KENAI PENINSULA BOROUGH SCHOOL DISTRICT

Health Care Plan
Summary Plan Description

Original Effective Date: January 1, 2002
Revised Date: January 1, 2021

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CONTACT INFORMATION

How to Reach Your Claims Administrator Office
Rehn & Associates Kenai Peninsula Borough School District 1322 N. Post Place Spokane, Washington 99201 Telephone: (509) 534-0600 Toll Free: (800) 872-8979 Fax: (509) 535-7883 Website: www.kpbsd.rehnonline.com
Office hours:
8:00 a.m. to 5:00 p.m. Monday through Thursday 8:00 a.m. to 4:00 p.m. Friday All times are Pacific Standard Time. Messages may be left on voice mail after hours.
How to Reach Your Pharmacy Benefit Manager
CVS Caremark PO Box 52136 Phoenix, AZ 85072 Customer Service: (866) 818-6911 Website: www.Caremark.com
Networks
Preferred Facilities Central Peninsula Hospital South Peninsula Hospital Alaska Regional Hospital Surgery Center of Anchorage **National Network Access Outside of Preferred Facilities Listed Above** Aetna Choice POS II (Open Access) **Find an Aetna PPO Provider:** www.aetna.com/docfind/home.do Network Name: Choice POS II (Open Access) **Teladoc** 24/7 telephone access to Board Certified Physicians Call (800) 835-2362 or online at www.teledoc.com

PREFACE

Introduction and Purpose

The Plan Sponsor, Kenai Peninsula Borough School District (KPBSD), has established the Plan for the benefit of eligible Employees, on the terms and conditions described herein. With the exception of large medical claims, for which the Plan Sponsor is protected by excess loss insurance, Plan benefits are paid by KPBSD and supplemented by the contributions you make to participate. The Plan is independent of all health care providers and is not itself a provider of health care.

The Plan Sponsor's purpose in establishing the Plan is to help offset, for eligible Employees, the economic effects arising from a non-occupational Injury or Illness. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent. Through careful use of the Plan, you, as a consumer of health care, can have a direct impact on the cost of the Plan. This will benefit you by allowing the Plan to continue to provide this high quality level of benefits.

This Document is both the "Plan Document" and the Summary Plan Description or "SPD." The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for hospital, medical, dental or vision charges. The Plan Document is maintained by the Plan Sponsor and may be inspected at any time during normal working hours by any Covered Person.

Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract

This Plan Document and any Amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between KPBSD and any Covered Person or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of KPBSD or to interfere with the right of KPBSD to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by KPBSD with the bargaining representatives of any Employees.

MONEY SAVING TIPS

1. **Carry Your Card** with you and show it to all health care providers and pharmacies. Your card has important information your doctor, dentist, pharmacist or provider needs in order to file your claim**.**

2. **It's important** to understand that this Plan offers higher benefits – saving you money – when you visit preferred (PPO) facilities such as Alaska Regional Hospital, Central Peninsula General Hospital, South Peninsula Hospital, Surgery Center of Anchorage and other PPO providers through Aetna. Utilizing Teledoc (24/7 telephone access to Board Certified Physicians), and purchase your prescription drugs through the appropriate pharmacy network.

3. **Please note** this plan does have exclusions, limitations and benefits that require preauthorization. Make yourself familiar with these benefits in order to utilize your plan effectively.

4. **Cut the cost of your prescriptions.** If possible, get your doctor to prescribe you generic drugs.

5. **Practice healthy** living. One of the easiest ways to lower your medical expenses over the long term is to establish and maintain a healthy lifestyle.

6. **Take advantage of the preventive care benefits your plan offers.**

7. **Never assume** anything about your Health Plan. Get your information up front and BEFORE you need it.

ABOUT THIS BOOKLET

This booklet describes Kenai Peninsula Borough School District Health Care Plan as of January 1, 2020, for eligible Plan participants.

The Kenai Peninsula Borough School District Health Care Plan was established January 1, 2002, to provide health coverage for members and their families.

We encourage you to become familiar with your benefits and the valuable protection they offer. This booklet will also help you understand what services are and are not covered and any special steps you need to take to get the highest level of coverage.

It's important for all Plan participants to use these benefits wisely, which starts with understanding them. Carefully read and keep this booklet for future reference, so you understand how to make the Plan work best for you.

If you have questions about your coverage or eligibility, please contact your Claim's Administrator, Rehn & Associates at (800) 872-8979.

GENERAL BENEFIT INFORMATION

In order to receive benefits under the Plan:

1. You must be covered under the Plan;
2. You must Incur an expense for which a benefit is payable;
3. The expense must be incurred during the period of time and under the conditions specified by this Plan; and
4. A claim must be filed within the specified time period.

The Plan Administrator has hired a claims administration organization, Rehn & Associates to perform certain administrative functions for the Plan and uses Aetna for Utilization Review (UR). If you have questions regarding your coverage or how benefits have been paid, please contact Rehn & Associates at (800) 872-8979.

Please read this benefit booklet thoroughly and become familiar with the provisions of the Plan. If you have questions regarding your Plan's benefits or the procedures necessary to receive these benefits, please call your Claims Administrator, Rehn & Associates.

Please Note: It is the employee's responsibility to notify the Plan Administrator of any change in status for the employee or any covered dependents.

You have 31 days to notify the Plan Administrator of:

- Marriage (Certified Copy of Marriage Certificate required)
- Birth (Copy of Birth Certificate required)
- Adoption (Copy of Adoption Documents required)

If an Employee fails to enroll themselves or a Dependent within 31 days of eligibility, enrollment can occur only under the conditions specified under the sections entitled "Special Enrollment" or "Open Enrollment."

Open Enrollment
A period in November and/or December of each Calendar Year has been designated as an annual open enrollment period during which individuals that are currently eligible for the Plan may add or delete themselves and/or their Dependents regarding their health care coverage. Any such changes will become effective January 1st. The Plan Administrator reserves the right to modify the open enrollment dates.

Changes in Family Status

You have 60 days to notify the Plan Administrator of:

- Divorce (Copy of Divorce Decree required)
- Loss of dependent status (attained limiting age)
- Legal separation (Court order required)
- Death

Failure to notify the Plan Administrator of a COBRA qualifying event could constitute a failure of COBRA election rights.

If you fail to notify the Plan Administrator within 60 days of the qualifying 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, your Dependent may be terminated retroactively and you may be responsible for any claims paid on your Dependent's behalf. Employees may be responsible for reimbursing the Plan for any claims that have been paid on their ineligible dependents.

Failure to notify could constitute insurance fraud.

