Plan Booklet

July 2019

ASEA/AFSCME Local 52
Health Benefits Trust

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PLAN CONTACTS

Health Trust Administrator:	Zenith American Solutions (509) 328-0300 (866) 553-8206 www.aseahealth.org "Contact Us"
Prescription Benefits Manager: (Including Prior Authorization of Prescriptions)	Caremark (866) 818-6911 www.caremark.com Mail Order: PO Box 94467 Palatine, IL 60094-4467 Paper Claims: PO Box 52136 Phoenix, AZ 85072-2136
Precertification, Utilization Review and Case Management Provider:	Aetna Provider customer service - (888) 632-3862
Vision Program:	VSP (800) 877-7195 www.vsp.com
Employee Assistance Program:	Lifeworks (877) 234-5151 www.lifeworks.com User ID: asea Initial password: eap
Disease Management:	Optum (855) 738-1768 https://asea.optum.com/mve
Telemedicine:	Teladoc 800-teladoc (835-2362) www.teladoc.com
Surgical Travel Benefit:	BridgeHealth (844) 249-8108 www.bridgehealth.com

Preferred Provider Facilities in Anchorage:	Alaska Regional Hospital 2801 DeBarr Road Anchorage, AK 99508 (907) 276-1131 www.alaskaregional.com Surgery Center of Anchorage 4001 Laurel St. Anchorage, AK 99508 (907) 563-1800 https://surgerycenterofanchorage.com Geneva Woods Birth Centers 2400 E. 42nd Avenue Anchorage, AK 99508 (907) 561-2626 www.genevawoodsbirthcenter.com
Physical Therapy Providers in Anchorage:	Alaska Hand Rehabilitation 4015 Lake Otis Parkway, Suite 200 Anchorage, AK 99508 (907) 563-8318 Ascension Physical Therapy 6200 Lake Otis Parkway, Suite 104 Anchorage, AK 99507 (907) 770-6693 Chugach Physical Therapy 2740 Lake Otis Parkway Anchorage, AK 99508-4141 (907) 272-8615
Preferred Provider Specialists in Anchorage:	Alaska Center for Ear, Nose and Throat (ACENT) 3841 Piper Street #230 Anchorage, AK 99508 (907) 202-7283 https://www.acentalaska.com Anchorage Fracture and Orthopedic Clinic / Alaska Medical Alliance 3831 Piper Street, Suite S-220 Anchorage, AK 99508 (907) 563-3145 www.afoc.com

Coalition Health Centers:	Fairbanks 575 Riverstone Way, Unit 1 Fairbanks, AK 99709 (907) 450-3300 Anchorage 2741 Debarr Road, Suite C210 Anchorage, AK 99508 (907) 264-1370 www.coalitionhealthcenter.com
Preferred Provider Facility In the Mat-Su Borough:	Mat-Su Regional Medical Center 2500 S. Woodworth Loop Palmer, AK 99645 (907) 861-6000 www.matsuregional.com
Nationwide Preferred Provider Network:	Aetna www.aetna.com - Search provider directories; select the "Aetna Choice POS II (Open Access)" network

For additional information on Preferred Providers in Anchorage, refer to the What You Need to Know to Use This Plan Wisely section of this booklet.

INTRODUCTION

ASEA/AFSCME Local 52 Health Benefits Trust provides comprehensive benefits for you and your family including hospitalization, medical, surgical, maternity care, and other services necessary for the diagnosis and treatment of a non-occupational injury or disease.

These benefits are subject to change as determined by the Board of Trustees. The Board of Trustees is the Plan fiduciary and has full authority to administer the Plan consistent with its terms, and to interpret any ambiguity in those terms.

You should ensure that you have the current booklet and any addendum by contacting ASEA/AFSCME Local 52 Health Benefits Trust or visiting the Trust website, www.aseahealth.org.

Health Care Reform Notice:
The Trust believes this Plan is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on essential benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the ASEA Health Trust Administrator at (866) 553-8206. You may also contact the U.S. Department of Health and Human Services at *www.hhs.gov*

HIGHLIGHTS

THE FLEXIBLE BENEFITS PLAN OFFERS YOU CHOICES

The Trust provides a Flexible Benefits Plan so you may select the health care coverage option that suits your needs. The following health plan options are currently offered:

- **Plan A. Full Plan for Employees and Families** offers medical, dental, vision, audio and prescription drug benefits.
- **Plan B. Full Plan for Employees Only** is identical to Plan A, but covers the Employee only.
- **Plan C. Supplemental Plan** provides 20% medical, audio and prescription drug coverage, as well as the same dental and vision benefits as Plan A. This plan is designed to coordinate with other health plan coverage you and your family has.
- **Plan D. Low Option Plan for Employees and Families** offers medical, audio and prescription drug coverage after you satisfy a high Deductible. No dental or vision benefits are provided in Plan D. Plan D includes a Health Reimbursement Arrangement (HRA) of $1,000 per Employee per Benefit Year.

A spousal surcharge will apply for a spouse in Plan A who is also eligible for medical coverage through his or her employer and who opts out of that coverage.

New Employees may enroll online at www.aseahealth.org or contact the Trust to obtain enrollment instructions.

Current participants have the opportunity to make benefit changes for the following Benefit Year during the annual Open Enrollment period (usually in the spring).

Note: Employees of ASEA/AFSCME Local 52 are eligible for Plan A only, and cannot enroll in Plans B, C, or D.

QUALIFYING EVENTS

Normally, changes cannot be made outside of Open Enrollment. However, if your family has a qualifying event at any other time of the year, you may change your benefits by contacting the Trust and making a new election within 60 days of the qualifying event. **If you fail to change your election within 60 days of a qualifying event, you will have to wait until the next Open Enrollment to make a change.** If you do not have supporting documentation such as a birth certificate, marriage license or Social Security number you may enroll your dependent and submit the document to the Trust at a later date. Although claims cannot be processed without the required documents, you should not delay enrolling your dependent in order to meet the 60 day deadline. If you change your election as a result of a qualifying event, the change will be effective on the 1st of the month after the Health Trust Administrator receives your new election form.

Qualifying events include:

- Marriage

- Birth or adoption of a child
- Divorce or legal separation
- Death of a dependent
- Dependent ceases to be eligible or gains eligibility
- Loss, gain, or significant change in spouse's coverage. Exception: HCRA elections may not be changed following a change in the benefits under the spouse's coverage or the cost of that coverage
- Declaration of an Open Enrollment period by the Board of Trustees
- Changing from Full-time to permanent Part-Time status or vice versa

If you wish to appeal a benefit election, you must submit your written appeal to the Trust Administrative Office no later than 45 days after the first payroll deduction resulting from the Plan election.

WHAT YOU NEED TO KNOW TO USE THIS PLAN WISELY

The benefits provided under each plan are summarized in the Benefit Summary section. In order to make the best use of this Plan, you should be aware of several important Plan provisions.

Preferred Provider Organization (PPO) Contracts

The Trust has several types of PPOs. The Trust has negotiated discounts through the PPO providers. In some cases, the Plan benefits are the same whether or not you use a PPO provider. In other cases, a penalty will apply if you use a non-PPO provider for services that could have been obtained at a PPO provider. For additional information on PPO Contracts, please refer to the Preferred Provider Provisions section.

Discount Only – No penalty applies for use of a non-PPO provider	**Penalty will apply if you use a non-PPO provider for services available at the PPO**
Aetna Preferred Provider Network	Alaska Regional Hospital and Surgery Center of Anchorage for Inpatient and Outpatient Services in the Municipality of Anchorage
Transplant Network	Physical Therapy PPO in Anchorage: Alaska Hand Rehabilitation, Ascension Physical Therapy, Chugach Physical Therapy
Mat-Su Regional Hospital	Geneva Woods Birth Center (can also use Alaska Regional Hospital)
Alaska Center for Ear, Nose and Throat	CVS / Caremark Prescription Drug Pharmacy Network
Anchorage Fracture & Orthopedic / Alaska Medical Alliance	
VSP Provider Network for Vision Care	

Precertification Requirements

Precertification is required for all inpatient hospital stays, confinement in a treatment facility or skilled nursing facility, inpatient mental health and substance use treatment, and many outpatient procedures. Precertification is done by an objective independent Utilization Review provider, who determines if the treatment is Medically Necessary.
For more information on the Plan's Precertification requirements, refer to the Precertification Requirements section.

Preauthorization of Travel Benefits

The Plan covers travel expenses to obtain medical services under certain conditions.
In order for the travel expenses to be considered for reimbursement, you must complete the Travel Preauthorization Form and submit the form to the Health Trust Administrator before you travel. Another Travel Preauthorization Form is required if two visits for the same condition are separated by 45 days or more. For more information on coverage of travel expenses, refer to the Preauthorization of Travel Expenses section.

Penalty for Emergency Room Visits for Non-Emergency Services

If you visit an emergency room for non-emergency services, a penalty of $100 will be applied to the claim before benefits are determined. This penalty will not apply to your Annual Out-of-Pocket Limit.

Services received in a physician's office or an urgent care facility is not subject to this penalty. The penalty will not apply to services provided after normal business hours, on weekends or on holidays.

Please see the Definitions section for the definition of an "Emergency Medical Condition."

OTHER PROGRAMS TO SAVE YOU MONEY

The Plan offers a variety of programs to enhance the services offered to you and save you money at the same time!

Teladoc

Use Teladoc to access healthcare providers anytime by phone, online or via mobile app. You pay $0 copay and no deductible. Please see the Teladoc section for more information.

BridgeHealth

BridgeHealth offers another option for elective and non-urgent surgeries. If you use Bridge Health for surgical services, the Trust pays 100% of the cost of the surgery and travel costs for you and a companion. Please see the BridgeHealth section for more information.

Coalition Health Centers

The Coalition Health Centers provide primary care and treatment of acute illness and injury. You pay $0 copay and no deductible when you use the Coalition Health Centers. Please see the Coalition Health Centers section for more information.

Patient Auditor Program

Under the Patient Auditor Program, if you find an error on a hospital or any health care provider's bill, you can share in the savings.

Always request an **itemized** bill when you leave the hospital, physician's office, or clinic. Review it carefully; checking to see that you are charged only for treatment and services you received. Look for duplicate entries of the same service. If you were hospitalized, check the admission and discharge dates for accuracy.

If you find an overcharge, discuss it with the hospital or physician and obtain a corrected itemized bill. Submit the original bill with the overcharges circled, along with the adjusted bill, and a Patient Auditor Form available from the Health Trust Administrator.

After verification of overcharges of at least $100 and recovery of any overpayments, the Health Trust Administrator will issue you a check for 50% of the savings. You may be awarded up to a maximum of $400 per year. All awards are considered taxable income.

Billing errors for items not covered are not eligible for awards. The program only applies when this Plan is the primary payor.

BENEFIT SUMMARY

BENEFIT YEAR

The Benefit Year for this Plan begins July 1 and ends June 30. All benefits limited in a Benefit Year are reset on July 1 each year.

MEDICAL BENEFITS

This information is only intended to be a summary of coverages provided. Please refer to the Medical Benefits section of this booklet for additional information on limitations and exclusions. Plan payment is based on the Plan's Allowable Expense.

	PLAN A **FULL PLAN FOR EMPLOYEES AND FAMILY**	**PLAN B** **FULL PLAN FOR EMPLOYEES ONLY**	**PLAN C** **SUPPLEMENTAL PLAN FOR EMPLOYEES AND FAMILIES WITH OTHER COVERAGE**	**PLAN D** **LOW OPTION PLAN FOR EMPLOYEES AND FAMILIES**
Annual Deductible Per Person Per Family	 $300 $600	 $300 N/A	 None	 $5,000 $10,000
Annual Out-of-Pocket Limit Per Person Per Person for Non-PPO Services in Anchorage*	$1,200 $2,400	$1,200 $2,400	None	None
Major Medical Maximum Per person	Unlimited	Unlimited	Unlimited	Unlimited

*The **Allowable Expense** for Non-PPO services within the Municipality of Anchorage is based on contracted rates at the PPO for inpatient visits. Outpatient visits are based on the PPO case rate or 50% of the billed charges if no case rate is available. Non-PPO physical therapy visits in the Municipality of Anchorage are based on the contracted rate at Chugach Physical Therapy. You are responsible for any charges in excess of the Trust's Allowable Expense. The excess charges will not apply to the Annual Out-of-Pocket Limit and will not be paid at 100% when the Annual Out-of-Pocket Limit is reached.

The **Annual Deductible** is the amount you pay for covered expenses each Benefit Year before the Plan starts to pay benefits. In the event of a common accident involving two or more family members, only one Deductible is required.

The **Annual Out-of-Pocket Limit** is the maximum amount you pay for covered medical expenses in a year, not including your Deductible. Plans A and B have an Annual Out-of-Pocket Limit. After you meet the annual Deductible, Plans A and B pay 80% of most covered expenses. Your out-of-pocket expense is 20%. When your out-of-pocket expenses total $1,200 for any one person, the Plan pays 100% of most covered medical expenses for that person for the rest of the Benefit Year.

Certain expenses are not credited to the Out-of-Pocket Limit and the Plan will not pay these expenses at 100% after the Out-of-Pocket Limit is satisfied. If you obtain services at a non-PPO hospital or physical therapy provider in Anchorage, the Out-of-Pocket Limit is increased to $2,400 per person for those services. Any amount applied to the $2,400 Non-PPO Out-of-Pocket Limit will also apply to the $1,200 Out-of-Pocket Limit and vice versa. The $2,400 Non-PPO Out-of-Pocket Limit is not applied in addition to the $1,200 Out-of-Pocket Limit. For example, if you satisfied $500 of the $1,200 Out-of-Pocket Limit before you went to a non-PPO provider, you would have to accrue another $1,900 in out-of-pocket expenses before you reached the $2,400 Non-PPO Out-of-Pocket Limit.

The following table summarizes the Plan's Reimbursement Percentage for certain types of services. The Reimbursement Percentage is the percentage of Allowable Expenses the Plan pays, *after the Deductible is met*.

	PLAN A **FULL PLAN FOR EMPLOYEES AND FAMILY**	**PLAN B** **FULL PLAN FOR EMPLOYEES ONLY**	**PLAN C** **SUPPLEMENTAL PLAN FOR EMPLOYEES AND FAMILIES WITH OTHER COVERAGE**	**PLAN D** **LOW OPTION PLAN FOR EMPLOYEES AND FAMILIES**
Covered Medical Expenses	80% (60% non-PPO*)	80% (60% non-PPO*)	20%	100% (80% non-PPO*)
Outpatient Surgery	100% (80% non-PPO*) (not subject to the Deductible)	100% (80% non-PPO*) (not subject to the Deductible)	20%	100% (80% non-PPO*)
BridgeHealth Surgical Services (including travel)	100% (not subject to the Deductible)	100% (not subject to the Deductible)	Not available	100% (not subject to the Deductible)
Outpatient Dialysis Treatment (Please refer to Dialysis Treatment – Outpatient)	80% of the Usual and Reasonable Charge for Outpatient Dialysis Treatment	80% of the Usual and Reasonable Charge for Outpatient Dialysis Treatment	20% of the Usual and Reasonable Charge for Outpatient Dialysis Treatment	100% of the Usual and Reasonable Charge for Outpatient Dialysis Treatment
Services at the Coalition Health Centers	100% (not subject to the Deductible)	100% (not subject to the Deductible)	100% (not subject to the Deductible)	100% (not subject to the Deductible)
Teladoc Visits	100% (not subject to the Deductible)	100% (not subject to the Deductible)	100% (not subject to the Deductible)	100% (not subject to the Deductible)

*The Allowable Expense for Non-PPO services within the Municipality of Anchorage is based on contracted rates at the PPO for inpatient visits. Outpatient visits are based on the PPO case rate or 50% of the billed charges if no case rate is available. Non-PPO physical therapy visits in the Municipality of Anchorage are based on the contracted rate at Chugach Physical Therapy. You are responsible for any charges in excess of the Trust's Allowable Expense. The excess charges will not apply to the Annual Out-of-Pocket Limit and will not be paid at 100% when the Annual Out-of-Pocket Limit is reached.

The Plan limits reimbursement for certain services, which are summarized below and on the following pages. The Reimbursement Percentage is the percentage of Allowable Expenses the Plan pays, *after the Deductible is met*. Additional Plan limitations may apply. Please refer to the Medical Benefits section of this booklet for more information.

	PLAN A **FULL PLAN FOR EMPLOYEES AND FAMILY**	**PLAN B** **FULL PLAN FOR EMPLOYEES ONLY**	**PLAN C** **SUPPLEMENTAL PLAN FOR EMPLOYEES AND FAMILIES WITH OTHER COVERAGE**	**PLAN D** **LOW OPTION PLAN FOR EMPLOYEES AND FAMILIES**
Surgical Treatment of Obesity*				
Reimbursement Percentage – first $35,000 of Allowable Expenses	90% (70% non-PPO**)	90% (70% non-PPO**)	20%	90% (70% non-PPO**)
Reimbursement Percentage – Allowable Expenses in Excess of $35,000	80% (60% non-PPO**)	80% (60% non-PPO**)	20%	80% (60% non-PPO**)
Maximum Out-of-Pocket Cost	None	None	None	None
Episodes of Treatment	1 per lifetime	1 per lifetime	1 per lifetime	1 per lifetime

*The cost of surgical treatment of obesity includes the Allowable Expenses for the professional fees and hospital charges for bariatric surgery and panniculectomy combined. The participant's cost for surgical treatment of obesity will not apply to the Annual Out-of-Pocket Limit and the Plan's reimbursement for surgical treatment of obesity will not increase to 100% of Allowable Expenses after the participant has met the Medical Annual Out-of-Pocket Limit. Charges due to complications resulting from surgical treatment of obesity will continue to be paid under the medical plan and subject to the medical plan's Deductible, Reimbursement Percentage, Out-of-Pocket Limits and all other medical plan provisions. Charges due to complications do not include the costs of services that would be provided in the absence of complications, such as the professional and facility fees for the surgery and related procedures and any charges incurred during the period of hospitalization that had been certified as Medically Necessary following the surgery.

**The Allowable Expense for Non-PPO services within the Municipality of Anchorage is based on contracted rates at the PPO for inpatient visits. Outpatient visits are based on the PPO case rate or 50% of the billed charges if no case rate is available. Non-PPO physical therapy visits in the Municipality of Anchorage are based on the contracted rate at Chugach Physical Therapy. You are responsible for any charges in excess of the Trust's Allowable Expense. The excess charges will not apply to the Annual Out-of-Pocket Limit and will not be paid at 100% when the Annual Out-of-Pocket Limit is reached.

The Plan limits reimbursement for certain services (cont'd)

	PLAN A FULL PLAN FOR EMPLOYEES AND FAMILY	PLAN B FULL PLAN FOR EMPLOYEES ONLY	PLAN C SUPPLEMENTAL PLAN FOR EMPLOYEES AND FAMILIES WITH OTHER COVERAGE	PLAN D LOW OPTION PLAN FOR EMPLOYEES AND FAMILIES
Chiropractic, Massage Therapy, and Acupuncture Services Reimbursement Percentage Allowable Visits Per Benefit Year (all services combined)	80% 20 visits	80% 20 visits	20% 20 visits	100% 20 visits
Wigs Reimbursement Percentage Lifetime Benefit	80% $600	80% $600	20% $600	100% $600
Home Health Care Reimbursement Percentage Allowable Visits Per Benefit Year	80% 120 Visits	80% 120 Visits	20% 120 Visits	100% 120 Visits
Skilled Nursing Facility	100%	100%	20%	100%
Second Surgical Opinions / Preoperative Testing	100% (not subject to the Deductible)	100% (not subject to the Deductible)	20%	100%

Please refer to the Medical Benefits section for more detailed information.

The following table summarizes the Plan's Reimbursement Percentage for preventive care services. The Reimbursement Percentage is the percentage of Allowable Expenses the Plan pays. *Preventive care services are not subject to the Deductible*. Your portion of the cost for these services is not credited to the Annual Out-of-Pocket Limit and will not be paid at 100% once the Annual Out-of-Pocket Limit is reached.

