
NEA – ALASKA HEALTH PLAN BENEFIT BOOKLET
FOR
ANCHORAGE EDUCATION ASSOCIATION

RESTATED: JULY 1, 2011

MEDICAL PLAN OPTION: PLAN A
DENTAL PLAN OPTION: PLAN A, WITHOUT ORTHODONTIA

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INTRODUCTION

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

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

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

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

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage.

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

Representations, Not Warranties. All statements made by the Member, the Plan or Covered Persons shall be considered representations and not warranties. All such statements will be made in good faith without any intention of fraud. No statement made while applying for coverage will cancel coverage or reduce benefits unless it is in a written document signed by the Plan or Covered Person. A copy of the document must be given to the person noted.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

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

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

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

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

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

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

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

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

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

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

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

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Claims Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Members/Employees

A Member/Employee eligible for coverage under the Plan shall include only Members/Employees who are Actively Employed by an Employer who has a current Participation Agreement with the NEA – Alaska Health Plan as administered by the NEA – Alaska Health Plan office and Employer *or* who are Members of an Association who have a current Participation Agreement with NEA Alaska Health Plan as administered by NEA – Alaska Health Plan office.

Eligibility Requirements for Coverage

A person is eligible for coverage when he or she works at least 15 hours during an average work week, and;

- (1) Is a covered Member under a current Collective Bargaining Agreement between a participating Public Education Union working in Alaska and NEA- Alaska; and
- (2) Completes any applicable Waiting Period as defined in the Collective Bargaining Agreement;

OR

- (3) Meets the definition of eligible Employee as defined in the Policy and Procedures Manual/Personnel Policy (or as documented by payroll record) of the participating Employer; and
- (4) Completes any applicable Waiting Period as defined in the Policy and Procedures Manual/Personnel Policy (or as documented by payroll record) of the participating Employer.

Note: The Collective Bargaining Agreement or Policy and Procedures Manual/Personnel Policy are on file at your Employer's administration office/human resources office.

Eligible Classes of Dependents.

A Dependent is any one of the following persons:

- (1) A covered Member's Spouse, Domestic Partner, and children from birth to the limiting age of 26 years, including adult dependent children of covered Members. When a child reaches the limiting age, coverage will end on the last day of the child's birthday month.

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

The term "Domestic Partner" shall mean a person of either opposite sex or of the same sex meeting the following criteria: share an intimate, exclusive committed personal relationship of mutual caring; are not related by blood closer than permitted under marriage laws of the State of Alaska; are not married; are not acting under fraud or duress, and who are both at least 18 years old and competent to enter into a contract; have no other Domestic Partner nor had a different Domestic Partner in the last 12 consecutive months; shared the same principle residence for the last 12 consecutive months; are jointly responsible for each other's basic living expenses and agree that anyone who is owed for these expenses can collect from either person; and each declares in writing as evidenced by the Statement of Financial Interdependence form, under penalty of perjury, that she or he is the other's Domestic Partner. All references to Spouse will also be applicable to a Domestic Partner, unless otherwise indicated.

The term "child(ren)" shall include natural children, adopted children, or children placed with a covered Member in anticipation of adoption. Step-children may also be included as long as a natural or adoptive parent remains married to the Member and the natural or adoptive parent resides in the Member's household. Children of the Member's Domestic Partner may also be included as long as the natural or adoptive parent remains in a Domestic Partner relationship with the Member and the natural or adoptive parent resides in the Member's household.

If a covered Member or his or her Spouse or Domestic Partner is the Legal Guardian of a child or children, these children may be enrolled in this Plan as covered Dependents.

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

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan. A participant of the Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

The Plan Administrator may require documentation proving dependency, including birth certificates or initiation of legal proceedings severing parental rights.

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

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

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

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

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

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

FUNDING

Cost of the Plan.

The level of any Member contributions is set by the Employer.

ENROLLMENT

Enrollment Requirements. A Member must enroll for coverage by filling out and signing an enrollment form. The covered Member is required to enroll his or her Dependent(s) for coverage as well [by filling out and signing an enrollment form and/or an add/change form.](#)

If a Member commits fraud or makes an intentional material misrepresentation in applying for or obtaining Dependent coverage or obtaining Dependent benefits under the Plan, then the Plan may void coverage for the Dependent for the period of time that the Dependent was ineligible for coverage.

Enrollment Requirements for Newborn Children. A newborn child of a covered Member will be automatically covered for the first **31 days** from birth. However, in order to continue coverage beyond the first 31 days, the newborn child must be enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section; otherwise there will be no payment from the Plan and the parents will be responsible for all costs.

TIMELY OR LATE ENROLLMENT OF DEPENDENTS

- (1) **Timely Enrollment** - The enrollment will be "timely" if the completed enrollment form is received by the Plan Administrator no later than **31 days** after the person becomes eligible for the coverage .

If two Members (husband and wife) are covered under the Plan and the Member who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Member (with no Waiting Period) as long as coverage has been continuous.

In the case of a newborn, the enrollment will be "timely" if the completed form is received by the Plan Administrator no later than **90 days** from the date of birth.

- (2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during an other opportunity to enroll for coverage.

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

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. ***Coverage will be effective the first of the month following receipt of the enrollment form and/or the add/change form.***

OPEN ENROLLMENT OPPORTUNITY

Every **June** is the annual open enrollment period. Individuals may enroll in or waive the Plan during open enrollment. Benefit choices made during the open enrollment period will become effective **July 1**.

ENROLLMENT OPPORTUNITIES OR WAIVER OF COVERAGE EVENTS

There may be opportunities for Members to enroll for coverage or waive coverage outside of the open enrollment period.

Proof of some qualifying special enrollment or waiver of coverage events may be required. Contact the Plan Administrator for additional information or to determine whether a qualifying special enrollment or waiver of coverage event has occurred.

Opportunities to waive or enroll for coverage:

- A Member may **waive** coverage for himself or herself and thereby also waive their dependent coverage because of other health insurance or group health plan coverage that may be available. The Member must notify the Plan Administrator within **31 days** of the effective date of the other health insurance or group health plan coverage.
- A Member may **waive** coverage for himself or herself and thereby also waive their dependent coverage due to acquisition of new Dependent by marriage, execution of a financially interdependent relationship, birth, adoption or placement for adoption or divorce or death.
- A Member may **enroll** for coverage for himself or herself or his or her Dependents (including their Spouse or Domestic Partner) when there is:
 - A loss of eligibility of other coverage, including but not limited to, termination of other coverage or reaching a Lifetime limit on all benefits. The enrollment period is a period of **31 days** and begins on the date of loss of other coverage.
 - Acquisition of new Dependent by marriage, execution of a financially interdependent relationship, birth, adoption or placement for adoption or divorce or death.

For marriage, the timely enrollment period is a period of **31 days** and begins on the date of the marriage.

For Domestic Partners, the timely enrollment period is a period of **31 days** and begins on the date the Statement of Financial Interdependence form is executed.

For birth adoption or placement for adoption, the timely enrollment period is a period of **90 days** and begins on the date of the birth, adoption, or placement for adoption.

The coverage of the Dependent and/or Member will be effective:

- (a) In the case of marriage, as of the date of marriage;
- (b) In the case of a Dependent's birth, as of the date of birth; or
- (c) In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.
- (d) In the case of a Domestic Partner, as of the date the Statement of Financial Interdependence form is executed. The Statement of Financial Interdependence form is available from the Plan Administrator or at <http://www.neaplan.com/>.

In addition, the following circumstances will be considered eligible enrollment/waiver opportunities, when applicable:

- (a) **Collective Bargaining Agreement** - An enrollment/waiver will be considered timely if received by the Plan Administrator no later than **31 days** after the Collective Bargaining Agreement has been ratified.
- (b) **Plan Fiscal Year** – An enrollment/waiver will be considered timely if received by the Plan Administrator **no later than prior to the beginning of the Plan's fiscal year**. The Plan's fiscal plan year begins July 1st.

EFFECTIVE DATE

Effective Date of Member Coverage. A Member will be covered under this Plan as of the first day that the Member satisfies the eligibility requirements of the Plan. **Note:** Funding must be received by the Plan Administrator.

If the Member has met all eligibility requirements of the Employer on the first working day of the month, coverage will begin that day.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility and Enrollment Requirements are met and the Member is covered under the Plan or as otherwise stated in the Enrollment section of this Plan.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

Members and their Dependents who are otherwise eligible for coverage under the Plan but who are not enrolled can enroll in the Plan provided that they request enrollment in writing within sixty (60) days from the date of the following loss of coverage or gain in eligibility:

- (a) The eligible person ceases to be eligible for Medicaid or Children's Health Insurance Program (CHIP) coverage; or
- (b) The eligible person becomes newly eligible for a premium subsidy under Medicaid or CHIP.

If eligible, the Dependent (and if not otherwise enrolled, the Member) may be enrolled under this Plan.

This Dependent Special Enrollment Period is a period of 60 days and begins on the date of the loss of coverage under the Medicaid or CHIP plan OR on the date of the determination of eligibility for a premium subsidy under Medicaid or CHIP. To be eligible for this Special Enrollment, the Member must request enrollment in writing during this 60-day period. *The effective date of coverage will begin the date of loss of coverage or gain in eligibility.*

If a State in which the Member lives offers any type of subsidy, this Plan shall also comply with any other State laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State law is applicable to the Plan, the Employer and its Employees.

For more information regarding your special enrollment rights, contact the Plan Administrator.

TERMINATION OF COVERAGE

When coverage under this Plan terminates, Plan Participants will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the Plan Administrator for a copy of these procedures and further details.

When Member Coverage Terminates. Member coverage will terminate on the earliest of these dates:

- (1) The date the Plan is terminated.
- (2) The date the covered Member's participating Employer ceases to have a valid participation agreement with the NEA – Alaska Health Plan.
- (3) The last day of the calendar month in which the covered Member ceases to be in one of the eligible classes. This includes death or termination of Active Employment of the covered Member (see the section entitled COBRA Continuation Coverage). It also includes a Member on disability or leave of absence, unless the Plan specifically provides for continuation during these periods.
- (4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

Note: In certain circumstances, a covered Member may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply, and how to select it, see the section entitled COBRA Continuation Coverage.

Continuation During Leave of Absence. If applicable, coverage under this Plan during an approved Leave of Absence will be administered under the formal written plan of the Employer.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor if, in fact, FMLA is applicable to the Employer and all of its Members.

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

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Member and his or her covered Dependents if the Member returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations will not be imposed unless they were in effect for the Member and/or his or her Dependents when Plan coverage terminated.

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

- (1) The maximum period of coverage of a person under such an election shall be the lesser of:
 - (a) The 24-month period beginning on the date on which the person's absence begins; or
 - (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- (2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Member share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Member wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. The Member may also have continuation rights under USERRA. In general, the Member must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Member may elect USERRA continuation coverage for the Member and their Dependents. Only the Member has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates:

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The date that the Member coverage under the Plan terminates for any reason including death (see the section entitled COBRA Continuation Coverage).
- (3) The date a covered Spouse loses coverage due to loss of dependency status.
- (4) On the last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan.

- (5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

Note: In certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply, and how to select it, see the section entitled COBRA Continuation Coverage.

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

MEDICAL BENEFITS

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

Pre- notification of certain services is strongly recommended by the Plan. Pre-notification provides information regarding coverage before the Covered Person receives treatment, services and/or supplies. *A benefit determination on a Claim will be made only after the Claim has been submitted. A pre- notification of services by EBMS/CareLink is not a determination by the plan that claims will be paid. All claims are subject to the provisions of the plan, including but not limited to medical necessity, exclusions and limitations in effect when services are received. See plan provisions for cost management services for additional details. Pre-notification is not required as a condition to paying benefits.*

Please refer to the COORDINATION OF BENEFITS section for additional information regarding benefit payment.

PREFERRED FACILITIES IN ALASKA:

NEA-Alaska Health Plan has negotiated significant fee reductions for covered *inpatient Hospital or outpatient surgical services* at the following Preferred Facilities:

First Choice Network Facilities
Mat-Su Regional Hospital
Licensed Birthing Centers

The Plan does not consider The Alaska Native Medical Center a Preferred Facility regardless of its affiliation with the First Choice Network.

If the Covered Person wishes to use a facility in Alaska that is more than 50 miles from a Preferred Facility (noted above), this facility will be treated as if it were a Preferred Facility for purposes of determining reimbursement. Members are encouraged to use First Choice facilities when more than 50 miles from an above-listed Preferred Facility.

When inpatient Hospital and outpatient surgical services are provided (except as noted in the above paragraph), it is required that the Covered Person use one of the above referenced facilities or the plan reimbursement will be reduced to 60% of the amount the Plan would have paid to such Preferred Facility under any rate reduction agreement between the Plan and the Preferred Facility at the time of service. Further benefit reductions may apply. See the specific benefit below.

FIRST CHOICE HEALTH NETWORK:

NEA-Alaska Health Plan has negotiated significant fee reductions for covered services with **First Choice Health Network** facilities, outpatient surgical facilities, and providers participating in the First Choice Network.

When inpatient Hospital and outpatient surgical services are provided (except as noted in the above section), it is required that the Covered Person use a facility located within the First Choice network or the plan reimbursement will be reduced to 60% of the amount the Plan would have paid to such Preferred Facility under any rate reduction agreement between the Plan and the Preferred Facility at the time of service. Further benefit reductions may apply. See the specific benefit below.

Additional information about this option, as well as a list of current facilities and providers, can be obtained by visiting the First Choice Health Web site at <http://www.fchn.com>

MULTI-PLAN:

NEA-Alaska Health Plan has negotiated significant fee reductions for covered inpatient Hospital and outpatient surgical services at **Multi-Plan** facilities for services outside of Alaska.

When inpatient Hospital or outpatient surgical services are provided outside of Alaska, it is required that the Covered Person use a Multi-Plan facility (**or a facility contracted by NEA – Alaska Health Plan) or the plan reimbursement will be reduced to 60% of the amount the Plan would have paid to such Preferred Facility under any rate reduction agreement between the Plan and the Preferred Facility at the time of service. Further benefit reductions may apply. See specific benefit below.