MEDICAL SUMMARY OF BENEFITS

Overview		
Deductible - Per Calendar Year		
	HSA Plan	HRA Plan
Individual	$1,500	$1,500
Family	*$3,000	$3,000
**Per IRS Regulations aggregate family deductible applies to any policy with more than one enrollee for the HSA Plan – individual deductible will not apply*		
Annual Out-of-pocket Maximum Per Calendar Year (Excluding Deductible)		
	HSA Plan	HRA Plan
Individual	$2,000	$2,000
Family	$4,000	$4,000
** These maximums do not apply to Non-PPO (non-emergency) Facility Charges*		
Utilization Review Non-Compliance Penalty (Inpatient Only)		
Per Claim	Denied in Full	
Annual and Lifetime Maximums PPO and Non-PPO (combined)		
Full Plan	Unlimited	

Calendar Year Maximums / Limits – *All services listed below are subject to Deductible(s).*	
Home Health Care	1 visit per day up to 100 visits
Skilled Nursing Facility	90 Days
Physical Therapy	24 visits
Chiropractic Services & Rolfing Services - Combined Limit	20 visits
Acupuncture	20 visits
Pre-Admission Testing	80%
Facility Charges by a Child Birth Center	
Home Health Care	
Skilled Nursing Facility	
Hospice	
Outpatient Surgery	
Occupational Therapy	
Outpatient Dialysis Treatment	80% of the Usual and Reasonable Charge for Outpatient Dialysis Treatment

Calendar Year Maximums / Limits – *All services listed below are subject to Deductible(s). (continued)*	
Hospital, X-ray and Lab Charges: • PPO Facility • Services outside PPO Network Area (Where PPO is not available) • Non-PPO Facility (non-emergency) Not subject to breakpoint.	 80% 80% 60% Constant
Physician Charges for Hospital Care and Surgery • PPO Facility • Services outside PPO Network Area (Where PPO is not available)	 80%
Preventative Care for Adults and Children as required under the Affordable Care Act (ACA)	100%
Office Visits	80%
Chiropractic Services & Rolfing Services	80%
Acupuncture	80%
Mental Health Conditions and Chemical Dependency Treatment	Same as any other Illness
Emergency Room Care: (Subject to $250 deductible for Non-Emergency) • If surgery is not performed • If surgery is performed: PPO Facility Services outside PPO Network Area (Where PPO is not available) Non-PPO Facility (Non-Emergency) Out-of-network emergency room visit for a life-threatening situation	 80% 80% 80% 60% Constant 80%
Other Covered Expenses	80%

PRESCRIPTION DRUG SUMMARY OF BENEFITS

Overview*	
Covered Prescription	*Co-Pay Amount
Retail Pharmacy – up to a 100-day supply – Participating Pharmacies	
Generic Drugs	$5
Preferred Brand Name Drugs	$25
Non-Preferred Brand Name Drugs	$50
Specialty	$100
Mail Order Pharmacy – up to a 100-day supply - Participating Pharmacies	
Generic Drugs	$5
Preferred Brand Name Drugs	$25
Non-Preferred Brand Name Drugs	$50
Specialty	$100

***Major Medical Deductible for the HSA plan must be met prior to these copays taking effect.**

Pharmacy Coordination of Benefits

Whenever the Kenai Peninsula Borough School District Health Care Plan is secondary on a prescription drug claim the Plan will pay for covered drugs if:

- the drug is covered by both plans and if the primary plan pays 100% of the cost except for the co-pay, this Plan will pay up to what it would have paid toward the cost of the prescription toward the amount of the primary plan's co-pay.
- the drug is covered by both plans and if the primary plan pays a portion of the cost of the prescription this Plan will pay up to the amount it would have paid as primary toward the unpaid portion of the cost of the prescription.
- the primary plan does not cover the drug, but this Plan does, or if both plans cover the drug but, the primary plan does not pay any of the cost of the prescription, this Plan will pay up to the amount it would have paid as primary payer less the appropriate co-pay.

Coordination of Benefits should be automatic through your Pharmacy Benefit Manager if the prescription is purchased at a network pharmacy and the participant uses their Health Plan Member Identification Card. If your network pharmacy is unable to process your coordination of benefits prescription, then please submit your pharmacy receipts direct to your Pharmacy Benefit Manager for reimbursement.

Out-of-Pocket Limit

HRA PLAN: The annual overall out-of-pocket expenses for a participant or family for PPO network providers (including deductible, coinsurance, and prescription drugs) shall not exceed the annual ACA limit, which is $8,550per person, $17,100per family for 2021.

HSA PLAN: The annual overall out-of-pocket expenses for a participant or family for PPO network providers (including deductible, coinsurance, and prescription drugs) shall not exceed the annual IRS limit, which is $7,000 per person, $14,000 per family for 2021.

If a Covered Person purchases a brand name medication when a generic equivalent is available, the Plan's payment will be based on the cost of the generic medication, and the brand copay will apply. The Covered Person will be responsible for the difference in price between the brand name medication and generic medication, in addition to the Covered Person's copay. The difference in price will not apply to your out-of-pocket maximum. This provision applies whether the brand name medication is requested by the Covered Person or the Covered Person's Physician or other lawful prescriber. If the Covered Person cannot take the generic medication, this provision may be waived and the Plan's payment may be based on the cost of the brand name medication, provided the Covered Person tried the generic medication and the reason for the waiver is medically justified. In order to obtain a waiver, the Covered Person must submit a form, completed by the Covered Person's Physician or other lawful prescriber. In the event of a waiver, the brand name copay will apply.

DENTAL SUMMARY OF BENEFITS

Overview	
Annual Deductible	Amount
Individual	$50
Family	$150
The calendar year deductible applies to all covered expenses except for Preventive Services.	
Calendar Year Maximum Benefit	Amount
Preventive, Basic and Major Care	$2,500
Benefit	Percentage
Preventive Care (not subject to Deductible)	100%
Basic Care	100%
Major Care	50%

VISION SUMMARY OF BENEFITS

Overview	
Benefit	Percentage
Eye Examinations	80%
One (1) Pair of Eyeglass Lenses or Contact Lenses	80%
Benefit	Maximum
One (1) Eye Examination	UCR
One (1) Pair of Eyeglass Lenses or Contact Lenses	UCR
One (1) Pair of Eyeglass Frames	80% up to $100
Prescribed for Medical Reasons	$150 per lens
Annual Maximum for Contacts prescribed for medical reasons	$600 (2 Pair)
Limitations:	

• One (1) complete eye exam per person per Calendar Year;
• Either
  • One (1) year supply of disposable contacts, or
  • One (1) pair of eyeglasses (lenses and/or frames), or
  • One (1) pair of hard contact lenses per person per Calendar Year;
• Notwithstanding the limit above, no more than one (1) set of frames per person in any two consecutive Calendar Years.
• Two (2) pair of contact lenses per person per Calendar Year for contacts prescribed for medical reasons.	

PREFERRED PROVIDER ORGANIZATIONS (PPO'S)

The Plan has negotiated discounts for Covered Persons through Preferred Provider Organizations (PPO's). Benefits and out-of-pocket requirements vary if covered services are obtained from a preferred provider versus a non-preferred provider or an out-of-area provider.

Participating Providers (In-Network)
Allowable charges will be paid for Medically Necessary covered services. For providers who participate in the PPO's, the allowable charge is the discounted fee that the providers have agreed to accept under our agreements with them. Participating providers will seek payment from the Plan when they provide services to you. You will be responsible for any applicable deductibles, co-payments, and coinsurance, charges in excess of stated benefit maximums and charges for services or supplies not covered under the Plan. These amounts will be reflected on the "Explanation of Benefits" sent to you.

A "participating provider" or "preferred provider" is a provider in any state that has an agreement in effect with KPBSD such as: Alaska Regional Hospital, Central Peninsula Hospital, South Peninsula Hospital or providers participating in the Aetna network, at the time services are rendered. To determine if a particular provider is a "participating provider" under the Aetna Network, please visit www.aetna.com/docfind/home.do (Network Name: Choice POS II (Open Access)) to find an Aetna PPO Provider.

