician or licensed or certified therapist. Covered services include, but are not limited to: physical, speech, and occupational therapy; and

Rehabilitative treatment for a congenital anomaly for a child.

7.50 Respiratory Therapy

Professional services of a licensed respiratory therapist, when specifically prescribed by a Physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of respiratory function.

7.51 Routine Care

See Preventive Care Services in this section.

7.52 Second Surgical Opinion

Charges for a second surgical opinion consultation and related diagnostic services following a surgeon's recommendation for surgery. The Physician rendering the second option regarding the Medical Necessity of a proposed surgery must be qualified to render such a service, either through experience, specialist training or education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

7.53 Skilled Nursing Facility

Room and board and ancillary supplies which are provided by a Skilled Nursing Facility and only when the confinement:

- is preceded by a covered confinement of at least three (3) days in a Hospital;
- is for the same condition causing the preceding confinement;

- commences within seven (7) days of discharge from such prior confinement;
- is not custodial in nature and is necessary for the treatment of or leading to the recovery from a Sickness or Accidental Injury.

A maximum benefit of ninety (90) days for Skilled Nursing Facility confinement is allowable.

7.54 Sleep Disorder Diagnosis and Treatment

Expenses for sleep disorder diagnosis and treatment will be covered subject to approval of the Plan. Medical necessity must be established.

Covered expenses include the reasonable and customary expenses for services and supplies that are medically necessary and appropriate treatment for the condition.

7.55 Speech Therapy

Services by a licensed speech therapist for restorative or rehabilitory speech therapy provided the therapy is for speech loss or impairment due to a Sickness or Accidental Injury, surgery on account of a Sickness or Accidental Injury, or impairment due to a congenital anomaly, provided such loss or impairment is not due to a functional nervous disorder. See also "Hearing/ Speech Evaluation".

7.56 Sterilization Procedures

Sterilization procedures for an eligible employee or dependent spouse, when performed by a licensed physician. Reversal of sterilization is not covered.

7.57 Surgical Procedures

Expenses incurred for medically necessary surgical procedures.

Expenses for an assistant surgeon when an assist surgeon is required to render technical assistance at an operation.

7.58 Surgical Center

Charges made by an ambulatory surgery center.

7.59 Urgent Care Facilities

Charges made by an urgent care facility.

7.60 Well Baby Care

See Preventive Care in this section.

7.61 Well Child Care

See Preventive Care in this section.

8 COVID-19 PANDEMIC

8.1 Voluntary Compliance of the Emergency Temporary Alaska Regulations

On March 11, 2020, the Governor of the State of Alaska issued a Declaration of Public Health Disaster Emergency Order. This order was issued to protect Alaskans from the adverse effects of the COVID-19 Pandemic.

This plan voluntarily complies with the emergency temporary regulations in accordance with Alaska's Division of Insurance and the Centers for Disease Control (CDC) requirements put forth in Bulletin B20-11: Requirements for Group Health Plans, Claims, and Telehealth Related to the COVID-19 Pandemic Public Health Disaster Emergency, and Bulletin B20-12: Temporary Suspension of Certain Utilization Review and Notification Requirements; during the COVID-19 Pandemic Health Disaster Emergency.

Both Bulletin B20-11 and Bulletin B20-12 are implemented on a voluntary compliance for this plan.

Therefore, in response to Bulletin B20-11, the following items are temporarily incorporated into this Plan.

- **Reduced Work Hours**

  It is understood that during the period of the COVID-19 Pandemic, and in accordance with direction of the State of Alaska, this Plan will allow an employee to remain covered under the Plan even if the employee would otherwise become ineligible due to a decrease in hours worked per week. The Plan will continue providing coverage to employees regardless of any "actively at work" or similar eligibility requirement in the Plan document.

- **Claim Submissions and Appeals**

  Due to potential staffing challenges in physician's offices, clinics and hospitals during the Alaska public health disaster emergency, the Plan shall suspend deadlines for claim filing and appeals. Following the end of the emergency, there may also be a backlog of insurance claims to be filed and these claims may also be extended.

- **Additional Telehealth Guidance**

  During the COVID-19 Pandemic services that can appropriately be offered through telehealth in order to avoid unnecessary exposure to the virus and prevent regression of symptoms will be covered.

- **Access to Prescriptions**

  In addition to the early refills, the Plan will cover off-formulary prescription drugs if there is not a formulary drug to treat a covered condition due to supply shortages related to COVID-19. The Plan will minimize prior authorization requirements to ensure that Plan members have access to the medications as needed.

In addition, in response to Bulletin B20-12, the following items are also temporarily incorporated into this Plan.

- **Temporary Suspension of Certain Utilization Review and Notification Requirements**

It is understood that during the period of the COVID-19 Pandemic hospitals may lack the staffing resources to respond to certain Utilization Review and Notification Requirements. As hospitals plan for these higher demands of Inpatient Hospital Services and deploy staff to provide direct patient care, their ability to perform certain administrative functions may be impacted. Moreover, with many hospitals delaying or suspending scheduled procedures, the need for certain administrative functions may be diminished. Because of this, certain Utilization Review and Notification Requirements will be suspended until June 1, 2020, subject to further evaluation, as the COVID-19 situation develops, as determined by the appropriate officials of the State of Alaska.

- **Government Facilities**

  It may become necessary for alternate medical hospital/clinical sites to be opened to handle hospital overcrowding. The Plan may currently contain exclusions or requirements for such facilities to hold specific licenses. This amendment waives such requirements so that the Plan Administrator may pay claims for covered services when members are billed for services located at sponsored by, or facilitated by the local, state, or federal government during this pandemic until such time that these alternate sites are closed.

- **Suspension of Preauthorization Requirements**

  Due to the increased demand for Inpatient and Outpatient Services for COVID-19 patients, many health care providers are shifting staff resources from administrative functions to direct patient care. This change in provider staffing resources requires that the Plan Administrator and its sub-subcontractor, while continuing to follow its normal procedures, may, at some point, find it necessary to suspend Preauthorization Review for Inpatient and Outpatient Services during the duration of the COVID-19 Pandemic as determined by the Chief Medical Officer of the State of Alaska. However, in such instances where suspension of Preauthorization Requirements is initiated all health care providers should use their best efforts to provide notice to the Plan Administrator's sub-subcontractor as soon as reasonably possible, including information necessary for them to assist in coordinating care and discharge planning.

- **Suspension of Concurrent Review for Inpatient Hospital Services**

  It is also understood that during the period of the COVID-19 Pandemic hospitals may lack the staffing resources to respond to Utilization Review requests for Concurrent Review while responding to the surge in-patient admissions. Therefore, while the Plan Administrator and its sub-subcontractor will continue to follow its normal procedures, from time to time, during the duration of the COVID-19 Pandemic, it may become necessary to suspend Concurrent Review for inpatient hospital services.

- **Suspension of Retrospective Review for Inpatient Services, Outpatient Services, Emergency Services, and Payment of Claims**

  It is also understood that during the period of the COVID-19 Pandemic Health Care providers may lack the staffing resources to respond to Utilization Review requests for Retrospective Review while responding to the surge in-patient admissions. Therefore, while the Plan Administrator and its sub-subcontractor will continue to follow its normal procedures, during the duration of the COVID-19 Pandemic, it may become necessary to suspend Retrospective Review for Inpatient and Outpatient Services, and Emergency Services.

The Plan Administrator and its sub-contractor may request information to perform a Retrospective Review, reconcile claims, and make any payment adjustments after June 1, 2020, subject to further evaluation as the COVID-19 situation develops.

- **Suspension of Preauthorization Requirements for Post-Acute Placements**

  It is also understood that during the period of the COVID-19 Pandemic, health care providers may lack the staffing resources to respond to Preauthorization Requirements for Post-Acute Placements while responding to the surge of in-patient admissions. Therefore, while the Plan Administrator and it's sub-contractor will continue to follow its normal procedures, from time to time, during the duration of the COVID-19 Pandemic in order to permit hospitals to discharge patients to lower levels of care when medically appropriate, the Plan Administrator and its sub-contractor may suspend Preauthorization Requirements for Post-Acute Placements, including but not limited to, Skilled Nursing Facilities, Home Health Care Services, Acute Rehabilitation Services, and Long-Term Acute Care Hospitals, following an inpatient hospital admission.

- **Waiver of Credentialing by Location for Payers**

  It is also understood that during the period of the COVID-19 Pandemic, Health Care providers may lack the staffing resources to respond to prompt Credentialing by Location of Payers while responding to the surge of inpatient admissions. Therefore, while The Plan Administrator and its sub-contractor will attempt to continue to follow its normal procedures, during the duration of the COVID-19 Pandemic, it may become necessary to waive the normal requirements for Location-Based Credentialing. This will allow providers to see patients in a variety of locations.

Due to the evolving nature of the COVID-19 Pandemic outbreak, the State of Alaska deemed that it's directions are subject to change, and that Insurers and self-funded plan administrators are advised to verify best practices in accordance with the Centers for Disease Control and Prevention (CDC), and that the voluntary compliance of the State of Alaska are in effect until June 1, 2020, unless otherwise updated by the State of Alaska.

8.2 Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief and Economic Security Act (CARES)

The following services will be provided for the condition of Covid-19. These services will be paid at 100% of PPO contracted rate and/or provider's cash price, as listed by the provider on a public website, or a lower negotiated price. There will be no prior authorization or medical management requirements for these services.

- **Approval of Covid-19 diagnostic testing shall include:**

  tests for which a developer has requested, or intends to request, emergency use authorization from the FDA (until the request is denied or the developer does not submit a request within a reasonable timeframe),

  tests that are developed in and authorized by a State, or

  tests that the Secretary of Health and Human Services (HHS) deems appropriate.

- **Diagnostic Testing:**

Items and services furnished to an individual during health care provider office visits (in-person and telehealth), urgent care center visits, and emergency room visits that result in an order or administration of the COVID-19 diagnostic testing, but only to the extent that such items and services relate to the furnishing of the COVID-19 diagnostic testing or to the evaluation of such individual for purposes of determining the need for COVID-19 diagnostic testing. This includes the examination of the person.

- **Preventive Services and Vaccines**

  Qualifying coronavirus preventive services including an item, service or immunization that is intended to prevent or mitigate COVID-19 and that is:

  an evidenced based item or service that has in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force or

  an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

  This requirement will take effect fifteen (15) business days after the date such recommendations may be made by the U.S. Preventive Services Task Force, or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention during the period of this Covid-19 Pandemic.

These benefits will remain in effect until the Secretary of HHS determines that the public health emergency has expired.

9 MEDICAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated otherwise, no benefits will be payable for:

9.1 Acupressure

Acupressure, services of a massage therapist, rolfing, reflexology or faith healing services, even if rendered by participating providers.

9.2 Audio Services

Audio services, except as specifically included. This exclusion includes charges for batteries or other ancillary equipment other than that obtained upon the purchase of the hearing aid device, charges for repairs, servicing or alterations of a hearing aid device, and charges for a hearing aid device more expensive than the one prescribed by the examining physician.

9.3 Cosmetic Surgery

Care, treatment or operations which are performed for cosmetic purposes, except as specifically included elsewhere in this document.

9.4 Complications

Complications of non-covered treatments. This exclusion includes care, services or treatment required as a result of complications from a treatment not covered under the Plan.

9.5 Diagnostic Hospital Admissions

Inpatient confinement primarily for x-rays, laboratory, diagnostic study, physiotherapy, hydrotherapy, medical observation, convalescent or rest care, or any medical examination or test not connected with an active illness or injury.

9.6 Duplication of Benefits

Duplication of benefits provided by any other program sponsored by Lower Kuskokwim School District.

9.7 Educational or Vocational Testing or Training

Testing and/or training for educational purposes or to assist an individual in pursuing a trade or occupation.

9.8 Eye Care

This exclusion includes radial keratotomy or other eye surgery to correct refractive disorders when vision can be corrected through the use of glasses or contact lenses.

The exclusion does not include routine eye examinations or hardware covered by the Vision Plan.

This exclusion does not include aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

9.9 Exercise Programs

Exercise programs. This exclusion includes exercise programs for treatment of any condition, except for physician-supervised cardiac rehabilitation, occupational therapy, or medically necessary physical therapy.

9.10 Foot Care

Services for foot care, including callus or corn paring or excision; toenail trimming; any manipulative procedure for weak or fallen arches, flat or pronated foot/feet, or foot strain, except for open cutting operations. Impression casting for appliances or orthotics; orthopedic shoes and supports.

9.11 Hair Loss
Services for hair loss, includes care and treatment for hair loss including wigs, hair transplants or any drug that promotes hair grown, whether or not prescribed by a physician. This exclusion does not include the purchase of a wig following chemotherapy.

9.12 Hospitalization for Convenience
Hospitalization ordered solely due to the patient's age, apprehension or emotional state, or for the convenience of the patient, family, or physician. This exclusion includes care and treatment billed by a hospital for a non-emergency admission on Friday or Saturday, unless surgery is performed within 24 hours of admission.

9.13 Hospital Late Fees
Hospital late discharge fees, telephone or television charges for the purpose of patient, family or physician convenience.

9.14 Hypnosis or Hypnotherapy

9.15 Illegal Activity
Any illness or injury arising in the course of illegal activity by a covered person. This exclusion includes charges which occur as a result of a covered person's illegal use of alcohol, and charges which occur as a result of a covered person's voluntarily taking or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a physician. Expenses will be covered for covered persons other than the person using alcohol or controlled substances. Expenses will be covered for medically necessary chemical dependency treatment as shown in the Summary of Medical Benefits, unless such treatment is court-ordered or related to deferred prosecution, deferred or suspended sentencing or driving rights.

This exclusion also includes care of inmates while in the custody of any state or federal law enforcement authority in jail or prison. Charges resulting from or occurring (1) during the commission of a crime by the covered person; or (2) while engaged in an illegal act, illegal occupation or aggravated assault.

This exclusion does not apply if the illness or injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

9.16 Impregnation
Artificial insemination, in-vitro fertilization, G.I.F.T. (Gamete Intrafallopian Transfer) or any type of artificial impregnation procedure, whether or not any such procedure is successful.

9.17 Infertility
Fertility studies, sterility studies, or procedures, drugs or supplies to correct infertility or to restore or enhance fertility, including charges for any related treatment. Infertility testing is covered by the Plan.

9.18 Maintenance Care
Maintenance care. Unless specifically mentioned otherwise, the Plan does not provide benefits for services and supplies intended primarily to maintain a level of physical or mental function.

9.19 Massage Therapy

9.20 Maternity Care for Dependent Children

9.21 Mental Examinations and Psychological Testing

Mental examinations or psychological testing and evaluations not provided as an adjunct to treatment or diagnosis of a mental disorder (e.g. mental examinations for the purpose of adjudication of legal rights, administrative awards or benefits, corrections or social service placement or any use except as a diagnostic tool for the provision of mental health or chemical dependency services as provided by the Plan.)

9.22 Motorized Transportation Equipment

Motorized transportation equipment, escalators or elevators, saunas, steam baths, swimming pools, blood pressure kits or humidifiers.

This exclusion applies even if supplies of common use are obtained upon the recommendation of a physician.

9.23 Non-Medical Self Help

Non-medical self-help such as "Outward Bound" or Wilderness Survival", recreational or educational therapy.

9.24 Non-Prescription Drugs

Drugs which can be purchased over-the-counter and without a Physician's written prescription. Drugs for which there is a non-prescription equivalent available.