Additional information about this option, as well as a list of Preferred Facilities, can be obtained by calling (800) 546-3887 or at the Multi-Plan Web site <http://www.multiplan.com>

** The Plan has contracted with certain facilities, known as a Center of Excellence, for negotiated discounts on charges for certain conditions such as cancer, transplants or cardiovascular conditions. A Center of Excellence is a licensed healthcare facility that has entered into a participation agreement with a national transplant network to provide approved transplant services to which the Plan has access. A Covered Person may contact CareLink at (866) 894-1505 to determine whether or not a facility is considered a Center of Excellence.

***** Please see the Transportation Benefit provision for details regarding transportation benefits under this Plan *****

In rare instances, an inpatient Hospital stay (reimbursed on a DRG or per diem PPO rate) can be repriced to exceed the billed amount. The Plan will be responsible for this overage.

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

- If a Covered Person obtains services at a Non-Preferred Facility due to a Medical Emergency, as defined by the Plan, charges will be paid at the Preferred Facility benefit level.
- If a Covered Person obtains services at a Non-Preferred Facility because the Preferred Facility is not accepting new patients or the Preferred Facility cannot provide the level of care required (with sufficient documentation), the charges at the Non-Preferred Facility will be paid at the Preferred Facility benefit level.

Deductibles payable by Plan Participants

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

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

Deductibles, per Calendar Year

Per Covered Person	\$100
Per Family Unit	\$300

Emergency Room Deductible

Per Incident.....	\$75
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Deductible is *waived* if the patient is admitted as an inpatient, if death occurs in the emergency room, if services are received for a Medical Emergency or accidental injury, or if treatment is received within 48 hours after an emergency.

Maximum out-of-pocket payments, per Calendar Year

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

Preferred Facility

Per Covered Person	\$1,000
Per Family Unit	\$3,000

Non-Preferred Facility

Per Covered Person	unlimited
Per Family Unit	unlimited

The Preferred Facility and Non-Preferred Facility Out-of-Pocket maximums do not apply to each other.

The charges for the following do not apply to the 100% benefit limit and are never paid at 100%:

- Deductibles
- Inpatient Hospital copayment
- Non-Preferred Facility Penalty
- Prescription copayments
- Any difference between the private and semi-private room rate when a semi-private room is available

Maximum Benefit Amount

Per Calendar Year, while covered	\$2,000,000
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FOLLOWING ARE OTHER MAXIMUMS ON INDIVIDUAL BENEFITS.

Inpatient Hospital Services –

Room and Board Daily limit	the average semi-private room rate or average private room rate (if no semi-private room is available)
Intensive Care Unit Daily limit	Hospital’s ICU Charge
Preferred Facility Reimbursement rate.....	80% after deductible and \$500 inpatient copayment

Non-Preferred Facility Reimbursement rate:

When inpatient Hospital services are provided in Anchorage, it is required that the Covered Person use one of the above referenced facilities or the plan reimbursement will be reduced to 60% of the amount the Plan would have paid to such Preferred Facility under any rate reduction agreement between the Plan and the Preferred Facility at the time of service. The deductible and \$500 inpatient copayment will also apply.

Only two inpatient copayments will be applied per Covered Person per Calendar Year.

The \$500 inpatient copayment will not apply if a newborn is Hospital confined solely as a result of the child’s birth and the confinement is less than five days.

Emergency Room –

Preferred Facility Reimbursement rate

Medical Emergency.....	80% after deductible
Non-Medical Emergency	80% after deductible and Emergency Room deductible

Non-Preferred Facility Reimbursement rate

Medical Emergency.....	80% after deductible
Non-Medical Emergency	60% after deductible and Emergency Room deductible

Outpatient Surgery Facility Charges–

Preferred Facility Reimbursement rate.....	80% after deductible
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Non-Preferred Facility Reimbursement rate:

When outpatient surgical services are provided in Anchorage, it is required that the Covered Person use one of the above referenced facilities or the plan reimbursement will be reduced to 60% of the amount the Plan would have paid to such Preferred Facility under any rate reduction agreement between the Plan and the Preferred Facility at the time of service. The deductible will also apply.

Outpatient Diagnostic X-ray and Lab Charges–

Reimbursement rate.....	80% after deductible
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Chemotherapy and Radiation Charges–

Reimbursement rate.....	80% after deductible
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Skilled Nursing Facility –

Daily limit.....	the facility’s average semiprivate room rate
Reimbursement rate.....	80% after deductible
Calendar Year maximum.....	90 days

Home Health Care –

Reimbursement rate.....	80% after deductible
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Home Infusion Therapy –

Reimbursement rate.....	80% after deductible
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Physician Services –

***Members are encouraged to use First Choice Providers for additional Plan discounts.**

Inpatient

Reimbursement rate.....	80% after deductible
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Office visit

Reimbursement rate..... 80% after deductible

Surgical services

Reimbursement rate..... 80% after deductible

Second Opinions

Physician recommended:

Reimbursement rate..... 100%, no deductible

Self referral:

Reimbursement rate..... 80% after deductible

Hospice Care –

Reimbursement rate..... 80% after deductible

Ambulance Service –

Reimbursement rate..... 80% after deductible

Temporomandibular Joint (TMJ) and Myofascial Pain Dysfunction (MPD)–

Reimbursement rate..... 80% after deductible

Wig after chemotherapy–

Reimbursement rate..... 80% after deductible

Calendar Year maximum..... \$300

Speech Therapy (See limitations under the Medical Benefits section) –

Reimbursement rate..... 80% after deductible

Occupational Therapy–

Reimbursement rate..... 80% after deductible

Physical Therapy –

Reimbursement rate..... 80% after deductible

Inpatient Rehabilitation Therapy –

Preferred Facility Reimbursement rate..... 80% after deductible and \$500 inpatient copayment

Non-Preferred Facility Reimbursement rate:

When inpatient services are provided in Anchorage, it is required that the Covered Person use one of the above referenced facilities or the plan reimbursement will be reduced to 60% of the amount the Plan would have paid to such Preferred Facility under any rate reduction agreement between the Plan and the Preferred Facility at the time of service. The deductible and \$500 inpatient copayment will also apply.

Calendar Year maximum..... 90 days

Durable Medical Equipment –

Reimbursement rate..... 80% after deductible

Prosthetics–

Reimbursement rate..... 80% after deductible

Orthotics –

Reimbursement rate..... 80% after deductible

Note: Foot orthotics are limited to one (1) pair per Calendar Year.

Mental Disorders Treatment –

Inpatient services

Preferred Facility Reimbursement rate..... 80% after deductible and \$500 inpatient copayment

Non-Preferred Facility Reimbursement rate:

When inpatient Hospital services are provided in Anchorage, it is required that the Covered Person use one of the above referenced facilities or the plan reimbursement will be reduced to 60% of the amount the Plan would have paid to such Preferred Facility under any rate reduction agreement between the Plan and the Preferred Facility at the time of service. The deductible and \$500 inpatient copayment will also apply.

Outpatient visits

Reimbursement rate..... 80% after deductible

Substance Abuse Treatment –

Inpatient services

Preferred Facility Reimbursement rate..... 80% after deductible and \$500 inpatient copayment

Non-Preferred Facility Reimbursement rate:

When inpatient Hospital services are provided in Anchorage, it is required that the Covered Person use one of the above referenced facilities or the plan reimbursement will be reduced to 60% of the amount the Plan would have paid to such Preferred Facility under any rate reduction agreement between the Plan and the Preferred Facility at the time of service. The deductible and \$500 inpatient copayment will also apply.

Outpatient visits

Reimbursement rate..... 80% after deductible

Spinal Manipulation/Chiropractic Services –

Reimbursement rate..... 80% after deductible

Calendar Year maximum..... 20 visits

Massage Therapy –

Reimbursement rate..... 80% after deductible,
\$230 per visit maximum

Acupuncture –

Reimbursement rate..... 80% after deductible

Organ Transplant Coverage Limits –

Covered Transplant Procedures:

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

Preferred Facility Reimbursement rate..... 80% after deductible and \$500 inpatient copayment

Donor and Procurement coverage maximum* \$60,000 per transplant procedure

***Unless otherwise included in a case rate**

Non-Preferred Facility Reimbursement rate:

When inpatient services are provided in Anchorage, it is required that the Covered Person use one of the above referenced facilities or the plan reimbursement will be reduced to 60% of the amount the Plan would have paid to such Preferred Facility under any rate reduction agreement between the Plan and the Preferred Facility at the time of service. The deductible and \$500 inpatient copayment will also apply.

A Preferred Facility under this provision is a Center of Excellence. A Center of Excellence is a licensed healthcare facility that has entered into a participation agreement with a national transplant network to provide approved transplant services to which the Plan has access. A Covered Person may contact CareLink to determine whether or not a facility is considered a Center of Excellence.

Well Newborn Nursery Care Limits–

Preferred Facility Reimbursement rate..... 80% after deductible

Non-Preferred Facility Reimbursement rate:

When inpatient services are provided in Anchorage, it is required that the Covered Person use one of the above referenced facilities or the plan reimbursement will be reduced to 60% of the amount the Plan would have paid to such Preferred Facility under any rate reduction agreement between the Plan and the Preferred Facility at the time of service. The deductible will also apply.

The \$500 inpatient copayment will not apply if the newborn is Hospital confined solely as a result of the child’s birth and the confinement is less than five days.

Preventive Care –

Reimbursement rate..... 100%, no deductible applies

Includes: Routine well care services **will include, but will not be limited to** the following services as recommended by the U.S. Preventive Services Task Force and Health Resources and Services Administration at <http://www.healthcare.gov/center/regulations/prevention/taskforce.html>

Routine physical examination, routine office visit, Pap smear, mammogram, prostate screening, gynecological exam, x-rays, laboratory tests, tobacco cessation counseling, nutrition education, diabetes

education, pediatric hearing, vision and other screenings, immunizations/flu shots, colonoscopy/ sigmoidoscopy, bone density scans.

Audio-Care (Hearing Aid) Benefit–

Reimbursement rate.....	80% after deductible
Maximum Benefit each thirty-six (36) months	\$800

All Other Eligible Charges–

Reimbursement rate.....	80% after deductible
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PRESCRIPTION DRUG BENEFIT

Pharmacy Option – 30 day supply

Copayment, per Prescription

For formulary name brand drugs.....	\$20
For non-formulary name brand drugs.....	\$30
For Generic drugs.....	\$10
For compound drugs.....	\$10

Mail Order Prescription Drug Option – 90 day supply

Copayment, per Prescription

For formulary name brand drugs.....	\$40
For non-formulary name brand drugs.....	\$60
For Generic drugs.....	\$20

Additional Information

- If the Covered Person requests a brand name drug when a generic equivalent is available, the Covered Person will pay the brand name copayment and the difference in cost between the Generic Drug and the brand name drug. If the Physician has prescribed the brand name drug with “Dispense As Written” on the prescription, the Covered Person will pay only the brand name copayment.
- Certain FDA-approved, Physician-prescribed lifestyle drugs not covered by the Plan, may be available at a discount price. To receive this discount, a Member will be required to pay a 100% copayment at the time of purchase when his or her ID card is shown.
- Influenza vaccinations are covered at 100%, no copayment required.

The following will be covered at 100%, no copayment required.

- (1) Physician-prescribed tobacco cessation products. Limited to a 168 day supply per Calendar Year of generic nicotine replacement products (nicotine patch, gum, lozenges) and a 168 day supply per Calendar Year of Physician-prescribed generic medications (Zyban, Chantix).
- (2) Physician-prescribed folic acid for covered female Members or covered Dependent Spouses planning or capable of Pregnancy.
- (3) Physician-prescribed aspirin to prevent cardiovascular disease (CVD) in adult men and women.
- (4) Physician-prescribed iron supplements for asymptomatic covered Dependent children aged 6 to 12 months who are at increased risk for iron deficiency anemia.
- (5) Physician prescribed fluoride supplements for covered Dependent children ages 5 years and under.

For further information please call **EBMS Rx Preferred Prescriptions** at 1-866-894-1504.

DENTAL BENEFITS

Calendar Year deductible, per person	\$50
per Family Unit	\$150

The deductible applies to these Classes of Service:

- Class B Services – Basic
- Class C Services – Major

Dental Percentage Payable – subject to Usual, Customary, and Reasonable Charges (UCR).

Class A Services – Preventive	100%
Class B Services – Basic	80%
Class C Services – Major	50%

Maximum Benefit Amount –

For Class A services, age 18 and under:

Per person per Calendar Year	No maximum
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For Class A services for Covered Persons age 19 and over; and Class B and C services for all Covered Persons:

Per person per Calendar Year	\$2,000
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VISION SERVICE PLAN BENEFITS

NEA – Alaska Health Plan has contracted with Vision Service Plan to provide vision care services for you and your Dependents. An outline of the benefits is provided below.

BENEFITS:	Examination	Once a Calendar Year starting January
	Lenses	Once a Calendar Year starting January
	Frame	Once a Calendar Year starting January

COPAYMENT*:	Examination	\$25.00
<i>*Copayment applies to in and out of network services.</i>	Materials	\$25.00

	Services from a VSP Participating Provider	Services from a Non-Participating Provider
Examination	Paid-in-Full (After copayment)	Up to \$50.00 (After copayment)
Single Vision Lenses	Paid-in-Full (After copayment)	Up to \$50.00 (After copayment)
Bifocal Lenses	Paid-in-Full (After copayment)	Up to \$75.00 (After copayment)
Trifocal Lenses	Paid-in-Full (After copayment)	Up to \$100.00 (After copayment)
Lenticular Lenses	Paid-in-Full (After copayment)	Up to \$125.00 (After copayment)
Frames	Paid-in-Full (Up to \$195)	Up to \$70.00 (After copayment)
Contact Lenses (Instead of spectacle lenses and frame)		
Necessary	Paid-in-Full (After copayment)	Up to \$210.00 (After copayment)
Elective	Up to \$130.00	Up to \$105.00
<i>Second Pair. This enhancement allows Members to receive a second pair of glasses or contacts, subject to the same copayment and frequency as the first pair. There is no examination reimbursement on the second pair.</i>		

THIS IS ONLY A SUMMARY

VISION SERVICE PLAN CUSTOMER SERVICE (800) 877-7195

Web site at <https://www.vsp.com/>

Mailing Address:
Vision Service Plan
P.O. Box 997105
Sacramento CA 95899-7105

Out-of-Network Providers:

If you wish to see an out-of-network provider, VSP will reimburse you up to the amount allowed under your plan's out-of-network provider reimbursement rate. Be aware that your out-of-network provider reimbursement rate does not guarantee full payment, and VSP cannot guarantee patient satisfaction when services are received from an out-of-network provider. Since your plan allows such reimbursements, pay the entire bill when you see the out-of-network provider and gather the following information:

- * The provider's bill, including a detailed list of the services you received
- * The covered Member's ID number
- * The covered Member's name, phone number and address

- * The name of the organization that provides your VSP coverage
- * Your name, date of birth, phone number and address
- * Your relationship to the covered VSP Member (such as “self, spouse, child, etc.”)