You have a free choice of any Physician or Surgeon, and the Physician-Patient relationship shall be maintained. You, together with your Physician, are ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The PPO providers are merely independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any PPO provider.

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

Preferred Provider Hospital in the Municipality of Anchorage
The Preferred Provider (Participating Provider or In-Network Provider) for inpatient and outpatient hospital services within the Municipality of Anchorage will be Alaska Regional Hospital.

If a Covered Person obtains services at a facility within the Municipality of Anchorage other than Alaska Regional Hospital, the Allowable Charge will be the negotiated rate at Alaska Regional Hospital, and will be paid at 60% of the Allowable Charge. No breakpoint will apply. For all services, the Allowable Charge shall be calculated as the per diem or case rate at Alaska Regional Hospital.

Other hospital facilities, freestanding imaging centers and freestanding outpatient surgery centers within the Municipality of Anchorage shall be considered Nonparticipating Providers (Out-of-Network), regardless of whether they are included in other PPO Networks, such as Aetna.

The Preferred Provider provisions shall not apply to services not available at Alaska Regional Hospital.

Nonparticipating Providers (Out-of-Network)
When you use a non-participating provider, allowable charges will be paid at the Usual Customary and Reasonable (UCR) level and no discount will be given. You are responsible for any billed amount in excess of UCR. You are also responsible for any applicable deductibles, co-payments, and coinsurance, charges in excess of the stated benefit maximums and charges for services or supplies not covered under the Plan. These amounts will be reflected on the "Explanation of Benefits" sent to you.

Covered Persons Who Live Out-of-Area

If you live more than 25 miles outside of the PPO Service Area, you are considered out-of-area. This means that this Plan does not have agreements with Providers in your area. If you need to receive care from an Acute Care Facility, and use a facility located within the 25-mile radius of where you live, your benefits will be paid at the same level as if you used a Preferred Acute Care Facility. If you travel beyond the 25-mile radius of where you live, you must use a Preferred Acute Care Facility, or your benefits will be based on the Plan's Non-PPO benefit payment percentage. Providence Seward is considered Out-of-Area.

Exceptions

Exceptions will be made under the following circumstances:

- If you must be taken to the nearest facility available for an Accident or Emergency; or
- If a participating acute care facility refers you to a non-participating facility.

Acute Care Facilities

To receive maximum benefits, you must use the participating providers listed below:

- Alaska Regional Hospital – Anchorage
- Central Peninsula Hospital – Soldotna
- South Peninsula Hospital – Homer
- Surgery Center of Anchorage
- Aetna Network
  To determine if a particular provider is a "participating provider" under the Aetna Network, please visit www.aetna.com/docfind/home.do (Network Name: Choice POS II (Open Access)) to find an Aetna PPO Provider.

Outpatient Ancillary Services

Aetna is your nationwide PPO network for all other providers. You are not required to access services from these providers; however, the discounted rates will save both you and the Plan money. To find an Aetna PPO provider, please visit their website at www.aetna.com. Log in to search for providers or go to www.aetna.com/docfind and select "Aetna Choice POS II (Open Access)" network.

Please note: Preferred providers are subject to change. Please verify providers' participation before obtaining any services.

UTILIZATION REVIEW

The Plan's Utilization Review (UR) Provider is Aetna. Your provider may pre-authorize services by calling Aetna directly at 888-632-3862.

The purpose of Utilization Review is the early identification of potential high dollar and high-risk treatment and services. Aetna's Utilization Review staff will review your proposed plan of treatment for medical appropriateness by comparing it with accepted standards of medical care. They will also assess if alternative options have been considered that may be less costly and/or more effective. This will be done before you have treatment and incur additional expenses for the plan and for you personally. Aetna's precertification team will work with your provider to determine the appropriateness and necessity of your proposed treatment.

Precertification from Aetna should be obtained before you receive certain treatments or services

Your medical treatment plan and ultimate patient care responsibility remains with your attending physician. Precertification does not release your physician from this responsibility.

Preauthorization and post authorization are not a guarantee of eligibility or payment of benefits. It only means that the Plan or its authorized representative has confirmed that your medical treatment plan and/or Hospital admission is Medically Necessary. Payment of benefits is based on the provisions of this Plan and your eligibility for coverage at the time the expense is incurred.

Utilization Review Requirements

The following is an explanation of the services that require certification:

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.

- 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 Pre-authorize 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 Pre-authorizing inpatient hospital and skilled nursing facility admissions. If the provider fails to Pre-authorize 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 preauthorized, the plan will deny all charges for failure to Pre-authorize inpatient medical admissions. If your provider fails to Pre-authorize, you will be responsible for those charges.

CAUTION: Failure to comply with the UR precertification/authorization requirements may reduce your benefit.

Individual Case Management

The Aetna Case Management Program provides assistance with catastrophic or long-term illness or injury or other health issues requiring extensive or costly medical care. Aetna's Medical Case Managers will help you obtain the best and most appropriate medical care. This is accomplished by working with you and your provider to coordinate and support your medical treatment plan for the best outcomes and the most effective use of your benefits. Case Managers work with hospital discharge planners, social workers, specialty therapists, home care providers, medical equipment suppliers, pharmacists, and any other medical provider who might contribute to your plan of care. They can also assist in obtaining discounts on drugs, equipment and other services. This program is a benefit provided to you by the Plan at no additional cost to you.

ELIGIBILITY AND ENROLLMENT - COMMENCEMENT AND TERMINATION OF COVERAGE

Eligibility for Individual Coverage

An Employee is a person who is regularly scheduled to work the minimum hours per week required by KPBSD. The definition of employee will determine who is eligible to enroll for employee coverage and the effective date of coverage.

- A regular status employee who is regularly scheduled to work the minimum hours per week required by KPBSD is eligible to enroll on the date of hire.
- Temporary employees, substitute teachers and substitute support employees who are hired as full-time (not variable hour) and regularly scheduled to work 30 or more hours per week will be eligible for coverage on the first day of the month following a waiting period of 60 days from the date of hire.
- Hourly employees who are not classified as regular status and who are working variable hours will be eligible for coverage if they average 30 or more hours of service per week during the look back measurement period designated by KPBSD. Coverage shall be effective on the first day of the corresponding stability period.
- Elected members of the KPBSD School Board will become effective the first day of the month following the date their official service begins

Each Employee will become eligible to enroll as a Covered Person provided, he or she has:

- submitted an application within thirty-one (31) days after becoming eligible; and
- paid any required contribution.

Enrolling after Contract Approval

Employees who are terminated at the end of the school year and must wait until funding approval to return to active employment will be effective the day following the end of the school year term date. An enrollment form must be signed within 31 days of being notified that a contract was awarded for the upcoming school year.

Enrollment Following Benefit Measurement Period

Employees (and their eligible Dependents) who qualified as eligible during the applicable measurement period may enroll in the Plan during the administrative period immediately following the measurement period. Coverage is effective the first day of the corresponding stability period.

Break in Service

An employee who is subject to a stability period remains in an eligible class through the duration of the stability period, unless the employee terminates employment. Employees who return to work following a break in service of 26 weeks or greater will be treated as new hires. If the break in service is less than 26 weeks, the employee will be treated as a continuing employee.