9.25 Not Medically Necessary/Not Physician Prescribed

Any services or supplies, which are: (1) not Medically Necessary and (2) not incurred on the advice of a Physician - except as expressly included herein.

9.26 Obesity

See Weight Control exclusion in this section.

9.27 Orthognathic Procedures

Orthognathic surgery, services and supplies to augment or reduce the upper or lower jaw, except when necessary due to an accidental injury or cancer. This exclusion includes osteotomy, orthognathic surgery and maxillofacial orthopedics.

9.28 Personal Comfort or Convenience Items

Services or supplies provided for personal comfort and not necessary for treatment of covered Sickness, Accidental Injury, or Pregnancy including, but not limited to, the purchase or rental of telephones, televisions, orthopedic mattresses, allergy-free pillows, blankets and/or mattress covers, non-hospital adjustable beds, waterbeds, motorized transportation equipment, elevators, escalators, professional medical equipment (such as blood pressure kits) or supplies or attachments to such equipment.

9.29 Private Duty Nursing and Private Hospital Rooms

These services are not covered regardless if the attending physician orders them.

9.30 Replacement of Braces and Prosthetic Devices

Replacement of braces or prosthetic devices, unless such replacement is made necessary due to physiological changes.

9.31 Sex Counseling or Treatment

Treatment, therapy, penile implants, devices, appliances, medications or counseling for sexual dysfunctions or inadequacies, which are not related to organic disease.

This exclusion includes all physician examinations and diagnostic laboratory or x-ray studies.

9.32 Smoking Cessation Programs
Smoking cessation programs and nicotine-containing preparations whether absorbed through the skin or digestive tract.

9.33 Sterilization Reversal Surgery
Reconstruction (reversal) of prior elective sterilization procedures.

9.34 Supplies and Equipment of Common Use
Purchase or rental of supplies of common use such as: exercise cycles, air purifiers, air conditioners, water purifiers, hypoallergenic pillows, mattresses and water beds.

9.35 Temporomandibular Joint Dysfunction (TMJ)
Appliances or restorations used solely to increase vertical dimension, reconstruct occlusion or correct or treat temporomandibular joint dysfunction or TMJ pain syndrome.

9.36 Transsexualism
Transsexualism, gender dysphoria or sexual reassignment or change.

9.37 Vitamins
Prescription or non-prescription organic substances used for nutritional purposes except pre-natal vitamins prescribed by a physician.

9.38 Vocational Testing or Training
Vocational testing, evaluation, counseling or training.

9.39 Weekend Admissions
Initial Friday, Saturday and Sunday room and board charges incurred in connection with a Hospital admission, which begins on Friday, Saturday or Sunday. However, this exclusion will not apply to an emergency admission or where a scheduled surgery is performed within the 24 hours immediately following admission.

9.40 Weight Control
All expenses for routine treatment or weight loss surgical procedures to reduce obesity or any charges for weight reduction programs at health spas or similar facilities. This would include but not limited to: Laparoscopic Gastric Bypass, Open Gastric Bypass Surgery, and Gastric Banding – including Lap Band and Realize Band and Duodenal Switch, also known as Biliopancreatic Diversion.

Charges that are not specifically described as a covered service are excluded services. It is further intended that benefits only be provided when such services are medically required in the diagnosis and treatment of an illness or injury

(See also General Health Coverage Exclusions sections.)

10 DESCRIPTION OF DENTAL BENEFITS

When dental care is necessary, the Plan covers the following Preventive, Basic and Major Services. All benefits are subject to the Medical Plan Limitations and Exclusions. Dental benefits are also subject to the Dental Plan Limitations and Exclusions of this document. All benefits are subject to Usual, Customary and Reasonable (UCR).

10.1 Annual Dental Maximum

The annual maximum dental benefit for each covered person is $1,000 per Calendar Year.

10.2 Dental Deductible: None

Table 9.1: Schedule of Dental Benefits				
DENTAL CARE	**1ST YEAR OF COVERAGE**	**2ND YEAR OF COVERAGE**	**3RD YEAR OF COVERAGE**	**4TH & SUBSEQUENT YEARS**
Class A *Diagnostic and Preventive Services*	70% until December 31st of the calendar year that benefits begin	80% until December 31st of the second calendar year of benefits	90% until December 31st of the third calendar year of benefits	100%
Class B *Basic and Restorative Services*	70% until December 31st of the calendar year that benefits begin	80% until December 31st of the second calendar year of benefits	90% until December 31st of the third calendar year of benefits	100%
Class C Major Services	50%	50%	50%	50%

In order to qualify for the increased benefit percentages shown in the above Summary, the covered person must have an oral examination each calendar year. If the covered person does not have an oral examination in any one calendar year, or does not follow the treatment recommended by his or her dentist or physician, the benefit percentage will be reduced by 10%; however, in no event will the benefit percentage be less than 70%.

If, during the second year of coverage, a covered person provides documentation that he or she had an oral examination during the preceding year prior to his or her effective date of coverage, such participant shall be eligible for the 80% benefit shown above for the second year of coverage.

10.3 Estimate of Benefits

If dental care will be extensive (over $500) the covered person should ask the dentist to submit a pre-treatment estimate of benefits. This will assist the patient and the dentist by estimating the patient liability in advance, as the Plan will determine its liability for the treatment, and notify the patient and dentist of available benefits. A pre-treatment estimate of benefits is not a guarantee of coverage or payment; final benefit payment will depend on the covered person's eligibility and the Plan benefits available at the time of service.

10.4 Class A – Diagnostic and Preventive Services

The following Diagnostic and Preventive Services are covered up to the UCR allowance.

- Diagnostic oral exam.

- Prophylaxis (cleaning) of the teeth.
- Bitewing x-rays.
- Topical application of fluoride for dependent children.
- Sealants for dependent children.
- Full-mouth (or panorex) x-ray, but not more than once per 24-month period.

10.5 Class B - Basic and Restorative Services

- Extractions and alveolectomy at the time of tooth extraction.
- Amalgam, silicate, acrylic and composite restorations (fillings). Silicate, acrylic and composite fillings are covered only for teeth in front of the first bicuspid.
- Oral surgery, including periodontal surgery.
- X-ray and lab services required for dental procedures.
- General anesthesia required for dental procedures.
- Palliative treatment for the relief of dental pain.
- Drugs that require a dentist's written prescription, including medication provided at the dentist's office.
- Space maintainers for dependent children age 14 or under, when used to maintain space for eruption of permanent teeth.
- Habit-breaking appliances for dependent children age 14 or under.
- Dental consultations.
- Reline or rebase of existing dentures.
- Endodontic services.
- Periodontal services.

10.6 Class C - Major Services

- Crowns, inlays and onlays necessary to restore the structure of teeth broken down by decay or injury when the tooth cannot be restored with filling materials such as amalgam, silicate or plastic. Crowns, inlays or onlays on the same teeth are covered once in a five-year period.
- Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be allowed only when the teeth must be restored with gold.
- Initial installation of fixed and removable bridgework (including wing attachments, inlays and crowns as abutments) to replace natural teeth which were extracted while the covered person was covered under this Plan (or another plan sponsored by the employer).

- Replacement of existing fixed and removable bridgework, dentures or crowns; or the addition of teeth, inlays, onlays, crowns or gold restorations to these appliances only if:
    - The existing appliance cannot be repaired or restored to use; and
    - The patient has been covered under this Plan or another plan sponsored by Lower Kuskokwim School District for at least 12 months; and
    - At least five years have passed since the previous placement; or
    - The replacement
        - Replaces an existing temporary appliance that was placed after the date that the patient became covered, and
        - Is placed within 12 months after such temporary appliance was placed; or
            - The replacement
                - Is needed because additional natural teeth were extracted while covered or due to an accidental injury to natural teeth that occurred while covered; and
                - Is completed within 12 months of the extraction or accidental injury.

If a covered person has a partial denture or bridge, and a natural tooth adjacent to such denture or bridge is extracted while the person is covered, the addition of another tooth to the denture or bridge will be covered.

No benefits will be provided for lost or stolen prosthetic devices. Charges for adjustments of prosthetic devices made within six months of installation are not covered.

- Initial installation of full or partial dentures to replace natural teeth which were extracted while the covered person was covered under this Plan (or another plan sponsored by the employer). Charges for adjustments of prosthetic devices made within six months of installation are not covered.
- Repairs to existing dentures or bridgework.
- Installation of precision attachments for removable dentures.
- Addition of clasp or rest to an existing partial removable denture.

If care is transferred from one dentist to another during a course of treatment, the Plan will only pay benefits up to the amount the Plan would have paid had only one dentist rendered service.

In all cases in which there are optional techniques of treatment which will produce an acceptable result in the opinion of the Plan, the Plan shall be liable for the amount of the treatment carrying the lesser fee.

Benefits will only be paid for claims incurred while the covered person is eligible under the Plan. A claim is incurred at the time of treatment (for crowns and prosthetic devices the claim is incurred when the device is seated).

The Plan has the right to request a second opinion for any treatment prior to benefit payment.

11 GENERAL DENTAL LIMITATIONS AND EXCLUSIONS

There are certain items specific to the Dental Plan that are not covered. They are listed below. All benefits are subject to all Medical Plan Limitations and Exclusions and General Health Care Coverage Exclusions, as well as the Dental Limitations and Exclusions.

1. Appliances or restorations to correct vertical dimension or occlusion, study models; night guards or occlusal splints. Habit-breaking appliances for dependents age 15 and over.

2. Charges for broken appointments, completion of charts, forms or patient management.

3. Charges for sealants for dependents age 15 or over.

4. Any charges covered by the medical or other portions of this Plan.

5. Rebasing or relining a denture in less than six months from the date of initial placement, or for the performance of such service more often than once in any 2-year period.

6. Dental implants, including any appliance and/or crown and the surgical insertion or removal of the implant.

7. Gold when billed separately.

8. Hospital costs or any additional fees charged by the dentist because the patient was hospitalized.

9. Myofunctional therapy.

10. Nitrous oxide (N_20) or any other sedative or analgesic, except general anesthesia or intravenous sedation when done in conjunction with open cutting procedures.

11. Oral hygiene instruction, dietary instruction, sterilization and contamination control, plaque control programs, home fluoride kits, or dental care appliances.

12. Orthodontic treatment, except tooth extraction, unless specifically provided for in the Plan.

13. Periodontal probing, charting, splinting or reevaluations, when billed separately.

14. Personalization of dentures.

15. Precision or semi-precision attachments, except as specifically provided for in the Plan.

16. Replacement of lost or stolen appliances.

17. Services for cosmetic or aesthetic reasons including, but not limited to, laminates, restorations due to misalignment or discoloration of teeth or bleaching.

18. Services that started prior to the covered person's effective date on the Plan.

19. Services or supplies that are not necessary for the treatment of the dental condition being treated.

20. Services rendered by a dentist beyond the scope of his or her license.

21. Services which are not included in the list of covered dental services.

22. Treatment that is not generally recognized as tested and accepted dental practice by the American Dental Association (ADA).

23. Upper or lower jaw augmentation or reduction procedures (orthognathic surgery) regardless of illness or injury.

24. Services received outside of the United States or Canada, if travel was for the sole purpose of obtaining such services.

25. Dental Replacements.

    a. A dental appliance or prosthetic device, crown, cast restoration or a fixed bridge within five years of the date it was last placed. This exclusion will not apply if replacement is needed due to an accidental injury received while covered.

    b. Initial installation of bridgework or dentures whose sole purpose is to replace natural teeth extracted prior to becoming covered under this Plan.

26. No benefits will be paid for duplicate bridges or dentures, or any other duplicate dental appliance, except if the existing denture is an immediate temporary denture and replacement by a permanent denture is placed within 12 months from the date of the initial installation of the temporary denture.

27. Permanent appliances that replace temporary appliances are limited to the maximum reasonable and customary charge for the permanent appliance.

If hospital charges are incurred in connection with a course of dental treatment, those charges will be considered for payment as medical expenses should they meet the medically necessary coverage under the medical plan. No coverage shall be provided for such service under the dental expense benefit.

12 DESCRIPTION OF VISION BENEFITS

When vision care is necessary, the Plan covers the benefits listed below. All benefits are subject to all Medical Plan Limitations and Exclusions, as well as the Vision Plan Limitations and Exclusions.

Eligible vision expenses are covered when performed by a licensed ophthalmologist, optometrist or optician.

Table 11.1: Schedule of Vision Benefits	
VISION CARE	**ALL PROVIDERS**
Eye Exam *Limited to one exam per calendar year*	100%
Lenses *Limited to one pair per calendar year* *Includes one pair of: single vision lenses, bifocals, trifocals or contact lenses* *~ or ~ a 12-month supply of disposable contact lenses*	100%
Frames *Limited to one frame per 24-month period*	100%

12.1 Covered Services

- Eye examination by a covered provider, limited to once per calendar year.
- One pair of lenses (single vision, bifocal, trifocal or lenticular) or one pair of contact lenses in lieu of lenses and frames, or a 12-month supply of disposable contact lenses, limited to once per calendar year.
- Frames, limited to once per 24-month period.

13 VISION PLAN LIMITATIONS AND EXCLUSIONS

There are certain items specific to the Vision Plan that are not covered. These are listed below. Please refer to the Medical Plan Limitations and Exclusions and General Health Care Coverage Exclusions for additional Vision Plan Limitations and Exclusions.

1. Orthoptics (eye muscle exercises).

2. Vision training or subnormal vision aids.

3. Lenses ordered without a prescription.

4. Safety goggles, sunglasses or artificial eyes including the prescription type.

5. Care, treatment or supplies for which a charge was incurred before a person was covered under the Plan.

6. Any charges that are covered under a health plan that reimburses a greater amount than this Plan.

7. Charges for routine eye examinations required by an employer as a condition of employment.

8. Replacement lenses, frames or contact lenses, except as specifically listed as a covered vision service.

9. Photo chromatic tinting, anti-reflective coating or any other vision service not specifically shown under covered services.

14 DESCRIPTION OF HEARING BENEFITS

When Hearing care is necessary, the Plan covers the benefits listed below. All benefits are subject to all Medical Plan Limitations and Exclusions, as well as the Hearing Plan Limitations and Exclusions.

14.1 Covered Services Include:

- Hearing examination by a covered provider, limited to once per 36-month period.
- Hearing aid device prescribed as a result of such hearing examination, limited to one per 36-month period.
- No deductible.

Table 13.1: Schedule of Hearing Benefits	
HEARING SERVICE	**BENEFIT**
One Hearing Exam and One Hearing Aid	80% up to a maximum of $400 per 36-month period

The covered person must obtain written confirmation from the examining physician stating the individual is suffering from a hearing loss that may be lessened by use of a hearing aid device. Such written confirmation must be obtained within a three-month period prior to the purchase of a hearing aid.

15 HEARING PLAN LIMITATIONS AND EXCLUSIONS

There are certain items specific to the hearing Plan that are not covered. They are listed below. Please refer to the Medical Plan Limitations and Exclusions and General Health Care Coverage Exclusions for additional Hearing Plan Limitations and Exclusions.

1. Charges exceeding the maximum benefit available shown in the Summary of Medical Benefits under "Audio Care."

2. Replacement of a hearing aid device, for any reason, more than once in a 36-month period.

3. Batteries or other ancillary equipment, other than that obtained upon purchase of the hearing aid device.

4. A hearing aid device more expensive than the one prescribed by the examining physician.

5. Expenses incurred after the termination of coverage under this Plan, except when prescribed by a physician and ordered prior to termination were delivered within 30 days after the date of termination.