Claims must be filed with VSP within six months after seeing the provider.

Please keep a copy of the information for your records and send the originals to:

Out-of-Network Provider Claims
Vision Service Plan
P.O. Box 997100
Sacramento, CA 95899-7100

MEDICAL BENEFIT DESCRIPTIONS

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

DEDUCTIBLE

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

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

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

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

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

BENEFIT PAYMENT

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

OUT-OF-POCKET LIMIT

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

MAXIMUM BENEFIT AMOUNT PER CALENDAR YEAR

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person in a Calendar Year. The Maximum Benefit applies to all Plans and benefit options offered under the NEA Alaska Health Plan for Members and Dependents of all Classes, including the ones described in this document. This amount is a one-sum amount applicable to each individual regardless of the number of NEA Alaska Health Plans that individual may be a Member or Dependent on.

COVERED CHARGES

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

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

Room charges made by a Hospital having only private rooms will be payable at 80% of the average private room rate of that facility, up to the out of pocket maximum, then 100%.

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

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

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

CareLink PRIORITY MATERNITY CARE

Priority Maternity Care is an educational and empowerment program for eligible female Members and Dependent Spouses.

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

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

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

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

The Covered Person will receive \$100 from the NEA-Alaska Health Plan after satisfying all requirements.

There is no coverage of Pregnancy for a Dependent child.

NEA-Alaska Health Plan Lactation Policy

The lactation policy is a means to provide a commercial grade breast pump to eligible female Members and Covered Dependent Spouses and Domestic Partners. ***This benefit is limited to one per Member, per Lifetime.***

Eligible Members should contact the NEA-Alaska Health Plan Office at (907) 274-7526 to receive a Lactation Policy Request Letter. The letter needs to be returned to the NEA-Alaska Health Plan Office. The Plan will then provide the Member with a Certificate of Redemption.

The Certificate of Redemption is to be redeemed the provider listed on the Certificate who will then provide a commercial grade breast pump after identification has been verified.

Any questions regarding the Lactation Policy should be directed to the Plan Administrator.

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

- (a) The patient is confined as a bed patient in the facility;
- (b) The confinement starts within five (5) days of a Hospital confinement of at least fourteen (14) days;

- (c) The attending Physician certifies that the confinement is Medically Necessary; and
- (d) The attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

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

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

- (a) Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:
 - (i) If multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual, Customary, and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual, Customary, and Reasonable Charge will be allowed for each additional procedure performed during the same operative session (with the exception of endoscopy with colonoscopy or multiple mole removals). Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;
 - (ii) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual, Customary, and Reasonable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual, Customary, and Reasonable percentage allowed for that procedure; and
 - (iii) If bilateral surgical procedures are performed by one (1) or more surgeons during the same operative session, benefits will be determined based on 150% of the Usual, Customary, and Reasonable Charge allowed for the procedure unless the actual charge for both sides is less than this amount.
 - (iv) If multiple and bilateral surgical procedures are performed during the same operative session, and both the bilateral and surgical procedures are subjected to multiple procedure reduction; the bilateral adjustment will be applied first per item (iii) above.

The surgical procedure with the highest allowable reimbursement, after the bilateral adjustment, and any other surgical procedures will be reimbursed per items (i) and (ii) above accordingly.
 - (v) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 25% of the surgeon's Usual, Customary, and Reasonable allowance.
- (b) Charges for anesthesia will be a Covered Charge subject to the following provisions:
 - (i) If anesthesia services are performed by one (1) physician, benefits will be determined based on the Usual, Customary, and Reasonable Charge that is allowed for the primary procedure(s).
 - (ii) If additional anesthesia services are performed by one (1) physician and one (1) CRNA with medical direction, benefits will be determined based on 50% of the Usual, Customary, and Reasonable Charge for the physician and 50% of the Usual, Customary, and Reasonable Charge for the CRNA.
 - (iii) If anesthesia services are performed by one (1) CRNA only or no physician services have been received, benefits will be determined based on the Usual, Customary, and

Reasonable charge that is allowed for the primary procedure(s).

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

- (a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.
- (b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

(6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness. The diagnosis, care, and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

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

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

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

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

(8) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

- (a) **Acupuncture.** Charges by a Physician for acupuncture when deemed Medically Necessary, including but not limited to the following conditions:
 - Acupuncture in lieu of other anesthesia for a surgical or dental procedure covered under the medical plan
 - Chronic back pain (maintenance treatment is not covered)
 - Migraine headaches
 - Pain due to osteoarthritis of the knee or hip
 - Postoperative and chemotherapy related nausea and vomiting
 - Postoperative dental pain
 - Pregnancy related nausea
 - Temporomandibular disorders
- (b) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.
- (c) **Anesthetic;** oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
- (d) **Audio Care (Hearing Aid)** Charges by a Physician for any audiometric examination. Audiometric examination means subjective tests by which a Physician determines which make

and model of hearing aid will best compensate for the Covered Person's loss of hearing. A follow-up visit, subsequent to obtaining the hearing aid, will be considered a covered expense.

Benefit includes eligible charges for:

- A hearing aid (monaural or binaural) of an approved function design, including ear molds and initial batteries, cords and other necessary equipment.
- Rental charges for the use of a hearing aid instrument for a period up to but not exceeding 30 days in the event the Covered Person elects to return the hearing aid before actual purchase.

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

- Replacement of a hearing aid for any reason more often than once in a three-year period;
 - Batteries or other ancillary equipment other than that obtained upon purchase of the hearing aid; and
 - Repairs, servicing or alteration of hearing aid equipment.
- (e) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.
- (f) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

Pre-notification of services, by the Plan Participant, for cancer treatment services is strongly recommended. The pre-notification request to EBMS/CareLink must include the Covered Person's plan of care and treatment protocol. Pre-notification of services should occur at least **15 days** prior to the initiation of treatment.

For pre-notification of services, call EBMS/CareLink at the following numbers:

Toll Free in the United States: (800) 777-3575
Local Call in Billings, Montana: (406) 245-3575

A pre-notification of services by EBMS/CareLink is not a determination by the plan that claims will be paid. All claims are subject to the provisions of the plan, including but not limited to medical necessity, exclusions and limitations in effect when charges are incurred. See plan provisions for cost management services for additional details. Pre-notification is not required as a condition to paying benefits.

- (g) Initial **contact lenses** or glasses required following cataract surgery.
- (h) **Contraceptives**, when prescribed by a Physician, including but not limited to intrauterine devices (IUDs), implants, and injections, and any related Physician charges. Contraceptive medications, when prescribed by a Physician, are covered under the Prescription Drug Benefit of this Plan.

- (i) **Durable Medical Equipment.** Rental of durable medical or surgical equipment if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator. Medically Necessary Durable Medical Equipment will be allowed for the first three months; after which, claims will be reviewed for continued Medical Necessity.
- (j) **Home Infusion Therapy.** The Plan will cover home infusion therapy services and supplies when they are Medically Necessary and are required for the administration of home infusion therapy regimen, when ordered by and are part of a formal written plan prescribed by a Physician and provided by an accredited home infusion therapy agency. The benefit will include all Medically Necessary services and supplies including the nursing services associated with patient and/or alternative care giver training, visits to monitor intravenous therapy regimen, emergency care, administration of therapy and the collection, analysis and reporting of the results of laboratory testing services required to monitor response to therapy.
- (k) Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome and Myofascial Pain Dysfunction.**
- (l) **Laboratory studies.**
- (m) **Mammography** (whether performed for an illness or routine).
- (n) **Massage Therapy.** Massage therapy by a Physician or massage therapist. Massage therapists must (1) have the appropriate certification and/or state licensure as required by the state in which the massage therapy services are rendered; (2) must be working under the direction of a Physician; and, (3) must bill his or her services through a Physician's office, when required by state law.

When a Physician's office is not available within 50 miles, a traveling massage therapist meeting the criteria above may provide services even when not provided in the Physician's office; however, documented orders from the referring Physician will be required.

In all cases, massage therapy must be referred or prescribed by a Physician.

Note: Massage therapy services provided by a Doctor of Chiropractic (D.C.) will not accrue toward the Spinal Manipulation/Chiropractic Services Calendar Year maximum.

- (o) Treatment of **Mental Disorders and Substance Abuse.** Covered charges are payable for care, supplies and treatment of Mental Disorders and Substance Abuse.

***Note:** Counseling and other services are also available through the Member Assistance Program, which provides Members and their families with confidential assistance when needing help dealing with problems and managing change.*

Please contact First Choice Health MAP at 1-888-298-2559 (Toll Free). Information can also be found on the NEA Plan Web site at <http://www.neaplan.com/> under "Forms."

- (p) Injury to or care of **mouth, teeth and gums.** Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be covered charges under Medical Benefits only if that care is for the following oral surgical procedures:
 1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
 2. Emergency repair due to Injury to sound natural teeth. This repair must be made within 12 months from the date of an accident.

3. Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
4. Excision of benign bony growths of the jaw and hard palate.
5. External incision and drainage of cellulitis.
6. Incision of sensory sinuses, salivary glands or ducts.
7. Medically Necessary Orthognathic Surgery and associated Hospital or facility charges. Orthognathic surgery is surgery to correct the position of the jaws in relation to each other. *Orthognathic surgery for cosmetic purposes is not covered under the Plan.*

Benefits will be provided for the following Medically Necessary indications:

- a. Masticatory malocclusion (jaw misalignment), as defined by the American Association of Oral and Maxillofacial Surgeons (AAOMS) that results in dysfunction in chewing, swallowing, speech articulation, and/or respiration that has not responded to nonsurgical interventions, and cannot be attributed to causes other than maxillary and/or mandibular skeletal facial deformities.

In addition, the Plan will cover **general anesthesia** when rendered in a Hospital or outpatient surgical facility and associated Hospital or facility charges for dental care when deemed Medically Necessary, when one of the following conditions are met:

- a. The general anesthesia must be administered by an anesthesiologist, a certified registered nurse anesthetist or another licensed health care professional, not the attending dental provider.
- b. The Covered Person's mental or physical condition prohibits the service being done in an office setting. The determination will be based on medical necessity and include at least one of the following:
 - i. A covered Dependent child five years of age or under; or
 - ii. A medical or mental condition that requires monitoring during dental procedures such as, but not limited to:
 1. Coronary disease;
 2. Asthma;
 3. Chronic Obstructive Pulmonary Disease (COPD);
 4. Heart Failure; or
 5. Developmental disability; or
 - iii. When Medically Necessary for complex oral surgical procedures with a greater than average incidence of life threatening complications, such as excessive bleeding or airway obstruction; or
 - iv. When non-dental systemic conditions for which the Covered Person is under current medical management (verified by appropriate medical documentation) and which currently are not in optimal control and, therefore, may increase the risk of serious complications; or
 - v. When there is removal of two or more impacted teeth on the same day; or
 - vi. When there is extraction of five or more teeth on the same day; or

- vii. When there are postoperative complications following outpatient dental/oral surgery.

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

Emergency Palliative Dental Care will be covered subject to the following:

- Emergency “pain management” for dental purposes will be paid under the Medical Benefits of this Plan.
 - Emergency “dental treatment” (extraction, abscess drainage, etc.) will be paid under the Dental Benefits of this Plan.
- (q) **Nutritional counseling and educational services** for individuals with diabetes and asthma.
- (r) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy. Continuation of occupational therapy that may not otherwise be covered under the parameters of this benefit may be allowed in the case of neurological disease or neurological injuries (e.g., Parkinson's disease, cerebral palsy, multiple sclerosis, or cerebral vascular accident/incident).
- (s) **Organ transplant limits.**

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

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

The following are eligible transplants under this benefit:

- Heart
- Heart/double lung
- Single lung
- Double lung
- Liver
- Kidney
- Pancreas with kidney
- Bone marrow
- Stem cell

Organ Procurement Limits

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

Benefits are subject to the limits as stated in the Schedule of Benefits. Donor charges include those for:

- Initial testing/screening of potential organ or tissue donor; subsequent or secondary testing/screening of potential organ or tissue donor; and organ acquisition/procurement of the approved organ or tissue donor;

- Evaluating the organ or tissue;
- Removing the organ or tissue from the donor; and
- Transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

Transplant Travel Expenses

Transplant travel expenses are available if the Covered Person is receiving an organ transplant at a Preferred Facility **and** he or she normally resides more than fifty (50) miles from the transplant facility **up to a maximum amount of \$5,000 per transplant procedure.**

Expenses related to reasonable lodging and meals incurred by the Covered Person receiving the organ transplant and one companion will be paid **up to \$150 per day**, which is subject to the above-referenced maximum of \$5,000 per transplant procedure.

Expenses related to actual travel, including commercial transportation (coach class only) to and from the site of the organ transplant for the Covered Person receiving the transplant and one companion, are also subject to the above-referenced maximum of \$5,000 per transplant procedure.

Boarding passes (if applicable) and receipts for all transplant travel-related expenses for the Covered Person receiving the transplant and one companion must be submitted to the Plan Administrator.