Returning After Approved Leave of Absence

Employees returning to active employment after an approved leave of absence are effective the day the employee returns to active employment. An enrollment form must be signed within 31 days of the return to active employment. If an Employee fails to enroll within 31 days of eligibility, enrollment can occur only under the conditions specified under the sections entitled “Special Enrollment” or “Open Enrollment.” Pre-existing condition limitations will apply, unless the Employee and applicable Dependents had continuous coverage. Please see the definition of “Employee.”

Eligibility for Dependent Coverage

An Employee may enroll his/her Dependents for coverage under the Plan only if he/she is a Covered Person. A Dependent is eligible if they meet the definition of “Dependent”:

1. The Employee’s legal spouse;
2. The Employee’s child who meets all of the following conditions:
    - Is a natural child, stepchild, legally adopted child, a child placed for adoption with the Employee, or a child who has been placed under the legal guardianship of the Employee;

- Is less than 26 years of age.

3. A covered dependent child who attains the limiting age while covered under the plan shall remain eligible for medical benefits if ALL of the following exist at the same time:
   - He or she is mentally or physically handicapped;
   - He or she is incapable of self-sustaining employment;
   - He or she suffered the incapacity prior to attaining 20 years of age;
   - He or she is dependent on the covered employee for at least 50% of his or her support and maintenance; and
   - He or she is unmarried

   The employee must furnish satisfactory proof to the Plan Administrator that above conditions continuously exist on and after the date the limiting age is reached. The Plan Administrator may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to the Plan Administrator, the child's coverage shall cease on the date such proof is due.

The term Dependent excludes these situations:

1. A spouse who is divorced from the employee. Such spouse must have met all requirements of a valid divorce decree in the state granting such divorce; or
2. Any person on active military duty.

Effective Date of Employee Coverage

If completed enrollment forms are received by the Plan Administrator within 31 days of the date of eligibility, the Employee's coverage shall become effective on the date of eligibility. If an Employee fails to enroll within 31 days of eligibility, enrollment can occur only under the conditions specified under the sections entitled "Special Enrollment" or "Open Enrollment."

If an eligible Employee is not actively at work due to a reason other than a medical condition on the date his coverage would otherwise become effective, coverage shall become effective on the day he returns to Active Employment.

Effective Date of Dependent Coverage

If completed enrollment forms are received by the Plan Administrator within 31 days of the date of eligibility, coverage for Dependents will be effective at 12:01 A.M. on the earliest of the following dates:

- On the Employee's effective date, if application is made at the same time as the Employee's initial enrollment; or
- On the first day of eligibility, if application is made within 31 days of the date the Dependents become eligible for coverage. Legal documentation (marriage, birth certificates, court orders) must be received within 90 days from the date the dependent becomes eligible.

If an Employee fails to enroll a Dependent within 31 days of eligibility, enrollment can occur only under the conditions specified under the sections entitled "Special Enrollment" or "Open Enrollment." A Dependent's effective date may not be prior to the Employee's effective date of coverage.

Special Enrollment

Special Enrollment for Individuals Losing Coverage

An Employee is entitled to enroll in the Plan during a Special Enrollment Period if he meets all of the following requirements:

1. The Employee is eligible for coverage under the Plan but is not currently covered under the Plan;
2. The Employee previously declined to enroll in the Plan and signed a written waiver of coverage, stating as the reason the existence of alternative group or other health coverage; and
3. The Employee was covered under such alternative group or other health coverage at the time he signed the waiver, and such coverage is no longer available, for any of the reasons set forth below under "Loss of Eligibility".

A Dependent is entitled to enroll in the Plan during a Special Enrollment Period if he meets all of the following requirements:

1. The Dependent is eligible for coverage under the Plan but is not currently covered under the Plan;
2. The Employee, Dependent or another appropriate person previously declined, on the Dependent's behalf, to enroll in the Plan and signed a written waiver of coverage, stating as the reason the existence of alternative group or other health coverage; and
3. The Dependent was covered under such alternative group or other health coverage at the time he signed the waiver, and such coverage is no longer available, for any of the reasons set forth below under "Loss of Eligibility".

Coverage (other than COBRA continuation coverage) will be considered no longer available when it terminates because of Loss of Eligibility or termination of employer contributions toward the cost of such coverage. COBRA continuation coverage will be considered no longer available when the COBRA coverage is exhausted.

"Loss of Eligibility" shall mean loss of coverage resulting from legal separation, divorce, death, termination of employment, a reduction in the number of hours of employment, or any loss of eligibility after a period that is measured based on any of those events. Loss of Eligibility shall not mean loss of coverage resulting from an individual's failure to pay premiums on a timely basis or any termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of fact in connection with such coverage.)

Special Enrollment for New Dependents

An Employee is entitled to enroll himself and his Dependents in the Plan during a Special Enrollment Period if all of the following requirements are met:

1. The Employee is eligible for coverage under the Plan but is not currently covered under the Plan;
2. The Employee previously declined to enroll in the Plan; and
3. An individual became a Dependent of the Employee through marriage, birth, adoption or placement for adoption.

"Special Enrollment Period" shall mean, with respect to individuals losing coverage, the period which begins on and ends 31 days after:

- The date on which the coverage is exhausted, if the coverage was COBRA continuation coverage; or
- The date on which the coverage terminated because of Loss of Eligibility or termination of employer contributions toward the cost of such coverage, for other individual or group health coverage.

With respect to special enrollment for new Dependents, the period which ends 31 days after the date of one of the following, triggers the special enrollment rights:

- Marriage;
- Birth;
- Adoption; or
- Placement for adoption.

Special Enrollment due to coverage under Medicaid or under a State Children's Health Insurance Program (CHIP)

If an Employee or eligible Dependent did not enroll in the Plan when initially eligible, but was otherwise eligible to enroll, he or she will be permitted to later enroll in the Plan under one of the following circumstances:

- The Employee or eligible Dependent was covered under Medicaid or CHIP at the time of initial enrollment and such coverage subsequently terminates; or
- The Employee or eligible Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP subsequent to the time they were initially eligible.

The Employee or eligible Dependent must request enrollment in the Plan within 60 days after coverage under Medicaid or CHIP terminates or within 60 days after his or her eligibility for premium assistance subsidy under Medicaid or CHIP is determined, whichever is applicable.

"Enrollment Date" shall mean the first day of coverage or, if there is a waiting period, the first day of the waiting period.

Changing Plan Elections due to a Special Enrollment Event

You may also change your plan election if you experience a qualifying event:

- Your dependent gains or loses other coverage;
- involuntary loss of your other coverage;
- change in your employment status;
- marriage or divorce;
- birth or adoption of a dependent, or placement of a dependent for adoption;
- or death of a dependent.

The plan change must be consistent with the qualifying event. You must make the change within 31 days of the qualifying event.

Open Enrollment

A period between November and/or December of each has been designated as an annual open enrollment period during which individuals that are currently eligible for this Plan may add or delete themselves and their Dependents to or from coverage. Any such changes will become effective January 1st of the Calendar Plan Year, unless the Employee has not satisfied any waiting period, in which event coverage for the Employee and his or her Dependents will become effective on the day following completion of the waiting period.