	PLAN A **FULL PLAN FOR EMPLOYEES AND FAMILY**	**PLAN B** **FULL PLAN FOR EMPLOYEES ONLY**	**PLAN C** **SUPPLEMENTAL PLAN FOR EMPLOYEES AND FAMILIES WITH OTHER COVERAGE**	**PLAN D** **LOW OPTION PLAN FOR EMPLOYEES AND FAMILIES**
Routine Newborn Care (Within 72 hours after birth)	100% (80% non-PPO*)	100% (80% non-PPO*)	20%	100% (80% non-PPO*)
Immunizations recommended by the Centers for Disease Control (CDC)	100%	100%	20%	100%
Physical exams and other preventive care services recommended under the Affordable Care Act (ACA)	100% (80% non-PPO*)	100% (80% non-PPO*)	100%	100% (80% non-PPO*)
All other preventive care services	80% (60% non-PPO*)	80% (60% non-PPO*)	20%	80% (60% non-PPO*)
Preventive Services at the Coalition Health Center	100%	100%	100%	100%

*The Allowable Expense for Non-PPO services within the Municipality of Anchorage is based on contracted rates at the PPO for inpatient visits. Outpatient visits are based on the PPO case rate or 50% of the billed charges if no case rate is available. You are responsible for any charges in excess of the Trust's Allowable Expense. The excess charges will not apply to the Annual Out-of-Pocket Limit and will not be paid at 100% when the Annual Out-of-Pocket Limit is reached.

Please refer to the Medical Benefits section for more detailed information.

PRESCRIPTION DRUG BENEFITS

This information is only intended to be a summary of coverages provided. Please refer to the Prescription Drug Benefits section of this booklet for additional information on limitations and exclusions. Plan payment is based on the Plan's Allowable Expenses.

	PLAN A **FULL PLAN FOR EMPLOYEES AND FAMILY**	**PLAN B** **FULL PLAN FOR EMPLOYEES ONLY**	**PLAN C** **SUPPLEMENTAL PLAN FOR EMPLOYEES AND FAMILIES WITH OTHER COVERAGE**	**PLAN D** **LOW OPTION PLAN FOR EMPLOYEES AND FAMILIES**
Generic Copay Retail or Mail Order Your Copay Plan Pays	 10% 90%	 10% 90%	 80% 20%	 Paid Under the Medical Benefit at 100% after Deductible
Brand Copay Retail or Mail Order Your Copay Plan Pays	 20% 80%	 20% 80%	 80% 20%	 Paid Under the Medical Benefit at 100% after Deductible
Maximum Copay per Prescription*	$60 $20 per 30-day supply of Specialty Medications	$60 $20 per 30-day supply of Specialty Medications	N/A	N/A
Maximum Copay per Person per Benefit Year*	$600	$600	N/A	N/A
Maximum Supply per Prescription	90 days or 100 units; 30 days for Specialty Medications	90 days or 100 units; 30 days for Specialty Medications	90 days or 100 units; 30 days for Specialty Medications	90 days or 100 units; 30 days for Specialty Medications

* The Allowable Expense at an out-of-network pharmacy will be the negotiated network rate. Any amount above the Allowable Expense will be your responsibility and will not apply to the maximum Copay per prescription or per person per Benefit Year.

Once you reach the maximum Copay per prescription, the remainder of the cost of that prescription is paid at 100%. Once you reach the maximum Copay per person per Benefit Year, the plan pays 100% of Allowable Expenses for prescriptions purchased at network pharmacies or from the Plan's mail order pharmacy for the remainder of the Benefit Year.

Prescription drug Copayments do not contribute to the Medical Annual Out-of-Pocket Limit. Please refer to the Prescription Drug section for more detailed information**.**

DENTAL BENEFITS

This information is only intended to be a summary of coverages provided. Please refer to the Dental Benefits section of this booklet for additional information on limitations and exclusions.

Plan payment is based on the Plan's Allowable Expenses.

	PLAN A **FULL PLAN FOR EMPLOYEES AND FAMILY**	**PLAN B** **FULL PLAN FOR EMPLOYEES ONLY**	**PLAN C** **SUPPLEMENTAL PLAN FOR EMPLOYEES AND FAMILIES WITH OTHER COVERAGE**	**PLAN D** **LOW OPTION PLAN FOR EMPLOYEES AND FAMILIES**
Annual Deductible*				
Per Person	$25	$25	$25	Not Covered
Per Family	$75		$75	
Reimbursement Percentage				
Preventive	100%	100%	100%	Not Covered
Restorative	85%	85%	85%	Not Covered
Prosthetic	50%	50%	50%	Not Covered
Maximum Plan Benefit per Benefit Year Applies to Restorative and Prosthetic services	$2,000	$2,000	$2,000	N/A

*Deductible does not apply to preventive services.

Please refer to the Dental Benefits section for more detailed information**.**

VISION BENEFITS

This information is only intended to be a summary of coverages provided. Please refer to the Vision Benefits section of this booklet for additional information on limitations and exclusions.

Plan payment is based on the Plan's Allowable Expenses. The benefits differ depending on whether the service is obtained at a VSP network provider or out-of-network.

	PLAN A **FULL PLAN FOR EMPLOYEES AND FAMILY**	**PLAN B** **FULL PLAN FOR EMPLOYEES ONLY**	**PLAN C** **SUPPLEMENTAL PLAN FOR EMPLOYEES AND FAMILIES WITH OTHER COVERAGE**	**PLAN D** **LOW OPTION PLAN FOR EMPLOYEES AND FAMILIES**
Exam Benefit **In-Network** **Out-of-Network**	Covered in full $150 maximum	Covered in full $150 maximum	Covered in full $150 maximum	Not Covered
Frame Benefit	$150 maximum	$150 maximum	$150 maximum	Not Covered
Lens Benefit **In-Network** **Out-of-Network**	Covered in full* $175 maximum	Covered in full* $175 maximum	Covered in full* $175 maximum	Not Covered
Contact Lens Benefit**	$200 maximum	$200 maximum	$200 maximum	Not Covered
Frequency of Benefits Exam Lenses Frames	Every Benefit Year Every Benefit Year (one pair) Every other Benefit Year	Every Benefit Year Every Benefit Year (one pair) Every other Benefit Year	Every Benefit Year Every Benefit Year (one pair) Every other Benefit Year	Every Benefit Year Every Benefit Year (one pair) Every other Benefit Year

*In network: Basic single vision or lined lenses are covered in full. Polycarbonate lenses and UV coatings are covered in full. One of the following is also covered in full: progressive or photochromic lenses, or anti-reflective coating.

**In lieu of frames and lenses.

The full allowance is available at the time of service, and unused money cannot be banked to use at another time. You may not use an allowance for one service toward another.

Please refer to the Vision Benefits section for more detailed information**.**

AUDIO BENEFITS

This information is only intended to be a summary of coverage provided. Please refer to the Audio Benefits section of this booklet for additional information on limitations and exclusions.

Plan payment is based on the Plan's Allowable Expenses.

	PLAN A **FULL PLAN FOR EMPLOYEES AND FAMILY**	**PLAN B** **FULL PLAN FOR EMPLOYEES ONLY**	**PLAN C** **SUPPLEMENTAL PLAN FOR EMPLOYEES AND FAMILIES WITH OTHER COVERAGE**	**PLAN D** **LOW OPTION PLAN FOR EMPLOYEES AND FAMILIES**
Deductible	$0	$0	$0	$0
Plan Pays	80%	80%	20%	80%
Maximum Benefit per Person for a Period of 3 Benefit Years	$5,000	$5,000	$5,000	$5,000

Please refer to the Audio Benefits section for more detailed information**.**

ELIGIBILITY

WHO IS COVERED

Employees

Benefits in this booklet are provided to permanent and long-term nonpermanent Employees of the State of Alaska covered under the General Government bargaining unit as shown below:

- Full-Time Employees (scheduled to work 30 or more hours a week on a regular basis).
- Full-Time seasonal Employees.
- Part-Time Employees who elect to participate in the Plan (scheduled to work at least 15 but less than 30 hours a week on a regular basis). If you are a Part-Time Employee and want to participate in the Group Health Plan, you must elect coverage within the first 30 consecutive calendar days of employment and elect to maintain coverage at each Open Enrollment.

Benefits are provided to Employees represented by PSEA Local 803 who work for the State of Alaska, City of Fairbanks, and the City of Ketchikan, in accordance with the applicable collective bargaining agreement. Employees of PSEA Local 803 are provided benefits in accordance with their special agreement.

Benefits are also provided to Employees of ASEA/AFSCME Local 52 who are members of Laborers' Local 341, in accordance with the collective bargaining agreement and to unrepresented Employees of ASEA/AFSCME Local 52, in accordance with their special agreement

"Employees" are those persons actively working and receiving earnings, or otherwise eligible to participate under the provisions of the underlying collective bargaining agreement or special agreement in force for the Benefit Year.

Dependents

Your eligible dependents include:

- Your spouse. You may be legally separated but not divorced.
- Your children, from birth up to 26 years of age only if they are:
- Your natural children and legally adopted children, or
- Your stepchildren, foster children placed through a State foster child program, or children for whom you are the legal, court-appointed guardian. The Trust will make the final determination on QMCSO determinations;

Children incapable of employment because of a mental or physical incapacity are covered even if they are past the maximum age. However, the incapacity must have existed before age 19 and the children must continue to rely chiefly on you for support and meet the definition of children, except for age. You must furnish the Health Trust Administrator evidence of the continuing incapacity, proof that the incapacity existed before age 19, and your most

recent tax return as proof of financial dependency. Children are covered as long as the incapacity exists and they meet the definition of children, except for age. Periodic proof of the continued incapacity may be required. If coverage is terminated because the child is determined to no longer meet the definition of Incapacitated for purposes of coverage under this provision, the child will not be granted coverage at a later date if the incapacity returns.

When you are first covered under the Plan, you must list any eligible dependents to be covered online at the Trust website, www.aseahealth.org or via paper on a Family Information Form, and provide proof of dependent status, such as a marriage certificate or birth certificate.

If your dependents change due to marriage, divorce, or other family status changes, you must complete a new Family Information Form to add or delete dependents.

These forms are available from the Health Trust Administrator or the Trust web site. Failure to complete these forms when required may delay payment of claims for your dependents.

If you a) enroll a dependent who does not meet the eligibility requirements of this plan; or b) fail to notify the plan of your divorce or other loss of dependent eligibility within 60 days of the event; you are intentionally misrepresenting a material fact and the plan will retroactively terminate coverage for your ineligible dependent. If the plan pays claims based on your misrepresentation, you may be responsible for any claims paid on your misrepresentation.

If more than one family member is covered under this Trust's Plan, each eligible family member may be covered by the Plan, both as an Employee and as a dependent, or as the dependent of more than one Employee.

EMPLOYEE CONTRIBUTIONS

You may be required to pay a portion of the monthly health cost. Your employer is required to pay a portion of the cost, as determined through collective bargaining. Unless otherwise stated in the collective bargaining agreement or special agreement, the employer contribution for Part-Time Employees is $^1/_2$ of the contribution for Full-Time Employees. Your contribution is the difference between the Plan cost and the amount contributed by your employer on your behalf.

The amount you must pay is available from the Trust and is subject to change, generally in July of each year. If applicable, your monthly contribution is split in half and is deducted from your paycheck before taxes are calculated. Contributions are withheld in the month coverage is provided. For example, contributions for July are withheld from checks issued in July. If your check is insufficient to pay your contribution, you should contact the Trust for information on paying your contribution directly.

WHEN COVERAGE BEGINS

New Employees

If you are a permanent or long-term nonpermanent **Full-Time** or **Full-Time seasonal** Employee, you and your eligible dependents are covered on the 1st of the month following 30 consecutive days in paid status, provided you have health benefit contributions reported to the Trust on your behalf. For example, if you begin work on October 10, you are covered on December 1, assuming you have no periods of leave without pay or do not terminate your employment during that time. **You must make a plan election within the first 30 days of employment. If you fail to make a plan election, you will be defaulted into Plan A.**

If you are a permanent or long-term nonpermanent **Part-Time** or **Part-Time seasonal** Employee who elects coverage during the first 30 days of employment, you and your eligible dependents are covered on the 1st of the month following 30 consecutive days in paid status. If you fail to elect coverage timely, you will not be covered by the Plan. If you experience a qualifying change in family status, you have 60 days to elect coverage. You and your eligible dependents are covered on the 1st of the month after the Trust Administrator receives your election. (Note: Part-Time Employees of Local 52 are not covered.)

If you have leave without pay during your first 30 days of employment, you are covered on the 1st of the month after you return to work and are in pay status for 31 consecutive days. For example, if you start work on October 1, but have leave without pay and return to work October 15, coverage begins on December 1.

Deferral Option for GGU Members

Members of the General Government Unit who are either:

- Seasonal Employees or
- Division of Forestry Long-Term Non-Permanent Employees working as Foresters, Natural Resource Technicians, or Wildland Fire & Resource Technicians,

may elect to defer the effective date for up to 2 months. Your coverage then ends on the last day of the month following the month in which you terminate employment or begin seasonal leave without pay if you deferred for one month. If you deferred coverage for 2 months, your coverage would end on the last day of the month 2 months after the month in which you terminate employment or begin seasonal leave without pay. To defer coverage, you must file a form with the Health Trust Administrator, postmarked within 30 days after your hire date or return to work as a seasonal. Deferrals apply only to that period of work. To defer coverage for each subsequent period, you must file a deferral each time you return to work. Deferral forms are available from the Trust office. **A deferral cannot be revoked.** (Note: this provision does not apply to Employees of Local 52, employees of Local 803, or employees covered by the PSEA collective bargaining agreements.)

Rehired Employees

If you were previously covered under this Plan as an actively working Employee and you are rehired **within** seven calendar days of the date your coverage terminated, your coverage begins on the 1st day of the period for which health benefit contributions are reported to the

Trust on your behalf. For example, if your coverage ends July 31 and you return to work on or before August 7, if your employer begins making health benefit contributions for the period beginning September 1, then your coverage begins September 1. If you were previously covered and you are rehired **more than** seven calendar days after your coverage terminated, you are considered a new Employee and coverage for you and your dependents begins on the 1st of the month following 30 consecutive days in paid status, as specified for new Employees above.

Employees Returning from Leave Without Pay or Layoff

If you were covered by this Plan prior to going on leave without pay or layoff, you are covered starting the 1st day you return to work (unless you defer coverage – see below) provided both you and your employer makes the required contribution for your coverage. Your dependents are eligible at the same time.

Returning seasonal Employees may elect to defer the effective date for 1 month. Your coverage then ends on the last day of the month following the month in which you begin seasonal leave without pay again. To defer coverage, you must file a form with the Trust, postmarked within 30 days after you return to work. Deferrals apply only to that period of work. To defer coverage for each subsequent period, you must file a deferral each time you return to work. Deferral forms are available from the Trust office. **A deferral cannot be revoked.** (Note: this provision does not apply to Employees of Local 52, employees of Local 803, or employees covered by the PSEA collective bargaining agreements.)

Employees Moving from a Nonparticipating Unit

Employees who move from another bargaining unit will be covered on the 1st day of the month after the bargaining unit change occurs. For example, if your bargaining unit change is effective October 15, your health benefits change on November 1. If the change is effective on the 1st of the month, health benefits also change on that day. For example, if your bargaining unit change is effective November 1, your health benefits change on that day. If you are not in pay status at the time the change occurs, you will not be covered until the day you return to pay status and the Trust receives contributions on your behalf. You must make a plan election within the first 30 days of employment in this bargaining unit. If you fail to make a plan election, you will be defaulted into Plan A if you are a Full-time Employee and will have no coverage if you are a Part-Time Employee.

Employees Moving from Part-Time Status to Full-Time Status

Employees who move from Part-Time status to Full-Time status will be covered on the first day of the month following the date of the status change. If you elected coverage as a Part-Time Employee, your plan election will remain in effect as a Full-Time Employee, and you will have 60 days from the date of the status change to change your plan election if you wish to do so. If you did not elect coverage as a Part-Time Employee, you have 30 days from the date of the status change to elect coverage as a Full-Time Employee. If you do not make an election, you will be placed into the default plan, Plan A.

Employees Moving from Non-Benefit-Eligible Status to Benefit-Eligible Status

Employees who move from non-benefit-eligible status (such as short-term permanent or short-term nonpermanent) to benefit-eligible status (such as permanent or long-term nonpermanent)

are covered on the 1st of the month following 30 consecutive days in paid status, provided you have health benefit contributions reported to the Trust on your behalf.

You must make a plan election within the first 30 days of employment in benefit-eligible status. If you fail to make a plan election, you will be defaulted into Plan A if you are a Full-time Employee and will have no coverage if you are a Part-Time Employee.

New Dependents

In order to add a dependent, you must fill out a Family Information Form and provide proof of dependent status. Failure to complete these forms when required may delay payment of claims for your dependents. If you do not have supporting documentation such as a birth certificate, marriage license or Social Security number you may enroll your dependent and submit the document to the Trust at a later date.

If you add new dependents, they are eligible for benefits immediately if you are covered under a family plan option. If you are covered under an Employee only plan option, you must notify the Health Trust Administrator that you acquired a new dependent and elect a family plan option, unless your newly acquired dependent has other health coverage. If you change your plan selection, the change will be effective on the 1st of the month after the Trust receives your new election form.

Your newborn or newly adopted child will automatically be covered regardless of your plan election for 31 days. If you are covered under an Employee only plan option, you must notify the Health Trust Administrator of the birth or adoption and elect a family plan option, unless your newly acquired dependent has other health coverage. If you change your plan selection, the change will be effective retroactive to the date of the birth or adoption.

Please contact the Health Trust Administrator for questions related to Eligibility.

WHEN COVERAGE ENDS

Employees on Leave Without Pay or Layoff

Coverage ends on the last day of the month in which you were last in pay status or in which you began seasonal overtime conversion. For example, if you worked or were on paid leave status on January 15 and then placed on leave without pay, layoff, or seasonal overtime conversion, coverage ends on January 31. If your leave without pay occurs while you are on federal FMLA Leave, your coverage will be extended to the end of the month in which your federal FMLA Leave ends, provided the required premium is paid. For information on your eligibility for family leave, contact your human resource office.

Employees on Donated, Catastrophic, and Emergency Leave

Coverage extended due to donated, catastrophic or emergency leave (or any combination thereof) will be limited to 3 consecutive months. Coverage ends on the last day of the third month in which coverage is extended based solely on donated, catastrophic or emergency leave

Employees Who Terminate Employment

Coverage ends on the last day of the month in which you last worked. For example, if you last worked on January 15 and terminated your employment, coverage ends on January 31.

Employees Moving to a Nonparticipating Unit

Coverage ends on the last day of the month in which you move out of the bargaining unit.

Employees Moving from Full-Time Status to Part-Time Status

Employees who move from Full-Time status to Part-Time status will cease to be covered as a Full-Time Employee on the last day of the month in which the status change occurred. State of Alaska Employees may elect to continue coverage as a Part Time Employee, effective on the first day of the month following the date of the status change, if you make a Part-Time plan election within 30 days of the change in status. If you do not elect coverage as a Part-Time Employee within 30 days of the change in status, you will not have coverage under the Trust.

Employees Moving from Benefit-Eligible Status to Non-Benefit-Eligible Status

Coverage ends on the last day of the month in which you are in benefit-eligible status.

Dependents

Coverage for a dependent ends on the same day as the Employee's coverage, unless:

- You divorce. Coverage for your spouse ends on the date the divorce is final.
- Your child no longer meets all eligibility requirements. Coverage ends on the last day of the month in which the child first fails to meet any of these requirements.

If you fail to notify the Health Trust Administrator that a dependent is no longer eligible, you will be liable for any resulting overpayment of benefits under the Plan.

Failure to Pay the Required Premium

Your coverage will terminate if you or your employer fail to pay the contribution. Coverage terminates at the end of the month for which the last required contribution was made. There are several options available for continuing health benefits when coverage ends. Please refer to the Continuation Coverage section for details about your options.

MEDICAL BENEFITS

HOW MEDICAL BENEFITS ARE PAID

Benefits are available for services and supplies necessary to diagnose, care for, or treat a physical or medical condition. To be eligible for benefits under the Plan, the service or supply must be:

- Medically Necessary, and
- A covered service under the Plan.

The Plan's benefit payment will be based on:

- Plan provisions, including any limitations or exclusions, and
- The Allowable Expense of the service or supply.

Medically Necessary Services

To be Medically Necessary, the service or supply must be:

- Care or treatment which is expected to improve or maintain your health or to relieve pain and suffering without aggravating the condition or causing additional health problems; or
- A diagnostic procedure which is expected to provide information to determine the course of treatment;

and must be no more costly than another service or supply which could fulfill these requirements.

In determining if a service or supply is Medically Necessary, the Plan will rely on the professional opinion of the Health Trust Administrator, Utilization Review provider, or other health care professionals contracted by the Plan. The Plan will consider:

- Information provided on the affected person's health status;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment;
- The opinion of health professionals in the generally recognized health specialty involved; and
- Any other relevant information brought to the Health Trust Administrator's attention.