The following will not be eligible for coverage under the transplant benefit of this Plan:

- Cornea transplantation
- Skin grafts
- Artery
- Vein
- Valve
- Transplantation of blood or blood derivatives (except for bone marrow or stem cells)

Coverage, when Medically Necessary, will be provided under the normal medical benefits of this Plan.

- (t) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. Replacement orthotic appliances will not be allowed unless the current appliance is not functional.

Note: Orthotics are not a covered benefit under this Plan, unless deemed Medically Necessary. Foot orthotics are subject to the limits as stated in the Schedule of Benefits.

- (u) **Physical therapy** by a licensed physical therapist. The therapy must be deemed Medically Necessary, non-maintenance care with regard to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy. Continuation of physical therapy that may not otherwise be covered under the parameters of this benefit may be allowed in the case of neurological disease or neurological injuries (e.g., Parkinson's disease, cerebral palsy, multiple sclerosis, or cerebral vascular accident/incident).
- (v) **PKU Dietary Formula.** Dietary formula which is Medically Necessary for the treatment of phenylketonuria (PKU), not to exceed an order for five cases (5) in any calendar month. If more than five (5) cases are required for use in any Calendar month, benefits will be provided for the additional formula once deemed Medically Necessary.

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

This mammoplasty coverage will include reimbursement for:

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

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

- (a1) Charges for **Rehabilitation therapy** up to the limits stated in the Schedule of Benefits. Services must be Medically Necessary to restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an accidental injury, illness, or surgery.
 - (i) Inpatient Care. Services must be furnished in a specialized rehabilitative unit of a Hospital and billed by the Hospital or be furnished and billed by a rehabilitation facility approved by the Plan. This benefit only covers care the Covered Person received within 24 months from the onset of the Injury or Illness or from the date of the surgery that made rehabilitation necessary. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physiatrist (a Physician specializing in rehabilitative medicine).
- (b1) **SAD Lights**. Seasonal Affective Disorder (SAD) lights, when deemed Medically Necessary.
- (c1) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either:
 - (i) Surgery for correction of a congenital condition of the oral cavity, throat or nasal complex of a person;
 - (ii) An Injury; or
 - (iii) A Sickness that is other than a learning or Mental Disorder, with the exception of Autism Spectrum Disorders/Pervasive Developmental Disorders.

Continuation of speech therapy that may not otherwise be covered under the parameters of this benefit may be allowed in the case of neurological disease or neurological injuries (e.g., Parkinson's disease, cerebral palsy, multiple sclerosis, or cerebral vascular accident/incident).

- (d1) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O., or D.C., subject to medical necessity.
- (e1) **Sterilization** procedures.

- (f1) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.
- (g1) **Tobacco cessation counseling.** Care and treatment for tobacco cessation counseling as described in the Schedule of Benefits. *Physician-prescribed tobacco cessation products and medications are covered under the Prescription Drug Benefits of this Plan.*
- (h1) **Transportation.**

Emergency Transportation

This Plan will provide benefits for round trip transportation by commercial airline (coach class only) or ferry from the place where the Illness or Injury occurred to the nearest Hospital where professional treatment can be obtained.

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.

Non-Emergency Transportation

All non-emergency travel must be pre-approved.

Benefits for non-emergency medical travel may be payable for transportation by commercial airline (coach class only, with at least a 14-day advanced fare pre-approved) or ferry from the place where the illness or injury occurred to the nearest hospital where professional treatment can be obtained. ***All non-emergency travel must be pre-approved by the Plan Administrator using the “NEA Alaska Health Plan Non-Emergency Medical Travel Request Form” or no benefits will be provided.*** After the travel has occurred, an “NEA Alaska Health Plan Non-Emergency Medical Travel Completed Form,” must be submitted with the boarding passes and signed off by the attending Physician or no benefits will be provided.

Transportation benefits in any one Calendar Year will be limited to two (2) round trips per Calendar Year.

The *NEA Alaska Health Plan Non-Emergency Medical Travel Request Form* and the *NEA Alaska Health Plan Non-Emergency Medical Travel Completed Form* are available from your Plan Administrator or at <http://www.neaplan.com>

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

Transportation benefits apply only to the conditions covered under this Plan. They do not apply to dental care benefits, unless approved by the Plan Administrator. Transportation benefits for any foreign medical or dental care will not be covered, including Canadian medical or dental care. Transportation benefits will not be given for diagnostic or second opinion diagnosis unless diagnostic services cannot be provided locally and are deemed Medically Necessary by the Plan Administrator.

If the patient is a child under 18 years of age, the transportation charges of a parent or Legal Guardian accompanying the child will be allowed.

If the patient is over age 18 and has a permanent mental or physical disability which requires the assistance of a caretaker during travel, the transportation charges of a parent, Legal Guardian, or assigned caretaker accompanying the patient will be allowed.

- (i1) Coverage of **Well Newborn Nursery/Physician Care.**

Charges for Routine Nursery Care. Routine well newborn nursery care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

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

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

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

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

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

- (j1) Charges associated with the initial purchase of a **wig after chemotherapy**. Benefits are subject to the limits as stated in the Schedule of Benefits.
- (k1) Diagnostic **x-rays**.

COST MANAGEMENT SERVICES

COORDINATED CARE

Coordinated Care is a program designed to assist Covered Persons in understanding and becoming involved with their diagnosis and medical plan of care, and advocates patient involvement in choosing a medical plan of care. Coordinated Care begins with the pre-authorization process.

Pre- notification of certain services is strongly recommended by the Plan. Pre- notification provides information regarding coverage before the Covered Person receives treatment, services and/or supplies. *A benefit determination on a Claim will be made only after the Claim has been submitted. A pre- notification of services by CareLink is not a determination by the Plan that a Claim will be paid. All Claims are subject to the terms and conditions, limitations and exclusions of the Plan at the time services are received. See plan provisions for cost management services for additional details. Pre- notification is not required as a condition to paying benefits.*

Examples of when the Physician and Covered Person should contact CareLink prior to treatment include:

- Inpatient admissions to a Hospital
- Inpatient admissions to free-standing chemical dependency, mental health, and rehabilitation facilities
- Cancer treatment programs, administered on an inpatient or outpatient basis
- Inpatient or outpatient surgeries relating to, but not limited to, hysterectomies, back surgery, or bariatric surgery.

These procedures apply to the Plan's pre-notification of services for treatments reviewed under the Plan's Coordinated Care program. Please note that pre-notification determinations provide information about coverage before the Covered Person receives treatment, services, and/or supplies and are not considered a Claim for benefits. All Claims are subject to the terms and conditions, limitations and exclusions of the Plan at the time the services are received.

The Physician or Covered Person should notify CareLink at least fifteen (15) days before services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Member
- The name, Member identification number and address of the Covered Person
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Hospital, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The plan of care, treatment protocol and/or informed consent, if applicable

If there is an emergency admission to the Hospital, the Covered Person, Covered Person's family member, Hospital or attending Physician should notify CareLink within two (2) business days after the admission.

Hospital Observation Room stays in excess of 23 hours are considered an admission for purposes of this program, therefore CareLink should be notified.

A CareLink nurse will contact the Covered Person to provide health education, pre-surgical counseling, inpatient care coordination, facilitation of discharge plan and post-discharge follow-up.

Contact the Coordinated Care administrator at:

CareLink (406) 245-3575 or (866) 894-1505

Monday through Thursday, 7:00 a.m. to 7:00 p.m. (Mountain Time)

Friday, 7:00 a.m. to 5:00 p.m. (Mountain Time)

PRE-NOTIFICATION DETERMINATION AND REVIEW PROCESS

The Claims Administrator, on the Plan's behalf, will review the submitted information and make a determination on a pre-notification request within fifteen **(15) days** of receipt of the pre-notification request and all supporting documentation. If additional records are necessary to process the pre-notification request, the Claims Administrator will notify the Covered Person or the Physician. The time for making a determination on the request will be tolled from the date that the additional information is requested until the date that the information is received.

The Physician and Covered Person will be provided notice of the Plan's determination. In the case of an adverse pre-notification determination, written notice will provide the reason for the adverse pre-notification determination.

The Plan offers a one-level review procedure for adverse pre-notification determinations. The request for reconsideration must be submitted in writing within thirty **(30) days** of the receipt of the adverse pre-notification determination and include a statement as to why the Covered Person disagrees with the adverse pre-notification determination. The Covered Person may include any additional documentation, medical records, and/or letters from the Covered Person's treating Physician(s). The request for reconsideration should be addressed to:

NEA-Alaska Health Plan
Attn: Claims Appeals
4003 Iowa Drive
Anchorage, Alaska
(907) 274-7526

The Plan Administrator or its designee will perform the reconsideration review. The Plan Administrator or its designee will review the information initially received and any additional information provided by the Covered Person, and determine if the pre-notification determination was appropriate. If the adverse pre-notification determination was based upon the medical necessity, the Experimental/ Investigational nature of the treatment, service or supply or an equivalent exclusion, the Plan may consult with a health care professional who has the appropriate training and experience in the applicable field of medicine. Written or electronic notice of the determination upon reconsideration will be provided within thirty **(30) days** of the receipt of the request for reconsideration.

CASE MANAGEMENT

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

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

- Individualized support to the patient
- Contacting the family to offer assistance for coordination of medical care needs
- Monitoring response to treatment
- Determining alternative care options
- Assisting in obtaining any necessary equipment and services

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

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources.

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

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

TELEPHONE CONSULTATION

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

CareLink PRIORITY MATERNITY CARE

Priority Maternity Care is an educational and empowerment program for eligible female Members and Dependent Spouses.

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

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

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

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

The Covered Person will receive \$100 from the NEA-Alaska Health Plan after satisfying all requirements.

DEFINED TERMS

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

Active Employment/Actively Employed means that a Member is on the regular payroll of the Employer and has begun to perform the duties of his or her job with the Employer as described in the Collective Bargaining Agreement or the Policy and Procedures Manual/Personnel Policy of the participating Employer.

Accident means a sudden and unforeseen event definite to a time and a place. This includes trauma happening involuntarily or as a result of a voluntary act entailing unforeseen consequences.

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

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

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

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

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

A **Center of Excellence** is a licensed healthcare facility that has entered into a participation agreement with a national transplant network to provide approved transplant services to which the Plan has access. A Covered Person may contact CareLink to determine whether or not a facility is considered a Center of Excellence.

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

Collective Bargaining Agreement means an exclusive agreement between the Member association (labor organization) and the Employer which outlines the contract duration, wages/salaries, working rules and conditions, rights and privileges and other conditions which are agreed to through the collective bargaining process.

Cosmetic Dentistry means dentally unnecessary procedures.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is a Member or Dependent who has met the Eligibility requirements and who is properly enrolled and covered under this Plan.

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

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

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, if applicable, the period between the trade related coverage loss and the start of special second COBRA election period under the Trade Act, does not count.

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

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

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

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee-Employer relationship.

Employer is Anchorage School District.

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

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

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

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

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

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.

Please note: Routine patient care costs for services received during the course of a clinical trial, which are the usual costs for medical care, such as doctor visits, Hospital stays, clinical laboratory tests and x-rays that a Covered Person would receive whether or not he or she were participating in a clinical trial, will not be considered Experimental or Investigational. Coverage will also be provided for the diagnosis or treatment of complications; drugs or devices approved by the FDA without regard to whether the FDA-approved the drug or device for use in treating a patient's particular condition, including the services necessary to administer a drug or device under evaluation in the clinical trial. Transportation for the patient that is primarily for and essential to the medical care will also be provided. Please refer to the Transportation benefit under the Medical Benefits section of this Plan for additional information.

Routine patient care costs **do not** include extra care, treatment, services and supplies that the Covered Person may need as part of a clinical trial protocol including but not limited to extra lab and x-ray tests (e.g., monthly CT scan for a condition usually requiring only a single scan.), any drug or device associated with the trial that has not been approved by the FDA, research doctor and nurse time, data collection and analysis of results, or clinical tests performed purely for research purposes. Routine care costs also do not include any expenses associated with a Phase I, II, or III clinical trial that should be funded by the clinical trial sponsor, pharmaceutical company, or some other source (other than the plan member and/or the Plan).

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

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

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolite, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

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

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

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain that in the absence of immediate medical attention would result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

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

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

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

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

Member is an Employee who is covered by a Collective Bargaining Agreement negotiated by an affiliate of NEA – Alaska.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of *International Classification of Diseases*, published by the U.S. Department of Health and Human Services or is listed in the current edition of *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association.

Morbid Obesity is a serious disease associated with a high incidence of medical complications and a significantly shortened life span. The current clinical standard measure for Morbid Obesity is a Body Mass Index (BMI) of 40+.

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

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

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

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist, Acupuncturist (L.Ac.), Naturopath (N.D.), Christian Science Practitioner authorized by the Mother Church of Christ, First Church of Christ Scientist, in Boston Massachusetts, and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means NEA – Alaska Health Plan, which is a benefits plan for certain Members of the Anchorage Education Association and is described in this document.

Plan Participant is any Member or Dependent who is covered under this Plan.

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

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

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

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

Policy and Procedures Manual/Personnel Policy is an Employer's documented processes and specific steps used to influence the course of action in determining decisions, actions and other matters related to conducting the business transactions and communications of the Employer.

Sickness is:

For a covered Member and covered Spouse: Illness, disease or Pregnancy.

For a covered Dependent other than Spouse: Illness or disease, not including Pregnancy or its complications.

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

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24-hour nursing services by licensed nurses, under the direction of a full-time registered nurse (R.N.).
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.
- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally handicapped, Custodial or educational care or care of Mental Disorders.
- (7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation Hospital, long-term acute care facility or any other similar nomenclature.

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

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

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Total Disability (Totally Disabled) means that due to Sickness or Injury:

- You lose the ability to safely and completely perform two (2) activities of daily living without another person's assistance or verbal cueing; or
- You have a deterioration or loss in intellectual capacity and need another person's assistance or verbal cueing for your protection or for the protection of others.