Qualified Medical Child Support Orders

The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a "Qualified Medical Child Support Order" ("QMCSO") if such an individual is not already covered by the Plan as an Eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

"Alternate Recipient" shall mean any child of an Employee who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Employee's Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible Dependent, but for purposes of the reporting and disclosure requirements, an Alternate Recipient shall have the same status as a Covered Person.

"Medical Child Support Order" shall mean any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

- Provides for child support with respect to an Employee's child or directs the Employee to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
- Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"National Medical Support Notice" or "NMSN" shall mean a notice that contains the following information:

1. Name of an issuing state agency;
2. Name and mailing address (if any) of an employee who is a Covered Person under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Covered person or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

"Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which an Employee or Eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Employee and the name and mailing address of each such Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

In addition, a National Support Notice shall be deemed a QMCSO if it:

- Contains the information set forth above in the definition of "National Medical Support Notice";
  - Identifies either the specific type of coverage or all available group health coverage. If the employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated; or
  - Informs the Plan Administrator that, if a group health plan has multiple options and the participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and
- Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Employees and Eligible Beneficiaries Dependents without regard to this Section 4.05, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator shall, as soon as administratively possible:

- Notify the Employee and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and
- Make an administrative determination if the order is a QMCSO and notify the Employee and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice, the plan Administrator shall:

- Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
  - Whether the child is covered under the Plan; and
  - Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
- Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator shall:

- Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order; and
- Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

When Coverage Ends

Your coverage will end on the last day of the month in which:

- The date the Employer terminates the benefits described in this booklet, or
- The date you are no longer eligible or your service ends, or
- The due date of the first contribution toward your coverage that you or the Employer fails to make.

Your Dependent coverage will end on the last day of the month in which:

- The date your coverage ends; or
- The date your Dependent is no longer eligible for benefits; or
- The due date of the first contribution toward Dependent coverage that you or the Employer fails to make.

Please note: An Employee must notify the Claims Administrator or the Plan Administrator immediately when an enrolled Dependent is no longer eligible to be enrolled in the Plan. If notice is not provided, the Employee is intentionally misrepresenting a material fact and the plan will retroactively terminate coverage for the ineligible Dependents. If the plan pays claims based on the misrepresentation, the ineligible Dependent may be terminated retroactively and the Employee may be responsible for any claims paid on your Dependent's behalf. The Plan Administrator has the right to determine the date on which coverage will end, and such termination may be retroactive.

Continuation during FMLA Leave

Regardless of the established leave policies below, the Plan shall at all times comply with FMLA. During any leave taken under FMLA, the Employee will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

CONTINUATION OF COVERAGE UNDER COBRA

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to Covered Persons when they otherwise would lose their group health coverage. It also can become available to other members of the Covered Persons family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the person. Coverage will end in certain instances, including if the Covered Person or their covered dependents fail to make timely payment of premiums. Covered Persons should check with their employer to see if COBRA applies to them and their covered dependents.

Cobra Continuation Coverage

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

What is the Affordable Care Act Market Place?

There may be other coverage options for you and your family. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees

For more information you can visit https://www.healthcare.gov/

Qualifying Events

Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." The Employee, the Employee's spouse, and the Employee's Dependent Child could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event.

A covered Employee (meaning an employee covered under the Plan) will become a Qualified Beneficiary if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events happens:

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

The spouse of a covered Employee will become a Qualified Beneficiary if he or she loses his or her coverage under the Plan because any of the following Qualifying Events happens:

- The Employee dies;
- The Employee's hours of employment are reduced;
- The Employee's employment ends for any reason other than his or her gross misconduct;
- The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- The Employee becomes divorced or legally separated from his or her spouse.

Dependent Children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

- The Employee dies;
- The Employee's hours of employment are reduced;
- The Employee's employment ends for any reason other than his or her gross misconduct;
- The Employee becomes entitled to Medicare benefits (Part A, Part B, or both);

- The parents become divorced, legally separated; or
- The child stops being eligible for coverage under the plan as a "Dependent Child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to Kenai Peninsula Borough School District, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and Dependent Children also will become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

Employer Notice of Qualifying Events

When the Qualifying Event is the end of employment, reduction of hours of employment, death of the covered Employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the Qualifying Event.

Employee Notice of Qualifying Events

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

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

The Plan Administrator is:

Kenai Peninsula Borough School District
Dave Jones
148 N Binkley Street
Soldotna, AK 99669
(907) 714-8888

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

Deadline for Providing the Notice

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

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

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

latest of:

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

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

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

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

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

Who Can Provide the Notice?

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

Required Contents of the Notice

The notice must contain the following information:

1. Name and address of the covered Employee or former employee;
2. Identification of the initial Qualifying Event and its date of occurrence, if the person is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period;
3. A description of the Qualifying Event (for example, divorce, legal separation, cessation of dependent status, entitlement to Medicare by the covered Employee or former employee, death of the covered Employee or former employee, disability of a Qualified Beneficiary or loss of disability status);
4. In the case of a Qualifying Event that is divorce, name(s) and address(es) of Spouse and Dependent Child(ren) covered under the Plan, date of divorce, and a copy of the decree of divorce;
5. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former employee, date of entitlement, and name(s) and address(es) of Spouse and Dependent Child(ren) covered under the Plan;
6. In the case of a Qualifying Event that is a Dependent Child cessation of dependent status under the Plan, name and address of the child, reason the child ceased to be an eligible Dependent (for example, attained limiting age);
7. In the case of a Qualifying Event that is the death of the covered Employee or former employee, the date of death, and name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan;
8. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled

Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;

9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and
10. A certification that the information is true and correct, a signature and date.

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

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

Electing COBRA Continuation Coverage

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

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their spouses, and parents may elect COBRA Continuation Coverage on behalf of their child(ren).

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

Duration of COBRA Continuation Coverage

COBRA Continuation Coverage will be available up to the maximum time period shown below. Generally, multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event; however, if the first Qualifying Event is the covered Employee's entitlement to Medicare benefits, followed by termination or reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

- 36 months after the date the covered Employee became entitled to Medicare benefits; and
- 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours.

For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the covered Employee (or former employee), the covered Employee's (or former employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce or legal separation, or a Dependent Child losing eligibility as a Dependent Child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the covered Employee's hours of employment, and the covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA

Continuation Coverage for Qualified Beneficiaries other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA Continuation Coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

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

Disability Extension of COBRA Continuation Coverage

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

Second Qualifying Event Extension of COBRA Continuation Coverage

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

Shorter Duration of COBRA Continuation Coverage

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

- The date the employer ceases to provide a group health plan to any employee;
- The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;
- The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first) (except as stated under COBRA's special bankruptcy rules). or
- The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Premium Requirements

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

Additional Information
Additional information about the Plan and COBRA Continuation Coverage is available from the Benefits Manager, who is:

Kenai Peninsula Borough School District
Stacey Cockroft
148 N Binkley Street
Soldotna, AK 99669
(907) 714-8879

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

The Trade Act of 2002
Two provisions under the Trade Act of 2002 (the "Trade Act") affect the benefits received under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 65% tax credit for premiums paid for certain types of health insurance, including COBRA premiums. Second, eligible individuals under the Trade Act who do not elect COBRA continuation within the election period will be allowed an additional 60-day period to elect COBRA continuation coverage. If the qualified beneficiary elects continuation during this second election period, the coverage period will run from the beginning date of the second election period. You should consult the Plan Administrator if you believe the Trade Act applies to you.