6. Any charges that exceed the maximum benefit for covered individual in any consecutive 36-month period.

16 GENERAL HEALTH CARE COVERAGE EXCLUSIONS

The following exclusions apply to all benefits and no benefit will be payable under these Health Care Coverages for:

16.1 Court-Ordered Care/Confinement/Treatment

Treatment that is court-ordered, or related to deferred prosecution, deferred or suspended sentencing, or driving rights.

16.2 Criminal Activities

Any illness or injury arising in the course of illegal activity by a covered person. This exclusion includes charges which occur as a result of a covered person's illegal use of alcohol, and charges which occur as a result of a covered person's voluntarily taking or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a physician. Expenses will be covered for covered persons other than the person using alcohol or controlled substances. Expenses will be covered for medically necessary chemical dependency treatment as shown in the Summary of Medical Benefits, unless such treatment is court-ordered or related to deferred prosecution, deferred or suspended sentencing or driving rights.

This exclusion also includes care of inmates while in the custody of any state or federal law enforcement authority in jail or prison. Charges resulting from or occurring (1) during the commission of a crime by the covered person; or (2) while engaged in an illegal act, illegal occupation or aggravated assault.

This exclusion does not apply if the illness or injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

16.3 Duplication of Benefits

Duplication of benefits provided by any other program sponsored by Lower Kuskokwim School District.

16.4 Excess Charges

Services and supplies that are not necessary for treatment of an active illness or injury, are in excess of reasonable and customary charges, or are not recommended and approved by a physician.

16.5 Experimental/Investigational Treatment

Expenses for treatments, procedures, devices, or drugs, which the Plan Sponsor determines, in the exercise of its discretion, are experimental, investigational, or done primarily for research. Treatments, procedures, devices, or drugs shall be excluded under this Plan unless:

- Approval of the U.S. Food and Drug Administration for marketing the drug or device has been given at the time it is furnished if such approval is required by law; and
- Reliable evidence shows that the treatment, procedure, device or drug is not the subject of ongoing phase I, II, or III clinical trials or under study to determine its minimum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses; and
- Reliable evidence shows that the consensus of opinion among experts' treatment, procedure, device, or drug is that further studies or clinical necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy as compared with the standard means of treatment or diagnoses.

"Reliable evidence" shall include anything determined to be such by the Plan Sponsor, within the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community.

16.6 Forms Completion

Charges made for the completion of claim forms or for providing supplemental information including records or reports.

16.7 Government-Operated Facilities

Services furnished the Covered Person in any veterans' hospital, military hospital, institution or facility operated by the United States government (except for treatment of non-service-related disabilities), or by any state government or any agency or instrumentality of such government, for which the Covered Person has no legal obligation to pay.

16.8 Military Service

Charges for treatment of any injury sustained or illness contracted while in the military service of any country declared or undeclared war, riot, insurrection, or invasion.

16.9 Missed or Broken Appointments

Expenses incurred for failure to keep a scheduled appointment or charges for broken appointments.

16.10 No Charge/No Legal Requirement to Pay

Services for which no charge is made or for which a Covered Person is not required to pay, or is not billed or would not have been billed in the absence of coverage under this Plan- Where Medicare coverage is involved and this Plan is a secondary" coverage, this exclusion will apply to those amounts which a Covered Person is not legally required to pay due to Medicare's "limiting charge" amounts.

NOTE: - This exclusion does not apply to any benefit or coverage, which is available through the Medical Assistance Act (Medicaid).

16.11 No Coverage

Charges incurred prior to the effective date of coverage under the Plan, or after coverage are terminated.

16.12 Not Customarily Recognized Treatment

Services, supplies or treatment not commonly and customarily recognized throughout the physician's profession or by the American Medical Association as generally accepted and medically necessary for the diagnosis and/or treatment of an active illness or injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value.

16.13 Not Listed Services or Supplies

Any services, care or supplies not specifically listed in the Plan Document as Eligible Expenses are NOT covered under the Plan.

16.14 Other Coverage

Services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominican or Province or any political subdivision thereof).

"Other Coverage" also includes services or supplies received from a health care department maintained by or on behalf of an employer, mutual benefit association, labor union, trustees or similar person(s) or group.

16.15 Outside United States
Charges incurred outside of the United States or its territories if the Covered Person traveled to such a location for the primary purpose of obtaining such services, drugs or supplies.

16.16 Relative or Resident Care
Any service rendered to a Covered Person by a relative (i.e., a spouse, or a parent, brother, sister, or child of the Employee or of the Employee's spouse) or anyone who customarily lives in the Covered Person's household.

16.17 Self-Inflicted Injury
Any expenses resulting from voluntary self-inflicted injury or voluntary attempted self-destruction which occurred while sane or insane. This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

16.18 Services by Contracted Professional
Professional services billed by a physician or nurse who is an employee of a hospital or skilled nursing facility, and paid by that hospital or facility for services rendered.

16.19 Services Not Medically Necessary
Services and supplies that are not necessary for treatment of an active illness or injury, are in excess of reasonable and customary charges, or are not recommended and approved by a physician.

16.20 Services Not Requiring Physician's Prescription
Drugs, medicines or supplies that do not require a physician's prescription.

16.21 Third Party Liabilities
Any expenses caused by any third party when payment for such expenses has been paid (or will be paid) by the third party or the third party's insurance company. See section entitled Subrogation for further information.

16.22 Timely Claims Filing
Charges for which a claim was not submitted to the Contract Administrator within six months of the date that the service was incurred.

16.23 Travel
Travel or accommodation charges, except as specifically included elsewhere in this document, even if recommended by a physician.

16.24 Treatment Proficiency by A Provider
Treatment by a provider who has not shown proficiency in the procedure, based on experience and satisfactory outcome in an acceptable number of cases, or is practicing outside the scope of the provider's license, registration, or certification as required by the state in which the provider is practicing.

16.25 Treatment in Excess
Treatment in excess of the least costly service or supply which will produce an acceptable result, in the opinion of the Plan

16.26 Work-Related Conditions
Any condition for which the Covered Person has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose. However,

if the Plan provides benefits for any such condition, the Plan Sponsor will be entitled to establish a lien upon such other benefits up to the amount paid.

17 COORDINATION OF BENEFITS (COB)

All benefits provided under the Health Care Coverages of the Plan are subject to the following provisions and limitations, unless specifically stated otherwise.

17.1 Definitions

As used in this provision, the following terms will be capitalized and will have the meanings indicated:

Other Plan - Other Plans include benefits, services or treatment provided by:

Group, blanket or franchise coverage, whether insured or not;

Group prepayment plans (HMOs, EPOs, etc.);

Group Blue Cross and Blue Shield coverages;

Mandatory auto insurance, which is subject to any state automobile insurance law. In a state where such "no fault" or Personal Injury Protection is mandated, a Covered Person will be presumed to have at least the minimum coverage requirement of the state of Jurisdiction, whether or not such coverage is actually in force;

Any other automobile policy providing medical or disability benefits where and to the extent that coordination of such benefits is permitted by law;

Any coverage under labor-management trustee plans, union welfare plans, employer or professional organization plans, or employee benefit organization plans;

Any coverage under government programs such as CHAMPUS/CHAMPVA, and any coverage required or provided by a statute (see NOTE). For purposes of implementing this provision, eligibility alone will constitute coverage.

NOTE: See "Special Provisions with Respect to Medicare" at the end of this section for Medicare-related handling.

An "Other Plan" includes benefits that are actually paid or payable or benefits that would have been paid or payable if a claim had been properly made for them.

This Plan - The medical, dental, and vision benefits that are described in this Benefit Document.

Allowable Expense - Any Usual, Customary and Reasonable item of expense incurred while the person for whom claim is made is covered under This Plan, at least a part of which is covered under one of the plans. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

NOTE: Any expense not payable by a primary plan due to the individual's failure to comply with any utilization review requirements will not be considered as an Allowable Expense.

Primary Plan – The plan which will have its benefits determined first.

In any state, which permits issuance of a "no fault" Personal Injury Protection policy with an optional high deductible, such deductible amount will not be considered an Allowable Expense hereunder and will be the direct responsibility of the Covered Person.

Claim Determination Period - A period which commences each January 1 and ends at 12 o'clock midnight on the next succeeding December 31, or that portion of such period during which the claimant is covered under This Plan.

17.2 Effect on Benefits Under the Plan

Whether This Plan is the Primary Plan or a Secondary Plan, coordination of benefits is determined in accordance with the following rules:

- If This Plan is the Primary Plan, then benefits will be determined first without taking into account the benefits or services of any Other Plan.
- If This Plan is not the Primary Plan, then benefits may be reduced so that the benefits and services of all the plans do not exceed the Allowable Expense.
- The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if the Covered Person were covered under This Plan only.

When Other Plan Does Not Contain a COB Provision

If an Other Plan does not contain a coordination of benefits provision, this Plan will pay its benefits after the Other Plan(s) and will pay the lesser of: (1) its normal liability or (2) total Allowable Expenses minus benefits paid by the Other Plan(s).

With Other Plan Contains a COB Provision

When an Other Plan also contains a coordination of benefits provision similar to this one, This Plan will determine its benefits using the "Order of Benefit Determination" guidelines below.

If, in accordance with those guidelines, This Plan is to pay benefits BEFORE an Other Plan, This Plan will pay its normal liability without regard to the benefits of the Other Plan. If this Plan, however, is to pay its benefits after an Other Plan(s), it will pay the lesser of: (1) its normal liability or (2) total Allowable Expenses minus benefits paid by the Other Plan(s).

NOTE: The determination of "normal liability" will be made for an entire Claim Determination Period (i.e., Calendar Year) and not on a claim-by-claim basis. Also, benefits payable under the Other Plan(s) include the benefits that would have been payable had claim been properly made for them.

17.3 Order of Benefit Determination

The rules establishing the order or benefit determination are:

- If an Other Plan does not contain a coordination of benefits provision, then the Other Plan will be primary and This Plan will be secondary.
- The benefits of a plan which covers the Claimant as an active employee will be determined before the benefits of a plan which covers such Claimant as a non-active enrollee (i.e., a retired or laid off employee, a COBRA enrollee, etc.) or as a dependent. If the Other Plan does not have this rule, and if as a result the plans do not agree on the order of benefit determination, the rule of the Other Plan will prevail:
- When Claimant is a dependent child and such child's parents are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in the year, but;

- If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time; or

- If the Other Plan does not have this rule, and if as a result the plans do not agree on the order of benefit determination, the rule of the Other Plan will prevail unless the Other Plan is also an ERISA self-funded plan, in which case the "birthday rule" will determine.

- However, when Claimant is a dependent child whose father and mother are legally separated or divorced:

    - The benefits of a plan which covers the Claimant as a dependent child of the parent with custody will be determined first, except that if a court decree assigns financial responsibility for the health care expenses of a dependent child to one of the parents, the benefits of the assigned-parent's plan will be determined first and the other parent's plan will be determined second;

    - The plan of the spouse of the parent with custody will be determined next; and

    - The plan of the parent not having custody of the child will be determined last.

If none of the above rules establish an order of benefit determination, the benefits of the plan, which has covered the Claimant for the longer period of time, are determined before those of the plan, which has covered that person for the shorter period of time.

When this provision operates to reduce the total amount or benefits otherwise payable as to a person covered under this Plan during any Claim Determination Period, each benefit that would be payable in the absence of this provision will be reduced proportionately, and such reduced amount will be charged against any applicable benefit limit of the Plan.

17.4 Right to Receive and Release Necessary Information

For the purpose of enforcing or determining the applicability of the terms of this provision of This Plan or any similar provision of any Other Plan, the Contract Administrator may, without the consent of any person, release to or obtain from any insurance company, organization or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under This Plan will furnish to the Contract Administrator such information as may be necessary to enforce this provision.

17.5 Reasonable Cash Value –

If an Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered the Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and This Plan's liability will be reduced accordingly.

17.6 Facility of Payment

A payment made under an Other Plan may include an amount that should have been paid under This Plan. If it does, the Contract Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Plan will not have to pay that amount again.

17.7 Right of Recovery

If the amount of the payments made by This Plan is more than it should have paid under this COB Section, This Plan may recover the excess from one or more of the persons it has paid or for whom it has paid – or any other person or organization that may be responsible for the benefits or services

provided for the Claimant. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

17.8 Dual Coverage

If both spouses are eligible employees, dual coverage may be elected, but each spouse will be required to satisfy deductibles/copayments before benefits will be coordinated. If both mother and father are employees, their children may be covered under both parents' Plans, but the children will be required to satisfy deductibles/copayments before benefits will be coordinated.

In the event that dual coverage is elected, or dependent children are covered under both parents' Plans through Lower Kuskokwim School District, if a Non-Preferred Provider facility is utilized, *the benefits payable under the secondary Plan will be no more than 60% of the balance due after the primary Plan's benefit, less any applicable deductibles and copayments.* In this instance, the covered person may have significant out of pocket expenses, other than those listed in the Summary of Medical Benefits, and Coordination of Benefits will not pay 100% on such Non-Preferred Provider expenses.

17.9 Special Provisions with Respect to Medicare

In accordance with the Tax Equity Fiscal Responsibility Act or 1982 (TEFRA - P.L. 97-248) and the Deficit Reduction Act (DEFRA - P.L. 98-369), an active Employee or spouse, who has attained age 65 and is eligible for Medicare, may elect or reject medical coverage under This Plan. If such person elects medical coverage under This Plan, the benefits of This Plan will generally be determined before any benefits provided by Medicare (i.e., This Plan will pay its benefits first and then the claims may be submitted to Medicare for consideration). Covered Persons should be certain to enroll in Medicare coverage in a timely manner to assure maximum coverage.

There may be an instance when, in accordance with Federal law, This Plan may assume a secondary position to Medicare (i.e., Medicare will determine its liability first). If this should occur, This Plan reserves the right to assume the secondary carrier position and benefits will be determined in accordance with the Coordination of Benefits provision above. In such instance, if the Claimant is eligible for Medicare, he will be deemed to be covered by Medicare parts "A" and "B,” whether or not he has actually enrolled for both parts. Also, he will be deemed to be covered by Medicare as of the earliest date any Medicare coverage could have been effective had he applied in a timely manner. Covered Persons should be certain to enroll in Medicare coverage in a timely manner to assure maximum coverage.

NOTE 1: If a Medicare-eligible Employee rejects coverage under the Plan, no Plan coverage will be available for any of his Dependents.

NOTE 2: It is the intent of the Plan to take a secondary position to Medicare (and reduce benefits by Medicare payments as described above) for those Covered Persons who would otherwise be subject to the “Working Aged Provision" (i.e., the Age Discrimination in Employment Act of 1967 as amended by the Tax Equity and Fiscal Responsibility Act of 1982, the Deficit Reduction Act of 1984 and the Consolidated Omnibus Budget Reconciliation Act of 1985) but who are enrolled in the Plan through a Participating Employer who does not have 20 or more employees In each of the 20 or more calendar weeks in the current or preceding Calendar Year. For these purposes, "current,” refers to the year in which expenses are incurred and for which benefits are being determined.

18 SUBROGATION

This provision applies when the covered person incurs medical or dental expenses resulting from injury or illness that occurred by the act or omission of a third party.