Cognitively impaired means you have a deterioration or loss in intellectual capacity resulting from Injury, Sickness, advanced age, Alzheimer's disease or similar forms of irreversible dementia and need another person's assistance or verbal cueing for your own protection or for the protection of others.

Activities of daily living mean:

- Bathing - The ability to wash yourself either in the tub or shower or by sponge bath with or without equipment or adaptive devices.
- Dressing - The ability to put on and take off all garments and medically necessary braces or artificial limbs usually worn.
- Toileting - The ability to get to and from and on and off the toilet, to maintain a reasonable level of personal hygiene, and to care for clothing.
- Transferring -The ability to move in and out of a chair or bed with or without equipment such as canes, quad canes, walkers, crutches or grab bars or other support devices including mechanical or motorized devices.
- Continence - Voluntarily controlling bowel and bladder function; or in the event of incontinence, maintaining a reasonable level of personal hygiene.
- Eating - Getting nourishment into your body by any means once it has been prepared and made available to you.

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

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

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

PLAN EXCLUSIONS

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

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

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

- (1) **Audio Care/Hearing Aids.** Care, services, or treatment for audio care/hearing aids, except as specifically stated as a benefit of this Plan.
- (2) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan.
- (3) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care, except as specifically stated as a benefit of this Plan.
- (4) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual, Customary, and Reasonable Charge.
- (5) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
- (6) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.
- (7) **Eye care.** Radial keratotomy or other eye surgery to correct near-sightedness. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting, except as specifically stated in the Schedule of Benefits. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.
- (8) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services, except for those Covered Persons within close proximity and who regularly utilize Canadian medical, vision and dental providers. Such treatment must be a covered benefit under this Plan, be documented with a paid receipt, and be submitted to the Plan Administrator with the following information in writing:
 - Name of Plan
 - Member name and ID number
 - Name of patient
 - Name, address, telephone number of the provider of care
 - Diagnosis
 - Type of services rendered, with diagnosis and/or procedure codes
 - Date of services
 - Charges

Prescription drugs purchased outside of the U.S. will not be eligible for reimbursement under this Plan except when purchased as a result of medical treatment due to a Medical Emergency or urgent care.

- (9) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
- (10) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy.

- (11) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- (12) **Illegal acts** Charges for services received as a result of an Illness or Injury occurring directly, or indirectly as a result of a serious criminal act, or a riot or public disturbance, or regardless of causation, if such Illness or Injury occurs in connection with, or while engaged in, or attempting to engage in, a serious criminal act, or a riot or public disturbance. For the purposes of this exclusion, the term "serious criminal act" shall mean any act or series of acts by the Plan Participant, or by the Plan Participant in concert with another or others, for which, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. For this exclusion to apply, it is not necessary that criminal charges be filed, or if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed. 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.

Charges for services, supplies, care or treatment to a Plan Participant for an Injury or Illness which occurred as a result of that Plan Participant operating a motor vehicle while under the influence of alcohol or drugs (illegal drugs and/or prescription drugs) or a combination thereof or operating a motor vehicle with a blood or breath alcohol content (BAC) above the legal limit. The arresting officer's determination of inebriation will be sufficient for this exclusion. It is not necessary for this exclusion to apply that criminal charges be filed, or if filed, that a conviction result. Expenses will be covered for injured Plan Participants other than the person operating the vehicle while under the influence or a BAC above the legal limit, and expenses may be covered for chemical dependency treatment as specified in this Plan. 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.

- (13) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence, except for treatment of erectile dysfunction following prostate surgery.
- (14) **Infertility.** Care and treatment for infertility, artificial insemination or in vitro fertilization.
- (15) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (16) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- (17) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (18) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
- (19) **Not specified as covered.** Services, treatments and supplies which are not specified as covered under this Plan.
- (20) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness, except as specifically stated as a benefit of this Plan. Medically Necessary charges for Morbid Obesity will be covered.
- (21) **Occupational Injury.** Care and treatment of an Injury or Sickness that is occupational – that is, arises from work for wage or profit and for which the Plan Participant is eligible to receive benefits under any Workers' Compensation or occupational disease law. This exclusion will apply if the Plan Participant was eligible to receive such benefits and failed to properly file a claim for such benefits or to comply with any other provision of the law to obtain such benefits.

- (22) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.
- (23) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.
- (24) **Pregnancy of daughter.** Care and treatment of Pregnancy and Complications of Pregnancy for a Dependent daughter only.
- (25) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
- (26) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. 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.
- (27) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
- (28) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
- (29) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.
- (30) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except as specifically stated as a benefit of this Plan.
- (31) **War.** Any charge that is due to a declared or undeclared act of war or caused during service in the armed forces of any country.

PRESCRIPTION DRUG BENEFITS

The Coordination of Benefits Provisions will not apply to prescriptions purchased at a participating Pharmacy for Covered Persons who are double covered under two NEA – Alaska Health Plans.

If this Plan is secondary to any plan that is not associated with the NEA – Alaska Health Plan, this Plan will pay the balance minus the NEA – Alaska Health Plan Prescription drug copayment. The total reimbursement will never be more than the amount that would have been paid if the secondary plan had been the primary plan. The balance due, if any is the responsibility of the Covered Person.

PHARMACY DRUG CHARGE

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. **EBMS Rx Preferred Prescriptions** is the administrator of the Pharmacy drug plan.

COPAYMENT

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

At select participating pharmacies, the Covered Person will be able to obtain a 90-day supply, per prescription, at the same copayment level as the mail order benefit (as shown in the Schedule of Benefits). For additional information or a current list of these select participating pharmacies, please contact the Claims Administrator or access the following Web site at www.ebms.com.

If a drug is purchased from a non-participating Pharmacy, or a participating Pharmacy when the Covered Person's ID card is not used, the Covered Person must pay the entire cost of the drug at the Pharmacy, will not receive a discount and will have to submit the receipt to the Claims Administrator for processing. The prescriptions will be processed at 100%, less any copayment listed in the Schedule of Benefits.

MAIL ORDER DRUG BENEFIT OPTION

Note: Some quantity limitations and/or prior authorizations may apply.

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

COPAYMENT

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

COVERED PRESCRIPTION DRUGS

Note: Some quantity limitations and/or prior authorizations may apply.

Certain FDA-approved, Physician-prescribed lifestyle drugs may be available at a discount price. To receive this discount, a Covered Person will be required to pay a 100% copayment at the time of purchase when his or her ID card is shown.

- (1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This does not include any drugs not covered under this Plan.

- (2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- (3) Insulin when prescribed by a Physician.
- (4) Contraceptives, when prescribed by a Physician, including but not limited to orals, transdermals, devices, and injectables. Contraceptive benefits for intrauterine devices (IUDs) and implants, when prescribed by a Physician, are covered under the Medical Benefit of this Plan.
- (5) Injectable drugs.
- (6) Diabetic supplies including insulin syringes/needles, glucose sticks, urine tablets, lancets, and test strips.
- (7) Renova, Retin A and Accutane.
- (8) Fluoride supplements.
- (9) Influenza vaccinations.

The following will be covered at 100%, no copayment required.

- (1) Physician-prescribed tobacco cessation products. Limited to a 168 day supply per Calendar Year of Physician-prescribed generic nicotine replacement products (nicotine patch, gum, lozenges) and a 168 day supply per Calendar Year of Physician-prescribed generic medications (Zyban, Chantix).
- (2) Physician-prescribed folic acid for covered female Employees or covered Dependent Spouses planning or capable of Pregnancy.
- (3) Physician-prescribed aspirin to prevent cardiovascular disease (CVD) in adult men and women.
- (4) Physician-prescribed iron supplements for asymptomatic covered Dependent children aged 6 to 12 months who are at increased risk for iron deficiency anemia.
- (5) Physician-prescribed fluoride supplements for covered Dependent children ages 5 years and under.

LIMITS TO THIS BENEFIT

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

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

EXCLUSIONS

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

- (1) **Administration.** Any charge for the administration of a covered Prescription Drug.
- (2) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- (3) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, blood glucose monitoring machines, insulin pumps and supplies, artificial appliances, braces, support garments, or any similar device. *These may be considered Covered Charges under the Medical Benefits section of this Plan.*

- (4) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.
- (5) **FDA.** Any drug not approved by the Food and Drug Administration.
- (6) **Growth hormones.**
- (7) **Immunization.** Immunization agents or biological sera, except as specifically stated as a benefit of this Plan.
- (8) **Impotence.** A charge for impotence medication, except as specifically stated as a benefit of this Plan.

In certain circumstances Physician-prescribed medication for impotence may not be covered under the Prescription Drug Benefit; however, a Covered Person may receive a discount at a Participating Pharmacy when his or her ID card is shown.

- (9) **Infertility.** A charge for infertility medication.

In certain circumstances Physician-prescribed medication for infertility may not be covered under the Prescription Drug Benefit; however, a Covered Person may receive a discount at a Participating Pharmacy when his or her ID card is shown.

- (10) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".
- (11) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.
- (12) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
- (13) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
- (14) **Obesity drugs,** except as specifically stated as a benefit of this Plan.

In certain circumstances Physician-prescribed medication for obesity may not be covered under the Prescription Drug Benefit; however, a Covered Person may receive a discount at a Participating Pharmacy when his or her ID card is shown.

- (15) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.
- (16) **Rogaine** (or similar drug) for topical application.

Although Physician-prescribed medication for Rogaine (or similar drug) may not be covered under the Prescription Drug Benefit; a Covered Person may receive a discount at a Participating Pharmacy when his or her ID card is shown.

- (17) **Vitamins,** except for pre-natal vitamins.

DENTAL BENEFITS

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

***** Please see the Transportation Benefit provision for details regarding transportation benefits under this Plan *****

DEDUCTIBLE

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

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

BENEFIT PAYMENT

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

MAXIMUM BENEFIT AMOUNT

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

DENTAL CHARGES

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

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

Extension of coverage. Services received or ordered when this Plan isn't in effect or when a member is not covered under the Plan (including services and supplies started before the effective date or after the date coverage ends) are not covered, with the exception for Major services and root canals that:

- Were started after your effective date and before the date coverage ended under this Plan; and
- Were completed within 30 days after the date coverage ended under this Plan.

The following are deemed service start dates:

- For root canals, it is the date the canal is opened.
- For inlays, onlays, laboratory-processed labial veneers, crowns, and bridges, it is the preparation date.
- For partial and complete dentures, it is the impression date.

The following are deemed service completion dates:

- For root canals, it is the date the canal is filled.
- For inlays, onlays, laboratory-processed labial veneers, crowns, and bridges, it is the seat date.
- For partial and complete dentures, it is the seat or delivery date.

COVERED DENTAL SERVICES

Class A Services: Preventive and Diagnostic Dental Procedures

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

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

Class B Services: Basic Dental Procedures

- (1) Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts.
- (2) Periodontics (gum treatments).
- (3) Endodontics (root canals).
- (4) Extractions. This service includes local anesthesia and routine post-operative care.
- (5) Repair and recementing bridges, crowns or inlays.
- (6) Fillings, other than gold.
- (7) General anesthetics or IV sedation when an oral surgeon performs a tooth extraction or upon demonstration of Medical Necessity.
- (8) Antibiotic drugs.

Class C Services: Major Dental Procedures

- (1) Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.
- (2) Installation of crowns.
- (3) Installing precision attachments for removable dentures.

- (4) Installing partial, full or removable dentures to replace one or more natural teeth. This service also includes all adjustments made during a six-month period following the installation.
- (5) Addition of clasp or rest to existing partial removable dentures.
- (6) Initial installation of fixed bridgework to replace one or more natural teeth.
- (7) Rebasing or relining of removable dentures.
- (8) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if one of these tests is met:
 - (a) The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.
 - (b) The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed.
- (9) Implants. Charges for implants, including any appliances and/or crowns and the surgical insertion or removal of implants.
- (10) Occlusal Guards

EXCLUSIONS

A charge for the following is not covered:

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

VISION BENEFITS

BENEFITS AND COVERAGES

Through its Member Doctors, VSP provides Plan Benefits to Covered Persons as may be Visually Necessary or Appropriate, subject to the limitations, exclusions, and Copayment(s) described herein. When you wish to obtain Plan Benefits from a Member Doctor, you should contact the Member Doctor of your choice, identify yourself as a VSP member, and schedule an appointment. If you are eligible for Plan Benefits, VSP will provide Benefit Authorization for you directly to the Member Doctor prior to your appointment.

Benefit payment for a Covered Person will be made as described in the Schedule of Benefits.

1. Eye Examination: A complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.
2. Lenses: The Member Doctor will order the proper lenses necessary for your visual welfare. The doctor shall verify the accuracy of the finished lenses.
3. Frames: The Member Doctor will assist in the selection of frames, properly fit and adjust the frames, and provide subsequent adjustments to frames to maintain comfort and efficiency.
4. Contact lenses: Unless otherwise indicated, contact lenses are available under this Plan in lieu of all other lens and frame benefits described herein for the current eligibility period.

Necessary contact lenses, together with professional services, will be provided as indicated.

When Elective contact lenses are obtained from a Member Doctor, VSP will provide an allowance toward the cost of professional fees and materials. A 15% discount shall also be applied to the Member Doctor's usual and customary professional fees for contact lens evaluation and fitting. Contact lens materials are provided at the Member Doctor's usual and customary charges.

1. If you elect to receive vision care services from a Member Doctor, Plan Benefits are provided subject only to your payment of any applicable Copayment. If your Plan includes Non-Member Provider coverage, and you choose to obtain Plan Benefits from a Non-Member Provider, you should pay the Non-Member Provider his/her full fee. VSP will reimburse you in accordance with the reimbursement schedule, less any applicable Copayment. **THERE IS NO ASSURANCE THAT THE SCHEDULE WILL BE SUFFICIENT TO PAY FOR THE EXAMINATION OR THE MATERIALS.** Availability of services under the Non-Member Provider reimbursement schedule is subject to the same time limits and Copayments as those described for Member Doctor services. Services obtained from a Non-Member Provider are in lieu of obtaining services from a Member Doctor and count toward plan benefit frequencies.
2. Low Vision Services and Materials (applicable only if included in your Plan Benefits): The Low Vision Benefit provides special aid for people who have acuity or visual field loss that cannot be corrected with regular lenses. If a Covered Person falls within this category, he or she will be entitled to professional services as well as ophthalmic materials, including but not limited to, supplemental testing, evaluations, visual training, low vision prescription services, plus optical and non-optical aids, subject to the frequency and benefit limitations. Consult your Member Doctor for details.