Multiple Qualifying Events
A second qualifying event could occur during the initial period of COBRA coverage due to the death of the former Employee, or the spouse if he elected separately and covered eligible Dependents, divorce, or other loss of eligibility such as a Dependent reaching the limiting age. When such a qualifying event occurs, the requirements specified in the sections entitled "Notice and Election Requirements" and "Premium Requirements" will apply. The maximum time period for continuation following the second qualifying event will be combined with the preceding period of coverage under COBRA so that the total period of coverage will not exceed 36 months from date of the original qualifying event. Coverage may cease before the end of the maximum period as described in the section entitled "Maximum Time Periods."

STATEMENT OF USERRA RIGHTS

As a Covered Person in the Plan, you are entitled to certain rights and protections under enacted the Uniformed Services Employment and Reemployment Rights Act (USERRA) enacted in Congress on October 13, 1994. This Act was intended to protect the rights of servicemen and servicewomen who need to leave their civilian employment for military service. The act provides job protection and allows service personnel to return to their jobs within prescribed time limits after their military service ends. Additionally, USERRA offers COBRA-like continuation benefits under the employer's group health benefit plan(s). The Veterans Benefits Improvement Act of 2004 (VBIA) modifies an employer's responsibility to service personnel with regard to their USERRA rights.

While coverage under the military health program is generally offered to the soldier and his/her family, USERRA created the requirement that employers also offer service personnel and their families continued coverage under the employer-sponsored plans for up to 18 months. This continuation period was extended to 24 months under VBIA for elections made after December 10, 2004. The continued coverage ends if the service member returns to employment before the end of the USERRA continuation period because, presumably, active employee coverage would begin at that point.

Individuals performing military duty of more than 30 days may elect to continue employer sponsored health care for up to 24 months; however, they may be required to pay up to 102% of the full premium. For military service of less than 31 days health care coverage is provided as if the service member had remained employed.

Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods except for service-connected illness or injuries.

Enforcement:
The U.S. Department of Labor, Veterans Employment and Training Service (VETS) are authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contract VETS at 1-800-4-USA-DOL or visit its website at http://www.dol.gov/vets.

An Interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm.

If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Council, depending on the employer, for representation.

You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

MAJOR MEDICAL BENEFITS

Deductibles
A Deductible is a specified dollar amount of Covered Expenses you must incur during a Calendar Year before any other Covered Expenses can be considered for payment at the percentages stated in the Summary of Benefits of this Plan. The amount credited toward the Deductible will not exceed the allowable charge for the covered service or supply.

APPLIES TO HRA PLAN ONLY: Covered Expenses that are incurred during the last three months of a Calendar Year which are applied to an individual's Calendar Year Deductible for that Calendar Year will also be allowed as credit toward the individual's Calendar Year Deductible amount in the next Calendar Year.

If two or more covered Family members are injured in the same Accident, only one individual Deductible will have to be satisfied before benefits are provided.

Covered Expenses
Covered medical expenses are the Usual Customary and Reasonable expenses Incurred by or on behalf of a Covered Person for the Hospital or other medical services listed below which are:

- Ordered by a Physician;
- Medically Necessary for the treatment of the Illness or Injury; and
- Not otherwise excluded under the Plan's provisions, exclusions or limitations.

Benefit Percentage
The Benefit Percentage is the percentage of Covered Expenses, in excess of the Deductible amount, which the Plan pays. The Benefit Percentage is listed in the Summary of Benefits. If the Plan pays benefits at less than 100%, the Member must pay the remaining percentage of covered services. This amount is in addition to any deductible amount.

Covered Major Medical Benefits
All medical benefits are subject to allowable covered expense guidelines. Network providers have agreed to a set fee schedule. A Member will not receive a bill for covered expenses over the scheduled amount.

For non-network providers, the allowable covered expense is determined by Usual Customary and Reasonable charge guidelines. The Usual Customary and Reasonable charge for each service or supply received will be the lesser of the fee usually charged by a provider and the fee usually charged by other providers in the same geographical area for these services and supplies. The member must pay any amount over Usual Customary and Reasonable charges.

What is Covered?
The following are covered expenses:

Acupuncture
The Plan covers expenses for services related to Acupuncture as medically necessary.

Chiropractic Services
The Plan covers expenses for services related to chiropractic care and treatment. Rolfing is covered at the same level of benefit as Chiropractic Services.

Clinical Trials
As required under the Patient Protection and Affordable Care Act (ACA), the Plan will not:

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

3. discriminate against the individual on the basis of the individual's participation in the trial.

A "qualified individual" is someone who is eligible to participate in an "approved clinical trial" and either the individual's doctor has concluded that participation is appropriate or the participant provides medical and scientific information establishing that their participation is appropriate.

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

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

Durable Medical Equipment (DME)
Charges for rental, up to the purchase price including glucose home monitors for insulin dependent diabetics. DME includes associated supplies for the necessary function of any equipment. At its option, and with its advance written approval, the Plan may cover the purchase of such items when it is less costly and more practical than rental. The Plan does not pay for:

- Repairs of equipment;
- Replacements for equipment still under warranty; or
- The rental or purchase of items which are not considered "Durable Medical Equipment" by the Plan.

Preauthorization may be required for some items.

Emergency Care
A $250 Emergency Room Deductible applies per hospital emergency room visit (waived if you are directly admitted as an inpatient, or treatment is for accidental injury and is received on the day of or within 2 days after the accident).

A Medical Emergency is a sudden onset of a medical condition or Accidental Injury manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result, in the Plan's judgment, in one of the following:

- Placing a participant's life in jeopardy;
- Causing serious impairment to bodily functions;
- Causing serious and permanent dysfunction of any bodily organ or part.

Family Planning
The Plan covers tubal ligations, vasectomies, elective abortions and infertility testing.

Home Health Care
The Plan covers home health care visits when services are provided by a licensed home health care agency. Services must be prescribed as an alternative or a follow-up to inpatient Hospital care. The Member must be restricted from leaving home due to a medical condition.

Care must be such that it cannot be learned or performed by the average, non-medically trained person. Care must be provided by technical or professional personnel or by home health aides working along with technical or professional personnel. Care must be required for a medical condition that is expected to improve significantly in a reasonable period

of time, unless the patient is eligible for Hospice Care. The Plan covers Home Health Care when it is provided in lieu of Hospice Care if no local Hospice Care Agency is able to provide services.

Hospice Care
The Plan covers hospice care if prescribed by a Doctor and the Member's life expectancy is six (6) months or less.

Hospital Care
The Plan covers semi-private room and board and ICU expenses as well as other inpatient and outpatient services, supplies and Doctor's charges. Hospital and Doctor charges for infant care through the first thirty-one (31) days of life are covered.

Maternity Coverage
Pregnancy related care for a female employee or spouse. This benefit does not cover dependent children.

The Plan covers prenatal, childbirth and postnatal care. Coverage for you and your baby, if dependent coverage is elected, includes a Hospital stay of 48-hours for a normal vaginal delivery and 96-hours for a C-section. The 48/96 hours begin following delivery of the last newborn in case of multiple-births. When delivery takes place outside a hospital, the 48/96 hours begin at the time of inpatient admission. The Hospital stay may be less than the 48-hour or 96 hours minimum if a decision for early discharge is made by the attending Doctor in consultation with the mother.