In no event will the following services or supplies be considered Medically Necessary:

- Those considered experimental or investigational;
- Those that do not require the technical skills of a medical or dental professional who is acting within the scope of his or her license;

- Those furnished mainly for the comfort or convenience of the person, the person's family, anyone who cares for him or her, a health care provider, or health care facility;
- Those furnished only because the person is in the hospital on a day when the person could safely and adequately be diagnosed or treated while not in the hospital; or
- Those furnished only because of the setting if the service or supply can be furnished in a doctor's or dentist's office or other less costly setting.

No benefits will be paid for Medically Necessary services that are not covered services under the Plan.

Allowable Expenses

The Plan's payment will be based on the Allowable Expenses for Medically Necessary covered services.

Allowable Expenses are the actual costs (billed amount) charged for services to the extent that such charges are Usual, Customary and Reasonable (UCR) for the area and the type of service. For non-PPO services in Anchorage, the Allowable Expense for inpatient hospital services will be limited to the contracted rate at Alaska Regional Hospital. The Allowable Expense for outpatient facility charges at a non-PPO provider in Anchorage will be based on the PPO case rate or 50% of the billed charges if no case rate is available. The Allowable Expense for non-PPO physical therapy visits in Anchorage will be based on the contracted rate at Chugach Physical Therapy.

Charges in excess of the Allowable Expense as determined by the Plan will not be paid by the Plan, and will not apply to your Annual Out-of-Pocket Maximum.

When the ASEA Health Plan is the secondary plan, this Health Plan's Allowable Expense will be limited to the expense that is allowed by the primary plan. In the event the primary plan's allowed expense has been reduced because you did not follow its plan rules and procedures, the ASEA Health Plan will not pay the amount of the reduction.

Usual, Customary, and Reasonable (UCR) Charges

Payment is based on Usual, Customary, and Reasonable charges for covered services. Charges or fees in excess of the Usual, Customary, and Reasonable charge level, as determined by the Health Trust Administrator, are your responsibility to pay.

Usual, Customary, and Reasonable (UCR) means the charge the Health Trust Administrator determines to be the prevailing rate charged in the geographic area where the service is provided or the provider's usual charge, whichever is less. The Trust uses the 90th percentile to determine the UCR. For most common procedures, 90% of the charges submitted for the procedure will be within the UCR allowance.

UCR charges are determined by collecting the claims submitted for each procedure, defined by the procedure code, in a specific geographic area. The geographic area is determined by where the procedure is performed. Some types of procedures, such as surgery, are based on claims data statewide or from a larger area to ensure sufficient information to establish UCR. A multiplier may be applied to reflect differences in the cost of services in a particular region. Other considerations may include:

- The prevailing charges in a greater geographic area;

- The complexity of the service or supply;
- The degree of skill needed;
- The type or specialty of the provider; and
- The range of services or supplies provided by a facility.

Allowable Expense for Multiple Surgical Procedures

When two or more surgical procedures are performed during the same operative session, the Health Trust Administrator will determine which procedure is primary and the Allowable Expense will be the lesser of the billed charge or:

- 100% of the UCR or the allowed amount for the primary procedure, and
- 50% of the UCR or the allowed amount for all other procedures.

The procedures shall not be considered Multiple Surgical Procedures if they are identified as exempt by the American Medical Association in the most current publication of Current Procedural Terminology (CPT).

Allowable Expense for Assistant Surgeon

When an assistant surgeon bills for services, the Allowable Expense will be the lesser of the billed charge or 25% of the UCR or the allowed amount for the procedure performed.

PREFERRED PROVIDER PROVISIONS

The Trust has several types of PPOs:

Transplant Network

The Trust is able to access network facilities for transplant services. Contact the Health Trust Administrator for more information. The Plan benefits are the same whether or not you use a transplant network facility when you obtain transplant services.

Aetna Preferred Provider Network

You are able to obtain discounted rates for services through the Aetna network of Preferred Providers. When you use a network Preferred Provider, you will receive discounted pricing and will not encounter charges over Usual, Customary and Reasonable (UCR). We encourage you to help save money for both you and the Health Plan by using a Preferred Provider. To find an Aetna provider go to www.aetna.com and select the Aetna Choice Pos II (open access network). When you call to make an appointment, or at the time of service, please verify that the provider participates in the Aetna network.

The Plan benefits are the same whether or not you use a Preferred Provider facility when you obtain services outside Anchorage. If you obtain inpatient or outpatient hospital services or physical therapy services in the Municipality of Anchorage, the PPO provisions described below will apply. Alaska Regional Hospital and the Surgery Center of Anchorage are the only PPO providers for inpatient or outpatient hospital services in the Municipality of Anchorage. All other hospitals, surgery centers, imaging centers, etc. are considered non-PPO. Chugach Physical therapy, Ascension Physical Therapy and Alaska Hand Rehabilitation are the only PPO physical therapy providers in the Municipality of Anchorage.

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

Mat-Su Regional Hospital

The Trust obtains discounted rates at Mat-Su Regional Hospital. The Plan benefits are the same whether you use Mat-Su Regional Hospital or another provider in the Mat-Su Borough.

Alaska Center for Ear, Nose & Throat (ACENT)

The Trust obtains discounted rates from ACENT. Your cost will be lower at this provider, due to the favorable pricing they offer to Trust participants. No penalty will apply if you choose to use another provider.

Anchorage Fracture & Orthopedic Clinic (AFOC) / Alaska Medical Alliance (AMA)

The Trust obtains discounted rates from AFOC / AMA. Your cost will be lower at this provider, due to the favorable pricing they offer to Trust participants. No penalty will apply if you choose to use another provider.

Geneva Woods Birth Center in Anchorage

The Trust obtains discounted rates at Geneva Woods Birth Center in Anchorage. The Plan benefits are the same whether you use Geneva Woods Birth Center or Alaska Regional Hospital in Anchorage. If you use a non-preferred hospital, the non-PPO provisions will apply.

Alaska Regional Hospital, Surgery Center of Anchorage, and Physical Therapy Contracts in Anchorage

If you obtain inpatient or outpatient hospital services or physical therapy services within the Municipality of Anchorage, the Plan will provide different benefits depending on whether the Preferred Provider facility is used. **Alaska Regional Hospital and the Surgery Center of Anchorage are the only Preferred Providers for inpatient and outpatient hospital services. Alaska Hand Rehabilitation, Ascension Physical Therapy, and Chugach Physical Therapy are the only Preferred Providers for physical therapy services.**

You may obtain services at the facility of your choice. However, the Plan's reimbursement will differ depending on whether a PPO or non-PPO facility is used. If you use a non-PPO facility in Anchorage, Plan payment will be based on the Plan's Allowable Expense, and the charges will be subject to a lower Reimbursement Percentage, as well as increased Out-of-Pocket Limits. The Allowable Expense for non-PPO inpatient hospital services will be limited to the contracted rate at Alaska Regional Hospital. The Allowable Expenses for outpatient hospital charges at a non-PPO provider in Anchorage will be the case rate at Alaska Regional Hospital, if any, or 50% of the billed charges if no case rate is available. The Allowable Expenses for non-PPO physical therapy services are the contracted rates at Chugach Physical Therapy. You are responsible for any charges in excess of the Trust's Allowable Expense, and the excess charges will not apply to the Annual Out-of-Pocket Limit.

See the following examples for a comparison of the Plan payment for an inpatient stay at a PPO facility vs. a non-PPO facility for a participant in Plan A or B. The Deductible and

Reimbursement Percentage for a participant in Plan D will differ. Preferred Provider penalties do not apply to Plan C.

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

Example: Claims Comparison of a PPO vs. non-PPO Claim in Anchorage

	PPO		**Non PPO**
AK Regional Discounted Charges	$ 15,000	Non PPO Hospital Bill	$30,000
Less Noncovered Expense	-$ 0	Less Noncovered Expense	-$15,000
Equals Covered Expense	$15,000	Equals Covered Expense at PPO Hospital	$15,000
Less Deductible	-$ 300	Less Deductible	-$ 300
Equals	$14,700	Equals	$14,700
Multiplied by % Payable		Multiplied by % Payable	
80% to maximum out-of-pocket		60% to maximum out-of-pocket	
100% of remainder		100% of remainder	
Equals Total Payment Made	$13,500	Equals Total Payment Made	$12,300
Your Out-of-Pocket Expense (Total hospital bill less payment made by the Plan)	**$ 1,500**	**Your Out-of-Pocket (Total hospital bill less payment made by the Plan)**	**$17,700**

When the PPO penalty provisions generally apply:

- The penalty provisions generally apply when you obtain inpatient or outpatient hospital services or physical therapy services at a non-PPO facility or physical therapy provider within the Municipality of Anchorage. If you have any questions about whether a facility is a PPO facility or a non-PPO facility, please contact the Trust.
- If your doctor directs you to a facility other than Alaska Regional Hospital for inpatient services.
- If your doctor directs you to a facility other than Alaska Regional Hospital, the Surgery Center of Anchorage, Alaska Hand Rehabilitation, Ascension Physical Therapy or Chugach Physical Therapy for x-rays, lab work, outpatient surgery, physical therapy or other outpatient services.

When the PPO penalty provisions generally do not apply:

- You will not be penalized for services obtained outside the Municipality of Anchorage.

- No penalty applies to services that are not available at Alaska Regional Hospital, the Surgery Center of Anchorage, Alaska Hand Rehabilitation, Ascension Physical Therapy or Chugach Physical Therapy. If you believe a service is not available at the PPO providers and you wish to obtain those services at the non-PPO facility, we encourage you to contact the Trust and obtain a waiver prior to obtaining the services.
- Services to treat an Emergency Medical Condition will not be penalized. However, the patient must be transferred to a Preferred Provider as soon as medically possible. Services incurred after the patient is able to be transferred will be subject to non-PPO reimbursement. An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:
  - placing the health of the individual (or with respect to a pregnant woman, the health of the woman and/or her unborn child) in serious jeopardy,
  - serious impairment to bodily functions, or
  - serious dysfunction of any bodily organ or part,

  as determined by the Health Trust Administrator.
- No penalty applies to physician services. This includes x-rays, lab work, or other outpatient services obtained in the doctor's office, by the doctor's staff, with the doctor's equipment. Some doctors maintain separate practices but share resources with other doctors in the same building. A penalty would apply to the services if the doctor or clinic does not own the equipment.

Your Choice of Physician

You may select the physician of your choice and generally the PPO provisions do not apply to charges for physician services. If your physician directs you to a non-PPO facility for inpatient or outpatient services, the PPO provisions will apply to the facility charges.

Most Anchorage-based physicians have privileges at Alaska Regional Hospital and the Surgery Center of Anchorage and are able to see patients and perform procedures there. A limited number of services are hospital-based; hospitals generally contract with pathologists, anesthesiologists, emergency room physicians and radiologists to provide in-hospital services. Privileges for these hospital-based services may be limited. The PPO provisions will apply to the facility charges as long as the services can be provided at that facility, regardless of whether a particular physician has privileges.

Coordination of Benefits With Other Health Plans

It is generally beneficial to follow the PPO provisions of the health plan that pays primary, or that offers the greatest benefit. For example, if you are covered by 2 health plans that each provide coverage with an 80% reimbursement, you should follow the PPO provisions for your primary plan.

The non-PPO penalties do not apply to participants in Plan C, the Supplemental Plan. Because Plan C is designed to provide supplemental benefits to participants with other

coverage, participants in this plan are encouraged to follow the PPO provisions of their other health plan.

Incentive for Mat-Su Borough Residents to Use Alaska Regional Hospital or the Surgery Center of Anchorage

The Plan will pay an incentive to participants who live in the Mat-Su Borough and choose to receive treatment at Alaska Regional Hospital or the Surgery Center of Anchorage instead of Mat-Su Regional Medical Center. The incentive payment will be 10% of the amount the Plan pays Alaska Regional Hospital, up to $500 for outpatient procedure/surgery services and $1,000 for inpatient hospital services for each treatment episode. Each period of hospitalization and each day of outpatient surgery, from facility admittance to check out, is considered one treatment episode.

The incentive:

- Applies to inpatient services or outpatient procedures/surgery only;
- Is based on the facility fees only; and
- Is only available when the Plan is the patient's primary medical plan.

The incentive does not apply to testing or radiology not provided as part of an inpatient hospitalization or outpatient procedure/surgery.

In order to receive the incentive payment, you must complete an Incentive Request form and submit it to the Health Trust Administrator within 365 days of the date of service.

Prescription Drug Pharmacy Network

If you obtain your prescriptions at participating network pharmacies or the mail order program, you pay only your prescription drug Copay. If you obtain your prescriptions at non-participating pharmacies, you must file a claim under the prescription Plan, and the Allowable Expense will be the negotiated network rate, so you may not receive reimbursement for the entire amount submitted.

VSP Provider Network for Routine Vision Care

VSP maintains a network of providers who give discounts off of their usual and customary fees. The Plan provides a greater benefit if you use a VSP Network Provider.

PRECERTIFICATION REQUIREMENTS

All in-patient hospital and skilled nursing facility admissions require Precertification. Certain outpatient surgery and other outpatient services may also require Precertification by a PPO provider. For non-PPO providers, Precertification is recommended for those outpatient procedures that require Precertification by PPO providers. Please refer to the ASEA website www.aseahealth.org for a complete list of outpatient procedures that require Precertification.

- **If you use an Aetna PPO provider**, the provider is responsible for obtaining necessary Precertification for you. Because Precertification is the provider's responsibility, if the provider fails to Precertify required services, their reimbursement will be limited and the provider cannot pass those costs on to you unless you sign a waiver.

- **If you use a non-PPO provider,** your provider is still responsible for Precertifying inpatient hospital and skilled nursing facility admissions. If the provider fails to Precertify those services, Aetna will review the medical necessity of those services when the claim is filed. If the service is not Medically Necessary and is not approved, no benefits will be paid. If the service is Medically Necessary, benefits will be paid according to the Plan. If the service was Medically Necessary but not Precertified, the Health Trust will apply a **$400 penalty for failure to Precertify inpatient medical admissions and a $200 penalty for failure to Precertify a skilled nursing facility admission. If your provider fails to Precertify, you will be responsible for those penalties.**

IMPORTANT: Precertification is done by an objective Utilization Review provider who determines if the treatment is Medically Necessary. Obtaining a Precertification does not guarantee eligibility or coverage for a particular procedure. You are responsible to contact the Health Trust Administrator to determine eligibility and coverage.

How to Precertify:

When Precertification is required, the hospital or your doctor should call Aetna at the number listed in the Plan Contacts section of this booklet. The number can also be found on your identification card.

Although your provider initiates the Precertification, it is ultimately your responsibility to ensure that Precertification has been obtained.

When To Call

Your provider should call:

- At least 14 days in advance of a prescheduled admission or as soon as the admission is scheduled (Your provider must call before the confinement or services begin); or,
- Within two working days following an emergency admission, or as soon as reasonably possible.

For the purposes of this section, an emergency admission is an admission where the physician admits the person to the hospital because of an Emergency Medical Condition.

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

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman and/or her unborn child) in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part,

  as determined by the Health Trust Administrator.

You will receive prompt written notice of the days and/or services certified. If you are to be confined in a hospital or other facility, Aetna sends notice to the hospital or the facility as well as to you and your physician.

Precertification of Additional Days

If your physician is considering lengthening a stay, your physician or the hospital or facility must call the Utilization Review provider to request Precertification for additional days. Call no later than the last day previously certified.

If there has been no prior contact, the Utilization Review provider may contact the facility on the last scheduled date of confinement to check your condition. If Medically Necessary, additional days of confinement may be certified at that time.

Precertification Does Not Guarantee Payment

When the Utilization Review provider Precertifies any confinement, procedure, service or supply, it is only for the purpose of reviewing whether the service is Medically Necessary to the care or treatment of the illness. **Precertification does not guarantee that all charges are covered under the Plan. All charges submitted for payment are subject to all other terms and conditions of the Plan, regardless of "certification" by the Utilization Review provider.** Contact the Health Trust Administrator to inquire about coverage for specific services.

If the Confinement, Procedure, Service or Supply is not Certified

If your provider attempts to Precertify a confinement, procedure, service, or supply and it is not certified by the Utilization Review provider, the Plan will pay no benefits for that treatment. You may appeal the decision of the Utilization Review provider. For more information on your appeal rights, refer to the If a Claim is Denied section of the booklet.

Penalties for Failure to Precertify

If you use an Aetna PPO provider, the provider is responsible for obtaining necessary Precertification for you. Because Precertification is the provider's responsibility, if they fail to Precertify required services, the provider's reimbursement will be limited, and they cannot pass those costs on to you.

If you use a non-PPO provider, your provider is still responsible for Precertifying inpatient hospital and skilled nursing facility admissions. If the provider fails to Precertify those services, Aetna will review the medical necessity of those services when the claim is filed. If the service is not Medically Necessary and is not approved, no benefits will be paid. If the service is Medically Necessary, benefits will be paid according to the Plan. If the provider fails to Precertify and the Plan determines the services are Medically Necessary, the following penalties will apply:

- Hospital or treatment facilities – the first $400 of Allowable Expenses will not be paid.
- Skilled nursing facilities – the first $200 of Allowable Expenses will not be paid.

No penalty will apply to a hospital stay for childbirth unless it exceeds 48 hours for a normal delivery or 96 hours following cesarean delivery.

Penalties applied for failure to Precertify will not apply to your Annual Out-of-Pocket Limit.

For members enrolled in Plan C, if required Precertification is not obtained for inpatient or outpatient services, no Precertification penalties will be applied to the benefits.

Please refer to the ASEA Health Trust website for a complete list of outpatient procedures that require Precertification.

EMPLOYEE-ELECTED SECOND OPINIONS

The Plan pays the covered expenses for obtaining a second surgical opinion when the first surgeon has recommended non-emergency surgery, according to the Reimbursement Percentage shown in the Benefits Summary section.

Charges for X-rays and diagnostic tests required in connection with the second opinions are included. However, to avoid duplication, the attending physician is encouraged to share his X-ray and test results with the consulting physician(s).

To qualify for second opinion benefits, the proposed surgery:

- Must be recommended by the physician who plans to perform it;
- Will, if performed, be covered under this Medical Plan; and
- Must require General or Spinal Anesthesia.

The second opinion must be obtained before you are hospitalized. You may choose your consulting physician.

PREAUTHORIZATION OF TRAVEL EXPENSES

The Plan covers travel expenses to obtain medical services, under certain conditions.

In order for the travel expenses to be considered for reimbursement, you must complete the Travel Preauthorization Form and submit the form to the Health Trust Administrator before you travel.

- Obtain a Travel Preauthorization Form from the Health Trust Administrator or download a copy of the form from the Trust website.
- Complete the top portion and have your referring physician complete the bottom.
- Submit the form to the Health Trust Administrator before you travel.
- The Health Trust Administrator will provide you with written Preauthorization.

Another Travel Preauthorization Form is required if two visits for the same condition are separated by 45 days or more.

If you do not have time to obtain the form or you have not received written Preauthorization you must call the Health Trust Administrator before you travel.

Penalties for Failure to Preauthorize Your Travel Expenses

No travel benefits will be paid. Refer to the Travel section for more detailed information.

CASE MANAGEMENT

Individual case management (CM) is a voluntary program to assist you if you suffer a long-term illness or injury. The case manager works with your medical providers to help ensure that all the necessary services are provided appropriately, efficiently and in a timely manner, within the framework of your benefit plan.

When reviewing claims for the CM program, the case management provider always works with you, your family, and your physician so you receive close, personal attention. The case management provider identifies and evaluates potential claims for CM, always keeping in mind that **alternative care must result in savings without detracting from the quality of care**.

Through case management, the case management provider can consider recommendations involving expenses usually not covered for reimbursement. This includes suggestions to use alternative medical management techniques or procedures, or suggestions for cost-effective use of existing Plan provisions such as home health care and convalescent facilities. All parties must approve alternate care before it is provided.

Examples of conditions that may qualify for CM include:

- Spinal Cord injuries with Paralysis;
- High Risk Infants undergoing Neonatal care;
- Traumatic Brain injury resulting from an accident;
- Severe burns;
- Multiple fractures;
- Stroke;
- Any confinement exceeding 10 days; and
- Conditions or injuries requiring substantial medical resources over a long period of time or those where another cost effective alternative may be available.

If you have questions regarding CM and its possible application to you, call the Health Trust Administrator.

DISEASE MANAGEMENT

If you are diagnosed with a chronic disease, the Plan may provide services to help you manage your condition. The Disease Management program is voluntary and confidential. The Disease Management provider works with you and your physician to enhance, but not replace, physician care.

Conditions eligible for disease management:

- Asthma
- Chronic Obstructive Pulmonary Disorder (COPD)
- Coronary Artery Disease
- Diabetes

- Heart Failure
- Musculoskeletal Pain

This program is offered to Employees and dependents. If you have questions regarding Disease Management and its possible application to you, call the Health Trust Administrator.