COPAYMENT

The benefits described herein are available to you subject only to your payment of any applicable Copayment(s) as described in this booklet. **ANY ADDITIONAL CARE, SERVICE AND/OR MATERIALS NOT COVERED BY THIS PLAN MAY BE ARRANGED BETWEEN YOU AND THE DOCTOR.**

EXCLUSIONS AND LIMITATIONS OF BENEFITS

This vision service Plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following options, the Plan will pay the basic cost of the allowed lenses, and you will be responsible for the options extra cost, unless it is defined as a Plan Benefit in the Schedule of Benefits attached as Exhibit A to the Group Plan maintained by your Group Administrator.

- Optional cosmetic processes.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

NOT COVERED

There is no benefit for professional services or materials connected with:

1. Orthoptics or vision training and any associated supplemental testing; plano lenses (less than $\pm .50$ diopter power); or two pair of glasses in lieu of bifocals.
2. Replacement of lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available.
3. Medical or surgical treatment of the eyes.
4. Corrective vision treatment of an Experimental Nature.
5. Costs for services and/or materials above Plan Benefit allowances.
6. Services/materials not indicated as covered Plan Benefits.

HOW TO SUBMIT MEDICAL CLAIMS

When services are received from a health care provider, a Plan Participant should show his or her **EBMS/NEA Alaska Health Plan** Identification card to the provider. Participating Providers may submit claims on a Plan Participant's behalf.

If it is necessary for a Plan Participant to submit a claim, he or she should request an itemized bill **which includes procedure (CPT) and diagnostic (ICD-9) codes** from his or her health care provider.

To assist the Claims Administrator in processing the claim, the following information must be provided when submitting the claim for processing:

- A copy of the itemized bill
- Group name and number (**NEA Alaska Health Plan** Group 0000350)
- Provider Billing Identification Number
- Member's name and Identification Number
- Name of patient
- Name, address, telephone number of the provider of care
- Date of service(s)
- Place of service
- Amount billed

Note: If the claim is the result of an accident, a Plan Participant can obtain an accident claim form from the Plan Administrator or the Claims Administrator. Claim forms are also available at <http://www.ebms.com>.

HOW TO SUBMIT PHARMACY CLAIMS

When obtaining a prescription, a Plan Participant should show his or her **EBMS/NEA Alaska Health Plan** Identification card to the pharmacist. Participating Pharmacies may submit claims on a Plan Participant's behalf.

If the pharmacy provider is unable to submit the claim, the Plan Participant should request a receipt.

To assist the Claims Administrator in processing a claim, the following information must be provided when submitting the claim for processing:

- A copy of the receipt
- Group name and number (**NEA Alaska Health Plan** Group 0000350)
- Member's name and Identification Number
- Provider Billing Identification Number
- Name of patient
- The prescribing Physician
- The prescription name
- An itemization for each separate prescription
- The date of purchase

WHERE TO SUBMIT CLAIMS

Employee Benefit Management Services, Inc., is the Claims Administrator. Claims for expenses should be submitted to the Claims Administrator at the address below:

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

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 365 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date will be declined.

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

Please refer to the COORDINATION OF BENEFITS section for additional information regarding timely filing of claims.

INTERNAL AND EXTERNAL CLAIMS REVIEW PROCEDURES

A **Claim** means a request for a Plan benefit, made by a Claimant (Plan Participant or by an authorized representative of a Plan Participant that complies with the Plan's reasonable procedures for filing benefit Claims). A Claim does not include an inquiry on a Claimant's eligibility for benefits, or a request by a Claimant or his Physician for a pre-notification of benefits on a medical treatment. Pre-notification of certain services is strongly recommended, but not required by the Plan. A pre-notification of services by CareLink is not a determination by the Plan that a Claim will be paid. A benefit determination on a Claim will be made only after the Claim has been submitted. A pre-notification is not required as a condition precedent to paying benefits, and cannot be appealed. Please refer to the Cost Management Services Section.

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

There are two types of claims.

Concurrent Care Determination

A Concurrent Care Determination is a reduction or termination of a previously approved course of treatment that is to be provided over a period of time or for a previously approved number of treatments. *If Case Management is appropriate for a Plan participant, Case Management is not considered a Concurrent Care Determination. Please refer to the Cost Management Services Section.*

Post-Service Claim

A Post-Service Claim is a Claim for medical care, treatment, or services that a Claimant has already received.

All questions regarding Claims should be directed to the Claims Administrator. All Claims will be considered for payment according to the Plan's terms and conditions, limitations and exclusions, and industry standard guidelines in effect at the time charges were incurred. The Plan may, when appropriate or when required by law, consult with relevant health care professionals and access professional industry resources in making decisions about Claims involving specialized medical knowledge or judgment.

A Claim will not be deemed submitted until it is received by the Claims Administrator.

Initial Benefit Determination

The initial benefit determination on a Claim will be made within 30 days of the Claim Administrator's receipt of the Claim (or 15 days if the Claim is a Concurrent Care Determination). If additional information is necessary to process the Claim, the Claims Administrator will make a written request to the Claimant for the additional information within this initial period. The Claimant must submit the requested information within 45 days of receipt of the request from the Claims Administrator. **Failure to submit the requested information within the 45-day period may result in a denial of the Claim or a reduction in benefits.** If additional information is requested, the Plan's time period for making a determination is suspended until such time as the Claimant provides the information, or the end of the 45 day period, whichever occurs earlier. A benefit determination on the Claim will be made within 15 days of the Plan's receipt of the additional information.

Notice of Adverse Benefit Determination

If a Claim is denied in whole or in part, the Plan shall provide written or electronic notice of the determination that will include the following:

- (1) Information to identify the claim involved.
- (2) Specific reason(s) for the denial, including the denial code and its meaning.
- (3) Reference to the specific Plan provisions on which the denial was based.
- (4) Description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is necessary.
- (5) Description of the Plan's Internal Appeal Procedures and External Review Procedure and the applicable time limits. This will include a statement of the Claimant's right to bring a civil action once Claimant has exhausted all available internal and external review procedures.
- (6) Statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

If applicable:

- (7) Any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the determination on the Claim.
- (8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational exclusion or similar such exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claim.
- (9) Identification of medical or vocational experts, whose advice was obtained on behalf of the Plan in connection with a Claim.

If the Claimant has questions about the denial, the Claimant may contact the Claims Administrator at the address or telephone number printed on the Notice of Determination.

An Adverse Benefit Determination also includes a rescission of coverage, which is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation. A rescission of coverage does not include a cancellation or discontinuance of coverage that takes effect prospectively, or is a retroactive cancellation or discontinuance because of the Plan participant's failure to timely pay required premiums.

Claims Review Procedure - General

A Claimant may appeal an Adverse Benefit Determination. The Plan offers a two-level internal review procedure and an external review procedure to provide the Claimant with a full and fair review of the Adverse Benefit Determination.

The Plan will provide for a review that does not give deference to the previous Adverse Benefit Determination and that is conducted by an individual who is neither the individual who made the determination on a prior level of review, nor a subordinate of that individual. Additionally, if an External Review is requested, that review will be conducted by an Independent Review Organization that was not involved in any of the prior determinations. In addition, the Plan Administrator may:

- Take into account all comments, documents, records and other information submitted by the Claimant related to the claim, without regard as to whether this information was submitted or considered in a prior level of review.
- Provide to the Claimant, free of charge, any new or additional information or rationale considered, relied upon or created by the Plan in connection with the Claim. This information or new rationale will be provided sufficiently in advance of the response deadline for the final Adverse Benefit Determination so that the Claimant has a reasonable amount of time to respond.
- Consult with an independent health care professional who has the appropriate training and experience in the applicable field of medicine related to the Claimant's Adverse Benefit Determination if that determination was based in whole or in part on medical judgment, including determinations on whether a treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary. A health care professional is "independent" to the extent the health care professional was not consulted on a prior level of review or is a subordinate of a health care professional who was consulted on a prior level of review. The Plan may consult with vocational or other experts regarding the Initial Benefit Determination.

Internal Appeal Procedure

First Level of Internal Review

The written request for review must be submitted within 180 days of the Claimant's receipt of a Notice of the Initial Benefit Determination (or 15 days for an appeal of a Concurrent Care Determination). The Claimant should include in the appeal letter: his or her name, ID number, group health plan name, and a statement of why the Claimant disagrees with the Adverse Benefit Determination. The Claimant may include any additional supporting information, even if not initially submitted with the Claim. The appeal should be addressed to:

Plan Administrator
% Employee Benefit Management Services, Inc. (EBMS)
P.O. Box 21367
Billings, Montana 59104
Attn: Claims Appeals

An appeal will not be deemed submitted until it is received by the Plan Administrator. The Claimant cannot proceed to the next level of internal or external review if the Claimant fails to submit a timely appeal.

The first level of review will be performed by the Claims Administrator on the Plan's behalf. The Claims Administrator will review the information initially received and any additional information provided by the Claimant, and determine if the Initial Benefit Determination was appropriate based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic Notice of Determination to the Claimant within 30 days of the receipt of the appeal (or 15 days for an appeal of a Concurrent Care Determination). The Notice of Determination shall meet the requirements as stated above.

Second Level of Internal Review

If the Claimant does not agree with the Claims Administrator's determination from the first Level of Internal Review, the Claimant may submit a second level appeal in writing within 60 days of the Claimant's receipt of the Notice of Determination from the First Level of Internal Review (or 15 days for an appeal of a Concurrent Care Determination), along with any additional supporting information to:

NEA-Alaska Health Plan
Attn: Claims Appeals
4003 Iowa Drive
Anchorage, Alaska 99517
(907) 274-7526

An appeal will not be deemed submitted until it is received by the Plan Administrator or the Claims Administrator on the Plan Administrator's behalf. The Claimant cannot proceed to an external review or file suit if the Claimant fails to submit a timely appeal.

The Second Level of Internal Review will be done by the Plan Administrator. The Plan Administrator will review the information initially received and any additional information provided by the Claimant, and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Plan Administrator will send a written or electronic Notice of Determination for the second level of review to the Claimant within 30 days of receipt of the appeal (or 15 days for an appeal of a Concurrent Care Determination). The Notice of Determination shall meet the requirements as stated above.

If the Claimant is not satisfied with the outcome of the final determination on the Second Level of Internal Review, the Claimant may request an External Review. The claimant must exhaust both levels of the Internal Review Procedure before requesting an External Review, unless the Plan Administrator did not comply fully with the Plan's Internal Review Procedure for the first level of review. In certain circumstances, the Claimant may also request an expedited External Review.

External Review Procedure

This Plan has an External Review Procedure that provides for a review conducted by a qualified Independent Review Organization (IRO) that shall be assigned on a random basis.

A Claimant may, by written request made to the Plan within 4 months from the date of receipt of the notice of the final internal adverse benefit determination or the 1st of the fifth month following receipt of such notice, whichever occurs later, request a review by an IRO of a final Adverse Benefit Determination of a Claim, except where such request is limited by applicable law.

For an Adverse Benefit Determination to be eligible for external review, the Claimant must complete the required forms to process an External Review. The Claimant may contact the Claims Administrator for additional information.

The Claimant will be notified in writing within 6 business days as to whether Claimant's request is eligible for external review and if additional information is necessary to process Claimant's request. If Claimant's request is determined ineligible for external review, notice will include the reasons for ineligibility and contact information for the appropriate oversight agency. If additional information is required to process Claimant's request, Claimant may submit the additional information within the four month filing period, or 48 hours, whichever occurs later.

Claimant should receive written notice from the assigned IRO of Claimant's right to submit additional information to the IRO and the time periods and procedures to submit this additional information. The IRO will make a final determination and provide written notice to the Claimant and the Plan no later than 45 days from the date the IRO receives Claimant's request for External Review. The notice from the IRO should contain a discussion of its reason(s) and rationale for the decision, including any applicable evidence-based standards used, and references to evidence or documentation considered in reaching its decision.

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

COORDINATION OF BENEFITS

Coordination of the benefit plans. The Plan's Coordination of Benefits provision sets forth rules for the order of payment of Covered Charges when two or more plans – including Medicare – are paying. The Plan has adopted the order of benefits as set forth in the National Association of Insurance Commissioners (NAIC) Model COB Regulations, as amended. When a Member is covered by this Plan and another plan, or the Member's Spouse is covered by this Plan and by another plan, or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges. If this Plan is secondary and there is a direct contract in place between the participating provider and the NEA – Alaska Health Plan, this Plan, as secondary, shall pay the balance due under the applicable terms of that agreement.

In the case of Prescription Drug copayments, if this Plan is secondary to any plan that is not associated with the NEA – Alaska Health Plan, this Plan will pay the balance minus the NEA – Alaska Health Plan Prescription drug copayment. The total reimbursement will never be more than the amount that would have been paid if the secondary plan had been the primary plan. The balance due, if any is the responsibility of the Covered Person.

If this Plan is secondary to any plan that is not associated with the NEA – Alaska Health Plan, any applicable preferred facility direction will not apply and no benefit reduction will be imposed. If this Plan is secondary to any other plan, timely filing of claims will be extended to 18 months from the date of service.

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

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs. This includes but is not limited to Medicare and Tricare.
- (5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (6) Any automobile insurance, including but not limited to, No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.
- (7) Any third-party liability insurance, including but not limited to, homeowners liability insurance, umbrella insurance and premises liability insurance, whether individual or commercial, or on an insured, uninsured, under-insured or self-insured basis.

If the Covered Person, or someone on behalf of the Covered Person, has received any compensation and/or benefits from any third-party source, this compensation and/or benefits shall be primary and shall be coordinated with the benefits that they may be eligible to receive through this Plan before they may receive any benefits from this Plan.