18.1 Acts of Third Parties

If a Covered Person incurs charges for treatment of an injury, sickness or other condition, which is caused by the act or omission of another person or another party, the Plan Sponsor will provide the benefits of the Plan only on condition that the Covered Person will agree in writing:

- To advise the Plan Sponsor of a claim or suit against a third person or coverage carrier within 60 days of such action;
- To provide the Plan with an assignment of benefits to the extent of benefits provided under the Plan; and
- To reimburse the Plan to the extent of benefits provided immediately upon collection of damages by him, whether by legal action, settlement or otherwise.

Upon conditional payment of the Plan benefits, the Plan Sponsor will file the assignment of benefits with the person or party whose act(s) caused the injuries, his agent, insurers, the court, or the provider(s)

The Plan Sponsor will also be entitled to file a lien against the proceeds of any settlement or judgment, which results from the Covered Person's claim or suit. The amount of the lien will equal the payments made by the Plan. Notice of such lien will be filed with the person or party whose act(s) caused the injuries, his agent, insurers, the court, or the provider(s) of the services.

NOTE: The payment to the Plan required under this provision shall not exceed the lesser of: (1) the proceeds of any such recovery after deducting reasonable and necessary expenditures in effecting such recovery, including attorney's fees or (2) the total benefits paid by the Plan.

18.2 Defined Terms

Recovery means moneys paid to the covered person or beneficiary by way of judgment, settlement, or otherwise to compensate for all losses caused by the injuries or illness whether or not said losses reflect medical or dental charges covered by the Plan. This right of refund also applies when a covered person recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

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

Refund means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the injury or illness.

Assignment of Rights - As a condition to the Plan making payment for any medical or dental expenses, the covered person must assign to the Plan his or her rights to any recovery arising out of or related to any act or omission that caused or contributed to the injury or illness for which such benefits are to be paid. The scope of this assignment is consistent with the amount subject to subrogation or refund set forth above.

19 ENROLLMENT, ELIGIBILITY AND LOSS OF COVERAGE

19.1 Eligibility

Coverage provided under the Lower Kuskokwim School District Benefit Plan for employees and their dependents shall be in accordance with the eligibility, effective date and termination provision as stated.

19.2 Eligible Classes of Employees

To be eligible for coverage under this Plan an employee must meet the following criteria:

All full-time permanent employees of Lower Kuskokwim School District in the following six divisions:

- **Classified employees** in the Lower Kuskokwim Educational Support Personnel Association bargaining unit with a regularly assigned work week of 30 or more hours;
- **Certificated employees** in the Lower Kuskokwim Education Association bargaining unit;
- **Certificated administrators** in the Lower Kuskokwim Administrative bargaining unit;
- **Classified employees** with a regularly assigned work week of 30 or more hours, who are not covered by any negotiated agreement;
- **Certificated administrators** who are not covered by any negotiated agreement; and
- **Rehired employees who were previously retired** must be provided same coverage eligibility as a new hire per the revised unified law of the State of Alaska, AS.14.20.135.

19.3 Eligibility Requirements for Employee Coverage

- Classified employees in the Lower Kuskokwim Educational Support Personnel Association bargaining unit: The negotiated agreement entitles such employees to participate in this Plan, provided that their regularly assigned work week is 30 or more hours. Such employees are eligible to participate in the Plan on the first day of the first full monthly pay period after completion of the review period.
- Certificated employees in the Lower Kuskokwim Education Association bargaining unit: These employees are generally the District's classroom teachers. Such employees are eligible to participate in the Plan on the first paid contract day on which the teacher has physically reported to work.
- Certificated administrators in the Lower Kuskokwim Administrative bargaining unit: The negotiated agreement defines these employees as Site Administrators and Vice-Principals. The practice of the District is that such employees are eligible to participate in the Plan on the first paid contract day on which the employee has physically reported to work.
- Classified employees with a regularly assigned work week of 30 or more hours, who are not covered by any negotiated agreement. This group of employees is generally managerial and supervisory. Such employees are eligible to participate in the Plan on the first day of the first full monthly pay period after completion of the review period.
- Certificated administrators who are not covered by any negotiated agreement: This group of employees includes Directors, Assistant Superintendents, and the Superintendent. Such employees are eligible to participate in the Plan on the first paid contract day on which the employee has physically reported to work.

- Rehired employees who were previously retired will be required to meet the eligibility requirements of their division stated above.

19.4 Enrollment Requirements

An employee has 31 days from the eligibility date to make application for enrollment to the Plan to be eligible for coverage under the Plan. If the employee wishes to cover dependents, he or she must enroll them at that time. If the employee does not have eligible dependents at the time of initial enrollment, but acquires eligible dependents at a later date, he or she must enroll them within 31 days of the date he or she acquires them.

19.5 Waiver of Coverage

If the employee declines enrollment for self or dependents, he or she must sign a Waiver of Coverage. The Waiver of Coverage states that coverage under another group health plan or other health insurance is the reason for declining enrollment, and the employee is asked to identify that coverage. If the Waiver of Coverage is not completed and signed, neither the employee nor his or her dependents will be entitled to Special Enrollment Right #1 described below, but will still be entitled to Special Enrollment Right #2.

19.6 Special Enrollment Rights

- If the employee declines enrollment for self or dependents (including spouse) because of other health coverage and that other health coverage ends, the employee may be allowed to enroll self or dependents in the Plan at that time, provided that enrollment is requested within 31 days after the other coverage ends.

- If the employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, he or she may be allowed to enroll self and dependents at that time, provided that enrollment is requested within 31 days after the marriage, birth, adoption or placement for adoption.

If the employee waives coverage and eventually enrolls but does not meet the criteria described, he or she will be treated as a "late enrollee." As a consequence, he or she must wait until the next Open Enrollment Period to enroll in the Plan, and the "enrollment date" for the purpose of determining pre-existing conditions will be the first day that benefits are in effect.

19.7 Open Enrollment Period

An employee who fails to enroll within the time period allowed under the Plan, or who waives coverage and does not qualify for the Special Enrollment Rights described previously must wait until the next Open Enrollment Period in order to make application for enrollment in the Plan. The annual Open Enrollment Period is December 1st through December 31st, for coverage beginning on January 1st.

19.8 Terminations/Changes in Enrollment

The Plan Sponsor must be notified within 31 days prior to a termination or a change in the employee or dependent's coverage.

19.9 Dependent Enrollment

Eligible dependents may also be covered under the Plan. Eligible dependents include:

- A covered employee's spouse and unmarried children from birth to the limiting age of 26 years. When the child reaches limiting age, coverage will end on the child's birthday.

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

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

- If a covered employee is the legal guardian of an unmarried child or children, these children may be enrolled in this Plan as covered dependents.

- Any natural child of the employee's minor dependent, who resides with the employee and is primarily dependent upon the covered employee for support and maintenance, may also, be covered under this Plan.

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

- Any child of a Plan participant who is an alternate recipient under a Qualified Medical Child Support Order shall be considered as having a right to dependent coverage under this Plan.

- A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

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

- A covered dependent child who reaches the limiting age and is totally disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

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

- These persons are excluded as dependents: other individuals living in the covered employee's home, but who are not eligible as defined; the legally separated or divorced former spouse of the employee; any person who is on active duty in any military service of any country.

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

19.10 Dual Coverage

If both spouses are eligible employees, dual coverage may be elected, but each spouse will be required to satisfy deductibles/copayments before benefits will be coordinated. If both mother and father are employees, their children may be covered under both parents' Plans, but the children will be required to satisfy deductibles/copayments before benefits will be coordinated.

In the event that dual coverage is elected, or dependent children are covered under both parents' Plans through Lower Kuskokwim School District, if a Non-Preferred Provider facility is utilized, *the benefits payable under the secondary Plan will be no more than 60% of the balance due after the primary Plan's benefit, less any applicable deductibles and copayments.* In this instance, the covered person may have significant out of pocket expenses, other than those listed in the Summary of Medical Benefits, and Coordination of Benefits will not pay 100% on such Non-Preferred Provider expenses.

19.11 Eligibility Requirements for Dependent Coverage

A family member of an employee will become eligible for dependent coverage on the first day that the employee is eligible for employee coverage and the family member satisfies the requirements for dependent coverage.

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

19.12 New Dependent Enrollment

If new dependents are acquired, the following rules apply:

- New Spouse: A new spouse is eligible on the date of marriage, provided that application for enrollment is made within 31 days of the marriage. If application for enrollment is made more than 31 days after the marriage, the new spouse will be considered a late enrollee, and coverage will not begin until after the next Open Enrollment Period

- Newborn Infant: A newborn child of a covered employee is <u>not</u> automatically enrolled in this Plan. Charges for covered nursery care will be applied toward the Plan of the newborn child. If the newborn child is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the parent(s) will be responsible for all costs.

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

  If the newborn is not enrolled within 31 days of birth, the enrollment will be considered a late enrollment, and coverage will not begin until after the next Open Enrollment Period.

- Adopted Child(ren): An adopted child is eligible on the date the adoption is finalized or the date that the child is placed in the employee's home, whichever occurs first, provided that an application for enrollment is made within 31 days of that date. If application for enrollment is made more than 31 days after the date of adoption or the date that the child is placed in the employee's home, the adopted child will be considered a late enrollee, and coverage will not begin until after the next Open Enrollment Period.

19.13 Rehire of a Laid-off or Terminated Employee

A terminated employee who is rehired within 15 months following an approved leave of absence for sabbatical purposes will have coverage reinstated on the date he or she returns to work. A terminated employee who is rehired within three months following a termination for any reason

other than an approved leave of absence for sabbatical purposes will have coverage reinstated on the date he or she returns to work.

On the date the employee returns to work, coverage for the employee and eligible dependents will be on the same basis as that provided for any other active employee and his or her dependents as of that date. However, any restrictions on coverage that were in effect before such reinstatement will still apply.

A terminated employee who does not meet the criteria described will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements, with the exception of an employee returning to work directly from COBRA coverage. This employee does not have to satisfy the employment waiting period.

19.14 Employees on Sabbatical Leave

Employees on Sabbatical Leave will remain eligible for the same coverage they had in place as Active Employees.

If benefits increase or decrease for Active Employees in the same class of employees, they will also increase or decrease for employees on Sabbatical Leave.

19.15 Employees on Military Leave

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

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

19.16 Loss of Employee Eligibility

If an employee is no longer eligible, his or her coverage and the coverage of all dependents will end per the relevant Negotiated Agreement.

19.17 Loss of Dependent Eligibility

Coverage ends for the spouse of an employee on the day the marriage is legally dissolved (by divorce or legal separation).

Coverage ends for a dependent child on the last day of the month in which the child no longer meets the eligibility requirements of the Plan.

A covered person who loses coverage may be eligible for COBRA Continuation. Please see page 70 of this document for information on COBRA Continuation of Coverage.

An eligible employee or dependent is required to notify the Plan Administrator within 60 days of any Qualifying Event of which the Plan Administrator would not otherwise be aware such as divorce, legal separation, or loss of eligible dependent status to be eligible for COBRA Continuation. Please see page 70 of this document for information on COBRA Continuation.

19.18 Employee and/or Dependents Covered in Error

Any employee and/or dependent who is enrolled in error under the Plan or who is enrolled in violation of any of the terms of the Plan shall not be entitled to any benefits hereunder. The Plan shall make proper adjustments to cover any contributions paid under such circumstances. The Plan shall have the right to recover from any employee and/or dependent the cost of any benefits furnished while such an employee and/or dependent was enrolled in error.

19.19 Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act (FMLA) applies only to groups that employ 50 or more employees during each of 20 or more calendar work weeks in the current or preceding calendar year and that are required by federal law to comply with FMLA provisions. Under this provision, eligible employees may receive up to 12 weeks of leave during a 12-month period, as provided by FMLA, under the following circumstances:

- The birth of the employee's child;
- The placement of a child with the employee for adoption or foster care;
- Care for the employee's seriously ill spouse, parent or child; or
- The employee's own serious physical or mental health condition.

Eligible employees and their covered dependents may continue coverage under this Plan during the FMLA leave. The employee may contact the Human Resources Department at Lower Kuskokwim School District for more detailed information on FMLA leaves.

20 RESCISSION OF COVERAGE

The following provisions will apply to the plan regarding rescission of coverage:

- A "rescission" is a cancellation or discontinuance of coverage that has a retroactive effect.
- A cancellation or discontinuation of coverage is not a rescission if it only has a prospective effect, or the retroactive effect is attributable to failure to timely pay required premiums or contributions.
- The plan can rescind coverage if an individual is involved in fraud or intentional misrepresentation.
- The plan will provide at least 30 days advance notice to each participant who would be affected before coverage may be rescinded.

21 CLAIMS PROCEDURES

It is the intent of the Plan Administrator that the following claims procedures comply with the United States Department of Labor ("DOL:") regulation, 29 CFR §2560.503-1, and the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Where any provision is in conflict with the DOL's claims procedure regulations, ERISA, or any other applicable law, such law shall control.

21.1 Submitting a Claim

A claim is a request for a benefit determination that is made, in accordance with the Plan's procedures, by a Claimant or his authorized representative. A claim must be received by the person or organizational unit customarily responsible for handling benefit matters on behalf of the Plan so that the claim review and benefit determination process can begin. A claim must name the Plan, a specific Claimant, a specific health condition or symptom or diagnostic code, and a specific treatment, service, or supply (or procedure/revenue codes) for which a benefit or benefit determination is requested, the date of service, the amount of charges, the address (location) where services are received, and provider name, address, phone number and tax identification number.

For purposes of the Plan, the Plan Administration, at its discretion, may contract with other entities to handle claims communications and benefit determinations for the Plan. Contact information for such entities is provided below.

21.2 Assignments to Providers

All Eligible Expenses reimbursable under the Plan will be paid to the covered Employee. No assignments shall be made to providers under the Plan.

21.3 Timely Filing

Written notice of injury or illness upon which claim may be based should be provided to the Contract Administrator within 30 days of the date of the commencement of the first loss for which benefits arising out of such injury or illness may be claimed, or thereafter as is reasonably possible.

Notice given by or on behalf of the claimant to the Contract Administrator with particulars sufficient to identify the covered person, shall be deemed to be notice. Failure to furnish notice within the time provided in the Plan shall not invalidate any claim if it shall be shown not to have been reasonably possible to furnish such notice and that such notice was furnished as soon as was reasonably possible.

However, when a covered person's coverage terminates for any reason, written proof of claim must be given to the Plan within 90 days of the date of termination of coverage, provided that the Plan remains in force. Upon termination of the Plan final claims must be received within 30 days of termination.

In no event will any claim be considered for payment of benefits that is presented more than six months from the date that such claim was incurred.

All claims should be filed within 90 days from the date of service. Claims filed over six months from the date of service are not eligible for benefits and will be denied unless it can be shown that it was not reasonably possible to give proof within such time, provided proof of loss is furnished as soon as reasonably possible.

21.4 Claims Time Limits and Allowances

For group health plans subject to the Employee Retirement Income Security Act (ERISA), the chart below sets forth the time limits and allowances which apply to the Plan and a Claimant with respect

to claims filings, administration and benefit determinations (i.e., how quickly the Plan must respond to claims notices, filings and claims appeals and how much time is allowed for Claimants to respond, etc.). If there is any variance between the following information and the intended requirements of the law, the law will prevail. The chart below shows the time frames for filing different types of claims with the Plan. If you have any questions about what type of claim you may have or the timing requirements that apply to your claim, please contact your Claims Administrator at the number shown on your ID cards.