TELADOC

Teladoc provides access to health care providers by phone, online or via mobile app. You pay $0 copay and the services are not subject to a deductible.

- **For non-emergency medical care.** Through Teladoc, you can access board-certified physicians 24 hours per day, 7 days a week. Teladoc providers can treat a variety of conditions such as cold & flu, allergies, sinus problems, sore throat or respiratory infection.
- **For behavioral health services.** Eligible adults 18 and older can get care for anxiety, depression, grief, family issues, and more through Teladoc Behavioral Health. There is no co-pay for Teladoc Behavioral Health visits. Choose to see a psychiatrist, psychologist, or therapist and establish an ongoing relationship. Teladoc Behavioral Health providers are available for appointments 7 days a week, 7am to 9pm local time. Sessions are available via video only.

BRIDGEHEALTH

The ASEA Health Trust has partnered with BridgeHealth to provide you with another option for elective and non-urgent surgeries if you wish to travel outside Alaska. Through BridgeHealth, you can have your surgery performed by a top-rated surgeon who is considered an expert for that procedure at a surgical facility that has a proven track record for healthy outcomes – at NO COST to you! The Health Trust is able to offer this benefit because the cost for these procedures can be much lower outside of the state of Alaska.

If you choose BridgeHealth, the Health Trust pays:

- All surgical costs during the episode of care*; and there is no deductible or coinsurance,
- Your travel expenses, including first-class airfare, lodging and food, up to benefit limitations,
- Travel expenses for a companion (whom you choose) to go with you as your caregiver.

**Other costs may be incurred which may be covered by your medical benefits but may be subject to your deductible or coinsurance such as medical clearance exam, durable medical equipment, additional imaging, follow up care with your local provider, and on-going physical therapy.*

Plan limitations and exclusions will apply with respect to surgical procedures covered by the Plan. If the ASEA Health Trust Plan is your secondary health plan or if you are covered under Plan C, BridgeHealth may not be available to you. Contact ASEA Health Trust Administrator for more information.

COALITION HEALTH CENTERS

The Coalition Health Centers provide a variety of services to help you and your covered dependents.

Primary Care	Acute Illness or Injury
Physical exams	Cough
Chronic disease management	Cold
Women's care	Sore throat
Immunizations	Earache
Laboratory services	Rash
Minor procedures	Strains
Medication management *(including dispensing some low cost generic medications)*	Sprains
Radiology services	

The Deductible is waived for services obtained at the Coalition Health Centers and benefits are paid at 100% of Allowable Expenses.

COVERED MEDICAL EXPENSES

Anesthetic

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

Autism and Pervasive Developmental Disorders

Diagnosis and treatment of autism and pervasive development disorders, including physical, speech and occupational therapy and therapy to treat cognitive delay will be covered if determined to be Medically Necessary by the Plan.

Chiropractic, Massage Therapy, and Acupuncture Services

A limit of 20 visits per person each Benefit Year applies to chiropractic, massage therapy, and acupuncture services combined.

The services subject to this limit are:

- Office visits;
- Examinations;
- Consultations;
- Regional manipulations;
- Massage therapy; and
- Acupuncture.

Massage therapy is covered when it is prescribed by a physician, chiropractor, or naturopath and performed under the physician's, chiropractor's or naturopath's supervision. Services do not have to be performed in a chiropractor's office. The limit does not apply if you are confined as a full-time inpatient in a hospital.

Acupuncture services must be performed by a licensed acupuncturist.

The 20 visit limit will apply to all services performed by a chiropractor.

The Plan will also pay for acupuncture therapy performed by a physician as a form of anesthesia in connection with surgery covered under the Plan, and these services are not subject to the 20 visit limit.

Colonoscopies, Endoscopies, Sigmoidoscopies, Laparoscopies and Arthroscopies

Important: If you obtain inpatient or outpatient hospital services within the Municipality of Anchorage, the Plan will provide different benefits depending on whether the Preferred Provider (PPO) facility is used. Alaska Regional Hospital is the PPO facility in Anchorage. Please refer to the Preferred Provider Provisions section of this booklet for more details.

These services are covered when Medically Necessary for the diagnosis or treatment of a condition. Preventive colonoscopies and sigmoidoscopies may be covered as part of the Preventive Care benefit.

Diabetes Education

The Plan covers diabetes education provided by a Certified Diabetes Educator when a participant:

- Is first diagnosed with diabetes;
- Reaches puberty or adulthood, if initially diagnosed as a juvenile;
- Is diagnosed with gestational diabetes during pregnancy; or
- Experiences a substantial lifestyle change.

Dialysis Treatment - Outpatient

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

- The Dialysis Program has been established for the following reasons:
  - the concentration of dialysis providers in the market in which Plan members reside may allow such providers to exercise control over prices for dialysis-related products and services,
  - the potential for discrimination by dialysis providers against the Plan because it is a non-governmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Plan members,
  - evidence of (i) significant inflation of the prices charged to Plan members by dialysis providers, (ii) the use of revenues from claims paid on behalf of Plan members to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of the Plan and other non-governmental and non-commercial plans by the dialysis providers as profit centers, and
  - the fiduciary obligation to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to Plan members, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the Plan members' interests, such as subsidies for other plans and discriminatory profit-taking.
- The components of the Dialysis Program are as follows:
  - Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, Plan members for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims").

- Claims Affected. The Dialysis Program shall apply to all dialysis-related claims received by the Plan on or after March 1, 2013, regardless when the expenses related to such claim were incurred or when the initial claim for such products or services was received by the Plan with respect to the Plan member.
- Mandated Cost Review. All dialysis-related claims will be subject to cost review by the Plan to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the Plan shall consider factors including:

    1. Market concentration: The Plan shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.
    2. Discrimination in charges: The Plan shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.

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

    1. Where the Plan deems it appropriate in order to minimize disruption and administrative burdens for the Plan member, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.
    2. Where the provider is or has been a participating provider under a Preferred Provider Organization (PPO) available to the Plan's members, upon the Plan's determination that payment limitations should be implemented, the rate payable to such provider shall be subject to the limitations of this Section.
    3. Maximum Benefit. The maximum Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or Deductibles.

4. Usual and Reasonable Charge. With respect to dialysis-related claims, the Plan shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.
5. Additional Information related to Value of Dialysis-Related Services and Supplies. The Plan member, or where the right to Plan benefits has been properly assigned to the provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Plan, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Plan based upon credible information from identified sources. The Plan may, but is not required to, review additional information from third-party sources in making this determination.
6. All charges must be billed by a provider in accordance with generally accepted industry standards.

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

— Discretion. The Board of Trustees shall have full authority and discretion to interpret, administer and apply this Section, to the greatest extent permitted by law.

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

Durable Medical Equipment/Supplies

When Medically Necessary, the Medical Plan may cover supplies prescribed by a physician. Some of these items may require Precertification. Please refer to the ASEA website for a complete list of medical equipment and supplies that need to be Precertified. The Plan may cover the following:

- Artificial Limbs and Eyes;
- Bandages and surgical dressings;

- Purchase or rental of auto-repositioning appliances, casts, splints, trusses, braces, crutches, and other similar, durable medical or mechanical equipment;
- Rental or purchase of a basic wheelchair or hospital-type bed;
- Insulin pumps and supplies;
- Rental or purchase of iron lungs or other mechanical equipment required for respiratory treatment;
- Blood transfusions, including the cost of blood and blood derivatives; and
- Oxygen or rental of equipment for the administration of oxygen. The Plan will also cover:
- Wigs for participants who experience hair loss due to cancer treatment, up to a lifetime maximum benefit of $600;
- Two special prosthesis bras every six months for participants who have undergone breast removal due to a medical condition;
- Custom orthotics when Medically Necessary, up to one pair per Benefit Year; and
- Prescription pressure gradient stockings, up to 8 pairs per Benefit Year.
- Charges for the purchase, repair, or replacement of durable medical and post-surgical equipment will be included as covered medical expenses as follows:
- The initial purchase of such equipment and accessories to operate the equipment is covered only if the Health Trust Administrator is shown that:
    - long-term use is planned; and
    - the equipment cannot be rented; or
    - it is likely to cost less to buy it than to rent it.
- Repair or replacement of purchased equipment and accessories will be covered only if the Health Trust Administrator is shown that:
    - it is needed due to a change in the person's physical condition; or
    - it is likely to cost less to buy a replacement than to repair the existing equipment or to rent similar equipment.

Not included are charges for more than one item of equipment for the same or similar purpose.

Durable medical and surgical equipment is equipment that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of a disease or injury;
- Suited for use in the home;
- Not normally of use to persons who do not have a disease or injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Emergency Room Visits

Visits to the emergency room of a hospital are paid at normal Plan benefits. However, if the visit is for non-emergency services, a penalty of $100 will be applied to the claim before benefits are determined.

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

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman and/or her unborn child) in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part,

as determined by the Health Trust Administrator.

A non-emergency is anything that does not meet these criteria.

Services received in a physician's office or an urgent care facility are not subject to this penalty. The penalty will not apply to services provided after normal business hours, on weekends or on holidays. This penalty will not apply to your Annual Out-of-Pocket Limit.

Employee Assistance Program (EAP)

The Employee Assistance Program (EAP) is a confidential counseling service, free of charge to you and your dependents, provided by a contracted, independent employee assistance vendor.

This service provides assessment, treatment, and referral services. The program is geared to provide assistance with difficulties that you may encounter at work, emotional problems, stress, family or relationship problems, and drug and alcohol abuse.

Call the number shown in the Plan Contacts section of this booklet for the EAP provider. Staff is available 24 hours a day, 7 days a week. When you call, you may be able to work through your problem on the telephone with an EAP counselor. In most cases though, the staff will try to schedule an appointment with a local counselor. The counselor will then assess your situation in person. Based upon this assessment, he or she will either counsel you or refer you to another professional for specialized care. In an emergency, the EAP staff will provide crisis counseling by telephone or will direct you immediately to appropriate medical or psychiatric facilities in your area.

Your call or visit to the EAP staff is completely confidential. Unless you choose to tell others, no one needs to know about your EAP counseling sessions. EAP counseling offices are located away from your work site. Discussions with an EAP counselor will not be revealed to anyone without your written permission. However, in cases involving child abuse or threatened harm to yourself or others, EAP counselors may be required by law to suspend confidentiality to protect the persons involved.

Gender Dysphoria

The Plan will cover Medically Necessary treatment of gender dysphoria including surgery and related medical treatment necessary for gender reassignment.

Genetic Counseling and Testing

The Plan will cover genetic counseling and testing when Medically Necessary. This may require Precertification. Please refer to the ASEA website for a list of genetic tests requiring Precertification.

Healthy Diet Counseling

The Plan will cover Healthy Diet Counseling for participants with chronic diet related diseases such as allergies, AIDS/HIV, cancer, diabetes, digestive or eating disorders, osteoporosis, obesity, hyperlipidemia or other known risk factors for cardiovascular disease. The plan will cover an initial assessment and up to 4 follow-up visits per Benefit Year. These will be considered preventive services, paid at 100% of Allowable Expenses. Counseling with licensed nutritional counselors and registered dietitians is covered for this benefit only.

Home Health Care

The Medical Plan may pay for the charges of a home health care agency for services and supplies furnished to you at home for care in accordance with a home health care plan. Please refer to the ASEA website for a list of home health care related services that may require Precertification.

A home health care agency is an organization:

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

A home health care plan provides for the treatment of a disease or injury in a place of confinement other than a hospital or skilled nursing facility. The attending physician must prescribe care and treatment in writing.

Treatment may include:

- Part-time or intermittent nursing care by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.);
- Part-time or intermittent home health aide services which consist primarily of caring for you;
- Physical, Occupational, or Speech Therapy;

- Medical supplies, drugs, and medicines prescribed by a physician if they would have been covered had you been confined in a hospital or skilled nursing facility; and
- Laboratory services provided by or on behalf of a home health care agency if they would have been covered had you been confined in a hospital or skilled nursing facility.

Up to 120 home health care visits to your home are covered in any one Benefit Year. A single visit may include any or all of the following:

- A visit by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) to provide skilled nursing care;
- A visit from therapists to provide Physical, Occupational, or Speech Therapy; and/or
- Up to four hours of assistance by a home health aide.

Skilled nursing care includes:

- Those services provided by a visiting R.N. or L.P.N. These visits may not last more than two hours and must be for the purpose of performing specific skilled nursing tasks; and
- May be defined as private duty nursing services provided by an R.N. or L.P.N. if the individual's condition requires skilled nursing services and visiting nursing care is not adequate.

Home health care expenses which are **not** covered include:

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

Hospice Care

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

Covered Hospice expenses are limited to:

- Room and Board for confinement in a Hospice,
- Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an injury or sickness,
- Medical supplies, drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition,
- Physician services and/or nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse,

- Home health aide services,
- Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide,
- Medical social services by licensed or trained social workers, psychologists or counselors,
- Nutrition services provided by a licensed dietician, and
- Respite care.

The written Hospice Care program must be submitted to the Health Trust Administrator by the attending Physician. The written program must be renewed every 30 days. Hospice Care ceases if the terminal illness enters remission.

Hospitalization

Important: Precertification is required for all inpatient hospital stays. If Precertification is not obtained, a $400 penalty will be assessed before any benefits will be paid. Please refer to the Precertification Requirements section in this booklet.

If you obtain inpatient or outpatient hospital services within the Municipality of Anchorage, the Plan will provide different benefits depending on whether the Preferred Provider (PPO) facility is used. Alaska Regional Hospital is the PPO facility in Anchorage.

Please refer to the Preferred Provider Provisions section of this booklet for more details.

A hospital is an institution providing inpatient medical care and treatment of sick and injured people. It must:

- Be accredited by the Joint Commission on Accreditation of Hospitals, be a medical care, psychiatric, or tuberculosis hospital as defined by Medicare, or have a staff of qualified physicians treating or supervising treatment of the sick and injured; and
- Have diagnostic and therapeutic facilities for surgical and medical diagnosis on the premises, 24-hour-a-day nursing care provided or supervised by registered graduate nurses, and continuously maintained facilities for operative surgery on the premises.
- For non-emergency hospital services outside the US, the hospital must be accredited by the Joint Commission International.

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

The Plan also provides for hospital services and supplies which include those charges made by a hospital on its own behalf for Medically Necessary services and supplies actually

administered during hospital confinement other than for room and board, intensive care unit, private duty nursing, or physicians' services. Services of a personal nature, including radio, television, and guest trays, are **not** included.

If benefits change during your stay, the benefits that were in effect the day you were hospitalized will apply. The new benefits are effective the day after you are discharged from the hospital.

Mental Disorders and Substance Use Treatment

The Medical Plan pays for treatment of substance use and mental disorders. Inpatient expenses for room and board and other necessary services and supplies are subject to the inpatient hospital Precertification requirement described in the Precertification Requirements section of this booklet. Also covered are physician's charges for inpatient or outpatient treatment.

Mental Health Care

Benefits for mental health services, including the diagnosis of pervasive development disorder (autism) and eating disorders are provided. Covered mental health services include inpatient care, partial hospitalization, and outpatient care to manage or lessen the effects of a psychiatric condition. Services must be consistent with generally recognized standards within a relevant health profession licensed by the state in which the care is given and recognized as a covered provider by the Plan.

Charges will be covered for:

- Individual and group counseling;
- Individual and group psychotherapy;
- Psychological testing; and
- Family counseling sessions in the service of one individual's ongoing individual treatment for a mental health diagnosis.

Mouth, Jaws, and Teeth – Treatment Under the Medical Plan

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

- Inpatient hospital care to perform dental services if required due to an underlying medical condition;
- Surgery needed to treat wounds, cysts, or tumors or to alter the jaw, joint, or bite relationships when appliance therapy alone cannot provide functional improvement;
- Non-surgical treatment of infections or diseases not related to the teeth, supporting bones, or gums;
- Dental implants, if necessary, due to disease or accident, but only if dentures or bridges are inappropriate or ineffective. False teeth or dentures for use with implants are covered when the implants are initially seated. Replacement false teeth or replacement dentures for use with implants are covered under the dental plan as a Class III service. Services needed to treat accidental fractures or dislocations of the

jaw or injury to natural teeth if the accident occurs while the individual is covered by the Plan. Treatment must begin during the year the accident occurred or the year following. The teeth must have been damaged or lost other than in the course of biting or chewing and must have been free of decay or in good repair;

- Diagnosis, appliance therapy (excluding braces), non-surgical treatment, and surgery by a cutting procedure which alters the jaw joints or bite relationship for temporomandibular joint disorder or similar disorder of the joint; and
- Orthodontia treatment for children born with a cleft lip and/or palate, when orthodontia is Medically Necessary in conjunction with surgery or as a part of an overall treatment plan.

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

Orthodontic treatment **is not** covered, even when provided in conjunction with covered medical treatment of the mouth, jaws and teeth, except as provided above for children born with a cleft lip and/or palate.

Newborn Care

Newborn care provided within the first 72 hours after birth (96 hours if delivered via cesarean) is covered according to the Summary of Benefits. This includes nursery charges, physician's services, circumcision, and other routine care for a newborn child. Circumcisions performed later than the first 72 hours after birth (96 if cesarean) but within 60 days of birth will be covered subject to Deductibles, Reimbursement Percentages and all other plan provisions.

Other well-baby care is covered under the Annual Preventive Care Benefit provided by the Plan.

Charges for a newborn who has suffered an injury, illness, premature birth, or other abnormal condition are covered like any other Medically Necessary services.

You must notify the Health Trust Administrator as soon as possible after the birth of the child to add the child to the Plan.

Obesity Treatment

Medical Supervision of Weight Reduction Programs

Medically Necessary expenses for medical supervision of weight reduction programs will be covered as any other medical condition when:

- The patient is 60% or more over ideal body weight, as determined by the Health Trust Administrator; or
- The patient is more than 30% over ideal body weight, as determined by the Health Trust Administrator, and has one or more of the following documented medical conditions: Diabetes, Cardiac Disease, Respiratory Disease, Hypertension, and Hypothyroidism. Diagnoses not acceptable for coverage include, but are not limited to:

- fasting
- hyperglycemia
- dyspnea on exertion
- lower back pain
- hiatal hernia

Covered services for medical supervision of weight reduction include history and complete physical exam, diagnostic tests, physician office visits, and anorectic (weight control) prescription drugs.

Coverage for ongoing medical supervision of a weight reduction program shall be continued for 3 months past the point when the patient no longer meets the criteria listed above.

Surgical Treatment of Obesity

The Plan requires Precertification of surgical treatment of obesity, and the participant must meet the criteria as determined by the Utilization Review provider.

The Plan limits coverage for surgical treatment of obesity as follows:

- The Plan limits reimbursement for the cost of the surgical treatment of obesity as described in the Summary of Benefits. The cost of surgical treatment of obesity includes the Allowable Expenses for the professional fees and hospital charges for bariatric surgery and panniculectomy combined.
- The participant's cost for surgical treatment of obesity will not apply to the Annual Out-of-Pocket Limit and the Plan's reimbursement for surgical treatment of obesity will not increase to 100% of Allowable Expenses after the participant has met the Medical Annual Out-of-Pocket Limit.
- The Plan will pay for no more than one episode of surgical treatment of obesity per participant.

Charges due to complications resulting from surgical treatment of obesity will continue to be paid under the Medical Plan and subject to the medical plan's Deductible, Reimbursement Percentage, Out-of-Pocket Limits and all other medical plan provisions. Charges due to complications do not include the costs of services that would be provided in the absence of complications, such as the professional and facility fees for the surgery and related procedures and any charges incurred during the period of hospitalization that had been certified as Medically Necessary following the surgery.

Non-covered services include, but are not limited to: intestinal bypass surgery, gastric bubble balloon surgery, special diet supplements, vitamin injections, hospital confinement for weight reduction programs, exercise, exercise equipment, whole body calorimeter studies, and psychiatric treatment/counseling including behavior modification, biofeedback, and hypnosis.

Outpatient Ambulatory Surgery

If you obtain inpatient or outpatient hospital services within the Municipality of Anchorage, the Plan will provide different benefits depending on whether the Preferred Provider (PPO) facility is used. Alaska Regional Hospital is the PPO facility in Anchorage. Please refer to the Preferred Provider Provisions section for more details.

The Medical Plan covers same-day ambulatory surgery according to the Summary of Benefits. To be considered Outpatient Ambulatory Surgery, the surgery must take place in a freestanding surgical facility or outpatient department of a hospital. It does not include surgeries which are normally performed in a doctor's office.