Pre-authorization is not required for the 48/96-hour Hospital stay. However, authorization is needed for a longer stay than as described above.

Treatment of complications of pregnancy is covered for all covered females.

Occupational Therapy
Charges for treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing Outpatient facility.

Office Visits
The Plan covers services and supplies provided in a Doctor's office; except where specifically excluded.

Other Medical Services and Supplies

- Nursing services.
- Ambulance services, (both surface and air) and commercial air coach air transportation. The plan will cover round trip coach airfare if it is certified by a health professional that adequate treatment cannot be provided locally. The Plan will also cover the round-trip coach air fare for an accompanying adult if the patient is a child or an incapacitated adult. Benefits are subject to the calendar year deductible and applicable coinsurance and limited to the nearest location where adequate treatment can be provided. Incapacitated will be defined when an individual cannot attend to all of the following:
    - Unable to board the aircraft; and
    - Deplaning; and
    - Arranging ground transportation to the facility where treatment is to be rendered; and
    - Process through admission at the facility where treatment is to be rendered.
- General anesthesia and associated facility charges for dental procedures when determined to be Medically Necessary.
- Custom-designed orthotics when prescribed by a Doctor and required for all normal, daily activities.
- Individualized nutritional evaluation and counseling that is (1) **medically necessary** for the management of the following medical conditions for which appropriate diet and eating habits are essential to the overall treatment

program, (2) prescribed by a **physician** or physician extender (a nurse practitioner or physician assistant), and (3) provided by a licensed health-care professional (e.g., a registered dietician) covered under the Plan.

Conditions for which nutritional evaluation and counseling may be considered **medically necessary** include:

- Anorexia Nervosa & Bulimia
- Diabetes
- Morbid Obesity

- Prescription drugs when received as an outpatient.
- Charges for the initial placement of prosthetics. Charges for replacement prosthetic if there is significant enough change in the Covered Person's physical condition to make the original device no longer functional. Repairs are not covered.
- Pediatric vision services to the extent required by federal law.
- Speech therapy which is medically necessary to treat breathing problems, including vocal cord dysfunction (VCD). Speech therapy will not be covered for the treatment of delays in speech development, to restore speech function, or to correct a speech impairment.

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

The Dialysis Program has been established for the following reasons:

- the concentration of dialysis providers in the market in which Plan members reside may allow such providers to exercise control over prices for dialysis-related products and services,
- the potential for discrimination by dialysis providers against the Plan because it is a non-federal 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 January 1, 2014, 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:

  - 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.

  - 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:

  - 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.

  - 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.

  - 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.

  - 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.

  - 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.

  - 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.

- 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.

Physical Therapy
Physical therapy is covered when such services are Medically Necessary to restore or improve a bodily function that was previously present but was lost as a result of an injury, illness, or surgery. Physical therapy may also be covered for children with developmental disability or delay when such services are Medically Necessary. A physician must refer the patient to physical therapy. Prior to payment of any claim for physical therapy, the therapist must file a copy of the Physician's referral and the therapist's treatment plan with Rehn & Associates. Benefit payment for physical therapy services is subject to the limits shown in the Schedule of Benefits. Additional visits may be approved if visits are Medically Necessary and the Covered Person continues to make improvement as a result of the therapy.

Preventive Care
The Plan shall cover the following preventive care services at 100% of Covered Expenses, and those expenses will not be subject to deductibles or copays.

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

The complete list of recommendations and guidelines for preventive care services that must be covered by plans is located at www.healthcare.gov.

Reconstructive Surgery following a Mastectomy
In connection with a mastectomy or lumpectomy will be covered in a manner determined in consultation with the attending Physician and the patient as follows:

- Reconstruction of the breast on which the surgical treatment has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Coverage for prostheses needed and any physical complications arising from all stages of surgical treatment, including lymphedemas. Prostheses to include both internal and external breast prostheses, including necessary replacements which are prescribed by the attending Physician. Post-mastectomy bras will be limited to two per Calendar Year.

Skilled Nursing Facility
The Plan covers care in a licensed skilled nursing facility. Care must be such that it requires the skills of technical or professional personnel, is needed on a daily basis and cannot be provided in the patient's home or on an outpatient basis. Care must be required for a medical condition which is expected to improve significantly in a reasonable period of time and

the Member must continue to show functional improvement. Coverage is limited to the usual charge of the facility for semi-private care. This amount includes room and board and all other services.

Surgery
Charges for surgical operations and procedures, unless otherwise specifically excluded under the plan, and limited as follows:

2. Multiple procedures will be allowed at;
   - 100% (full Usual, Customary and Reasonable value) for the first or major procedure;
   - 50% for the second and subsequent procedures.
3. Bilateral procedures which, which are provided at the same operative session, will be allowed at;
   - 100% (full Usual, Customary and Reasonable value) for the first or major procedure;
   - 50% for the second and subsequent procedures.
4. Charges made for services rendered by an assistant surgeon will be allowed at 25% of the Usual, Customary and Reasonable for the primary surgeon allowance for the type of surgery performed.

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

Transplant Services
Covered expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your dependents may require an organ transplant. Organ means solid organ; stem cell; bone marrow; and tissue.

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;
- Intestine;
- Bone Marrow/Stem Cell;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (Stem Cell);
- Sequential transplants;
- Re-transplant of same organ type within 180 days of the first transplant;
- Any other single organ transplant, unless otherwise excluded under the plan.
- The following will be considered to be more than one Transplant Occurrence: Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant);
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant);
- Re-transplant after 180 days of the first transplant;
- Pancreas transplant following a kidney transplant;
- A transplant necessitated by an additional organ failure during the original transplant surgery/process;
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

The network level of benefits is paid only for a treatment received at a facility designated by the plan as an Institute of Excellence™ (IOE) for the type of transplant being performed. Each IOE facility has been selected to perform only certain types of transplants.

Services obtained from a facility that is not designated as an IOE for the transplant being performed will be covered as out-of-network services and supplies, even if the facility is a network facility or IOE for other types of services.

The plan covers:

- Charges made by a physician or transplant team.
- Charges made by a hospital, outpatient facility or physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.
- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant; or upon the date you are discharged from the hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program;

2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;

3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement; and

4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

If you are a participant in the IOE program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any covered expenses you incur from an IOE facility will be considered network care expenses.

Important Reminders

To ensure coverage, all transplant procedures need to be preauthorized by Aetna. Refer to the "How the Plan Works" section for details about precertification.

Refer to the Schedule of Benefits for details about transplant expense maximums, if applicable.

Limitations

Unless specified above, not covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not covered under this plan;
- Home infusion therapy after the transplant occurrence;

- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness;
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Aetna.

Network of Transplant Specialist Facilities

Through the IOE network, you will have access to a provider network that specializes in transplants. Benefits may vary if an IOE facility or non-IOE or out-of-network provider is used. In addition, some expenses are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure you require. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

Treatment of Mental Health Conditions and Chemical Dependency
The Plan covers inpatient and outpatient treatment of mental health conditions, alcoholism, drug addiction and other chemical dependency.