Table 20.1: Time Frames for Processing a Claim				
Claim Process	**Urgent Care Claim**	**Concurrent Care Claim**	**Pre-Service Health Claim**	**Post-Service Health Claim**
Claims Administrator determines initial claim is improperly filed (not filed according to Plan procedures) or is not complete	Within 24 hours after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Within 24 hours after receipt of request for extension of urgent concurrent care	Within 5 days after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Not applicable
Claims Administrator determines that you must submit additional information required to complete claim	Within 48 hours after receipt of notice that your claim is incomplete	Not applicable	Within 45 days after receipt of notice that additional information is required	Within 45 days after receipt of notice that additional information is required
Claims Administrator reviews claim and makes determination of:		For urgent care claims, within 24 hours after receipt of the claim, provided request is submitted at least 24 hours prior to expiration of prescribed period of time or number of treatments. If not submitted within 24 hours prior to expiration of prescribed period of time or number of treatments, not later than 72 hours after receipt of claim. * For non-urgent care claims, determination will be made within time frame designated for type of claim (pre- or post-service) and prior to expiration of prescribed period of time or number of treatments. *		
complete/proper claim	Within 48 hours after the earlier of: receipt of requested information, or at end of period allowed for you to provide information		Within 15 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information	Within 30 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information
initial claim	Within 24 hours of receipt of initial claim		Within 15 days of date initial claim is received	Within 30 days of date initial claim is received

Extension period, ** if required due to special circumstances beyond control of Claims Administrator	Not applicable	Not applicable	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 15-day period	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 30-day period

* A request for extension of treatment will be deemed to be an initial claim. A reduction or termination of approved, ongoing treatment will be deemed to be an adverse claim decision. If the Claims Administrator makes an adverse decision, you will be notified of the reduction/termination within a time frame that allows you to submit an appeal and have a determination on the appeal prior to the expiration of the prescribed period of time or number of treatments.

** Whenever an extension is required, the Plan must notify you before the current determination period expires. The notice must state the circumstances requiring the extension and the date a determination is expected to be made.

21.5 Authorized Representative May Act for Claimant

Any of the above actions that can be done by the Claimant can also be done by an authorized representative acting on the Claimant's behalf. The Claimant may be required to provide reasonable proof of such authorization. For an urgent claim, a health care professional, with knowledge of a Claimant's Dental condition, will be permitted to act as the authorized representative of the Claimant. "Health care professional" means a dentist, physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

21.6 Written or Electronic Notices

The Plan shall provide a Claimant with written or electronic notification of any benefit reduction or denial. Written or electronic notice of an approved benefit must be provided only for Pre-Service benefit determinations.

21.7 Claims Denials

If a claim is wholly or partially denied (see NOTE), the Claimant will be given written or electronic notification of such denial within the time frames required by law – see "Claims Time Limits and Allowances." The Notice will include the following and will be provided in a manner intended to be understood by the Claimant:

- The specific reason(s) for the decision to reduce or deny benefits:
- Specific reference to the Plan provision(s) on which the denial is based as well as identification of and access to any guidelines, rules, and protocols which were relied upon in making the decision. Where a Plan utilizes a specific internal rule or protocol, the notice may either set forth the protocol or include a statement that a copy of such protocol will be furnished to the Claimant or his authorized representative free of charge and upon request. A notification of denial or benefit reduction based upon Dental Necessity or experimental treatment or other similar exclusion or limit must explain the scientific or clinical judgment of the Plan in applying the terms of the Plan to the Claimant's Dental circumstances, or must include a statement that such explanation will be provided to the Claimant free of charge upon request;
- A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information relevant to the Claimant's claim for benefits;
- The identity of any Dental or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice, or a statement that the identity of the expert(s) will be provided upon request;

- A description of any additional information needed to change the decision and an explanation of why it is needed;

- A description of the Plan's procedures and time limits for appealed claims, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA. A denial of an urgent claim must describe the expedited appeal process for urgent health claims. An urgent claim denial may be made orally to the Claimant if a written or electronic notification is furnished to the Claimant within 3 days after the oral notification.

NOTE: A claim denial, or an "adverse benefit determination", means any of the following: a denial, reduction (which includes any instance where the Plan pays less than the total amount of expenses submitted with regard to a claim), termination of a benefit, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Dentally Necessary or appropriate.

Denial of a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize the life or health of the patient (e.g., the patient is unconscious and is in need of immediate care at the time Dental treatment is required) is prohibited.

21.8 Appeal Procedures

To appeal a denied claim or to review administrative documents pertinent to the claim, you or your representative must send a written request to the Plan. The time frames for appealing a claim are shown in the following chart.

If you or your representative submits an appeal, state why you think your claim should be reviewed and include any data, documents, questions, or comments, along with copies of itemized bills and claim forms relating to your claim. You may request, free-of-charge, copies of all documents, records, and other information relevant to your claim. A reviewer who did not make the initial claim determination will be responsible for reviewing your appeal. Also, you will be notified of any expert advice obtained on behalf of the Plan in reviewing the denied claim, regardless of whether such advice was relied upon in reviewing your claim. Such experts will not be individuals who were consulted in making the initial claim determination.

Table 20.2: Time Frames for Appealing Denied Claims

Appeal Process	Urgent Care Claim	Concurrent Care Claim	Pre-Service Health Claim	Post-Service Health Claim
You may submit an appeal of denied initial claim to the Claims Administrator	Within 180 days of receiving notice of denied claim	You will be notified of reduction or termination of benefit in time to submit appeal and receive determination before benefit ends	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
Claims Administrator reviews your first appeal and makes determination	Within 72 hours after appeal is received	Prior to reduction or termination of benefit	Within 15 days of date appeal is received	Within 30 days of date appeal is received

You may submit a second appeal to the Plan Administrator	N/A	N/A	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
The Plan Administrator reviews your second appeal and makes final determination	N/A	N/A	Within 15 days of date appeal is received	Within 30 days of date appeal is received

You will be notified of the Plan Administrator's decision in writing. If your claim is denied, the Plan Administrator will give you in writing the specific reason(s) that your claim was denied, the specific reference to the Plan provisions on which the denial was based, any internal rules, guidelines, protocols, or similar criteria used as basis for the decision, a statement that you 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, and a statement regarding your right to bring civil action in Federal court under Section 502(a) of ERISA.

The decision of the Plan Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law.

21.9 Exhaustion Required

If you do not file a claim, follow the claims procedures, or appeal a claim within the timeframes permitted, you will give up all legal rights, including your right to file suit in Federal court, as you will not have exhausted your internal administrative appeal rights. Participants or claimants must exhaust all remedies available to them under the Plan before bringing legal action. Additionally, legal action may not be brought against the Plan more than one year after a final decision on appeal has been reviewed under the Plan.

21.10 External Review Rights/ Independent Review Organization ("IRO")

On August 23, 2010, the U.S. Departments of Labor (DOL), Health and Human Services (HHS), and Treasury collectively released interim guidance to establish procedures for the Federal external review process required by healthcare reform.

Until the final procedure becomes available, the Plan will make every effort to comply with the limited-enforcement safe harbor provisions established by DOL Technical Release 2010-01 which provides guidance on the interim review process for self-funded group health plans.

If your final appeal for a claim is denied, you will be notified in writing that your claim is eligible for an external review and you will be informed of the time frames and the steps necessary to request an external review. You must complete all levels of the internal claims and appeal procedure before you can request a voluntary external review.

If you decide to seek external review, an independent external review organization (an "IRO") will be assigned your claim, and the IRO will work with a neutral, independent clinical reviewer with appropriate medical expertise. The IRO does not have to give deference to any earlier claims and appeals decisions, but it must observe the written terms of the Plan document. In other words, the IRO is not bound by any previous decision made on your claim. The ultimate decision of the IRO will be binding on you, the Claims Administrator, and the Plan.

21.11 Requesting an External Review

After you (or your designated representative) request an external review, the Claims Administrator must, within five business days, make a preliminary assessment of your claim, confirming:

- You were covered under the Plan at the time the service was requested or provided;

- The determination relates to medical judgment or a rescission of coverage;
- You have exhausted the internal appeals process (unless the Plan or Claims Administrator did not strictly adhere to the appeal requirements); and
- You have provided all paperwork necessary to complete the external review.

The Claims Administrator must notify you in writing within one business day of completing the preliminary assessment. If your request is complete but not eligible for external review, the Claims Administrator's notice will provide (1) the reasons your request is ineligible and (2) contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If your request is not complete, the notice will describe the missing information or materials. The Claims Administrator will then allow you to complete the request for external review before the end of the original four-month filing period or within 48 hours, whichever is later.

Once your request is complete and determined to be eligible for external review, the Claims Administrator will assign an accredited IRO and provide the IRO with the materials considered during the internal appeals process. The IRO will timely notify you in writing to (1) confirm your request's eligibility and acceptance for external review, and (2) provide you an opportunity to submit in writing, within ten business days following the date of receipt, additional information that the IRO should consider when conducting the external review. The IRO will forward any additional information you provide to the Claims Administrator so that it may consider whether to approve your claim based on the new information.

21.12 Requesting an Expedited External Review

You may immediately request an expedited external review at the time you receive:

- An initial internal claim denial involving a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if you followed the normal claim procedure guidelines;
- A final internal appeal denial involving a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if you followed the normal claim procedure guidelines; or
- A final internal appeal denial involving an admission, availability of care, continued stay, or a health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of your request, the Claims Administrator will determine whether the request is eligible for expedited external review and will immediately send you a notice of its eligibility determination.

If the Claims Administrator determines that your request is eligible for an expedited external review, the Claims Administrator will assign an IRO. The IRO will render a decision as quickly as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, the assigned IRO will provide you, the Claims Administrator, and the Plan with written notification of its decision within 48 hours.

For additional information about the external IRO process, contact the Claims Administrator at the telephone number shown on your ID card.

22 DEFINITIONS

When capitalized herein, the following items will have the meanings shown below.

22.1 Accident

A bodily injury sustained independently of all other causes, that is sudden, direct, unforeseen and is exact as to time and place.

22.2 Active Employee

Any employee who is on the regular payroll of the employer and who has begun to perform the duties of his or her job on a full-time basis.

22.3 Allowable Charge

The fee that the Contract Administrator finds is the UCR (Usual, Customary and Reasonable) charge for medically necessary covered services. A UCR charge is a charge that is within the range of usual charges for the same or similar services(s) billed by most providers within the geographical area in which services are rendered, or is justified by all of the attending circumstances of a particular case. This amount will not be more than the provider's actual charge. The patient is responsible for any amount that exceeds the allowable charge.

22.4 Ambulatory Surgical Center

An institution or facility, either freestanding or as a part of a hospital with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and which a patient is admitted to and discharged from within a 24-hour period. An office maintained by a physician for the practice of medicine or dentistry, or for the primary purpose of performing termination of pregnancy, shall not be considered to be an Ambulatory Surgical Center.

22.5 Amendment

A formal document that changes the provisions of the Plan Document, and is duly signed by the authorized person or persons as designated by the Plan Administrator.

22.6 Approved Clinical Trial

A phase I, phase II, phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection or treatment of cancer or other life-threatening disease or condition and is federally funded through a variety of entities or departments of the federal government, is conducted in connection with an investigational new drug application reviewed by the Food and Drug Administration, or is exempt from investigational new drug application requirements.

22.7 Approved Treatment Plan

A written outline of proposed treatment that is submitted by the attending physician to the Contract Administrator for review and approval.

22.8 Birthing Center

A facility, staffed by physicians, which is licensed as a Birthing Center in the jurisdiction where it is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery (no more than 24 hours); provide care under the full-time supervision of a physician and either a registered nurse (RN) or a licensed nurse-midwife; and have a written agreement with a hospital in the same locality for immediate acceptance of patients who develop complications or require pre-or post-delivery confinement.

22.9 Benefit Percentage
That portion of eligible expenses to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. It is the basis used to determine any out-of-pocket expenses in excess of the annual deductible which are to be paid by the employee.

22.10 Calendar Year
The period of time commencing at 12:01 a.m. on January 1 of each year and ending at 12:01 a.m. on the next succeeding January 1. Each succeeding like period will be considered a new Calendar Year.

22.11 Centers of Excellence
Centers of Excellence are medical centers/hospitals throughout the country that frequently perform highly specialized medical care and achieve the highest success rates in patient outcomes and care. They are selected on the basis of quality indicators, such as survival rates and morbidity, as well as cost efficiencies (based on national average costs for similar procedures). Typically, the procedures performed by these Centers include heart, lung, liver, pancreas-kidney, and bone marrow transplants.

22.12 Certified Nurse-Midwife
A registered nurse (R.N.) certified by the American College of Nurse-Midwives. For services to be covered, the nurse-midwife must work under the direction of a doctor, bill for services under the doctor's taxpayer ID, and provide services in line with nurse-midwife certification.

22.13 Chemical Dependency
A condition characterized by a physiological or psychological dependence, or both, on alcohol or a state-regulated controlled substance. It is further characterized by a frequent or intense pattern of pathological use to the point that the user:

- Loses self-control over the amount and circumstances of use;
- Develops symptoms of tolerance, psychological and/or physiological withdrawal if use is reduced or stopped; and
- Substantially impairs or endangers his or her health or substantially disrupts his or her social or economic function.

Chemical Dependency includes alcohol and drug psychoses, alcohol and drug dependence syndromes.

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

22.15 Claimant
Any Covered Person on whose behalf a claim is submitted for benefits under the Plan.

22.16 Close Relative
The spouse, mother, father, sister, brother, daughter, son, or father-in-law or mother-in-law of the covered person.

22.17 COBRA

The Consolidated Omnibus Budget Reconciliation Act. This Federal law allows a continuation of health care coverage in certain circumstances.

22.18 COBRA Beneficiary

Any former employee or dependent covered under this Plan, who is continuing participation under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its amendments.

22.19 Coinsurance

The percentage of the cost of covered expenses a participant must pay after meeting any applicable deductible.

22.20 Community Mental Health Agency

A health care provider which is licensed as a mental health agency by a state's Department of Social and Health Services or comparable state agency, which has in effect a plan for quality assurance, peer review and supervision by a physician or licensed psychologist.

22.21 Complete Claim/Proper Claim

A previously incomplete claim for which a participant has submitted the missing or additional information required for the Plan to make a determination.

22.22 Complication of Pregnancy

The term "Complication of Pregnancy" means the following:

- Direct:
    - Hyperemesis gravidarum (pernicious vomiting of pregnancy) eclampsia of pregnancy (toxemia with convulsions), severe antepartum hemorrhaging due to premature separation of the placenta for any reason, postpartum hemorrhaging severe enough to require the transfusion of blood, missed abortion, or RH incompatibility requiring amniotic fluid test, analysis for intrauterine fetal transfusion;
    - Cesarean section; or
    - Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.
- Indirect:
    - Bodily or mental disorder whose diagnosis is distinct from pregnancy, but which is adversely affected by pregnancy or is caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation and similar medical and surgical conditions of comparable severity; or
    - Therapeutic abortion necessary as part of the treatment of severe bodily or mental disorder included in one above.

In no event shall the term "Complication of Pregnancy" include cesarean section delivery as an alternative to vaginal delivery after the 35th week of pregnancy, false labor, occasional spotting, physician prescribed rest, morning sickness, preeclampsia or similar conditions associated with the management of a difficult pregnancy, but not constituting a classifiable distinct complication of pregnancy.

22.23 Co-payment
The fixed dollar amount of covered expenses a participant must pay before Plan pays.

22.24 Contract Administrator
The person or firm employed by Lower Kuskokwim School District to provide claim processing, billing and eligibility service to Lower Kuskokwim School District in connection with the operation of the Plan.