Outpatient Preoperative Testing

If you obtain inpatient or outpatient hospital services within the Municipality of Anchorage, the Plan will provide different benefits depending on whether the Preferred Provider (PPO) facility is used. Alaska Regional Hospital is the PPO facility in Anchorage. Please refer to the Preferred Provider Provisions section for more details.

The Plan covers preoperative testing performed while on an outpatient basis, as outlined in the Summary of Benefits, provided the surgery is a covered expense under the Plan. You must be tested within seven days prior to your surgical procedure.

Physician's Services

The Medical Plan pays for covered medical treatment and surgery performed by a qualified physician. Providers who are covered by the Plan are people licensed to practice:

- Medicine and surgery (MD)
- Osteopathy and surgery (DO)
- Dentistry (DDS or DMD)
- Ophthalmology (MD or DO)

Also covered are:

- Psychologists
- Occupational Therapists
- Physical Therapists
- Licensed Clinical Social Workers
- Licensed Professional Counselors
- Licensed Marriage and Family Therapists
- Licensed Acupuncturists
- Certified Diabetes Educators
- Registered Dietitians (for Healthy Diet Counseling benefit only)

- Licensed Nutritional Counselors (for Healthy Diet Counseling benefit only)
- Audiologists
- Optometrists
- State-certified Nurse Midwives or Registered Midwives
- Naturopaths
- Chiropractors
- Massage Therapists, if massage therapy is prescribed by a physician, chiropractor, or naturopath, and the services are performed under a physician's, chiropractor's, or naturopath's supervision.
- Podiatrists
- Christian Science Practitioners authorized by the Mother Church, First Church of Christ Scientist, in Boston, Massachusetts
- Nurse Practitioners
- Psychological Associates
- Practitioners with a master's degree in Psychology or Social Work if supervised by a Psychologist, Medical Doctor, or Licensed Clinical Social Worker

To the extent State licensing is available or required, providers must be licensed by the State in which they practice and practicing within the scope of their license. Not all services rendered by covered providers are covered services under the Plan.

Plastic, Cosmetic, and Reconstructive Surgery

Reconstructive or other procedures that may be considered cosmetic may require Precertification. Please refer to the ASEA website for a list of procedures requiring Precertification. The Plan covers plastic, cosmetic, or reconstructive surgery **only** as needed to:

- Improve the function of a part of the body (excluding teeth or any structure that supports the teeth) that is malformed as a result of:
    - a severe birth defect, including cleft lip/palate or webbed fingers or toes; or
    - disease, or surgery performed to treat a disease or injury; or
- Repair an injury sustained in an accident, which occurs while you are covered under the Plan, provided such treatment is started within 90 days of the accident; or
- Reconstruction of the breast on which a mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications at all stages of mastectomy, including lymphedemas.

Pregnancy

If you obtain inpatient or outpatient hospital services within the Municipality of Anchorage, the Plan will provide different benefits depending on whether the

Preferred Provider (PPO) facility is used. Alaska Regional Hospital and Geneva Woods Birth Center are the PPO facilities in Anchorage. Please refer to the Preferred Provider Provisions section for more details.

Pregnancy and childbirth are covered like any other medical condition as long as you are covered under the Medical Plan.

Coverage is provided for a hospital stay for childbirth for at least 48 hours following a normal delivery or 96 hours following a cesarean delivery.

If you are totally disabled as a result of a pregnancy complication and your coverage ends, you may be eligible for extended benefits. See the Continuation Coverage section for more details.

Prescription Drugs

The Plan pays for prescription drugs for the treatment of an illness, disease, or injury if dispensed upon prescription of a provider who is licensed to prescribe drugs and is acting within the scope of his or her license.

You may obtain your medication from a participating pharmacy, the mail order program, or any other provider. For prescription drug benefits, a provider is defined as a pharmacy, physician, dentist, or other legally authorized dispenser of drugs.

You may receive up to a 90-day or 100-unit supply. Specialty medications will be limited to a 30-day supply. Compound medications are limited to one-fill per 25 days. Certain controlled substances are subject to additional quantity limitations.

Prescriptions Obtained While in a Hospital, Skilled Nursing Facility, Psychiatric Facility or Similar Institution

Inpatient prescription drug benefits are paid under the Medical Plan.

Participating Network Pharmacies

If you obtain your prescriptions at participating network pharmacies, you will only need to pay your prescription drug Copay. The pharmacy will file a claim for you so that you don't have to pay for the prescription and file a claim for reimbursement. You must present your Health Plan identification card to a participating pharmacy. A list of participating pharmacies is available from the Trust and is posted on the Trust website.

Non-Participating Pharmacies

If you obtain your prescriptions at non-participating pharmacies, you must file a claim with the prescription benefit provider. The Allowable Expense at an out-of-network pharmacy will be the negotiated network rate. Any amount above the Allowable Expense will be your responsibility and will not apply to the maximum Copay per prescription or per person per Benefit Year.

Mail Order Program

If you take maintenance medication, you can take advantage of this optional program. Refer to the Plan Contacts section of this booklet for the mail order pharmacy provider.

To use this program, obtain an order form from the mail order pharmacy or print one off of the Trust website. Complete the form and send it to the mail order pharmacy along with your

physician's prescription. Unless indicated by the physician, you receive the generic equivalent when available and permissible by law.

Coordination of Benefits

The prescription plan coordinates benefits. Online claim adjudication at the pharmacy will only work when the Trust Plan is the primary claims payor. If your other health plan is primary, you should use your other Plan's prescription drug card or submit the claim to your other coverage first. Once your primary carrier makes its payment, you may file a paper claim with the prescription benefits manager for reimbursement of the unpaid portion of the claim. For more information about determining primary/secondary claims payors, refer to the General Provisions section, Coordination of Benefits.

Other Plan Provisions

A Prescription Drug is defined as a medical substance which cannot be dispensed in the US without a prescription.

The Plan covers needles and syringes purchased simultaneously with insulin, as well as other diabetic supplies and monitors.

The Plan also covers prescription birth control drugs and devices. Prior Authorization is not required for these items.

A generic drug is:

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

Formulary

The CVS/Caremark drug formulary is a list of generic and brand name prescription drugs that are evaluated by a committee of experts and chosen for their safety and effectiveness. Drugs which are not in the formulary may be excluded from coverage.

The Plan shall exclude from coverage any new drug or any new indication for an existing drug, approved by the U.S. Food and Drug Administration (FDA) on or after October 1, 2019, with an incremental cost-effectiveness ratio greater than $100,000 per additional quality-adjusted life-year for drugs not indicated in rare conditions and $150,000 per additional quality-adjusted life-year for drugs indicated in rare conditions , unless such drug or indication has been granted breakthrough therapy designation by the FDA. The Plan or its designee, CVS/Caremark, shall determine which drugs or indications exceed the incremental cost-effectiveness ratio threshold by: (1) reference to reports issued by the Institute for Clinical and Economic Review or similar organization; (2) assessment of peer-reviewed, published cost-effectiveness analysis; (3) consultation with qualified health care professionals; or (4) leveraging other unbiased sources.

Exclusions

In addition to the Limitations and Exclusions listed in the Medical Expenses Not Covered section, benefits are not payable under any prescription drug benefit for:

- A device of any type;
- Any drug entirely consumed at the time and place it is prescribed;
- The administration or injection of any drug, except vaccines;
- More than the number of refills specified by the prescriber. The Health Trust Administrator, before paying the claim, may require a new prescription or evidence as to need. For example, the need may be questioned if the prescriber did not specify the number of refills or if the frequency or number of prescriptions or refills appears excessive under accepted medical practice standards;
- Any refill of a drug dispensed more than one year after the latest prescription for it;
- Artificial saliva products and select skin or topical barriers, and
- Certain new drugs and new indications for existing drugs, approved by the U.S. Food and Drug Administration (FDA) on or after October 1, 2019, that exceed a minimum cost-effectiveness threshold established by the Plan, unless the drug has been granted breakthrough therapy designation by the FDA. The Plan threshold establishes a minimum value standard for prescription drugs measured by the benefit to patients through lengthening life or improving the quality of life.

You may obtain excluded drugs and supplies at your expense. Please log into www.caremark.com for up-to-date formulary and drug exclusion information.

Drugs Requiring Prior Authorization

Certain medications require Prior Authorization. These include:

- Specialty medications (see www.cvscaremarkspecialtyrx.com/);
- Non-specialty medications, refer to the list on the ASEA website;
- Compound medication that cost more than $300 per prescription;
- Prescriptions for non-specialty drugs that cost more than $1,500.

Note: prescription medications that are Medically Necessary to treat erectile dysfunction are subject to quantity limits. Medical benefits are allowed for related office visits and lab work when a prescription is written by the provider for the treatment of erectile dysfunction.

Diabetic test strips are limited to 200 strips per month without prior authorization, or up to 300 strips per month with prior authorization.

Preferred Specialty Drugs

CVS/Caremark has preferred options for certain specialty drugs such as growth hormones or medications used to treat auto-immune diseases (such as rheumatoid arthritis), infertility, multiple sclerosis, hepatitis, osteoarthritis, osteoporosis, pulmonary arterial hypertension, hematology, or chronic myeloid leukemia. You may be required to try a preferred medication before accessing a non-preferred medication or receive approval for the non-preferred medicine. If you choose a non-preferred specialty drug without first trying the preferred

medication or receiving prior approval, you may be responsible for the full cost of the non-preferred medication.

Brand-Name Drugs when Generic is Available
If you purchase a brand-name prescription when a generic equivalent is available (even if your doctor's prescription does not allow a substitution), the Plan will pay 80% of the generic equivalent. The difference in price between the brand name and generic will not apply to your Copay Maximum.

Preventive Care

The Plan provides coverage for physical exams and other preventive care services recommended under the Affordable Care Act (ACA).

In addition to the services recommended under the ACA, the Plan provides coverage for other preventive care services, such as:

- Immunizations. Although many immunizations are recommended under ACA, the Plan also includes other preventive immunizations for communicable diseases, including serums administered by a nurse or doctor, which are recommended by the CDC.
- Preventive screening tests provided through a health fair.
- Population groups for whom the risk of colon cancer is higher and screening at an earlier age is the standard of care.

Radiation, X-rays, and Laboratory Tests

If you obtain inpatient or outpatient hospital services within the Municipality of Anchorage, the Plan will provide different benefits depending on whether the Preferred Provider (PPO) facility is used. Alaska Regional Hospital is the PPO facility in Anchorage. Please refer to the Preferred Provider Provisions section for more details.

Certain forms of radiation may require Precertification. Please refer to the ASEA website for a complete list of services requiring Precertification.

The Medical Plan covers X-rays, radium treatments, and radioactive isotope treatments if you have specific symptoms. This includes diagnostic X-rays, lab tests, TENS therapy, and analyses performed while you are hospitalized. When these services are provided as part of a routine physical exam, preventive care exam or as part of a routine wellness check-up, they will be paid according to the Preventive Care benefit provided by the Plan.

Rehabilitative Care

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

Rehabilitative care includes:

- Physical Therapy and Occupational Therapy. To be considered physical therapy, the service must be provided by a licensed physical therapist;
- Speech Therapy if existing speech function (the ability to express thoughts, speak words, and form sentences) has been lost and the Speech Therapy is expected to restore the level of speech the individual had attained before the onset of the disease or injury; and
- Rehabilitative counseling or other help needed to return the patient to activities of daily living but excluding maintenance care or educational, vocational, or social adjustment services.

Rehabilitative care must be part of a formal written program of services consistent with your condition. .

Skilled Nursing Care

The Medical Plan pays for charges by a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or nursing agency for skilled care.

Covered services include:

- Visiting nursing care of an R.N. or L.P.N. of not more than two hours to perform specific skilled nursing tasks; and
- Private duty nursing by an R.N. or L.P.N. if your condition requires skilled nursing services and visiting nursing care is inadequate.
- Care provided for skilled observation for no more than 4 hours per day for a period of no more than 10 consecutive days following the occurrence of:
    - a change in patient medication;
    - the need for urgent or emergency medical services provided by a physician or the onset of symptoms indicating the likely need for such services;
    - surgery; or
    - release from inpatient confinement.

Skilled nursing services which are not covered, include:

- Nursing care that does not require the education, training, and technical skills of an R.N. or L.P.N., such as transportation, meal preparation, charting of vital signs, and companionship activities;
- Private duty nursing care given while the person is an inpatient in a hospital or other health care facility;
- Care provided to help a person in the activities of daily life, such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting; or
- Any service provided solely to administer oral medicines, except where applicable law requires that such medicines be administered by an R.N. or L.P.N.

Skilled Nursing Facility

Important: Precertification is required before any skilled nursing facility care is received. If Precertification is not obtained, a $200 penalty will be assessed before any benefits will be paid. Please refer to the Precertification Requirements under the Medical Benefits section.

The Medical Plan pays 100% of covered expenses, after the Deductible, for charges of a skilled nursing facility while you are confined for recovery from a disease or injury.

The following services at a skilled nursing facility are covered:

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

A skilled nursing facility is a licensed institution providing the following on an inpatient basis for persons convalescing from disease or injury:

- 24-hour professional nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.), if directed by a full time R.N.;
- Physical restoration services to help a patient meet a goal of self-care in daily living activities;
- Full time supervision by a Physician or R.N.;
- A complete medical record on each patient; and
- A utilization review plan.

It is **not** an institution for rest or care of the aged, people with mental disorders, or people who are chemically dependent or mentally Incapacitated.

Speech Therapy following Cochlear Implant Surgery

Habilitative speech therapy is covered following cochlear implant surgery.

Telemedicine

The Plan will cover virtual office visits that include both video and audio interaction. The Plan requires that telemedicine services include both video and audio (phone conversations only are not covered) and must be for a covered condition and service. The patient must be present (except for certain family therapy services) and medical records or chart notes must be submitted when requested. This benefit is separate from the services provided through Teladoc.

Transplant Benefits

The Plan requires Precertification for Organ Transplants.

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

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

Organ Procurement Limits

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

- Evaluation, screening and candidacy determination process.
- Removing the organ or tissue from the donor; and
- Transportation of the organ or tissue from within the United States or Canada to the facility where the transplant is to be performed. For a live donor, benefits are allowed for the donor's travel expenses, consistent with the Plan's travel benefit.

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

Travel

Important: Preauthorization is required for reimbursement of travel expenses, unless otherwise noted. If Preauthorization is required and is not obtained, no benefits will be payable. Please refer to the Preauthorization of Travel Expenses section in this booklet.

The Medical Plan pays travel and ambulance costs within the contiguous limits of the United States, the State of Alaska and the State of Hawaii. This includes:

- Transportation to the nearest hospital by Professional Ambulance.
- Round-trip transportation, not exceeding the cost of coach class commercial air transportation from the site of the illness or injury to the nearest professional treatment. If you use ground transportation and the most direct one-way distance exceeds 100 miles, reimbursement of expenses for ground transportation shall be calculated by applying the IRS mileage allowance for the distance traveled. Frequent flyer miles are not reimbursable. If you obtain services in a location other than the site of the nearest professional treatment, the maximum Allowable Expense will be the cost of travel to the site of the nearest professional treatment, as determined by the Plan.

- If the patient is a child under 18 years of age, a parent's or legal guardian's transportation charges are allowed. The Plan covers travel costs for a companion of an Incapacitated adult. An Incapacitated person may be unable to receive and evaluate information, communicate responsible personal decisions, and/or may exhibit an inability to meet his/her own personal needs for medical care, nutrition, clothing, shelter, safety or carry out the activities of daily living. When authorized by the Health Trust Administrator, travel charges for a physician or a registered nurse are covered.
- Travel does not include the cost of food and lodging (except as specified), or local ground transportation such as airport shuttles, cabs, or car rental.
- Travel benefits apply only to the conditions covered under the Medical Plan. They do not apply to the audio, dental, or vision plans.
- Once travel benefits are preauthorized, if the services incurred change as a result of the provider's medical judgment, the benefits will be paid according to the original Preauthorization. For example, if travel is preauthorized for treatment not available locally, and after the participant travels to the location of treatment the provider determines the anticipated treatment cannot or should not be provided, travel expenses will still be covered by the Plan.
- Travel, as described above, is covered only in the circumstances set forth in the sections below.

Emergencies

Travel is covered if you have an emergency condition requiring immediate transfer to a hospital with special facilities for treating your condition. Preauthorization is waived if you are immediately transferred in a ground or air ambulance; you do not need to call the Health Trust Administrator before this occurs.

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

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman and/or her unborn child) in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part,

as determined by the Health Trust Administrator.

Treatment Not Available Locally

Travel is covered for you to receive treatment which is not available in the area you are located when the need for treatment occurs. **Treatment must be received for travel to be covered, unless your provider determines the services cannot or should not be administered.**

These benefits are limited during each Benefit Year to:

- One visit and one follow-up visit for a condition requiring therapeutic treatment. Therapeutic treatment **does not** include:
  - diagnostic office visits and tests;
  - writing a prescription for medication or treatment; or
  - formulation of a treatment plan.
- One visit for prenatal or postnatal maternity care and one visit for the actual maternity delivery;
- One visit for each allergic condition; and
- One pre-surgical or post-surgical visit and one visit for the surgical procedure.

Food and Lodging

The Trust will cover food and lodging during the period associated with preauthorized travel, in the following circumstances:

- If you require preoperative testing within 7 days prior to surgery, the Plan will cover food and lodging for the days on which you actually receive preoperative testing;
- The Trust covers food and lodging for the period between treatments or between a treatment and a follow-up visit, when the follow-up care or additional treatment is provided within seven calendar days following treatment for which travel benefits are payable;
- For one primary care parent to care for a newborn child receiving treatment not available locally.

Food and lodging is reimbursed as follows:

- The Plan will reimburse actual expenses up to an Allowable Expense of $31 per day without overnight lodging, subject to the Deductible; or
- $80 per day, subject to the Deductible, if overnight lodging is required; and
- If a parent or legal guardian accompanies a child under age 18 or a companion accompanies an Incapacitated adult, the Plan pays up to an additional $31 per day.
- You must submit your receipts for the actual expenses to the Health Trust Administrator in order to receive reimbursement for food and lodging.

Second Surgical Opinions

Travel is covered if you require a second surgical opinion, which cannot be obtained where you are currently located. This will count as a pre-surgical trip as shown above.

Diagnostic Testing Not Available Locally

Travel is covered for you to receive diagnostic testing which is not available in the area in which you are located. Diagnostic testing must be received for travel to be covered and you must:

- Ensure your completed travel Preauthorization form is signed by a local referring health care provider and clearly states the reasons the diagnostic testing is recommended, and
- You must travel to the city in which the testing will be provided no earlier than 24 hours prior to the time in which the services are scheduled and return no later than 24 hours after testing is completed, unless it is Medically Necessary to arrive earlier or remain for a specified period after service is provided, or if there is no scheduled air or ferry service within the required time frames.

The Plan will pay 80% of Allowable Expenses for travel, and your out-of-pocket costs will not apply to your Annual Out-of-Pocket Limit. These benefits are limited to one diagnostic trip per year.

For members enrolled in Plan C, the Plan will pay 20% of Allowable Expenses for travel.

Surgery In Other Locations

Travel is covered if you have surgery which is provided less expensively in another location.

If the actual total cost of surgery, hospital room and board, necessary lodging and travel to another location for the surgery is less expensive than the Plan's Allowable Expense for the same services at the nearest location you could obtain the surgery, your travel costs may be paid. The Plan's coverage for necessary overnight lodging is limited to a maximum of $80 per day.
Preauthorization from the Health Trust Administrator is not required before you travel for this situation. To use this benefit, you will need to provide the Trust with documentation showing the savings for obtaining services in another location. Send your documentation, including a comparison between the charges that would have been incurred for local care and the actual cost of the out-of-area care covered by the Plan, including travel receipts to the Health Trust Administrator. The amount of reimbursement, if any will be determined when the claim is processed.

MEDICAL EXPENSES NOT COVERED

Limitations and Exclusions

The Medical Plan does not cover any condition, ailment, or injury for which you receive:

- Benefits from your employer's liability plan, federal or state Workers' Compensation, or similar law;
- Benefits available under any federal or state act (except services received from Alaska Native Health), even if you waive rights to those benefits; or
- Benefits for any condition, ailment or injury caused by the act or omission of a liable third party.

At the Medical Plan's option, the Medical Plan may advance benefits pursuant to the Conditional Benefits and Subrogation provisions of the Medical Plan while the liability of the

employer, federal or state Workers' Compensation program, or similar law is formally controverted, or while the liability of the third party or their insurer is established.