Allowable Charge(s). For a charge to be allowable it must be a Usual, Customary, and Reasonable Charge and at least part of it must be covered under this Plan.

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

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

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

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

- (A) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (B) Plans with a coordination provision will pay their benefits up to the Allowable Charge.

The first rule that describes which plan is primary is the rule that applies:

- (1) The benefits of the plan which covers the person directly (that is, as a Member, Retiree, or subscriber) ("Plan A") are determined before those of the plan which covers the person as a Dependent ("Plan B").

For Qualified Beneficiaries, coordination is determined based on the person's status prior to the Qualifying Event.

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

- (2) Unless there is a court decree stating otherwise, when a child is covered as a Dependent by more than one plan the order of benefits is determined as follows:

When a child is covered as a Dependent and the parents are married or living together, these rules will apply:

- The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
- If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.
- When a child's parents are divorced, legally separated or not living together, whether or not they have ever been married, these rules will apply: A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent. This rule applies beginning the first of the month after the plan is given notice of the court decree.
- A court decree may state both parents will be responsible for the Dependent child's health care expenses. In this case, the plans covering the child shall follow order of benefit determination rules outlined above when the parents are married or living together (as detailed above);
- If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the

child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are married or living together.

If there is no court decree allocating responsibility for the Dependent child's health care expenses, the order of benefits are as follows:

- 1st The plan covering the custodial parent,
- 2nd The plan covering the spouse of the custodial parent,
- 3rd The plan covering the non-custodial parent, and
- 4th The plan covering the spouse of the non-custodial parent.

- (3) The benefits of a benefit plan which covers a person as a Member who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Member. The benefits of a benefit plan which covers a person as a Dependent of a Member who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Member. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
 - (4) The benefits of a benefit plan which covers a person as a Member who is neither laid off nor retired or a Dependent of a Member who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary. This rule does not apply if rule #1 can be used to determine the order of benefits.
 - (5) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.
- (C) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.
- (D) The Plan will pay primary to Tricare to the extent required by federal law.

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

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

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

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

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

Exception to Medicaid. The Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

Coordination With Medicare. Medicare Part A, Part B and Part D will be considered a plan for the purposes of coordination of benefits. This Plan will coordinate benefits with Medicare whether or not the Covered Person is actually receiving Medicare Benefits. This means that the plan will only pay the amount that Medicare would not have covered, even if the Covered Person does not elect to be covered under Medicare. Also, failure to enroll in Medicare Part B or Part D when a person is initially eligible may result in the person being assessed a significant surcharge by Medicare for late enrollment in Part B or Part D.

(A) For Working Aged

A covered Member who is eligible for Medicare Part A or Part B as a result of age may be covered under this Plan and be covered under Medicare, in which case this Plan will pay primary.

A covered Dependent Spouse, eligible for Medicare Part A or Part B as a result of age, of a covered Member may also be covered under this Plan and be covered under Medicare, in which case the Plan again will pay primary.

(B) For Covered Persons who are Disabled

The Plan is primary and Medicare will be secondary for the covered Member and his/her covered Dependent Spouse or child who is eligible for Medicare by reason of disability, if the Member is actively employed by the Participating Employer.

(C) For Covered Persons with End Stage Renal Disease (ESRD)

Except as stated below* for Members and their Dependents, if Medicare eligibility is due solely to End Stage Renal Disease (ESRD), this Plan will be primary only during the first thirty (30) months of Medicare coverage. Thereafter, this Plan will be secondary with respect to Medicare coverage, unless after the thirty-month period described above:

- A. The Covered Person has no dialysis for a period of twelve (12) consecutive months and then resumes dialysis, at which time the Plan will again become primary for a period of thirty (30) months; or
- B. The Covered Person undergoes a kidney transplant, at which time the Plan will again become primary for a period of thirty (30) months.

*If a Covered Person is covered by Medicare as a result of disability, and Medicare is primary for that reason on the date the Covered Person becomes eligible for Medicare as a result of ESRD, Medicare will continue to be primary and the Plan will be secondary.

THIRD PARTY RECOVERY

By enrollment in the Plan, a Covered Person agrees to the provisions of this Section as a condition precedent to receiving benefits under this Plan. If the Covered Person fails to comply with the requirements of this Section, the Plan may reduce or deny benefits otherwise available under the Plan.

Defined Terms

"Covered Person" means anyone covered under the Plan, including but not limited to minor dependents and deceased Covered Persons. Covered Person shall include the parents, trustee, guardian, heir, personal representative or other representative of a Covered Person, regardless of applicable law and whether or not such representative has access or control of the Recovery.

"Recover," "Recovered," "Recovery" means all monies recovered by way of judgment, settlement, reimbursement, or otherwise to compensate for any loss related to any Injury, Sickness, condition, and/or accident where a Third Party is or may be responsible. "Recovery" includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, wages and/or any other recovery of any form of damages or compensation whatsoever.

"Subrogation" means the Plan's right to exercise the Covered Person's rights to Recover or pursue Recovery from a Third Party who is liable to the Covered Person for expenses for which the Plan has paid or may agree to pay benefits.

"Third Party" means any third party including but not limited to another person, any business entity, insurance policy or any other policy or plan, including but not limited to uninsured or underinsured coverage, self-insured coverage, no-fault coverage, automobile coverage, premises liability (homeowners or business), umbrella policy.

Right to Reimbursement

This provision applies when the Covered Person incurs medical or dental expenses due to an Injury, Sickness, condition, and/or accident which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against a Third Party for payment of such expenses. To the extent the Plan paid benefits on the Covered Person's behalf, the Covered Person agrees that the Plan has an equitable lien on any Recovery whether or not such Recovery(s) is designated as payment for such expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person, and/or anyone on his or her behalf, agrees to hold in trust for the benefit of the Plan, that portion of any Recovery received or that may be received from a Third Party and to which the Plan is entitled for reimbursement of benefits paid by the Plan on the Covered Person's behalf. The Covered Person shall promptly reimburse the Plan out of such Recovery, in first priority for the full amount of the Plan's lien. The Covered Person will reimburse the Plan first, even if the Covered Person has not been fully compensated or "made whole" and/or the Recovery is called something other than a Recovery for healthcare, medical and/or dental expenses

The Plan shall only be responsible for its proportionate share of attorney fees associated with pursuing a claim against a Third Party. All other reductions in the Plan's equitable lien must be agreed upon in writing by the Plan Administrator or subject to the terms of a court order.

Right to Subrogation

This provision applies when the Covered Person incurs medical or dental expenses due to an Injury, Sickness, condition, and/or accident which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against a Third Party for payment of such expenses.

The Covered Person agrees that the Plan is subrogated to any and all claims, causes of action or rights that the Covered Person may have now or in the future against a Third Party who has or may have caused, contributed aggravated, and or be responsible for the Covered Person's Injury, Sickness, condition, and/or accident to the extent the Plan has paid benefits or has agreed to pay benefits. The Covered Person further agrees that the Plan is subrogated

to any and all claims or rights that the Covered Person may have against any Recovery, including the Covered Person's rights under the Plan to bring an action to clarify his rights under the Plan. The Plan may assert this Right of Subrogation independently of the Covered Person. The Plan is not obligated to pursue this right independently or on behalf of the Covered Person, but may choose to exercise this right, in its sole discretion.

Provisions Applicable to Both the Right to Reimbursement and Right to Subrogation

The Covered Person automatically assigns to the Plan any and all rights he or she has or may have against any Third Party to the full extent of the Plan's equitable lien. The Covered Person agrees to:

1. Cooperate fully with the Plan and its agents, regarding the Plan's rights under this section;
2. Advise the Plan of any right or potential right to reimbursement and/or subrogation on the Plan's behalf;
3. Provide to the Plan in a timely manner any and all facts, documents, papers, information or other data reasonably related to the Covered Person's Injury, Sickness, condition, and/or accident, including any efforts by another individual to Recover on the Covered Person's behalf;
4. Execute all assignments, liens, or other documents that the Plan or its agents may request to protect the Plan's rights under this section;
5. Obtain the Plan's consent before releasing a Third Party from liability for payment of expenses related to the Covered Person's Injury, Sickness, condition, and/or accident;
6. Hold in trust that portion of any Recovery received by the Covered Person or on the Covered Person's behalf equal to the Plan's equitable lien until such time as the Plan is repaid in full;
7. Agree not to impair, impede or prejudice in any way, the rights of the Plan under this section; and
8. Do whatever else the Plan deems reasonably necessary to secure the Plan's rights under this section.

The Plan may take one or more of the following actions to enforce its rights under this section:

1. The Plan may require the Covered Person as a condition of paying benefits for the Covered Person's Injury, Sickness, condition, or accident, to execute documentation acknowledging the Plan's rights under this section;
2. The Plan may withhold payment of benefits to the extent of any Recovery received by or on behalf of a Covered Person;
3. The Plan may, to the extent of any benefits paid by the Plan, exercise its Right of Reimbursement against any Recovery received, or that will be received, by or on behalf of Covered Person; or
4. The Plan may, to the extent of any benefits paid by the Plan, exercise its Right of Subrogation directly against a Third Party who is or may be responsible.

The Plan Administrator is vested with full discretionary authority to interpret and apply the provisions of this section. In addition, the Plan Administrator is vested with the discretionary authority to waive or compromise any of the Plan's rights under this section. Any decision of the Plan Administrator made in good faith will be final and binding. The Plan Administrator is authorized to adopt such procedure as deemed necessary and appropriate to administrate the Plan's rights under this section.

Right to Recover Benefits Paid in Error

The Plan has the right to recover any benefits the Plan paid in error to the Covered Person or on behalf of a Covered Person to which the Covered Person is not entitled, for services which were not covered under the Plan, or for benefits paid in excess of the Plan's allowable charges. The Plan may recover benefits paid in error from the Covered Person, the provider who received a payment from the Plan on the Covered Person's behalf, or from any person who may have benefited. The Plan may also offset any future benefits otherwise payable to or on the Covered Person's behalf, or from any other Covered Person enrolled through the same covered Member.

COBRA CONTINUATION COVERAGE

Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”). COBRA Continuation Coverage can become available to you when you otherwise would lose your group health coverage. It also can become available to other members of your family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the Covered Member (or former Member), Qualified Beneficiary, or any representative acting on behalf thereof. Coverage will end in certain instances, including, but not limited to, if you or your Dependents fail to make timely payment of premiums. You should check with your Employer to see if COBRA applies to you and your Dependents.

What is COBRA Continuation Coverage?

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

What is a Qualifying Event?

Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a “Qualified Beneficiary.” You, your Spouse or Domestic Partner, and your Dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event.

Domestic Partners and Children of a covered Member’s Domestic Partner, who otherwise satisfy the Eligibility requirements set forth in the Eligibility provision and are covered under this Plan, will also be offered the opportunity to make an independent election to receive COBRA Continuation Coverage. All references to Spouse will also be applicable to a Domestic Partner, unless otherwise indicated.

If you are a Covered Member (meaning that you are a Member and are covered under the Plan), you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

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

If you are the Spouse of a Covered Member, you will become a Qualified Beneficiary if you lose your coverage under the Plan due to one of the following Qualifying Events:

- Your Spouse dies;
- Your Spouse’s hours of employment are reduced;
- Your Spouse’s employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both);
- You become divorced or legally separated from your Spouse; or
- In certain circumstances, you are no longer eligible for coverage under the Plan.

Note: Medicare entitlement means that you are eligible for and enrolled in Medicare.

Your Dependent children will become Qualified Beneficiaries if they lose coverage under the Plan due to one of the following Qualifying Events:

- The parent-covered Member dies;
- The parent-covered Member’s hours of employment are reduced;
- The parent-covered Member’s employment ends for any reason other than his or her gross misconduct;

- The parent-covered Member becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage under the plan as a “Dependent child.”

If this Plan provides retiree health coverage, sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any retired Member covered under the Plan, the retired Member will become a Qualified Beneficiary with respect to the bankruptcy. The retired Member’s Spouse, surviving Spouse, and Dependent children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Employer must give notice of some Qualifying Events

When the Qualifying Event is the end of employment, reduction of hours of employment, death of the Covered Member, commencement of proceeding in bankruptcy with respect to the Employer, or the Covered Member’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.

You must give notice of some Qualifying Events

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

1. Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Member (or former Member) from his or her Spouse;
2. Notice of the occurrence of a Qualifying Event that is an individual’s ceasing to be eligible as a Dependent child under the terms of the Plan;
3. Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;
4. Notice that a Qualified Beneficiary entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration (“SSA”) to be disabled at any time during the first 60 days of Continuation Coverage; and
5. Notice that a Qualified Beneficiary, with respect to whom a notice described in (4) above has been provided, has subsequently been determined by the SSA to no longer be disabled.

The Plan Administrator is:

Plan Administrator
 NEA – Alaska Health Plan
 4003 Iowa Drive
 Anchorage, AK 99517
 (907) 274-7526

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

Deadline for providing the notice

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

- The date on which the relevant Qualifying Event occurs;

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

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

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

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

For a change in disability status described in (5) above, the notice must be furnished by the date that is 30 days after the later of:

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

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

Who can provide the notice?

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

Required contents of the notice

The notice must contain the following information:

- Name and address of the covered Member or former Member;
- If you already are receiving COBRA Continuation Coverage and wish to extend the maximum coverage period, identification of the initial Qualifying Event and its date of occurrence;
- A description of the Qualifying Event (for example, divorce, legal separation, cessation of Dependent status, entitlement to Medicare by the covered Member or former Member, death of the covered Member or former Member, disability of a Qualified Beneficiary or loss of disability status);
- In the case of a Qualifying Event that is divorce or legal separation, name(s) and address(es) of Spouse and Dependent child(ren) covered under the Plan, date of divorce or legal separation, and a copy of the decree of divorce legal separation;

- In the case of a Qualifying Event that is Medicare entitlement of the covered Member or former Member (or in certain circumstances, the Spouse), date of entitlement, and name(s) and address(es) of Spouse and Dependent child(ren) covered under the Plan;
- In the case of a Qualifying Event that is a Dependent child's cessation of Dependent status under the Plan, name and address of the child, reason the child ceased to be an eligible Dependent (for example, attained limiting age);
- In the case of a Qualifying Event that is the death of the covered Member or former Member, the date of death, and name(s) and address(es) of Spouse and Dependent child(ren) covered under the Plan;
- In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's Notice of Award letter;
- In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
- A certification that the information is true and correct, a signature and date.