22.25 Convalescent Hospital
See Skilled Nursing Facility.

22.26 Cosmetic Dentistry
An unnecessary dental procedure performed solely for the improvement of a covered person's appearance or well-being rather than for the improvement or restoration of dental function.

22.27 Cosmetic Procedure
A procedure performed solely for the improvement of a covered person's appearance or well-being rather than for the improvement or restoration of bodily function.

22.28 Covered Person
An employee, a dependent or a participating COBRA beneficiary meeting the eligibility requirements for coverage as specified in the Plan, and properly enrolled in the Plan.

22.29 Covered Provider
An individual who is:

- Licensed to perform certain health care services and who is acting within the scope of his license; OR
- In the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association;

AND who is one or more of the following:

- Audiologist
- Certified Nurse Anesthetist
- Certified or Registered Nurse Midwife
- Chiropractor (D.C.)
- Dentist (D.D.S. or DM.D.)
- Licensed Clinical Social Worker (L.C.S.W)
- Licensed Practical Nurse (L.P.N.)
- Licensed Psychiatric Nurse
- Licensed Vocational Nurse (L.V.N.)
- Marriage, Family, Child Counselor (M.F.S.C)
- Nurse Practitioner

- Occupational Therapist (O.T.R.)
- Optometrist (O.D.)
- Physical Therapist (P.T. or R.P.T.)
- Physician - see definition of “Physician"
- Podiatrist or Chiropodist (D.P.M., D.S.P., or D.S.C.)
- Prosthetist or Prosthetist-Orthotist
- Psychologist (Ph.D. or Ed.D.) - with at least two years clinical experience in a recognized health setting or has met the standards of the National Register of Health Service Providers in Psychology
- Registered Nurse (R.N.)
- Registered Nurse Anesthetist (R.N.A.)
- Respiratory Therapist
- Speech Pathologist or Therapist
- Visiting Nurse Association

A "Covered Provider" will also include any of the following when appropriately licensed and providing services that are covered by the Plan:

- Facilities as are defined herein including, but not limited to, Hospitals, Ambulatory Surgical Facilities, Birthing Centers, etc.;
- Licensed Outpatient mental health facilities;
- Home Health Agency;
- Freestanding public health facilities;
- Hemodialysis and Outpatient clinics under the direction of a Physician (M.D.);
- Enuresis control centers;
- Portable X-ray companies;
- Independent laboratories;
- Blood banks;
- Ambulance companies.

22.30 Creditable Coverage

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

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

22.31 Custodial Care

That type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a covered person, whether or not totally disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision of medication which can normally be self-administered.

22.32 Dental Care

Any treatment, operation procedure or service performed by a dental practitioner which is accepted as or defined as dentistry and meets the standards of dental practice accepted by the American Dental Association.

22.33 Dental Hygienist

A person who is licensed to practice dental hygiene and who is practicing within the scope of an applicable license.

22.34 Dentist

A licensed Doctor of Dental Surgery (DDS) or Dental Medicine (DMD) practicing within the scope of the applicable license or a licensed dental practitioner authorized by the license to perform the particular dental service rendered.

22.35 Denturist

A person who is licensed to make, fit and repair dentures, and who is practicing within the scope of the applicable license.

22.36 Deductible

A specified dollar amount of covered expenses, which must be incurred during a calendar year before any other covered expenses can be considered for payment according to the applicable benefit percentage.

22.37 Dependent

- The employee's lawful spouse, unless legally separated;
- The unmarried natural children, stepchildren who reside with the employee, adopted children and children for whom the employee is the legal guardian or the employee is under a Qualified Child Medical Support Order to provide health coverage for a child.
    - Eligible dependent children must be reliant upon the employee for primary support and maintenance, unless under a court order.
- Dependent children, including children of same-sex partner (as defined and documented by 2 AAC38.010 – 2 AAC 38.100) must be under 26 years of age (i.e., through age 25). The child need not: (1) reside with the Employee or any other person, (2) be a student, (3) be a tax-code dependent of the Employee or financially dependent on the Employee or any other person, (4) be unmarried, or (5) be unemployed.
- Or an unmarried child age 26 or older who is incapable of self-sustaining employment and dependent upon the employee for support due to a mental or physical illness or handicap. Proof of disability must be submitted to the Plan within 31 days of the date the child becomes 26 or the date the coverage would have terminated due to the child's age.

22.38 Durable Medical Equipment

Equipment which is:

- Able to withstand repeated use;
- Primarily and customarily used to serve a medical purpose or not generally useful to a person in the absence of illness or injury.

22.39 Election Period
The 60-day period during which a Qualified Beneficiary who would lose coverage as a result of a Qualifying Event may elect COBRA Continuation Coverage. This 60-day period begins no later than the date of termination of coverage as a result of a Qualifying Event and ends not earlier than 60 days after the later of such date of termination of coverage or the receipt of notice of the right to elect COBRA Continuation Coverage under this Plan.

22.40 Elective Surgical Procedure/Elective Surgery
A non-emergency surgical procedure which is scheduled at the covered person's convenience without endangering the covered person's life or without causing serious impairment to the covered person's bodily functions.

22.41 Eligible Expense(s)
Expense that is: (1) covered by a specific benefit provision Document and (2) incurred while the person is covered by the Plan Document.

22.42 Emergency
A sudden, unexpected acute medical condition that, without medical care within 48 hours of onset, could result in death or cause serious impairment to bodily functions.

Emergency Services – If a Covered Person requires care for an Emergency Medical Condition and must use the services of a Non-Network provider, any such expenses will be paid at the Network benefit levels until the patient's condition has been stabilized to the point that he could be transferred to Network-provider care. At that point, the Covered Person must be transferred to Network-provider care or Non-Network benefit levels will commence.

22.43 Employee
Any person who is rendering personal services on a full-time basis to Lower Kuskokwim School District for compensation, please reference the Enrollment & Eligibility section of this document for work requirements for eligibility.

22.44 Employer(s)
Lower Kuskokwim School District.

22.45 Enrollment Date
The employee's date of hire, or in the case of employees and/or dependents who are enrolled subsequent to the original eligibility date, the first day of the waiting period or the actual date benefits begin, whichever is earlier.

22.46 ERISA
The Employee Retirement Income Security Act of 1974, as amended, a Federal law that governs group benefit plans.

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

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

- If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

- If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

- If reliable evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is the research, experimental, study or investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

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

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

22.48 Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) is a Federal law that provides for an unpaid leave of absence for up to 12 weeks per year for:

- the birth or adoption of a child or placement of a foster child in a participant's home;

- the care of a child, spouse or parent (not including parents-in-law), as defined by Federal law, who has a serious health condition;

- a participant's own serious health condition; or

- any qualifying exigency arising from an employee's spouse, son, daughter, or parent being a member of the military on "covered active duty". Additional military caregiver leave is available to care for a covered service member with a serious injury or illness who is the spouse, son, daughter, parent, or next of kin to the employee.

Generally, you are eligible for coverage under FMLA if you have worked for your Company for at least one year; you have worked at least 1,250 hours during the previous 12 months; your Company has at least 50 employees within 75 miles of your worksite; and you continue to pay any required premium during your leave as determined by the Company. You should contact the Company with any questions you have regarding eligibility for FMLA coverage or how it applies to you.

22.49 Family Status Change

A status change brought about by the occurrence of one or more of the following events:

- Birth or adoption of a child;
- Divorce;
- Marriage;
- Death of a spouse; involuntary reduction in employment hours; involuntary loss of a spouse's employment due to layoff; or employee termination.

22.50 Family Unit
A covered employee and persons covered under this Plan as such covered employee's dependents.

22.51 Fiduciary
Lower Kuskokwim School District, the board of directors, or the Plan Administrator, but only with respect to the specific responsibilities of each with respect to the administration of the Plan.

22.52 Freestanding Chemical Dependency Treatment Center
A facility that meets the following requirements:

- It is accredited by the Joint Commission on Accreditation of Hospitals or is licensed by the appropriate state licensing authority as a Chemical Dependency Treatment Center;
- It is operated chiefly for the treatment of Chemical Dependency;
- It provides only treatment which is directly under the supervision of a physician; and
- It provides 24-hour nursing service by licensed nurses.

22.53 Full-Time Employment
A basis whereby an employee is employed by Lower Kuskokwim School District for a minimum of 30 hours per week. Such work may occur either at the usual place of business of Lower Kuskokwim School District or at a location to which the business of Lower Kuskokwim School District requires the employee to travel, and for which he or she received regular earnings from Lower Kuskokwim School District.

22.54 Generic Drug
A prescription drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider a generic drug a Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

22.55 Home Health Care Agency
An agency or organization which:

- Is primarily engaged in and duly licensed, if such licensing is required by the appropriate licensing authority, to provide skilled nursing services and other therapeutic services; AND
- Has policies established by a professional group associated with the agency or organization which includes at least one registered graduate nurse (R.N.) to govern the services provided; AND
- Provides for full-time supervision of such services by a Physician or by a registered graduate nurse; AND
- Maintains a complete medical record on each patient; AND

- has a full-time administrator.

In rural areas where there are no agencies, which meet the above requirements, or areas in which the available agencies do not meet the needs of the community, the services of visiting nurses may be substituted for the services of an agency.

22.56 Home Health Care Plan
A program for care and treatment of the covered person established and approved by the covered person's attending physician, which is in lieu of continued confinement as an inpatient in a hospital in the absence of the services and supplies provided as part of the home health care plan.

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

22.58 Hospice
An entity providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel that includes at least one Physician and one registered graduate nurse, and must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

22.59 Hospice Care Plan
A plan of terminal patient care that is established and conducted by a hospice agency and supervised by a physician.

22.60 Hospital
An institution which:

- Complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located; AND
- Is primarily engaged in providing medical treatment to sick and injured persons as registered bed patients and maintains permanent facilities for five or more such patients; AND
- Is operated under the supervision of a staff of Physicians; AND
- Continuously provides 24-hour-a-day nursing service by registered graduate nurses; AND
- Maintains a daily medical record for each patient; AND
- Maintains facilities for diagnosis of injury or disease; AND
- Maintains permanent facilities for major surgical operations on its premises, except that this requirement will not apply for a facility specializing in the care and treatment of mentally ill patients; AND
- Is not, other than incidentally, a place of rest, for custodial care, for the aged, or for the care of senile persons; a nursing home; a hotel; a school or a similar institution; or an institution that is supported in whole or in part by a federal government fluid.

For treatment of substance abuse, a "Hospital" will mean a facility or institution which provides a program for treatment of alcohol or other drug dependency pursuant to a written treatment plan approved and monitored by a Physician, provided the facility meets at least one (1) of the following requirements:

- It is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the A.M.A. and A.H.A.; OR
- It is affiliated with a Hospital as defined above, under a contractual agreement with an established system for patient referral; OR
- It is a state agency; OR
- It is licensed certified or approved as an alcohol or other drug dependency treatment program or center by any state agency having legal authority to so license, certify, or approve.

22.61 Illness
A bodily disorder, disease, physical illness, or psychiatric disorder of a covered person.

22.62 Improper Claim
A claim that is not filed according to Plan procedures. A participant or his or her representative will be notified if a claim is determined to be filed improperly. The notice will contain the steps and the time frame that must be followed to resubmit the claim for a determination.

22.63 Incomplete Claim
A claim that does not contain sufficient information for a determination to be made. A participant or his or her representative will be notified if a claim is determined to be incomplete. The notice will contain a description of the additional information required and the time frame that must be followed to resubmit the claim for a determination.

22.64 Incurred Date
The incurred date for purposes of determining eligible expenses is as follows:

- For dental appliances or changes to dental appliances, the date in which the appliance is seated;
- For a crown, bridge or a cast restoration on the date it is seated;
- For root canal therapy, the date in which the pulp chamber is opened for therapy; and
- For all other charges, the date the service or procedure is performed or the supplies are furnished.

22.65 Incurred Expenses
The cost of those services and supplies rendered to a covered person. Such expenses shall be considered to have been incurred at the time or date the service or supply is actually provided.

22.66 Injury
A condition caused by accidental means which results in damage to the covered person's body from an external force.

22.67 Inpatient
Confinement as a registered bed patient in hospital, skilled nursing facility, hospice, or freestanding chemical dependency treatment center.

22.68 Intensive Care Unit (I.C.U.)

A Hospital area or accommodation exclusively reserved for critically and seriously ill patients requiring constant observation as prescribed by the attending Physician, which provides room and board, specialized registered professional nursing and other nursing care and special equipment and supplies on a stand-by basis and which is separated from the rest of the Hospital's facilities. This includes Coronary Care Unit (C.C.U), Burn Unit, or Intermediate Care Unit.

22.69 Late Enrollment (Late Enrollee)

An employee or dependent who waives coverage and later wants to enroll but does not qualify for the Special Enrollment Rights described in the Enrollment and Eligibility section of this document. Late enrollees may apply for benefits only during the Open Enrollment Period.

22.70 Lifetime

For the purposes of this Plan document, lifetime is understood to mean while a person is covered under this Plan. Under no circumstances does lifetime mean during the entire lifetime of the covered person.

22.71 Medically Necessary

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

All of these criteria must be met; merely because a physician recommends or approves certain care does not mean that it is medically necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is medically necessary.

22.72 Medicare

All benefits under Parts A and/or B of Title XVIII of the Social Security Act of 1965, as amended.

22.73 Mental Health Care/Treatment

Treatment for mental health disorders or conditions, as accepted by the general psychiatric community.

22.74 Midwife

A licensed professional person deemed as a midwife by state law, who assists in the delivery of newborns.

22.75 Newborns' and Mother's Health Protection Act (NMHPA)

The Newborns' and Mother's Health Protection Act of 1996, as amended. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

22.76 Newborn Nursery Care
The hospital charge for the room and board of a newborn child while the mother is hospital confined due to delivery. Healthy newborn nursery care extends for a maximum of five days.

22.77 Non-Emergency Hospital Admission
A hospital admission (including normal childbirth) which may be scheduled at the convenience of a person without endangering such person's life or without causing serious impairment to that person's bodily functions.

22.78 Nurse
An individual who has received specialized nursing training and is authorized to use the designation "RN" (Registered Nurse) or "LPN" (Licensed Practical Nurse) and is duly licensed by the state or regulatory agency responsible for such license in the state in which the individual performs the nursing services.

22.79 Occupational Therapy
A program of care which focuses on the physical, cognitive and perceptual disabilities that influence the patient's ability to perform functional tasks. The therapist evaluates the patient's ability to use his or her fingers and hands, (fine motor skills), perceptual skills, cognitive functioning and eye-hand coordination. Therapy sessions may involve physical movement exercises. Functional tasks may be used; the therapist may also perform splinting of the patient's arms or hands and may provide the patient with special equipment. Therapy that is intended to address primarily vocational rehabilitation issues (i.e. return to work skills) will not be considered covered services under this Plan.

22.80 Out-of-Pocket Maximum
The maximum dollar amount a participant will pay for covered medical expenses in any one benefit period, unless otherwise specified in the Summary of Medical Benefits.

22.81 Outpatient
Medical services furnished while not confined as a registered bed patient in a hospital, skilled nursing facility or hospice.

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

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

22.84 Physician Office Visit
All services performed and billed by a physician on the same date as the actual office visit.

22.85 Plan
The Plan Document and all amendments and/or riders or waivers now or hereafter attached, signed by the Plan Sponsor.