The following services and supplies are **not covered** and are excluded when determining benefits:

- Charges in connection with an occupational injury or illness. An occupational injury or illness is one that arises out of or in the course of any work for pay or profit (including self-employment), or in any way results from any injury or illness, which does. However, if proof is furnished that an individual is covered under Workers' Compensation or similar law but is not covered for a particular illness under such law, that illness will not be considered occupational regardless of cause.
- Charges for plastic, cosmetic, and reconstructive surgery; services or supplies which improve, alter, or enhance appearance are not covered, even if they are for psychological or emotional reasons, except as provided for in the Plastic, Cosmetic and Reconstructive Surgery section under Covered Medical Expenses.
- Services provided in an institution, which is primarily a rest home, for the aged or a nursing home.
- Custodial care regardless of where services are provided, or any portion of a hospital stay which is primarily custodial. Custodial care is comprised of services and supplies, including room and board and other institutional services, whether or not the individual is disabled, primarily to assist in the activities of daily living. These services and supplies are designated as custodial care without regard to the prescription, recommendation, or performance of the practitioner or provider.
- Education, training, and room and board while confined in an institution, which is primarily a school, or other institution for training.
- Hospitalization primarily for physiotherapy or diagnostic studies.
- Medical examinations or tests for diagnostic purposes unless related to a specific illness, disease, or injury, except as specified in the Covered Medical Expenses section.
- Artificial insemination, in vitro fertilization, or embryo transfer procedures.
- Reversal of a sterilization procedure.
- Charges for examinations, tests and medical care associated with being a surrogate mother, including expenses incurred during pregnancy and delivery.
- Charges for services or supplies that the Health Trust Administrator determines are not Usual, Customary, and Reasonable or that exceed the Plan's Allowable Expense.
- Physical exams, X-ray, laboratory, pathological services, and machine diagnostic tests, unless related to a specific illness, injury, or a definitive set of symptoms, except as provided in the Covered Medical Expenses section.
- Services or supplies that are not Medically Necessary as determined by a medical review by the Health Trust Administrator, Utilization Review provider or other health care professional contracted by the Plan, even if prescribed, recommended, or

approved by a physician for the diagnosis or treatment of a physical or mental condition.

- Marriage, child, relationship, career, social adjustment, pastoral, financial, sexual, or family counseling, except as provided for in the Mental Disorders and Substance Use Disorders section or the Employee Assistance Program section.
- Habilitative, education, training or treatment for conduct disorders, or oppositional defiance disorders.
- Services, therapy, drugs, or supplies for sexual dysfunctions, including services or supplies for prosthesis in connection with impotency, except as specified in the Covered Medical Expenses section.
- Visual analysis, therapy, or training relating to muscular imbalance of the eye (orthoptics).
- Routine foot care procedures, such as:
  - the trimming of nails, corns, or calluses.
  - fallen arches.
  - other symptomatic complaints of the feet.
  - routine hygienic care.
- Treatment designed primarily to provide a change in environment or a controlled environment (milieu therapy).
- Care furnished mainly to provide surroundings free from exposure that can worsen the person's disease or injury.
- Those charges you would not pay if you did not have health care coverage, except those for covered services furnished, paid for, or reimbursed under the Maternal/Child Health Unit and Handicapped Children's Program Section, Division of Public Health, Department of Health and Social Services of the State of Alaska.
- Any services or supplies for which no charge is made or would not be made if this Plan were not in effect nor for services or supplies for which you would not be legally liable if this Plan were not in effect.
- Services or supplies that are, as determined by the Health Trust Administrator or Utilization Review and Case Management provider, experimental or investigational. A drug, device, procedure, or treatment will be determined to be experimental or investigational if:
  - there is insufficient data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;
  - approval, as required by the FDA, has not been granted for marketing;
  - a recognized National Medical or Dental Society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or

- the written protocols or informed consent used by the treating facility or any other facility studying substantially the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

However, this exclusion **will not apply** to services or supplies (other than drugs) received in connection with a disease if the Health Trust Administrator determines that:

- the disease can be expected to cause death within one year in the absence of effective treatment; and
- the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination, the Health Trust Administrator will take into account the results of a review by a panel of independent medical professionals selected by the Health Trust Administrator. This panel will include professionals who treat the type of disease involved.

Also, this exclusion **will not apply** to drugs under the following situations:

- drugs that have been granted treatment investigational new drug (IND) or Group c/treatment IND status;
- drugs that are being studied at the Phase III level in a National clinical trial sponsored by the National Cancer Institute; or
- if the Health Trust Administrator or Utilization Review provider determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

- Injury or other loss sustained as a result of war or an act of war or any international armed conflict, whether declared or not.
- Services, treatment, education, testing, or training related to learning disabilities or developmental delay.
- Services of a resident physician or intern rendered in that capacity.
- Orthopedic shoes.
- Premolded orthotics.
- Primal therapy, Rolfing, psychodrama, megavitamin therapy, craniosacral therapy, or carbon dioxide therapy.
- Eye refractions or hearing aids or the fitting of eyeglasses or hearing aids, except as described under the Vision Benefits and Audio Benefits sections. Postoperative eye refractions after cataract surgery are covered under the Medical Plan.
- Services or supplies which any school system is required to provide under the law.
- Services or supplies for education, special education, or job training whether or not given in a facility that also provides medical or psychiatric treatment, except as specified for in the Diabetes Education section.

- Charges you incur during a hospital confinement prior to the date you became covered under the Medical Plan.
- Charges for treatment of Employees who specialize in the mental health care field and who receive treatment as a part of their training in that field.
- Orthodontics, even when obtained in conjunction with treatment for TMJ, except as specified in the Covered Medical Expenses section.
- Services or supplies not specifically listed as a covered benefit under the Plan.

DENTAL BENEFITS

HOW DENTAL BENEFITS ARE PAID

Benefits are available for services and supplies necessary to diagnose, care for, or treat a dental condition. To be eligible for benefits under the plan, the service or supply must be:

- Medically Necessary for the dental health of the patient, and
- A covered service under the Plan.

The Plan's benefit payment will be based on:

- Plan provisions, including any limitations or exclusions, and
- The Usual, Customary and Reasonable allowance for the service or supply.

Pediatric oral services will be covered to the extent required under federal law.

COVERED DENTAL SERVICES

Information on Deductibles, Reimbursement Percentages and benefit limits for each Plan Option is shown in the Dental Benefits section under Benefits Summary. Services must be rendered by a licensed dental practitioner operating within the scope of his or her license.

Class I - Preventive Services

Class I services include:

- Oral examinations.
- Dental X-rays required for the diagnosis of a specific condition.
- Routine dental X-rays but not more than one full mouth or panoramic per Benefit Year.
- Topical fluoride application (painting the surface of the teeth with a fluoride solution).
- Prophylaxis, including cleaning, scaling, and polishing.
- Dental sealants for children through age 18.

Class II - Restorative Services

Class II services include:

- Fillings of silver amalgam, silicate, and plastic restoration. If a tooth can be restored with amalgam or similar material and you and your dentist select another type of restoration, your benefits are limited to the appropriate charges for amalgam or similar material.
- Repair of dentures, bridges and dental implants.
- Palliative (alleviation of pain) emergency treatment.
- Extractions (removal of teeth).
- Endodontics (treatment of disease of the tooth pulp) including pulpotomy, pulp capping, and root canal treatment.

- Space maintainers.
- Oral surgery, including surgical extractions.
- Apicoectomy (surgical removal of a root tip).
- Periodontic services (treatment of the supporting tooth structures), including periodontal prophylaxis.
- Nitrous oxide, general anesthesia and IV sedation.

Class III - Prosthetic Services

Class III services include:

- Inlays and onlays.
- Crowns.
- Fixed and removable bridges, initial placement.
- Full and partial dentures, initial placement.
- Dental implants when selected as an alternative to dentures or bridges.
- Mouth guards prescribed to treat bruxism, up to once every five years. (Athletic mouth guards and orthodontic retainer mouth guards are not covered.) Prosthetic services are paid on the seat date.

DENTAL SERVICES NOT COVERED

The Dental Plan **does not** provide benefits for:

- Services for congenital deformities (these are covered by the Medical Plan) or for purposes of improving personal appearance.
- Services that the dentist is not licensed to perform.
- Charges that are higher than would have been charged if there were no Dental Plan.
- Services for dentures, bridges, crowns, or other devices started before the effective date of coverage.
- Charges made after your coverage ends, unless they are for prosthetic devices fitted and ordered while you were covered and arriving within 90 days of the date coverage ends.
- Services rendered after the end of coverage, even if you are in the course of an approved treatment plan.
- Charges of more than one dentist for the same services in the same visit.
- Appliances or restorations necessary to increase vertical dimensions or restore occlusions.
- Services for straightening teeth or correcting bite (orthodontics), except for tooth extractions necessary to proceed with orthodontic services.
- Prosthetic replacement made less than five years after the last one was obtained, whether or not it was covered by this Plan.

- Replacement costs of a lost or stolen denture if this benefit has been used within the last five years.
- Replacement of crowns within 5 years of placement.
- Special techniques or personalized restoration for the construction of a denture beyond the standard procedure charges.
- Myofunctional therapy including in-mouth appliances to correct or control harmful habits.
- All other exclusions listed in the Medical Expenses Not Covered section.

The Health Trust Administrator may, at its discretion, make benefit payments directly to either the dentist or other provider furnishing the service, the Employee, or both.
To determine whether dental needs and treatment are within Plan limitations and exclusions, the Health Trust Administrator reserves the right to review your dental records, including X-rays, photographs, and models, and consult with health care professionals contracted by the Plan. The Health Trust Administrator, at the Plan's expense, also has the right to request that you obtain an oral examination by a dentist of its choice.

ADVANCE CLAIM REVIEW

Before beginning treatment for which charges are expected to exceed $1,000, ask your dentist to file a description of the proposed course of treatment and expected charges with the Health Trust Administrator. The Health Trust Administrator will then review the proposal and advise you and your dentist of the estimated benefits payable.

A course of treatment is a planned program of one or more services or supplies. It may be rendered by one or more providers for the treatment of a condition diagnosed by the attending physician or dentist as a result of an examination. It commences on the day the provider first renders the service to correct or treat such a condition. Emergency treatments, oral examinations, cleanings, and dental X-rays are considered part of a course of treatment, but you may seek these services without advance claim review.

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

As part of advance claim review and proof of loss for any claim, the Health Trust Administrator has the right to require you to obtain an oral examination at the Plan's expense. You must furnish to the Health Trust Administrator all diagnostic and evaluative material required to establish your right to benefits. Evaluative material includes dental X-rays, models, charts, and written reports. In many cases, alternate services or supplies may be used to treat a dental condition. If so, benefit coverage is limited to the services and supplies customarily employed to treat the disease or injury and recognized by the dental profession to be appropriate according to broadly accepted national standards of practice. The Plan takes into account your total oral condition.

Examples of alternative services or supplies for restorative care are:

- Gold or baked porcelain restorations, crowns, and jackets. If a tooth can be restored with amalgam or similar material and you and your dentist select another type of

restoration, your benefits are limited to the appropriate charges for amalgam or similar material.

- Reconstruction. Covered expenses only include charges for procedures necessary to eliminate oral disease and replace missing teeth. Appliances or restorations to increase vertical dimension or restore the occlusion are considered optional and are not covered.

Examples of alternative services or supplies for prosthodontic care are:

- Partial dentures. If cast chrome or acrylic partial dentures will restore a dental arch satisfactorily and you and your dentist choose a more elaborate precision appliance, covered expenses are limited to the appropriate charges for cast chrome or acrylic.
- Complete dentures. If you and your dentist decide on personalized restorations or specialized techniques, as opposed to standard dentures, covered expenses are limited to appropriate charges for the standard dentures.
- Replacement of existing dentures. Charges for denture replacements are covered only if the existing dentures are not or cannot be made serviceable; otherwise, covered expenses are limited to appropriate charges for services necessary to make appliances serviceable.

VISION BENEFITS

HOW VISION BENEFITS ARE PAID

Benefits are available for services and supplies necessary to diagnose, care for, or treat a visual condition. To be eligible for benefits under the plan, the service or supply must be:

- Medically Necessary, and
- A covered service under the Plan.

The Plan's benefit payment will be based on:

- Plan provisions, including any limitations or exclusions, and
- The Allowable Expense of the service or supply.

Pediatric vision services will be covered to the extent required by federal law.
The Trust contracts with VSP to administer vision claims. VSP maintains a network of providers who offer discounts off of their usual and customary fees. The Plan provides a greater benefit if you use a VSP network provider.

COVERED VISION AND OPTICAL SERVICES

Information on Reimbursement Percentages and benefit limits for each Plan Option are shown in the Vision Benefits section under Benefits Summary.

The following services and supplies are covered:

- Complete vision examination including required refraction, by a legally qualified ophthalmologist or optometrist.
- Single vision, bifocal, trifocal, or lenticular lenses.
- Frames.
- Contact lenses.

VISION AND OPTICAL SERVICES NOT COVERED

Benefits are not payable for the following services:

- Anti-reflective coatings.
- Tinting.
- Two (2) pairs of glasses in lieu of bifocals.
- Non-prescription glasses or special purpose visual aids, even if prescribed.
- Prescription sunglasses or light-sensitive lenses in excess of the amount which would be covered for non-tinted lenses.
- Medical or surgical treatment of the eyes.

- Eye examinations which a labor agreement requires the employer to provide, which are required as a condition of employment, or which are required by any government law.
- Replaced or duplicate lenses if this benefit has been utilized in the Benefit Year, regardless of the reason.
- Replacement or duplicate frames if this benefit has been utilized in the current or prior Benefit Year, regardless of the reason.
- Charges for special procedures such as orthoptics or vision training.
- Services or supplies provided under other provisions of this Plan.
- Services or supplies which are covered in whole or in part under any Workers' Compensation law or any other law of similar purpose.
- Services or supplies you received prior to becoming eligible for coverage, including lenses and frames ordered as part of a prior examination, even if you receive the lenses and frames after becoming eligible for this Plan.
- All other exclusions listed in the Medical Expenses Not Covered section.

AUDIO BENEFITS

HOW AUDIO BENEFITS ARE PAID

Benefits are available for services and supplies necessary to diagnose, care for, or treat an audio condition. To be eligible for benefits under the plan, the service or supply must be:

- Medically Necessary, and
- A covered service under the Plan.

The Plan's benefit payment will be based on:

- Plan provisions, including any limitations or exclusions, and
- The Allowable Expense of the service or supply.

COVERED AUDIO SERVICES

Information on Reimbursement Percentages and benefit limits for each Plan Option are shown in the Audio Benefits section under Benefits Summary section.

The following services are covered:

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

You must provide the Health Trust Administrator with written certification from the examining physician or audiologist explaining that you are suffering a hearing loss that may be lessened by the use of a hearing aid.
You may choose any qualified health care provider for your hearing care. Claims for audio services must be submitted by your medical provider directly to Aetna at the address on your identification card.

AUDIO SERVICES NOT COVERED

The Audio Plan does **not** pay for:

- Replacement of a hearing aid, for any reason, more than once (1) in a three Benefit Year period.
- Batteries or other supplementary equipment other than those obtained upon purchase of the hearing aid.
- A hearing aid exceeding the specifications prescribed for correction of hearing loss.
- Expenses incurred after coverage ends, unless you order a hearing aid before the termination and receive it within 90 days of the coverage end date.
- All other exclusions listed in the Medical Expenses Not Covered section.

HOW TO FILE A CLAIM

VERIFICATION OF OTHER HEALTH CARE COVERAGE

Before the Plan will pay benefits, you must submit a signed Family Information Form each Benefit Year for yourself and your eligible dependents. Failure to complete this form may delay the processing of claims for yourself and your dependents. Submission of an Open Enrollment form via paper or online, waives the requirement to submit a Family Information Form each year.

This requirement applies even if a provider submits a computerized or other billing directly to Aetna or the Health Trust Administrator for you. In that case, if you do not already have a Family Information Form on file for you and/or your dependents for that year, benefits may be held pending receipt of the form.
Submission of an Open Enrollment form via paper or online waives the requirement to submit a paper claim form each year.

CLAIM FILING DEADLINE

Claims must be submitted no later than 12 months after the date of service, even if the delay in filing is a result of a third party's failure to provide timely information to you, the Plan, or another medical plan which coordinates coverage with this Plan. A claim will not be considered to have met the claim filing deadlines unless it is a clean claim.
A clean claim is a claim that includes all relevant details and documentation to determine whether the claim is payable by the Plan. A claim will be considered to have met the claim filing deadlines if it has no defect or impropriety and all outstanding information required for determining coverage or liability is received within 12 months after the date you incurred the expense.

HOSPITAL SERVICES

When you are admitted to a hospital, give your health identification card to the admitting clerk. The hospital must bill Aetna directly at the address on your identification card. The Health Trust Administrator will send you an Explanation of Benefits (EOB) form that shows the amount charged and the amount paid to the hospital.

Your health care coverage is good worldwide. If you are hospitalized in a licensed, general hospital anywhere, you can use your hospital benefits. If services are provided in a foreign country, the claim must be translated into English prior to submission. For non-emergency hospital services outside the US, the hospital must be accredited by the Joint Commission International. You must submit reimbursement requests to the Health Trust Administrator for health care services received in a foreign country.

PHYSICIAN AND OTHER MEDICAL PROVIDER SERVICES

Medical bills including audio services must be submitted by your medical providers directly to Aetna at the address on your identification card. If your provider has questions about the billing process, they should contact the Aetna provider customer service telephone number also listed on your identification card.

The Health Trust Administrator will send you an Explanation of Benefits (EOB) form that shows the amount charged and the amount paid to the medical provider.

For covered medical services, the following are examples of the information that may be needed to process your claim:

- Nursing care. If you need special nursing services at home or in the hospital, your claim must include the date, hours worked, and the name of the referring physician.
- Blood and blood derivatives. You are encouraged to replace blood or blood derivatives that you use. If you do not, you must get a bill from the blood bank, which includes the date of service, location where the blood was transported, and the total charge.
- Appliances—braces, crutches, wheelchairs, etc. The bill must include a description of the item, indicate whether it was purchased or rented, list the name of the physician who prescribed the item, and show the total charge.
- Ambulance. The bill must include the date of the service, where you were transported to and from, and the total charge.

DENTAL SERVICES

Your provider must submit your dental bill with your Aetna member ID number to the Health Trust Administrator at the address on your identification card. If your provider has questions about the billing process, they should contact the Health Trust Administrator customer service telephone number listed on your identification card.

If your provider will not submit the bill for dental services on your behalf, you can request a reimbursement form from the Health Trust Administrator or download the form from the Trust website, www.aseahealth.org. Attach an itemized statement to the Medical/Dental Benefits form, and submit it to the Health Trust Administrator.

The Health Trust Administrator will send you an Explanation of Benefits (EOB) form that shows the amount charged and the amount paid to you or the provider.

VISION SERVICES

VSP is your vision service provider and they process all vision claims. If you received care from a VSP participating provider they will file claims for you. Your provider must submit your vision claim with your ASEA member ID number.

If your provider is not a VSP participating provider, you may need to submit the bill to VSP. You can request a reimbursement claim form from the Health Trust Administrator

or download a VSP out-of network reimbursement form from the Trust website, www.aseahealth.org. Include your ASEA member ID number and send the completed form to the VSP address on the form.

PRESCRIPTION DRUGS

No claim filing is necessary if the ASEA Health Benefits Trust is your primary claims payor and you obtain your drugs from a participating pharmacy or the mail-order program.

If the Plan is the secondary claims payor, you must submit your prescription drug claims to your primary insurance provider first. Once your primary provider has processed the claim, you may submit a secondary claim to the Plan. Be sure to provide the original claim and the Explanation of Benefits (EOB) from the primary carrier.

If you do not use a participating pharmacy or the mail order program, you must submit your claims to the Prescription Benefits Manager. Be sure to obtain a receipt from the pharmacist. Cash register receipts are not acceptable. Medicines that do not require a prescription are not covered. Send the receipt with a prescription drug claim form to the Prescription Benefits Manager. You can request the prescription drug claim form from the Health Trust Administrator or download a prescription drug claim form from the Trust website, www.aseahealth.org.

The receipt must include:

- Patient's name;
- Date of purchase;
- Prescription number;
- Itemized purchase price for each drug;
- Quantity;
- Name of drug and NDC number from the prescription bottle; and
- Name of pharmacy.

MEMBER REIMBURSEMENTS

If you pay for health care at the time of service, you can submit a reimbursement request to the Health Trust Administrator. Member reimbursement requests for the following should be submitted to the Health Trust Administrator:

- Health care services received in a foreign country
- Expenses related to preauthorized travel for health care
- Incentive payments for members who reside in the Mat-Su Borough and utilize Alaska Regional Hospital
- Patient auditor program awards

OTHER CLAIM FILING TIPS

For medical, dental and audio claims you must list the covered Employee's social security number or the Aetna member ID number on all bills or correspondence. Send all correspondence and dental bills to the Health Trust Administrator's address listed in the Plan Contacts section of this booklet. This address is also on your identification card.