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

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

Electing COBRA Continuation Coverage

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

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Members may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

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

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage will be available up to the maximum time period shown below. Generally, multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event. However, if, pursuant to the Plan, the first Qualifying Event is the covered Member's entitlement to Medicare benefits, followed by termination or reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than the covered Member ends on the later of (i) 36 months after the date the covered Member became entitled to Medicare benefits, and (ii) 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

If, pursuant to the Plan, the Qualifying Event is the death of the covered Member (or former Member), the Covered Member's (or former Member's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA Continuation Coverage lasts for up to a total of 36 months.

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

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

Disability extension of 18-month period of COBRA Continuation Coverage

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

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage

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

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?

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

- The date your Employer ceases to provide a group health plan to any Employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first), except as stated under COBRA's special bankruptcy rules. However, a Qualified Beneficiary who becomes covered under a group health plan which has a pre-existing condition limit must be allowed to continue COBRA Continuation Coverage for the length of a pre-existing condition or to the COBRA maximum time period, if less;
- The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension; or
- On the same basis that the Plan can terminate for cause the coverage of a similarly situated non-COBRA participant.

Payment for COBRA Continuation Coverage

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

This Plan shall be in compliance with the American Recovery and Reinvestment Act of 2009 (ARRA), in effect as of the first period of COBRA Continuation Coverage starting on or after February 17, 2009, and as amended from time to time. ARRA may reduce the COBRA premium in some cases. You may qualify for a premium reduction. This premium reduction may only continue for a limited time and you may be subject to certain eligibility restrictions and obligations. You should consult either the Plan Administrator or the COBRA Administrator if you have questions or if you believe you are eligible for a premium reduction.

The Trade Act of 2002, as amended by ARRA, may affect the benefits received under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a tax credit for premiums paid for certain types of health insurance, including COBRA premiums. Second, eligible individuals under the Trade Act who do not elect COBRA Continuation Coverage within the election period will be allowed an additional 60-day period to elect COBRA Continuation Coverage. If the Qualified Beneficiary elects COBRA Continuation Coverage during this second election period, the coverage period will run from the beginning date of the second election period. If you elect a tax credit under the Trade Act, you will not be eligible for other Federal COBRA premium subsidies which may be available. You should consult the Plan Administrator if you believe the Trade Act applies to you.

Additional Information

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

Plan Administrator
NEA – Alaska Health Plan
Plan Administrator
4003 Iowa Drive
Anchorage, AK 99517
(907) 274-7526

Employee Benefit Management Services, Inc.
COBRA Administrator
P.O. Box 21367
Billings, MT 59104
406-245-3575 or 800-777-3575

For more information about your rights under COBRA and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or visit the EBSA website at www.dol.gov/ebsa.

Current Addresses

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

RESPONSIBILITIES FOR PLAN ADMINISTRATION

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

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

Service of legal process may be made upon the Plan Administrator

DUTIES OF THE PLAN ADMINISTRATOR.

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes which may arise relative to a Plan Participant's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Administrator to pay claims.
- (7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

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

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

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

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

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

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

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

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

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

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

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

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

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION COMPLIANCE WITH HIPAA

The Plan shall comply with the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and its implementing regulations restrict the Plan Sponsor’s ability to use and disclose protected health information (“PHI”). The Plan shall not use or further disclose PHI other than as permitted by the Plan documents or as required by applicable law.

- (1) Protected Health Information. Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a Participant; the provision of health care to a Participant; or the past, present, or future payment for the provision of health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant. Protected health information includes information of persons living or deceased.
- (2) Privacy Official. The Plan Manager will be the Privacy Official for the Plan, responsible for the development and implementation of policies and procedures relating to the use and disclosure of PHI. The Privacy Official will also serve as the contact person for Participants and other Covered Persons who have questions, concerns, or complaints about uses and disclosures of their PHI

Access to PHI is Limited to Certain Employees.

The use and disclosure of PHI shall be limited to the minimum necessary extent to perform a particular Plan function.

- (1) Non-Plan Personnel Have No Access to PHI. No other Members of the Plan Sponsor’s workforce beyond personnel employed to administer the Plan shall be deemed to have a job-related need for access to PHI created or maintained by the Plan.
- (2) Plan Personnel Access is the Minimum Necessary. Based on job duties, the size and nature of the Plan’s operations and workforce, each Member of the Plan’s workforce shall be entitled to access any and all PHI created or maintained by the Plan. PHI may include payment, claims administration, enrollment and

eligibility information, which each Member of the Plan's workforce may be called upon to access, interpret, use for Plan operations, and disclose in accordance with the Plan's written privacy policy. The Members of the Plan's workforce designated as entitled to access PHI created or maintained by the Plan include to following job titles:

- (a) **Plan Administrator**
- (b) **Chief Financial Officer**
- (c) **Trust Claims Analyst**
- (d) **Administrative Assistant**

These designated Employees with access may use and disclose PHI for Plan administrative functions, and they may disclose PHI to other Employees with access for Plan administrative functions. Employees designated as having access to PHI may not disclose PHI to other Plan Sponsor Employees without access unless an appropriate authorization is in place or the disclosure otherwise is in compliance with the Plan's policies and procedures and applicable law.

Permitted Uses and Disclosures for Payment and Plan Operations. PHI may be disclosed for the Plan's own payment purposes, and PHI may be disclosed to other covered entities for the payment purposes of that covered entity. PHI may be disclosed for purposes of the Plan's own operation, and PHI may be disclosed to another covered entity for purposes of the other covered entity's quality assessment and improvement, case management, or health care fraud and abuse detection programs, provided that the other covered entity has (or had) a relationship with the Participant and the PHI requested pertains to that relationship.

- (1) **Payment.** Payment includes activities undertaken to obtain Plan contributions or to determine or fulfill the Plan's responsibility for provisions of benefits under the Plan, or to obtain or provide reimbursement for health care. Payment may include other Plan administrative functions, including but not limited to: (i) eligibility and coverage determinations including coordination of benefits and adjudication or subrogation of health benefit claims; (ii) risk adjusting based on enrollee status and demographic characteristics; and (iii) billing, claims, management, collection activities, obtaining payment under a contract for reinsurance and related health care data processing.
- (2) **Operations.** Plan operations may include any of the following activities to the extent that they are related to Plan administration: (i) conducting quality assessment and improvement activities; (ii) reviewing Plan performance; (iii) underwriting and premium rating; (iv) conducting or arranging for medical review, legal services and auditing functions; (v) business planning and development; and (vi) business management and general administrative activities.

PHI May Not Be Used Or Disclosed Other Than for Plan Administrative Purposes. PHI may not be used or disclosed for the payment or operations of the Plan Sponsor's non-Plan benefits (e.g., sick leave, disability, workers' compensation, life insurance, etc.), or for other non-Plan employment purposes (e.g., administration of the Plan Sponsor's duties under the Americans with Disabilities Act, Family Medical Leave Act, etc.), unless the Participant has provided an appropriate authorization for such use or disclosure, or as required by applicable law.

Mandatory Disclosures of PHI. A Participant's PHI must be disclosed to the individual who is the subject of the information; and to the Department of Health and Human Services ("DHHS") for purposes of enforcing of HIPAA. The Plan shall also make its internal practices and records relating to the use and disclosure of PHI created or maintained by the Plan available to DHHS upon request.

Permissive Disclosures of PHI. PHI may be disclosed in the following situations without a Participant's authorization, when specific conditions exist: (i) reporting about victims of abuse, neglect or domestic violence; (ii) for judicial and administrative proceedings; (iii) for law enforcement purposes; (iv) for public health activities; (v) for health oversight activities; (vi) reporting about decedents; (vii) for cadaveric organ, eye or tissue donation purposes; (viii) for certain limited research purposes; (ix) to avert a serious threat to health or safety; (x) for specialized government functions; and (xi) to comply with state workers' compensation programs.

Disclosures of PHI Pursuant to an Authorization. PHI may be disclosed for any purpose if a written authorization is provided by the Participant that satisfies HIPAA's requirements for authorizations, as determined by the Privacy Official. All uses and disclosures made pursuant to an executed authorization must be consistent with the terms and conditions of the authorization.

Use and Disclosure of PHI Must Be The Minimum-Necessary. When PHI is used or disclosed by the Plan, the amount disclosed or used generally must be limited to the minimum necessary to accomplish the purpose of the use or disclosure, except where the use or disclosure is: (i) made to the individual; (ii) made pursuant to a valid authorization; (iii) made to DHHS; or (iv) is required by applicable law.

Disclosures of PHI to Business Associates. Plan Employees described in above may disclose PHI to the Plan's Business Associates and allow the Plan's Business Associates to create or receive PHI on its behalf.

- (1) Business Associate. A Business Associate is an entity that (i) performs or assists in performing a Plan function or activity involving the use and disclosure of protected health information (including claims processing or administration, data analysis, underwriting, etc.); or (ii) provides legal, accounting, actuarial, consulting, data aggregation, management, accreditation, or financial services, where the performance of such services involves giving the service provider access to PHI.
- (2) Contractual Assurances. Prior to disclosing PHI to a Business Associate, the Plan shall obtain written assurances from the Business Associate that it shall comply with the same restrictions and conditions that apply to the Plan and Plan Sponsor as regards the use or disclosure of PHI.

Access and Requests for Amendment to PHI. Participants and other Covered Persons shall have the right to access and obtain copies of their PHI that the Plan (or its Business Associates) maintains. Participants shall have the right to request that their PHI maintained by the Plan (or its Business Associates) be amended if such PHI is inaccurate or incomplete. The Plan will provide access to PHI and it will consider requests for amendment as provided in its policies and procedures regarding such uses and disclosures, and in accordance with applicable law.

Accounting for PHI. Participants and other Covered Persons shall have the right to obtain an accounting of certain disclosures of their PHI that the Plan (or its Business Associates) maintains. This right to an accounting extends to disclosures made in the last six years, other than disclosures: (i) to carry out treatment, payment or health care operations; (ii) to individuals about their own PHI; (iii) incident to an otherwise permitted use or disclosure; (iv) pursuant to an authorization; (v) for purposes of creation of a facility directory or to persons involved in the patient's care or other notification purposes; (vi) as part of a limited data set; or (vii) for other national security or law enforcement purposes. The Plan will provide accountings as provided in its policies and procedures regarding such uses and disclosures, and in accordance with applicable law.

Impermissible Use or Disclosure. The Plan Sponsor shall report to the Privacy Official any use or disclosure of PHI that is inconsistent with this Article Sixteen. The Privacy Official shall receive, investigate and to the extent reasonable mitigate any issues of non-compliance with the Plan's provisions regarding the use or disclosure of PHI. Plan Employees described above who fail to comply with the Plan's provisions regarding the use or disclosure of PHI may be subject to discipline under the Plan Sponsor's employment policies.

Certification of Compliance and Destruction or Return of PHI Received By Plan Sponsor. The Plan Sponsor agrees to the restrictions on the use and disclosure of PHI as provided in this Article Sixteen and applicable law. Should the Plan Sponsor receive PHI pursuant to a valid authorization or as otherwise permitted under applicable law, the Plan Sponsor shall arrange for the destruction or return of such PHI to the Plan, to the greatest extent feasible, when such information is no longer needed for the purpose for which disclosure was made. If the return or destruction of the PHI is not feasible, the Plan Sponsor shall limit further uses and disclosures of such PHI to those purposes that make the return or destruction of the information infeasible.

**STANDARDS FOR SECURITY OF ELECTRONIC PROTECTED
HEALTH INFORMATION (THE “PRIVACY STANDARDS”)
ISSUED PURSUANT TO
THE HEALTH INSURANCE PORTABILITY AND
ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA)**

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

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

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

AMENDING AND TERMINATING THE PLAN

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

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

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

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

PLAN NAME

NEA – Alaska Health Plan

PLAN NUMBER: 502

TAX ID NUMBER: 92-6027877

PLAN EFFECTIVE DATE: July 1, 1996

PLAN YEAR ENDS: June 30

EMPLOYER INFORMATION

Anchorage School District

PLAN ADMINISTRATOR

Plan Administrator
NEA – Alaska Health Plan
4003 Iowa Drive
Anchorage, Alaska 99517
(907) 274-7526

NAMED FIDUCIARY

Plan Administrator
NEA – Alaska Health Plan
4003 Iowa Drive
Anchorage, Alaska 99517
(907) 274-7526

AGENT FOR SERVICE OF LEGAL PROCESS

Plan Administrator
NEA – Alaska Health Plan
4003 Iowa Drive
Anchorage, Alaska 99517
(907) 274-7526

CLAIMS ADMINISTRATOR

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

TRUSTEES

Barb Angaiak
4003 Iowa Drive
Anchorage, Alaska 99517

Ron Fuhrer
4003 Iowa Drive
Anchorage, Alaska 99517

Kathy Bell
4003 Iowa Drive
Anchorage, Alaska 99517

Stephen Byers
4003 Iowa Drive
Anchorage, Alaska 99517

Keri Clark
4003 Iowa Drive
Anchorage, Alaska 99517

Lynn Kracke
4003 Iowa Drive
Anchorage, Alaska 99517

Mike Scott
4003 Iowa Drive
Anchorage, Alaska 99517

Plan Name: NEA – Anchorage Education Association

Restated: July 1, 2011

I, Lydia Garcia, certify that I am the Plan Administrator
Name Title

for the above named Health Plan, and further certify that I am authorized to sign this Plan Document/Summary Plan Description. I have read and agree with the above referenced Plan Document and am hereby authorizing its implementation as of the effective date stated above.

Signature:  _____

Date: 5-17-11 _____