22.86 Plan Administrator
Lower Kuskokwim School District, which is responsible for the day-to-day functions and arrangements of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services.

22.87 Plan Document
A formal written document that describes the plan of benefits and the provisions under which such benefits will be paid to Covered Persons, including any amendments.

22.88 Plan Sponsor
The entity sponsoring this Plan. The Plan Sponsor may also be referred to as the Plan Administrator. See General Plan Information section for further information.

22.89 Plan Year
An annual period beginning on July 1 and ending June 30 or upon termination of the Plan, whichever occurs earlier.

22.90 Post-Service Health Claim
A claim for a benefit under the Plan that is not a pre-service claim.

22.91 PPACA
The Patient Protection and Affordable Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

22.92 Pre-Admission Testing
The charges made by a hospital for services rendered to a covered person on an outpatient basis which are medically necessary prior to a scheduled inpatient confinement at the same facility.

22.93 Pregnancy
The condition of being pregnant and all conditions and/or complications resulting therefrom. Pregnancy is covered the same as any other illness for employees and dependent spouses.

22.94 Prescription Drug
A Food and Drug Administration-approved drug or medicine which, under Federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed physician. Such drug must be medically necessary in the treatment of a covered illness or injury.

22.95 Pre-Service Health Claim
A claim for a benefit that, under the terms of the Plan, requires a participant to receive, in whole or in part, prior approval from the Plan as a condition.

22.96 Psychiatric (Mental Health) Treatment Facility
An administratively distinct governmental, public, private or independent unit or part of such unit that provides psychiatric services and care; such facility is at all times supervised by a staff of physicians; provides at all times skilled nursing care by licensed nurses who are directed by a full-time registered nurse (RN); prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs which is supervised by a physician, and meets appropriate licensing standards.

22.97 Qualified Beneficiary (COBRA)
An individual who, on the day before a Qualifying Event, is a covered person under this Plan.

22.98 Qualified Medical Child Support Order (QMCSO)

Any court order that: 1) provides for child support with respect to the employee's child or directs the employee to provide coverage under a health benefit plan under a state domestic relations law, or 2) enforces a law relating to medical child support described in the Social Security Act, Section 1908, with respect to a group health plan. A QMCSO or a National Medical Support Notice (NMSN) also may be issued through an administrative process established under state law. A participant must notify the Plan Administrator if he or she is subject to a QMCSO or an NMSN to receive the benefit.

22.99 Qualifying Event (COBRA)

Any of the following events which result in the loss of coverage of a Qualified Beneficiary:

- The death of the covered employee;
- The termination (except by reason of such covered employees' gross misconduct) or reduction in hours of the covered employee's employment;
- The divorce or legal separation of the covered employee from such covered employee's spouse;
- The covered employee becoming entitled to benefits under Title XVIII of the Social Security Act (Medicare);
- A dependent child ceasing to be a dependent child under the terms of this Plan;
- A child born to the covered member or who is placed for adoption with the covered member during a period of COBRA Continuation Coverage is also a Qualified Beneficiary; and
- Lower Kuskokwim School District filing for Chapter 11 reorganization.

22.100 Recipient (Organ and/or Tissue Transplant)

The person who receives an organ transplant from the organ donor. The recipient must be a covered employee or covered dependent under the provisions of the Plan. Only those organ transplants not considered experimental in nature and specifically covered herein are eligible for coverage under this Plan.

22.101 Rescission of Coverage

The Plan may not rescind an individual's coverage under the Plan (e.g., cancelling coverage after a Covered Person has submitted a claim). However, the Plan may rescind coverage if a Covered Person commits fraud or makes an intentional misrepresentation

22.102 Rehabilitation Center

A legally operating institution or distinct part of an institution which has a transfer agreement with one or more hospitals, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, hospital and rehabilitative inpatient care and is duly licensed by the appropriate government agency to provide such services. It does not include institutions which provide only minimal care, custodial care, ambulatory or part-time care services, or an institution which primarily provides treatment of a mental disorder, chemical dependency or tuberculosis except if such facility is licensed, certified or approved as a rehabilitation facility for the treatment of medical conditions, drug addiction or alcoholism in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission, the Accreditation of Health Care Organizations or the Commission for the Accreditation on Rehabilitation Facilities.

22.103 Second Surgical Opinion

The second opinion of a physician or surgeon to determine the medical advisability of a person undergoing a planned surgical procedure. If the second opinion does not confirm that the planned surgical procedure is medically advisable, then second surgical opinion shall also mean and include a third surgical opinion.

22.104 Sickness

Sickness will mean bodily illness or disease (other than mental health conditions), and congenital abnormalities of a covered newborn child. Also, a Physician must diagnose a condition in order to be considered a Sickness by this Plan.

22.105 Skilled Nursing Facility

An institution or distinct part thereof which meets all the following conditions:

- It is approved by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) and or Medicare;
- It provides nursing services by licensed staff under the 24-hour per day direction of a registered nurse;
- It maintains a complete medical record for each individual patient;
- Skilled nursing or skilled rehabilitation services are provided on a daily basis by appropriately licensed personnel; and
- The facility is not a place for rest, the aged, drug addicts, alcoholics, the mentally incapacitated or for the care of mental disorder, nor is the facility meant for custodial care that is provided for the primary purpose of assisting an individual in meeting the basic activities of daily living.

22.106 Speech Therapy/Pathology

A program of care which evaluates the patient's motor-speech skills, expressive and receptive language skills, writing and reading skills, and determines if the patient requires an extensive hearing evaluation by an audiologist. The therapist also evaluates the patient's cognitive functioning, as well as his or her social interaction skill such as the ability to maintain eye contact and initiate conversation. Therapy may also involve developing the patient's speech, listening and conversational skills, and higher-level cognitive skills such as understanding abstract thought, making decisions, sequencing, etc. Therapy may be considered medically appropriate even for patients who do not have apparent speech problems, but who do have deficits in higher-level language functioning as a result of trauma or identifiable organic disease process.

22.107 Substance Abuse/Chemical Dependency

The physiological and psychological addiction to a controlled drug or substance, or to alcohol. Dependence upon tobacco, nicotine, and caffeine are not included in this definition.

22.108 Substance Abuse Treatment Facility

An institution which provides a program for diagnosis, evaluation and effective treatment of alcoholism, and/or drug use or abuse, provides detoxification services, infirmary level medical services or arranges at a hospital in the area for any other medical services that may be required; is at all times supervised by a staff of physicians; provides at all times skilled nursing care by licensed nurses who are directed by a full-time registered nurse (RN); and prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs which are supervised by a physician, and meets licensing standards.

22.109 Surgical Procedure

"Surgical Procedure" includes, but is not limited to, cutting, suturing, treating burns, reduction of fractures, reducing dislocations, manipulating a joint under general anesthesia, electocauterizing, paracentesis, applying plaster casts, administering pneumothorax, endoscopy, injecting sclerosing solution, arthroscopic procedures or urethral dilation.

22.110 Temporomandibular Joint (TMJ) Disorder

Jaw joint disorders including conditions of structures linking the jaw bone, skull, the complex of muscles, nerves and other tissues related to the Temporomandibular Joint. Treatment of TMJ is not covered by this Plan.

22.111 Total Disability or Totally Disabled

A physical state of a covered person resulting from an injury or illness which wholly prevents:

- In the case of an employee, from engaging in any and all business or occupation and from performing any and all work for compensation or profit; or

- In the case of a dependent, a COBRA Beneficiary or a retiree, from performing the normal activities of a person for that age and sex in good health.

22.112 Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

A Federal law covering the rights of participants who have a qualified uniformed service leave.

22.113 Urgent Care Claim

A claim for medical treatment which, if the regular time periods observed for claims were adhered to, 1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or 2) would, in the opinion of a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed. Any claim that a physician with knowledge of the claimant's medical condition determines to be a "claim involving urgent care" will be deemed to be an urgent care claim. Otherwise, whether a claim is an urgent care claim or not will be determined by an individual acting on behalf of the Plan, and applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

22.114 Urgent Care Facility

A freestanding facility which is engaged primarily in providing minor emergency and episodic medical care and which has:

- A board-certified Physician, a registered nurse (R.N.) and a registered x-ray technician in attendance at all times; AND

- Has x-ray and laboratory equipment and a life support system.

An Urgent Care Facility does not include a clinic located at, operated in conjunction with, or in any way made a part of a regular Hospital.

22.115 Usual, Customary and Reasonable

The lesser of:

- The usual fee - the charge most frequently made for the covered services or supplies by a physician, or hospital;

- The customary fee - the charge made for covered services or supplies by those of similar professional standing in the same geographic area; or

- The reasonable fee - the charge determined by considering the complexity involved, the degree of professional skill required and other pertinent factors, if (1) and (2) above cannot be easily determined.

22.116 Visit

Each session of treatment, consultation, therapy or related service given by a health care provider.

22.117 Waiting Period

The period of time which a full-time employee must satisfy before becoming eligible for coverage under this Plan.

22.118 Women's Health and Cancer Rights Act (WHCRA)

The Women's Health and Cancer Rights Act of 1998, as amended. Your medical coverage under the Plan includes coverage for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your covered dependent who is receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for: 1) All stages of reconstruction of the breast on which the mastectomy was performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; 3) Prostheses; and 4) Treatment of physical complications at all stages of mastectomy, including lymphedema.

23 FUNDING - SOURCES AND USES

23.1 Contribution Determinations

The Plan Sponsor will, from time to time, evaluate the costs of the Plan and determine the amount to be contributed by the Employer(s) and the amount to be contributed (if any) by each Employee.

23.2 Employee Obligations

The coverage(s) afforded to an Employee by this Plan may require Employee contribution but will be at least partially funded by the Employer. If an Employee elects to enroll Dependent(s) under the Plan, the Employee may be responsible for payment of all or a portion of the Dependent contributions suitable to cover such enrollment. For active Employees, the Employer will deduct such costs on a regular basis from the Employee's wages or salary.

23.3 Employer Obligations

The Employer will make contributions to the Plan for the Health Care Coverage(s) of Employees and may contribute to the cost of Dependent coverage.

Employer contributions and those paid by Employee, if any, will be placed in a special account or accounts administered by the Contract Administrator to provide the non-Insured benefits under the Plan. Contributions for insured coverages or ancillary coverages (see Additional Plan Coverages section, if any) will be paid directly to the provider for such coverage.

23.4 Plan Funded Benefits

The contributions will be applied to provide the benefits under the Plan.

23.5 Insurance Policy(ies)

Contributions may be used to purchase insurance coverage(s) to ensure that the Plan will meet its self-funded Health Care Coverage obligations. The policy(ies) may be reviewed upon request submitted to the Plan Sponsor. The Plan Sponsor is also available to answer any questions about the coverages. The provisions of the Plan Document in no way modify those of any insurance policy.

23.6 Administration Expenses

Contributions may also be used to pay: (1) administrative expenses of the Plan in accordance with the terms and conditions of any administration agreement between the Plan Sponsor and Contract Administrator(s) and (2) other reasonable operating expenses of the Plan.

23.7 Taxes

Any premium or other taxes that may be imposed by any state or other taxing authority and which are applicable to the coverages of the Plan will be paid by the Plan Sponsor.

NOTE: To provide benefits, purchase insurance protection, pay administrative expenses and any necessary taxes, the contributions that are paid by Employees will be used first and any remaining Plan obligations will be paid by Employer contributions. Should total Plan Liabilities in a Plan Year be less than total Employee contributions, any excess will be applied to reduce total Employee contribution requirements in the subsequent Plan Year or at Plan Sponsor's discretion, may be used in any other manner which is consistent with ERISA guidelines.

24 ADMINISTRATIVE PROVISIONS

The following sections contain administrative information you may need.

24.1 Administration

Certain benefits of the Plan are administered by Contract Administrator(s) under the terms and conditions of administration agreement(s) between the Plan Sponsor and the Contract Administrator(s).

24.2 Alternative Care

In addition to the benefits specified herein, the Plan may elect to offer benefits for services furnished by any provider pursuant to an approved alternative treatment plan for a Covered Person.

The Plan will provide such alternative benefits at the Plan Sponsor's sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost-effective, and that the total benefits paid for such services do not exceed the total benefits to which the Claimant would otherwise be entitled under this Plan in the absence of alternative benefits.

If the Plan elects to provide alternative benefits for a Covered Person in one instance, it will not be obligated to provide the same or similar benefits for that person or other Covered Persons in any other instance, nor will such election be construed as a waiver of the Plan Sponsor's right to administer the Plan thereafter in strict accordance with the provisions of the Plan Document.

24.3 Amendment or Termination of the Plan

The Plan Sponsor expects the Plan to be permanent, but since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right to, without the consent of any participant or beneficiary:

- Determine eligibility for benefits or to construe the terms of the Plan;
- Alter or postpone the method of payment of any benefit; and
- Amend any provision of these administrative provisions; and
- Make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements or the applicable sections of the internal Revenue Code or ERISA; and
- Terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis, if necessary, provided, however, that no modification or amendment shall divest an Employee of a right to those benefits to which he has become entitled under the Plan.

NOTE: Any modification, amendment or termination action will be done in writing, and by resolution of a majority of the Plan Sponsor's board of directors, or by written amendment that is signed by at least one Fiduciary of the Plan.

24.4 Annual Statements

If required by law, the Plan Sponsor will furnish to each Employee within a reasonable period of time following the close of a Plan Year, a written statement showing the amounts paid or expenses incurred by the Plan Sponsor for Plan benefits during the prior Plan Year.

24.5 Anticipation, Alienation, Sale or Transfer

Except for assignments to providers of service (see Claims Procedures for Health Care Coverage(s) section), no benefit payable under the provisions of the Plan will be subject in any manner to

anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

24.6 Clerical Error

Clerical error by the Employer or Plan Sponsor will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

24.7 Conflict of Provisions

With regard to any contract of insurance or reinsurance which is or becomes a part of the Plan, if any provision of such contract has been omitted from or is in conflict with the provisions of the Plan Document, the appropriate insurance or reinsurance contract wording shall prevail.

24.8 Discrepancies

In the event that there may be a discrepancy between the booklet(s) provided to Employees (the "Summary Plan Description" and the Plan Document, the Plan Document will prevail.

24.9 Entire Contract

The Plan Document, any amendments, and the individual applications, if any, of Covered Persons will constitute the entire contract between the parties. The Plan does not constitute a contract of employment or in any way affect the rights of an Employer to discharge any Employee.

24.10 Facility of Payment

Every person receiving or claiming benefits under the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which he can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Employee, or to any other person or Institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brothers, or sisters, or the Employee's estate, as the Plan Sponsor in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Plan.

If a guardian, conservator or other person legally vested with the care or the estate of any person receiving or claiming benefits under the Plan is appointed by a court of competent jurisdiction, payments will be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Fiduciaries. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefore under the Plan.

24.11 Fiduciaries

Fiduciaries will serve at the discretion of the Plan Sponsor and will serve without compensation, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. The Plan Sponsor may at any time and from time to time remove any Fiduciary or appoint new Fiduciaries. Any Fiduciary may resign at any time upon 30 days' notice in writing delivered to the Plan Sponsor. Fiduciaries may act at a meeting or without a meeting, by a majority of the Fiduciaries at the time in office. The Fiduciaries may appoint a member as its secretary who will have such powers and responsibilities relating to the administration of benefits under the Plan as the Fiduciaries may delegate.