If you have other health coverage in addition to this Plan, you should submit your claims to the primary plan first. Then send a copy of the claim and the Explanation of Benefits (EOB) from the primary plan to the secondary plan so that benefits will be coordinated properly between plans. Refer to the Coordination of Benefits section to determine which plan is primary.

If you have claim problems, call or write to the Health Trust Administrator. When you call, be sure to have your identification card or Explanation of Benefits (EOB) form available. Also, include your Aetna identification number on any letter you write. The Health Trust Administrator needs this information to identify your particular coverage.

BENEFIT PAYMENTS

For hospital, medical and audio provider claims, Aetna will pay the provider directly and you will receive the Explanation of Benefits form (EOB) from the Health Trust Administrator. For dental claims, your Health Trust Administrator will send you the EOB and the benefit payment directly to your provider. If the provider is not a Preferred Provider and you have already paid the provider and this fact is clearly shown on the claim form, the Health Trust Administrator will send the benefit check to you along with the Explanation of Benefits form.

BEFORE FILING A CLAIM

Remember, hospital, medical and audio bills should be submitted by your provider to the Aetna address on your identification card.

Before you file a claim for dental services or other member reimbursements:

- Submit your bills with a claim form for each family member.
- Always check to make sure your dentist has not already submitted your claim. If you give your provider permission to submit a claim, do not submit one yourself.
- Complete the claim form fully and include information on any other group health care programs covering you and your dependents. If you have other coverage, which should pay before this plan, include a copy of that plan's Explanation of Benefits showing the amount they paid for the services.

RECORDKEEPING

Keep complete records of expenses for each of your dependents. Important records are:

- Names of physicians and others who furnish services;
- Dates expenses are incurred; and
- Copies of all bills and receipts.

You should also keep **all** Explanation of Benefits forms sent to you, as it may not be possible for the Health Trust Administrator to provide duplicate copies.

PHYSICAL EXAMINATIONS

The Health Trust Administrator will have the right and opportunity to have a physician of its choice examine any person for whom Precertification or benefits have been requested. This will be done while Precertification or a claim for benefits is pending or under review, and will be done at no cost to you.

APPEALS

INITIAL BENEFIT DETERMINATIONS

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

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

No claimant shall at any time, either during the time in which he/she is a covered participant in the Plan, or following his/her termination as a covered participant, in any manner, have any right to assign his/her right to sue to recover benefits under the Plan, to enforce rights due under the Plan to appeal a denial of benefits, or to any other causes of action which he/she may have against the Plan or its fiduciaries.

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

- Pre-Service Non-Urgent Health Claims. A pre-service health claim is a properly filed claim for medical or dental benefits that must be preauthorized to receive full benefits from the Plan. Pre-service claims are only claims to the extent that preauthorized services are reviewed and determined to be Medically Necessary for the appropriate level of care requested. Pre-service determinations do not address the Claimant's eligibility or Plan coverage for specific services or treatment. Failing to obtain Precertification for a pre-service claim may result in reduced or denied benefits. Pre-service claims include, but are not limited to non-emergency admission to a Hospital, or a Skilled Nursing Facility, Home Health Care or Hospice Care. A pre-service claim will generally be processed within 15 days of receipt. This period may be extended for up to 15 days if the Plan determines an extension is necessary due to matters beyond the control of the Plan, and notifies the claimant within the initial 15-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If an extension is necessary due to the claimant's failure to submit the information necessary to process the claim, the notification of the extension will be provided to the Claimant as soon as possible, but not later than 5 days after the receipt of the claim. The notice will describe the specific necessary information needed to process the claim, and the Claimant will be provided at least 45 days from receipt of the notification to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information within the extension period described in the notice of not less than 45 days from the notice.

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

- Post-Service Health Claims. A post-service health claim is any properly filed claim for medical, dental, vision, audio, or prescription drug benefits that is not a pre-service claim and does not involve urgent care, where the treatment or services have already been provided. A post-service claim will generally be processed within 30 days of receipt. This period may be extended for up to 15 days if the Plan determines an extension is necessary due to matters beyond the control of the Plan, and notifies the Claimant within the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If an extension is necessary due to the Claimant's failure to submit the information necessary to process the claim, the notification of the extension will describe the necessary information, and the Claimant will be provided at least 45 days from receipt of the notification to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the Claimant responds to the request for additional information within the extension period described in the notice of not less than 45 days from the notice.
- Urgent Care Health Claims. Urgent care health claims are pre-service claims with respect to which the normal time frames for review of a claim could seriously jeopardize the life or health of the claimant, or expose the Claimant to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim. Urgent care claims may be filed, orally or in writing, by the Claimant or by the health care provider with knowledge of the Claimant's medical condition. A decision on an urgent care will generally be made within 72 hours after receipt of a claim that is complete when submitted. Claimants will be notified within 72 hours if additional information is required to process the claim, and will be provided at least 48 hours to submit the additional information. If additional information is required to process the claim, a determination will be made within 48 hours of the earlier of the Plan's receipt of the requested information, or the end of the period afforded the Claimant to provide the additional information. A determination involving urgent care may be provided orally within the time frames in this section, with a written notification furnished not later than three days after the oral notification.

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

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

REMEDIES AVAILABLE SHOULD A CLAIM BE DENIED

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

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

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

consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

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

Internal Review

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

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

ASEA/AFSCME Local 52 Health Benefits Trust
Health Trust Administrator, Zenith American Solutions
111 West Cataldo Avenue #220
Spokane, WA 99201-3201

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

1. The name of the Claimant;
2. The Claimant's alternative Plan identification number or social security number;
3. All facts or theories supporting the claim for benefits;
4. A statement in clear and concise terms of the reason or reasons based on the Plan provisions for the disagreement with the handling of the claim; and
5. Any material or information that the Claimant has which indicates that he/she is entitled to benefits under the terms of the Plan.

Timing and Notification of Benefit Determination on Appeal

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

- Urgent Care Claims – within a reasonable period of time appropriate to the medical circumstances, but not later than 72 hours after receipt of the claim.

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

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

Manner and Content of Notification of Adverse Benefit Determination

If a claim is denied or partially denied, the Claimant will be notified in writing. For questions about the denial of benefits, the Claimant should contact the Health Trust Administrator at the address and telephone number shown on the Notice of Determination.

Level 1- Internal Appeal Review

If the Claimant does not agree with the determination, the Claimant can submit a written appeal to the Health Trust Administrator. The Administrator will provide the first level review of the appeal and notify the Claimant, in writing or electronically, notice of the determination.

If the denial of benefits for the claim is upheld, the notice to the claimant will give the following:

1. Information to identify the claim, including, the date of service, the health care provider, the claim amount (if applicable).
2. Specific reasons for the denial;
3. Specific reference to pertinent Plan provision(s) on which the denial is based;
4. A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy of the same will be provided free of charge to the Claimant upon request;
6. If the denial is based on medical necessity, or experimental or investigational treatment, or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the

Claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request;

7. A statement that the participant is entitled to receive, upon request, and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;
8. A description of the Plan's internal review and External Review Procedure and the applicable time limits.
9. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice, will only be released subject to state or federal regulations; applicable state and federal regulations must be followed.
10. The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established by the Public Health Service Act Section 2793.

Level 2 – Internal Appeal Review

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

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

The Trustees will review a properly filed appeal of a post-service claim at the next regularly scheduled Board of Trustees meeting following receipt of the properly submitted second level appeal, provided the second level appeal is received at least thirty (30) calendar days prior to such regularly scheduled Board of Trustees meeting. If the second level appeal is not received within 30 calendar days of the next regularly scheduled Board of Trustees meeting, the appeal will be set for hearing at the next Trustee meeting.

If the claim involves the reduction or termination of a previously approved claim for Concurrent Care or Non-Urgent Pre-Service care, the Trustees will review the second level appeal within 15 days of receipt of the properly filed second level appeal regardless of the date of the next regularly scheduled Board of Trustees meeting. The Trustees will review a properly filed second level appeal of an Urgent Care claim within 72 hours after receipt of the appeal regardless of the date of the next regularly scheduled Board of Trustees meeting. In such cases, such appeal hearing may be conducted via teleconference or email poll.

All necessary information on a claim for Concurrent Care, Non-Urgent Pre-Service Care, or Urgent Care may be transmitted between the Plan and the claimant by telephone, facsimile, or other available expeditious method. The Trustees may delegate the decision on an expedited appeal to a Committee of not less than three Trustees or to the Health Trust Administrator upon prior approval of a quorum of the Board of Trustees. Decisions on Concurrent Care, Non-Urgent Pre-Service Care, or Urgent Care second level appeals will be provided to the appellant telephonically by the Administrator following the meeting, with a written decision to follow as soon as practical, but not more than five (5) days following the decision.

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

External Review Procedure

The Plan has an external review procedure that provides for a review conducted by a qualified Independent Review Organization (IRO).

The Claimant cannot request an External Review (as described more fully below) unless the appeal was filed timely and Levels 1 and 2 of the Internal Review processes were completed. The Claimant may request a review by an IRO within 4 months after the date of the notice of the Plan's adverse decision regarding the Level 2 Internal Review. If there is no corresponding day 4 months after the date of the notice on the Level 2 Internal Review appeal determination notice, then the request must be filed by the 1st day of the fifth month following the date of the notice. As with the original appeal, the Claimant's request for external review must be submitted in writing to the Health Trust Administrator and include all of the items set forth in 1-5 of the section above entitled Level 1 – Internal Review. The Plan is entitled to charge a fee of $25 to initiate an External Review, which the Claimant must pay to the Plan when submitting the Request for External Review Form to initiate the process.

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 obtain the appropriate forms and information on the filing process by contacting the Claims Administrator.

The external review process is only for appeals involving 1) medical judgment, including but not limited to determinations that involve medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, experimental or investigational treatments; and, 2) Rescissions of coverage (whether or not the rescission has any effect on any particular benefit at that time). Medical judgment excludes

determinations that only involve contractual or legal interpretation or those related to a participant's eligibility for benefits under the terms of the Plan, without any use of medical judgment. You cannot request an external review unless your appeal was filed timely and Levels 1 and 2 of the internal process have been completed.

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

Preliminary Review for External Review Request

Within 6 business days following the date of receipt of the Claimant's external review request, the Health Trust Administrator will send the Claimant a written notice stating whether the request is eligible for external review and if additional information is necessary to process the request. If the request is determined to be ineligible, the notice will include the reasons for ineligibility and provide contact information for the appropriate state or federal oversight agency. If additional information is required to process the external review request, the notice will describe the information needed and you may submit the additional information within the 4 month filing period or within 48 hours of receipt of the notification, whichever is later.

Timing of Notice from the IRO

After receiving your request for an external review from the Health Trust Administrator, The IRO will notify you in writing of your rights to submit additional information to the IRO and the applicable time period and procedure for submitting such information.

The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will contain the reasons and rationale for the decision, including any applicable evidence-based standards used, and references to the evidence or documentation considered in reaching the decision.

Decision of IRO Final

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

DENIAL OF ENROLLMENT OR ELIGIBILITY

Appeals will be reviewed and decided by the Trustees at the next regularly scheduled Board of Trustees meeting or Appeals Committee meeting following receipt of the enrollment or eligibility appeal, provided that the written appeal is received by the Health Trust Administrator at least 10 days prior to the meeting date.

Enrollment or eligibility appeals must be submitted in writing to the Board of Trustees, in care of the Health Trust Administrator, within 45 calendar days after the first payroll to which the

enrollment applies. The Board of Trustees, after consideration of the appeal, will communicate in writing to the participant no later than 30 days after the meeting in which the appeal is decided.

The Board of Trustees has the sole and exclusive authority to make decisions regarding enrollment or eligibility appeals, and its decisions will be considered final pursuant to the authority granted by the governing Trust Agreement for the ASEA/AFSCME Local 52 Health Benefits Trust.

CONTINUATION COVERAGE

COBRA CONTINUATION COVERAGE

Federal law requires most employers sponsoring group health plans to offer Employees and their families the opportunity to elect a temporary extension of health coverage (called "continuation coverage" or "COBRA coverage") in certain instances where coverage under a group health plan would otherwise end. A group health plan includes any major medical, dental, vision, health care spending account, or other plan that we may maintain that provides for medical care. For simplicity, any such group health plan is referred to in this section as the "Plan". You do not have to show that you are insurable to elect continuation coverage.

This section provides a brief overview of your rights and obligations under current law. With the exception of a special provision for participants who lose coverage because of temporary layoff (including layoff as a seasonal worker) or leave of absence without pay, the Plan offers no greater COBRA rights than what the COBRA statute requires and this section should be construed accordingly.

Both you (the Employee) and your spouse should read this summary carefully.

Qualifying Events

If you are an **Employee** of the Employer and are covered by the Plan, you have a right to elect continuation coverage under the Plan because of any one of the following two "qualifying events":

1. Termination (for reasons other than your gross misconduct) of your employment.
2. Reduction in the hours of your employment.

If you are the **spouse** of an Employee covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any of the following four "qualifying events":

1. The death of your spouse.
2. A termination of your spouse's employment (for reasons other than your spouse's gross misconduct) or reduction in your spouse's hours of employment with the Employer.
3. Divorce or legal separation from your spouse.
4. Your spouse becomes entitled to Medicare benefits.

In the case of a **dependent child** of an Employee covered by the Plan, he or she has the right to elect continuation coverage if group health coverage under the Plan is lost because of any of the following five "qualifying events":

1. The death of the Employee parent.
2. The termination of the Employee parent's employment (for reasons other than the Employee parent's gross misconduct) or reduction of the Employee parent's hours of employment with the Employer.

3. Parents' divorce or legal separation.
4. The Employee parent becomes entitled to Medicare.
5. The dependent ceases to be a "dependent child" under the Plan.

Your Important Notice Obligations

If your spouse, or dependent child loses coverage under this Plan because of divorce, legal separation, or a dependent child losing dependent status under the Plan, you (the Employee) or your spouse, or dependent has the responsibility to notify the Health Trust Administrator of the divorce, legal separation, or child losing dependent status. You or your spouse, or dependent *must* provide notice no later than 60 days after the divorce, legal separation, or child losing dependent status, or if later, the date coverage terminates under the Plan. *If you or your spouse, or dependent fail to provide this notice to the Health Trust Administrator during this 60-day notice period, any spouse, or dependent child that loses coverage will NOT be offered the option to elect continuation coverage.* Furthermore, if you or your spouse, or dependent fail to give such notice and if any claims are mistakenly paid for expenses incurred after the divorce, legal separation, or child's losing dependent status, then you, your spouse, and/or dependent children will be required to reimburse the Plan for any claims so paid.

If the Health Trust Administrator is provided with timely notice of a divorce, legal separation, or a child losing dependent status that has caused a loss of coverage, the Health Trust Administrator will notify the affected family member of the right to elect continuation coverage.

You (the Employee) and your spouse, and/or dependent children will be notified of the right to elect continuation coverage without any action on your part upon the following events that result in a loss in coverage: the Employee's termination (other than for gross misconduct), reduction of hours, or death, or the Employee becoming entitled to Medicare.

Election Procedures

You (the Employee) and/or your spouse, and dependent children must elect continuation coverage within 60 days after Plan coverage ends, or, if later, 60 days after the Health Trust Administrator provides you or your family member with notice of the right to elect continuation coverage. *If you or your spouse, and dependent children do not elect continuation coverage within this 60-day period, you will lose your right to elect continuation coverage.* A COBRA election mailed to the Health Trust Administrator is considered to be made on the date of the mailing (evidenced by the postmark).

You (the Employee) and/or your spouse, and dependent children may elect continuation coverage even if covered under another employer-sponsored group health plan or entitled to Medicare.

Under a special election period extension that took effect August 6, 2002, if you lose your coverage as a result of the importation of articles from other countries pursuant to U.S.-negotiated trade agreements that are competitive with those made by the Company (i.e., if you experience a "TAA- Related Loss of Coverage") but did not elect Continuation Coverage and then become eligible for a trade readjustment allowance (TAA) (i.e., you become a "TAA-eligible individual"), you may elect continuation coverage during the 60-day period that begins on the first day of the month in which you become a TAA-Eligible Individual, but only if your

election is made not later than six months after the date of the TAA-Related Loss of Coverage.

Type of Coverage

Ordinarily, the continuation coverage that is offered will be the same coverage that you, your spouse, or dependent children had on the day before the qualifying event. Therefore, an Employee, spouse, or dependent child who is not covered under the Plan on the day before the qualifying event is generally not entitled to COBRA coverage. If the coverage is modified for similarly situated Employees or their spouses, or dependent children, then COBRA coverage will be modified in the same way.

If you lose coverage because of temporary layoff (including layoff as a seasonal worker) or leave of absence without pay, you may continue your health coverage or you can elect a low option medical plan.

If you elect COBRA coverage, you will be allowed to make annual Open Enrollment elections, just like a similarly situated active Employee.

COBRA Premiums You Must Pay

The premium payments for the "initial premium months" must be paid for you (the Employee) and for any spouse or dependent child by the 45th day after the election of continuation coverage is made.

Once you (spouse, or dependent child) elect continuation coverage, you have the right to continue coverage subject to timely payment of the required COBRA premiums up to the maximum COBRA coverage period applicable to you. Coverage will not be effective for any initial premium month until that month's premium is paid within the 45-day period after the election of continuation coverage is made.

All other premiums are due on the 1st day of the month for which the premium is paid, subject to a 30-day grace period. If you do not make the full premium payment by the due date or within the 30-day grace period, then COBRA coverage will be cancelled retroactively to the 1st of the month. You will be responsible to reimburse the Plan for any claims paid on behalf of you or your eligible dependents that were incurred during a period for which you did not pay the premium.

A premium payment is made on the date it is sent (evidenced by the postmark).

Maximum Coverage Periods

36 Months. If you (spouse, or dependent child) lose group health coverage because of the Employee's death, divorce, legal separation, or the Employee's becoming entitled to Medicare, or because you lose your status as a dependent under the Plan, then the maximum coverage period (for spouse, or dependent child) is three years from the date of the qualifying event.

18 Months. If you Employee, spouse, or dependent child) lose group health coverage because of the Employee's termination (other than for gross misconduct) or reduction in hours, then the maximum continuation coverage period (for Employee, spouse, and dependent children) is 18 months from the date of termination or reduction in hours.

The 18-month coverage period may be extended:

If an Employee or family member is disabled at any time during the first 60 days of continuation coverage (running from the date of termination of employment or reduction in hours), then the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the date of termination or reduction in hours. The Social Security Administration must formally determine under Title II (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the disability exists and when it began. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided to the Health Trust Administrator within both the 18-month coverage period and 60 days after the date of the determination.

If a second qualifying event that gives rise to a 36-month maximum coverage period (for example, the Employee dies, becomes divorced, or occurs within an 18-month or 29-month coverage period), then the maximum coverage period (for the spouse, and dependent children) becomes 36 months from the date of the initial termination or reduction in hours.

If the qualifying event occurs within 18 months after the Employee becomes entitled to Medicare, then the maximum coverage period (for the spouse, and dependent children) ends 36 months from the date the Employee became entitled to Medicare.

Children Born to or Placed for Adoption with the Covered Employee During the COBRA Period

A child born to, adopted by, or placed for adoption with a covered Employee during a period of continuation coverage is considered a qualified beneficiary provided that, where the covered Employee is a qualified beneficiary, the covered Employee has elected continuation coverage for himself or herself. The covered Employee or other guardian has the right to elect continuation coverage for the child, provided that the child satisfies the otherwise applicable plan eligibility requirement (for example, regarding age). The covered Employee or a family member must notify the Health Trust Administrator within 60 days of the birth, adoption, or placement for adoption to enroll the child on COBRA, and COBRA coverage will last as long as it lasts for other family members of the Employee. (The 60-day period is the Plan's normal enrollment window for newborn children, adopted children or children placed for adoption.) *If the covered family member fails to so notify the Health Trust Administrator in a timely fashion, then the covered Employee will not be offered the option to elect COBRA coverage for the child.*

HIPAA Special Enrollment Rights

HIPAA's special enrollment rights will apply to those who have elected COBRA.

Termination of COBRA Before the End of Maximum Coverage Period

Continuation coverage of the Employee, spouse, and/or dependent child will automatically terminate (before the end of the maximum coverage period) when any one of the following six events occurs:

1. The Plan no longer provides group health coverage.
2. The premium for the qualified beneficiary's COBRA coverage is not paid timely.

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

You Must Notify the Health Trust Administrator about Marital Status and Dependent Status Changes

If your marital status changes, if a dependent ceases to be a dependent eligible for coverage under the Plan terms, or if your, your spouse's, or your dependent's address changes, you must immediately notify the Health Trust Administrator. You will be required to reimburse the Plan for any claims paid in error on an ineligible spouse, or dependent child as a result of your failure to notify the Plan timely of an event which would cause eligibility for such spouse, or dependent child to cease.

DISABLED EMPLOYEES OR DEPENDENTS

Disabled Employees or dependents who lose coverage are eligible for the plans described in this section. In addition, disabled Employees may be entitled to an extension of their medical benefits.

You or your covered dependents may be entitled to extended benefits if you are totally disabled due to injury, illness, or pregnancy when coverage terminates. Extended benefits for total disability are provided for the number of months you have been covered under the Plan, to a maximum of 12 months. However, only the condition which caused the disability is covered. Coverage is provided only while the total disability continues. The disability extension is only available if you do not have coverage through another State of Alaska benefit plan (e.g. retiree coverage).

You or your covered dependent must be under a physician's care and submit evidence of disability to the Health Trust Administrator within 90 days after regular coverage ends. The physician must complete a Statement of Disability form available from the Health Trust Administrator. You must satisfy any unpaid portion of the Deductible within three months of the date your coverage terminates.

Totally disabled means the complete inability of an individual to perform everyday duties appropriate for their occupation, employment, age, or sex. The inability may be due to disease, illness, injury, or pregnancy. The Plan reserves the right of determination of total disability based upon the report of a duly qualified physician, or physicians, chosen by the Plan.

FAMILY AND MEDICAL LEAVE - AS FEDERALLY MANDATED

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

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

In the event you or your spouse are both covered as members of ASEA/AFSCME Local 52 Health Benefits Trust, the continued coverage under (1) may not exceed a combined total of 12 weeks. In addition, if the leave is taken to care for a parent with a serious health condition, the continued coverage may not exceed a combined total of 12 weeks.

Conditions

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

d. you continue to pay any required premium for yourself and any eligible dependents in a manner determined by your employer.

3. In the event you choose not to pay any required premium during your leave, your coverage will not be continued during the leave. You will be able to reinstate your coverage on the day you return to work, subject to any changes that may have occurred in the Plan during the time you were not covered. You and any covered dependents will not be subject to any evidence of good health requirement provided under the Plan. Any partially-satisfied waiting periods, which are interrupted during the period of time premium was not paid will continue to be applied once coverage is reinstated.
4. You and your dependents are subject to all conditions and limitations of the Plan during your leave, except that anything in conflict with the provisions of FMLA will be construed in accordance with the FMLA.
5. If requested by the Health Trust Administrator, you or your employer must submit proof acceptable to the Health Trust Administrator that your leave is in accordance with FMLA.
6. This FMLA continuation is concurrent with any other continuation option except for COBRA, if applicable. You may be eligible to elect any COBRA continuation available under the Plan following the day your FMLA continuation ends.
7. FMLA continuation ends on the earliest of:
    a. the day you return to work;
    b. the day you notify your employer that you are not returning to work;
    c. the day your coverage would otherwise end under the policy; or
    d. the day coverage has been continued for 12 weeks.

Definitions

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

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

Serious Health Condition is defined as stated in the FMLA.

Important Notice

Contact your employer for additional information regarding FMLA.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS - AS FEDERALLY MANDATED

Definitions

Health Coverage means hospital, surgical, medical, dental, vision, or prescription drug coverage provided under the Plan. Health Coverage is subject to change as a result of Open Enrollments or plan modifications.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to such ACT and any interpretive regulation or rulings).

Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

Uniformed services means the United States Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

Continuation of Group Health Insurance

1. **For you and your eligible dependents:** If Health Coverage ends because of your service in the uniformed services, you may elect to continue such Health Coverage if required by USERRA, until the earlier of:
    a. the end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
    b. 18 consecutive months after insurance ended.
2. To continue coverage, you or your dependent must pay the required premium, (including your former employer's share and any retroactive premium), unless your service in the uniformed service is for fewer than 31 days, in which event you must pay your share, if any, of the premium. The Health Trust Administrator will inform you or your dependents of procedures to pay premiums.
3. **End of Continuation.** A covered person's continued Health Coverage will end at midnight on the earliest of:
    a. the day the Trust ceases to provide any group health plan to any member;
    b. the day premium is due and unpaid;
    c. the day a covered person again becomes covered under the Plan; or
    d. the day Health Coverage has been continued for the period of time provided in part 1. (a) or (b) above (or any longer period provided in the Plan).
4. **Other Continuation Provisions.** In the event Health Coverage is continued under any other continuation provision of the Plan, the periods of continued coverage will run concurrently. If another continuation provision provides a shorter continuation

period for which premium is paid in whole or in part by your employer, then the premium you are required to pay may increase for the remainder of the period provided above.

Reemployment (following service in the uniformed services)

Following your discharge from such service, you may be eligible to apply for reemployment with your former employer in accord with USERRA. Such reemployment includes your right to elect reinstatement in any then existing health coverage provided by your employer.

Important Notice

In the event of a conflict between this provision and USERRA, the provisions of USERRA, as interpreted by your employer or former employer, will apply.

GENERAL PROVISIONS

COORDINATION OF BENEFITS

If you are entitled to benefits from other sources, such as employer or government sponsored health plans, the Trust may have the right to offset against or recover from those other plans or persons so that you do not duplicate recovery of medical expenses.

The Trust Plan coordinates benefits with other group health care plans to which you or your covered dependents belong. Other group plans are defined as benefit sources recognized for coordination of benefits and are listed below:

- Group or blanket disability insurance or health care programs issued by insurers, health care services contractors, and health maintenance organizations.
- Labor-management trustee, labor organization, employer organization, or employee benefit organization plans.
- Governmental programs, including Medicare.
- Plans or programs required or provided by any statute.
- Group student coverage provided or sponsored by a school or policy, whether it is subject to coordination or not.

You may be covered both as an Employee and as a dependent of another covered Employee. If that occurs, you will receive benefits from both plans. However, the benefits received may be subject to the coordination of benefits provisions as indicated in this section.

Note: The State of Alaska Plan will pay 30% of covered charges for you and/or your dependents if your family is eligible for coverage by a State employee health trust, and that coverage:

- Has been waived
- Pays less than 70% of covered expenses
- Has an individual out-of-pocket maximum, including Deductible, of more than $3,500

Here's how benefits will be coordinated if the plans follow the National Association of Insurance Commissioners' COB rules (see example):

- The primary plan pays benefits first, without regard to any other plan.
- When the Trust Plan is secondary, the amount it pays will be figured by subtracting the benefits paid by the other plan from 100% of expenses covered by the Trust Plan on that claim. The Plan pays the difference between the amount the other plan paid and 100% of expenses the Trust plan would pay.
- Neither plan pays more than it would without coordination of benefits. Benefits payable under another plan include the benefits that would have been payable whether or not a claim was actually submitted to that plan.

Example:

	Primary Plan	Secondary Plan
Covered Expenses	$1,000	$1,000
Less Deductible	- $ 100	- $ 250
	= $ 900	= $ 750
Plan Reimbursement	X 80%	X 80%
Plan Payment without Coordination	= $ 720	= $ 600
Plan Payment with Coordination	= $ 720	= $ 280

Determining Order of Payment

A plan without coordination provisions is always the primary plan. If all plans have a coordination provision:

- The plan covering the Employee or retiree directly, rather than as a dependent, is the primary plan.
- If a child is covered under both parents' plans, and the parents are living together whether they are married (but not separated or divorced) or unmarried, the plan of the parent whose birthday falls earlier in the year is the primary plan. If both parents have the same birthday, the plan that has covered a parent longer is the primary plan.
- For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

  (a) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage that Plan is primary. If the parent with responsibility has no health care coverage for the child's health care expenses but that parent's spouse does, that parent's spouse is the primary plan;

  (b) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the order of benefits shall be determined using the rules applied to parents living together;

  (c) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the order of benefits shall be determined using the rules applied to parents living together; or

(d) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(i) The Plan covering the custodial parent;
(ii) The Plan covering the spouse of the custodial parent;
(iii) The Plan covering the non-custodial parent; and then;
(iv) The Plan covering the spouse of the non-custodial parent.

- For an active Employee or retired or laid-off Employee. The Plan that covers a person as an active Employee is the primary plan. The Plan covering that same person as a retired or laid-off Employee is the secondary plan. The same would hold true if a person is a dependent of an active Employee and that same person is a dependent of a retired or laid-off Employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- For Employees on COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an Employee, member, subscriber or retiree or covering the person as a dependent of an Employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- Longer or shorter length of coverage. The Plan that covered the person as an Employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

It is your responsibility to report the existence of any plan, or the benefits payable to you under any plan, in the interests of computing services or benefits due under this Plan.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered is considered a covered service and a benefit paid. The reasonable cash value of any services that any service organization provides is considered an expense incurred by you or your covered dependent, and the liability under this Plan is reduced accordingly.

Coordination of Benefits with Medicare (other than for End Stage Renal Disease)
Unless otherwise specified by Federal law, an active Employee plan is primary to Medicare, whether the plan covers the person as an Employee or dependent.

Coordination of Benefits with Medicare for End Stage Renal Disease
If an eligible individual under this Plan becomes entitled to Medicare because of End Stage Renal Disease (ESRD), this Plan generally pays primary and Medicare pays secondary for 30 months starting the month in which Medicare ESRD coverage begins. The Plan will pay secondary after the end of this 30-month period.

Secondary Coverage

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

SUBROGATION AND REIMBURSEMENT PROVISIONS

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

- The Plan specifically excludes coverage of claims for injury or illness for which a third party is liable;
- The Plan will pay benefits for that injury or illness subject to the Plan's Conditional Benefits and Subrogation Provisions and only on the condition that you or your dependent (or the legal representative of you or your dependent):
  - — will not take any action which would prejudice our reimbursement or subrogation rights; and
  - — will cooperate in doing what is reasonably necessary to assist the Plan in enforcing our reimbursement or subrogation rights, including signing a Subrogation and Reimbursement Agreement upon the written request of the Plan. If you fail to execute the Subrogation and Reimbursement Agreement, the Plan may suspend payment of benefits for treatment related to the injury or illness caused by the third party, and seek reimbursement of any benefits already paid for such treatment. If you have hired an attorney to represent you against the liable third-party or their insurer, your attorney will be required to execute the attorney section of the Subrogation and Reimbursement Agreement.
- The Plan's reimbursement or subrogation rights will not be reduced because the recovery is not described as being related to medical costs or loss of income. The Plan is entitled to full reimbursement on a first-dollar basis, regardless of whether the settlement or judgment fully compensates you for the injury or sickness you incurred.

- The Plan may enforce the Plan's reimbursement or subrogation rights by filing a lien with the third party, the third party's insurer or another insurer, a court having jurisdiction in this matter or any other appropriate party.
- The Plan shall have an equitable lien and constructive trust in any and all recovery against the liable third party or its insurer to the full extent of the benefits paid on your behalf for such injury or illness.
- The Plan may elect to charge any reimbursement due under this provision against any future benefits payments for you or your covered dependent under this Plan. This will not reduce the Plan's right to be paid first out of any recovery up to the amount of Plan benefits not yet reimbursed as related to the injury or illness.
- After reimbursement for benefits paid by the Plan, the Plan shall be relieved from any obligation to pay further benefits to you or your dependent for such injury or illness up to the entire net amount of the balance of the settlement or judgment recovered by you or your dependent.
- The Board of Trustees will review a request for waiver of subrogation rights, in part or in whole, in the event enforcement of the subrogation and reimbursement rights by the Plan would subject you or your dependent to undue hardship due to a lack of adequate insurance proceeds or recoverable funds. The Trustees have full discretionary authority in the determination of whether to waive any portion of the Plan's subrogation lien.

ACCESS TO RECORDS

All Plan participants consent to and authorize all providers to examine and copy any portions of the hospital or medical records requested by the Plan when processing a claim, during Precertification, or during a claim appeal.

CHANGES TO PLAN

Plan changes may be made at the discretion of the Board of Trustees.

CONTRACT LIABILITY

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

EPIDEMICS AND PUBLIC DISASTERS

The services this Plan provides are subject to the availability of hospital facilities and the ability of hospitals, hospital employees, physicians and surgeons, and other providers to furnish services. The Plan does not assume liability for epidemics, public disasters, or

other conditions beyond its control which make it impossible to obtain the services that this Plan provides.

FACILITY OF PAYMENT

Whenever payments, which should have been made under this Plan, are made under other programs, this Plan has the right, at its discretion, to pay over to any organizations making other payments, any amounts it determines are warranted. These amounts are considered benefits paid under this Plan, and, to the extent of such payments, this Plan is fully discharged from liability under this contract.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

You may select any hospital, physician or surgeon who meets the definition of provider under the Plan. Refer to the **Covered Medical Expenses** section for Hospitalization and Physician's Services for those definitions.

The payments made under this Plan for services that a physician or surgeon renders are not construed as regulating in any way the fees that the physician or surgeon charges. Payment of benefits under the Plan is subject to the Allowable Expense as determined by the Plan.

Under this Plan, payments may be made, at the discretion of the Health Trust Administrator, to the physician, another person or organization furnishing the service or making the payment, to the Employee, or to such person or organization and the Employee jointly.

The hospitals and providers that furnish hospital care and services or other benefits to members do so as independent contractors. The Plan is not liable for any claim or demand from damages arising from or in any way connected with any injuries that members suffer while receiving care in any hospital or services from any provider.

MEDICAL OUTCOMES

The Health Trust Administrator makes no express or implied warranties and assumes no responsibility for the outcome of any covered services or supplies.

NOTICE

Any notice that the Health Trust Administrator is required to send is considered adequate if it is mailed to the member, at the address appearing on the Health Trust Administrator's records. Any notice required of the member is considered adequate if mailed to the principal office of the Health Trust Administrator.

PLAN ADMINISTRATION

The Board of Trustees shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Board of Trustees shall have maximum legal discretionary authority

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

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

PLAN MUST BE EFFECTIVE

Health coverage is expense incurred coverage only and not coverage for the disease or injury itself. This means that this Plan will pay benefits only for expenses incurred while this coverage is in force. Except as described in the extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced, or after coverage has terminated, even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, 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.

PREMIUMS

The amount of the monthly Employee contribution may be changed. If you fail to pay any required Employee contribution, your rights under this Plan will be terminated, except as provided under disability extended benefits. Benefits will not be available until you have been reinstated under the provisions of the Plan as defined in this booklet.

RIGHT OF RECOVERY

Whenever the Plan pays for covered services in excess of the maximum amounts payable, or pays for covered services during a period in which you are not eligible, no matter to whom the benefits are paid, the Plan has the right:

- To require the return of the overpayment on request; or
- To reduce by the amount of the overpayment from any future benefit payment made to or on behalf of that person or another covered person in his or her family.

This right does not affect any other right of recovery this Plan may have with respect to this overpayment.

If repayment is not made upon demand by the Plan, and an offset is not available against future benefits, the Plan may bring a legal action to recover the overpaid benefit amount. In the event that the Plan must file legal action to recover overpaid benefits, the Plan will be entitled to an award of its costs and attorney's fees upon prevailing in such legal action.

If benefits are overpaid as a result of the submission of a fraudulent submission of eligibility, the Plan shall have, in addition to the rights set forth above, the right to report the matter for criminal prosecution to the appropriate law enforcement agency. The Plan may also have the right to rescind coverage retroactively to the date of the fraudulent submission and/or prospectively.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

The Plan may release or obtain information it considers relevant to a claim made under this Plan from any other insurance plan, subject to the restrictions and exceptions imposed on the Plan by HIPAA. This information may be released or obtained without the consent of or notice to you or any other person or organization. You must furnish the Plan with information necessary to implement the Plan's provisions.

TRANSFER OF BENEFITS, ASSIGNMENT, GARNISHMENT, AND ATTACHMENT

All rights to benefits under this Plan are personal and available only to you. They may not be transferred to anyone else. Benefits or other rights of members of this Plan are not assignable or subject to garnishment, alienation or attachment by creditors.

Also, this Plan is not obligated by any attempted or purported assignment, garnishment, or attachment. The Plan may pay for services or supplies to a member by remitting funds to you, the provider of services or supplies, the group, other carrier, or jointly to any of these. The Plan's good faith remittance discharges its obligation to the extent of the remittance amount, and it is not liable to anyone because of the selection of the payee.

VESTED RIGHTS

Except as cited under the Continuation Coverage section, this Plan does not confer rights beyond the date that coverage is terminated. For this reason, no rights from this Plan can be considered "vested" rights. You are not eligible for benefits or payments from this Plan for any services, treatment, medical attention, or care rendered after the date your coverage terminates. The Board of Trustees retains the right to change the benefits provided under the Plan in its discretion as the Plan fiduciary.

In the event of Plan termination, the allocation of Plan assets shall be accomplished according to the provisions contained in the Trust agreement.

DEFINITIONS

Allowable Expenses are the actual costs (billed amount) charged for services to the extent that such charges are Usual, Customary and Reasonable (UCR) for the area and the type of service, or Usual and Reasonable Charge for Outpatient Dialysis Treatment. For non-PPO services in Anchorage, the Allowable Expense for inpatient Hospital services will be limited to the contracted rate at Alaska Regional Hospital. The Allowable Expense for outpatient facility at a non-PPO provider in Anchorage will be the case rate at Alaska Regional Hospital or 50% of the billed charges, if no case rate is available. The Allowable Expense for non-PPO physical therapy services in Anchorage will be the contracted rate at Chugach Physical Therapy. Charges in excess of the Allowable Expense as determined by the Plan will not be paid by the Plan, and will not apply to your Annual Out-of-Pocket Maximum.

Benefit Year is the period beginning July 1 and ending June 30. All benefits limited in a Benefit Year are reset on July 1 each year.

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

Copay is your portion of prescription drug costs and the amount you pay for each visit to the Coalition Health Center.

Deductible is the amount you pay for covered expenses each Benefit Year before the Plan starts to pay benefits.

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

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman and/or her unborn child) in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part,

as determined by the Health Trust Administrator.

Employee is a person actively working and receiving earnings.

Full-Time means scheduled to work 30 or more hours a week on a regular basis.

HIPAA means the Health Insurance Portability and Accountability Act.

Incapacitated means a person that may be unable to receive and evaluate information, communicate responsible personal decisions, and/or may exhibit an inability to meet his/her own personal needs for medical care, nutrition, clothing, shelter, safety or carry out the activities of daily living.

Medically Necessary means a service that is:

- Expected to improve or maintain your health or to relieve pain and suffering without aggravating the condition or causing additional health problems; or

- Expected to provide information to determine the course of treatment;

and is no more costly than another service or supply which could fulfill these requirements.

Please refer to the Medical Benefits section, Medically Necessary Services for additional information.

Open Enrollment is the period in which all participants may make a new Plan election.

Out-of-Pocket Limit is the maximum amount you pay for covered medical expenses in a year, not including your Deductible. Plans A and B have an Annual Out-of-Pocket Limit.

Part-Time means scheduled to work at least 15 but less than 30 hours a week on a regular basis.

Preauthorization is a request for coverage of travel expenses. In order to be considered for coverage, Preauthorization must be requested before you travel.

Precertification or ***Precertify*** is also a request for the determination of Medical Necessity for a particular procedure, treatment or hospital stay.

Preferred Provider is a facility or pharmacy with which the Trust contracts and that agrees to provide negotiated discounts. The Trust has several types of Preferred Provider Organizations (PPOs). The benefits provided for treatment at Preferred Provider facilities may be greater than the benefits provided at non-preferred facilities. Please refer to the Preferred Provider Provision section for additional information.

Prior Authorization is a request for the determination of Medical Necessity for a prescription drug.

Reimbursement Percentage is the percentage of Allowable Expenses the Plan pays, after the Deductible is met.

Usual Customary & Reasonable (UCR) means the charge the Health Trust Administrator determines to be the prevailing rate charged in the geographic area where the service is provided or the provider's usual charge, whichever is less.

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

IMPORTANT INFORMATION ABOUT THIS PLAN

Plan Fiduciary:	Board of Trustees ASEA/AFSCME Local 52 Health Benefits Trust 111 West Cataldo Avenue, Suite #220 Spokane, WA 99201-3201 (509) 328-0300 or (866) 553-8206
Health Trust Administrator:	Zenith American Solutions 111 West Cataldo Avenue, Suite #220 Spokane, WA 99201-3201 (509) 328-0300 or (866) 553-8206
Plan Funding:	The Plan is self-funded
Plan TIN:	92-0174160
Benefit Year:	July 1 to June 30