24.12 Fiduciary Responsibility, Authority and Discretion

Fiduciaries will discharge their funds under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

In carrying out their responsibilities under the Plan, Fiduciaries will have discretionary authority to interpret the terms of the Plan and Plan Document, even if the terms are found to be ambiguous, and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

The Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to provider networks or utilization management organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant or other person or third party selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan. However, the Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: (l) establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

24.13 Force Majeure

Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

24.14 Gender and Number

Except when otherwise indicated by the context, any masculine terminology will also include the feminine (and vice-versa) and any term in the singular will also include the plural (and vice-versa).

24.15 Illegality of Particular Provision

The legality of any particular provision of the Plan Document will not affect the other provisions, but the Plan Document will be construed in all respects as if such invalid provision were omitted.

24.16 Incontestability

No statement made by any person covered under the Plan relating to the person's good health will be used in contesting the validity of the coverage with respect to which such statement was made after such coverage has been in force prior to the contest for a period of two (2) years during such person's lifetime, nor unless it is contained in a written instrument signed by such person.

Any statements made by the person covered will be deemed representations and not warranties, and no statement made by any person covered will void the coverage or be used in any contest

unless a copy of the instrument containing the statement is or has been furnished to such person or to such person's beneficiary.

24.17 Indemnification

To the extent permitted by law, Employees of the Employer, the Fiduciaries, and all agents and representatives of the Fiduciaries will be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

24.18 Legal Actions

No Employee, Dependent or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under this Plan will be resolved by the Plan Sponsor under and pursuant to the Plan Document

No legal action may be brought to recover on the Plan within sixty (60) days after written proof of loss has been given as required by the Plan. No such action may be brought after three (3) years from the time written proof of loss is required to be given.

24.19 Misstatement of Age

If the age of a Covered Person has been misstated in an enrollment form and if the amount of the contribution required of an Employer with respect to such Covered Person is based on age, an adjustment of such contribution amount will be made based on the Covered Person's true age. Contributions so affected wilt be adjusted on the contribution due date next following the date of the discovery of such misstatement.

If age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of age of a Covered Person in an enrollment form or claims filing, his eligibility or amount of benefits, or both, will be adjusted in accordance with his true age. Upon the discovery of a Covered Person's misstatement of age, benefits affected by such misstatement will be adjusted immediately.

Any misstatement or age will neither continue coverage otherwise validly terminated, nor terminate coverage otherwise validly in force.

24.20 Misuse of Identification Card

If an Employee or covered Dependent permits any person who is not a covered member of the family unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his HMOs) coverage will be terminated at the end of 31 days from the date written notice is given.

24.21 Physical Examination and Autopsy

The Plan Sponsor, at Plan expense, will have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require during the pendency of any claim and to make an autopsy in case of death where it is not forbidden by law.

24.22 Purpose of the Plan

The purpose of the Plan is to provide certain health care benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents.

24.23 Reimbursements

Whenever any benefit payments which should have been made under the Plan have been made by another party, the Plan Sponsor and the Contract Administrator will be authorized to pay such

benefits to the other party, provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the fill extent thereof.

24.24 Right of Recovery

Whenever any benefit payments have been made by the Plan in excess of the maximum amount required under the terms of the Plan Document, the Plan will have the right to recover all such excess amounts from any persons, insurance companies or other payees and the Employee or Dependent will make a good faith attempt to assist the Contract Administrator in such recovery.

The Plan Sponsor may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided the Plan will be entitled to recoup and recover the amount paid therefore from the Covered Person or the provider of service in the event it is determined that such care or services are not covered hereunder. The Covered Person (parent, if a minor) will execute and deliver to the Plan all assignments and other documents necessary or useful to the Plan Sponsor or Contract Administrator for the purpose of enforcing the Plan's rights under this provision.

24.25 Rights Against the Plan Sponsor or Employer

Neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

24.26 Substitution

The Plan Sponsor will be substituted for all rights of an Employee to recover attorney fees against any adverse party. Employees will do nothing to prejudice such rights of the Plan Sponsor and further they agree to do all acts necessary to preserve and take advantage of such rights. If payment has been made by the Plan in such instances and if the adverse party reimburses the Employee directly, the Plan will have the right to recover such payment from an Employee.

24.27 Titles or Hearings

Where titles or headings precede explanatory text throughout the Plan Document, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Plan Document and will not affect the validity, construction or effect of the Plan Document provisions.

24.28 Type of Plan

This is an employee welfare benefit plan whose purpose is to provide certain welfare benefits for eligible Employees of the Employer(s), their eligible Dependents, and Qualified Beneficiaries under COBRA.

24.29 Workers' Compensation

The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

25 STATEMENT OF RIGHTS OF EMPLOYEES

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to the following.

25.1 Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series), if applicable, and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

25.2 Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free-of-charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request the certificate before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

25.3 Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

25.4 Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the previously mentioned rights. For instance, if you request a copy of Plan documents (i.e., Summary Plan Descriptions and Summary of Material Modifications) or the latest annual report from the Plan and do not receive it within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to

provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If, after you exhaust your appeals, you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. Such suit must be filed within 180 days from the date of an adverse appeal determination notice. In addition, if you disagree with the Plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous), the court may order you to pay these costs and fees.

25.5 Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration at 1-866-444-3272.

26 CONTINUATION OF COVERAGE OPTION (COBRA)

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985, the Plan includes a Continuation of Coverage Option which is available to certain Covered Persons whose Health Care Coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with that law and if it is found to be incomplete or in conflict in any way with the law and its amendments the law will prevail.

NOTE: This continuation shall run concurrently with any continuation period that may be mandated by state law.

26.1 Definitions

Qualified Beneficiary - A covered Employee or a Dependent of a covered Employee who was a Covered Person on the date preceding the date on which the Qualifying Event occurred and whose Participating Employer, in the Calendar Year prior to the Calendar Year or the Qualifying Event, employed at least 20 employees on a typical business day i.e., had 20 or more employees on at least 50% of its working days).

Qualifying Event - Except as noted, any one of the following which would result in the loss of coverage under the Plan:

- The death of the covered Employee;
- The termination of employment of the covered Employee (other than by the Employee's gross misconduct);
- Reduction in a covered Employee's hours of employment to an ineligible status; the divorce or legal separation of the covered Employee from the Employee's spouse; the Employee's coverage termination due to his becoming entitled to Medicare benefits; the cessation of covered Dependent coverage by operation of Plan Document provision.

While an individual may incur more than one Qualifying Event, the length of continued coverage will never exceed 36 months from the date of the first Qualifying Event.

NOTE: A Qualifying Event will also occur on the date an Employee's FMLA leave terminates, whether or not the Employee continued Plan coverage during the leave for himself or his eligible Dependents. For these purposes, an FMLA leave is ONLY a leave granted by the Employer in accordance with the Family and Medical Leave Act of 1993 and, for these purposes, the date of termination of such leave will NOT be affected by any state or local laws that may require the Employer to provide coverage for longer than the FMLA requirements.

26.2 Notification

An Employee or Qualified Beneficiary must notify the Employer's Benefits Office or the Plan Administrator within 60 days of the Qualifying Event in event of divorce, legal separation, or Dependent child becoming ineligible.

The Employer or Plan Administrator must notify Qualified Beneficiaries of their Continuation of Coverage rights within 14 days after receiving notice of a Qualifying Event Notice mailed to Qualified Beneficiary's last known address will be considered adequate. Notice to a spouse is treated as notification to all other Qualified Beneficiaries residing with spouse at the time notice is made.

26.3 Election and Election Period

Continuation of Coverage may be elected during the period beginning on the date coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following:

- Sixty (60) days after coverage ends due to a Qualifying Event;
- Sixty (60) days after the notice of the Continuation of Coverage Option rights is sent.

Unless specified otherwise on the election form, if continued coverage is elected by one Qualified Beneficiary, it will be deemed to be an election for all other beneficiaries who would otherwise lose coverage due to the Qualifying Event. However, each individual who would otherwise lose coverage is entitled to make an individual election which would allow one to elect continued coverage even if others in the same family have declined or, if optional benefits were available, an eligible Employee and his/her Dependents could elect different coverage(s).

26.4 Effective Date of Coverage

Continuation of Coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event and Qualified Beneficiary will be retroactively charged for coverage accordingly.

26.5 Level of Benefits

Continuation of Coverage elected hereunder will be equivalent to coverage provided to a similarly situated person to whom a Qualifying Event has not occurred. If coverage is modified to similarly situated Employees, the same modification will apply to Qualified Beneficiaries.

26.6 Cost of Continuation of Coverage

The cost of coverage may be paid in monthly installments and such cost will not exceed 102% of the cost of coverage, during the same period, for a similarly situated Covered Person to whom a Qualifying Event has not occurred. Retroactive premiums must be paid by the Qualified Beneficiary to the Plan within 45 days of election of Continuation of Coverage hereunder.

NOTE: For Qualified Beneficiaries who reside in a state with a health insurance premium program, whatever name it may be called, the state may pay the cost of COBRA coverage for a Qualified Beneficiary who is eligible for health care benefits from the state through a program for the medically-indigent or due to a certain disability(ies). Contact the Employers personnel offices for additional information.

26.7 Termination of Continuation of Coverage

Coverage under this provision will terminate on the earlier of:

- The end of thirty-six (36) months if the Qualifying Event is death of the covered Employee, divorce or separation. Employee's entitlement to Medicare, or a Dependent child who no longer qualifies as a Dependent;
- The end of eighteen (18) months if the Qualifying Event is employment termination or reduction of hours to non-eligible status. However, a Qualified Beneficiary who is determined under Title II or Title XVI of the Social Security Act to have been disabled at the time of termination (i.e., at the time of the Quaking Event) may notify the Plan Sponsor of such disablement before the end of the 18-month period and extend the continued coverage from 18 to 29 months or until the Qualified Beneficiary is no longer disabled, if earlier. The cost of such extended coverage may be 150% of the active Employees' cost for months 19 through 29;
- The termination or an Employer-sponsored group health plans;

- The failure to make untimely premium payments to the Plan (coverage may be terminated if the beneficiary Is more than 30 days delinquent in paying his/her premium);

- The date the Qualified Beneficiary becomes covered under any other group health plan as a result of employment, re-employment or remarriage, which does not contain any exclusion with respect to any pre-existing condition of such beneficiary; or

- The date the Qualified Beneficiary becomes entitled to Medicare benefits.

27 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PRIVACY PRACTICES

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. This section provides an overview of those rights. You will receive from the Plan Administrator a separate "Notice of Privacy Provisions" which contains additional information about how your individually identifiable health information is protected and who you should contact with questions or concerns.

27.1 HIPAA Privacy

HIPAA applies to medical and prescription drug plans. These plans are commonly referred to as "HIPAA Plans" and are administered to comply with the applicable provisions of HIPAA.

Protected Health Information (PHI) is information created or received by the HIPAA Plans that relates to an individual's physical or mental health or condition (including genetic information as provided under the Genetic Information Nondiscrimination Act), the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper, or oral.

The Plan will comply with all privacy requirements defined in the HIPAA Privacy Policy and will use or disclose PHI only if the use or disclosure is permitted or required by HIPAA Regulations and any other applicable Federal, state, or local law.

The HIPAA Plans may disclose PHI to the Plan sponsor only for limited purposes as defined in the HIPAA Privacy Rules. The Plan sponsor agrees to use and disclose PHI only as permitted or required by HIPAA. PHI may be used or disclosed for Plan administration functions that the Plan sponsor performs on behalf of the HIPAA Plans. Such functions include:

- enrollment of eligible individuals;
- eligibility determinations;
- payment for coverage;
- claim payment activities;
- obtaining stop-loss or excess loss coverage,
- coordination of benefits; and
- claim appeals.

If a Plan participant wants to exercise any of his or her rights concerning PHI, he or she should contact the specific Claims Administrator involved with the PHI in question. The Claims Administrator will advise the Plan participant of the procedures to be followed.

The Plan will require any agents, including subcontractors, to whom it provides PHI to agree to the same restrictions and conditions that apply to the Company or Plan sponsor with respect to such information. The Company or Plan sponsor will report to the Plan any use or disclosure of PHI it knows is other than as permitted by the Plan and HIPAA Regulations.

Any HIPAA Plan will maintain policies and procedures that govern the HIPAA Plan's use and disclosure of PHI. These policies and procedures include provisions to restrict access solely to the previously listed positions/departments and only for the functions listed previously. The HIPAA Plan's policies and procedures will also include a mechanism for resolving issues of noncompliance.

In accordance with the Health Breach Notification Rule (16 CFR Part 18), the Plan sponsor agrees to notify both participants and the Federal Trade Commission of the use or disclosure of any PHI or electronic PHI provided for Plan Administration purposes that is inconsistent with the uses or disclosures provided for, or that represents a PHI Security Incident, of which the Plan sponsor or any Business Associate of the Plan sponsor becomes aware.

27.2 HIPAA Electronic Security Standards

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Plan documents must reflect certain obligations required of the Employer.

- The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

- The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

- The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in compliance with HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers.

27.3 Certificate of Creditable Coverage

HIPAA also requires that participants automatically receive a certificate of creditable coverage within a reasonable period of time after coverage ceases (if not eligible for COBRA continuation coverage) or after COBRA coverage ends (including any grace period for non-payment of COBRA premiums). For participants who are eligible to elect COBRA continuation coverage, the certificate will be provided no later than 44 days after a qualifying event (See Continuing Health Care Coverage through COBRA below.)

The standard certificate includes basic health plan participation information and a statement as to whether you and your covered dependent(s) had at least 18 months of coverage without a significant break (more than 63 days). If you or your dependent(s) had less than 18 months of coverage, the statement will include the date coverage began and ended as well as the date of any waiting period.

A certificate never will cover longer than an 18-month period without a 63-day break, which is the maximum creditable coverage that an individual would need under the pre-existing condition exclusion rules and the rules for access to the individual market. You automatically will receive the standard statement when coverage ends. A single certificate may be used for all covered persons in a family who are losing coverage at the same time.

If you need to establish creditable coverage to reduce any pre-existing exclusion imposed by any subsequent health plan for mental health/substance abuse treatment and/or prescription drugs, an alternative certificate also is available by request.

To request another, copy of the standard certificate and/or the alternative certificate, contact the Plan Administrator within 24 months after the end of a period of continuous coverage. Your certificate will be sent in a reasonable and prompt fashion or, alternatively, if all parties agree, the Plan Administrator may provide this information by phone.

28 GENERAL PLAN INFORMATION

Table 27.1 below describes the General Information of the Plan.

Table 27.1: General Plan Information	
Name of Plan	Lower Kuskokwim School District Employee Healthcare Plan
Plan Sponsor	Lower Kuskokwim School District
Address	Business Manager
	P O Box 305 Bethel, AK 99559
Business Phone Number	(907) 543-4820
Plan Sponsor ID Number (EIN)	92-0056756
Plan Number	501
Plan Year	July 1 through June 30
Type of Plan	Self-Funded Employee Benefit Plan
Claims Administrator	Integrity Administrators
Address	1787 Tribute Road, Suite E P O Box 13128 Sacramento, CA 95813
Phone	916-921-3388
Statutory Agent for Service of Legal Process	The Plan Sponsor named above

LOWER KUSKOKWIM SCHOOL DISTRICT
BENEFIT PLAN

ADMINISTERED BY
INTEGRITY ADMINISTRATORS, INC.

1787 TRIBUTE ROAD, SUITE E
SACRAMENTO, CA 95815

P O BOX 13128
SACRAMENTO, CA 95813-3128

(800) 562-9383 FAX (916) 921-3383