Treatment of TMJ and Related Disorders
The Plan covers treatment of temporomandibular disorders and craniofacial muscle disorders.

Is There a Limit on My Expenses?
The breakpoint maximums are shown in the Medical Summary of Benefits.

Calendar Year Breakpoint
If in any one calendar year a Member's covered expenses reach the individual breakpoint, all other covered services for that Member during the rest of that calendar year will be payable at 100%. No more than the individual breakpoint per Member will be applied to the family breakpoint.

The family breakpoint is a total calendar year amount of expenses that can be incurred by any combination of covered Members of a family. Once the family breakpoint has been met, you and each covered Member of your family will be considered to have met the individual breakpoint for the rest of that calendar year.

Expenses Excluded from the Breakpoint
Expenses that are not applied toward the breakpoint include:

- services and supplies not covered under this Plan.
- services and supplies used to satisfy any deductible amounts.
- services provided at a non-PPO facility.
- services that are payable at 100%.
- claimed amounts in excess of UCR.

Claim Self-Audit
Your employer wants you to carefully review your health claims. If you find an error such as treatment billed but not received, incorrect arithmetic, drugs or supplies not received, and the error results in an overcharge, submit a copy of the bill with the error noted. If you find an error on a bill that has been paid by the Claims Administrator, you will be reimbursed 50% of the overpayment recovered by the Plan, up to a maximum of $500.

MEDICAL BENEFIT LIMITATIONS/EXCLUSIONS

No amount will be payable for:

- Services not Medically Necessary.
- Custodial care. "Custodial care" means skilled and non-skilled health care, personal comfort and convenience services that provide general maintenance, support, preventive or protective care for a Member whose current medical condition is not expected to improve or change over a specified period of time. Custodial care does not seek a cure.
- Special nursing services if those same services could be provided by the regular nursing staff of any Hospital in which the Member is confined.
- Charges by a Doctor for any phone call or interview during which the Member is not examined, other than as specifically allowed under the Plan.
- Confinement, treatment, services or materials for educational or training problems or learning disorders.
- Services or supplies which are primarily for the Member's education, training or development of skills needed to cope with an injury or sickness, except as specifically provided in the Plan.
- Any expense or charge associated with exercise equipment.
- Travel or transportation expenses, except for ambulance services, even if to reach a network facility. (Except as specifically addressed under "Other Medical Services and Supplies")
- Plastic or reconstructive surgery and all related expenses, except where surgery is Medically Necessary or required following a mastectomy.
- Gene manipulation therapy.
- The reversal of any sterilization procedure.
- Massage, except as prescribed by a physician and provided by a licensed therapist. Rolfing services are covered on the same basis as chiropractic services.
- Maternity coverage for a Dependent Child.
- Surgical procedures for the improvement of vision when vision can be corrected through the use of glasses or contact lenses.
- Eyeglasses, contact lenses, eye exams to assess visual acuity or the fitting of glasses and lenses. (Vision services are covered under the Vision Plan.)
- Dental services other than treatment of accidental injuries to natural teeth within six (6) months after the Accident. Chewing injuries are not considered accidental injuries. (Dental services are covered under the Dental Plan.) (Except as specifically addressed under "Other Medical Services and Supplies")
- Non-prescription drugs or medicines, or drugs or medicines that are not approved by the Food and Drug Administration.
- Treatment for the purposes of weight loss, except for medically necessary surgical treatment of obesity, or as required as preventive care under the ACA.
- Hearing aids or the fitting of hearing aids, including cochlear implants, external speech processor and controller, integrated system.
- Outpatient treatment of speech, hearing, except as specifically provided in the Plan.
- Any family planning procedure that requires outside intervention, such as, but not limited to, artificial insemination, in-vitro fertilization, GIFT or ZIFT.
- Infertility treatment.

- Routine or Screening. Charges for items not directly linked with a medical condition, illness, or symptom unless specifically included under Preventative Care.
- Miscellaneous charges incurred for education or training (except as specifically stated as covered), hypnosis, standby Physician services, completion of forms, mailing and shipping expenses, missed appointments, telephone calls, milieu therapy, or chelation therapy (except to treat heavy metal poisoning).
- Experimental or Investigational treatment or procedures.
- Anti-obesity drugs and formulas, except as specifically provided in the Plan.
- Broken appointments.
- Care provided by a government health plan or for which there would be no cost if the Member did not have coverage. If the Member is entitled to benefits under a state-sponsored medical assistance program, benefits under the Plan will be paid to the state.
- Expenses incurred for care provided by the Member or Member's spouse's immediate or extended family.
- Care received for an Illness that is a result of war, engaging in a riot or insurrection or from an intentionally self-inflicted injury.
- An accidental injury that occurs while working for pay or profit.
- A sickness for which the Member can receive benefits under any Worker's Compensation or similar law.
- Any non-emergency Hospital charges incurred at a Hospital in New York. Non-emergency charges will be those charges for services that do not meet the definition of Emergency as defined herein.
- Drugs and medicines that may be lawfully obtained over the counter (OTC) without a prescription. OTC drugs are excluded even if prescribed by a practitioner, unless otherwise stated in this benefit. Examples of such non-covered items include, but are not limited to nonprescription drugs and vitamins, food and dietary supplements, herbal or naturopathic medicines and nutritional and dietary supplements (e.g. infant formulas or protein supplements).

PRESCRIPTION DRUG BENEFITS

Participating pharmacies ("Participating Pharmacies") have contracted with the Plan to charge Covered Persons reduced fees for covered drugs. Covered Persons will be issued an identification card to use at the pharmacy at time of purchase. Covered Persons will be held fully responsible for the consequences of any pharmacy identification card after termination of coverage.

The co-payment is applied to each charge and is shown on the Summary of Benefits. The co-payment amount is not counted toward any out-of-pocket maximums under the Plan.

What is Covered?

- Legend Drugs;
- Compounded medication of which at least one ingredient is a prescription Legend Drug;
- Insulin on prescription;
- Any other drug which under the applicable state law may only be dispensed upon written prescription of a Physician or other lawful prescriber.

How to file a Prescription Drug Claim

Members who purchase drugs at a participating pharmacy and present the ID card will receive preferred pricing from the pharmacy. The member will pay the required co-pay.

The only time a claim will need to be filed for reimbursement is when drugs are purchased at a pharmacy that is not a participating network pharmacy, or when the Member does not show the ID card. Ask the Employer for a claim form. Complete the form and attach your prescription drug receipt. Mail to the address listed on the claim form. Your reimbursement will be based upon the amount that the Plan would have paid if you had used a Participating Network Pharmacy, and you will be responsible for the cost of the lost discount and your co-payment.

Whenever the Kenai Peninsula Borough School District Health Care Plan is secondary on a prescription drug claim the Plan will pay for covered drugs:

- If the drug is covered by both plans and if the primary plan pays 100% of the cost except for the co-pay, this Plan will pay up to what it would have paid toward the cost of the prescription toward the amount of the primary plan's co-pay.
- If the drug is covered by both plans and if the primary plan pays a portion of the cost of the prescription this Plan will pay up to the amount it would have paid as primary toward the unpaid portion of the cost of the prescription.
- If the primary plan does not cover the drug, but this Plan does, or if both plans cover the drug but, the primary plan does not pay any of the cost of the prescription, this Plan will pay up to the amount it would have paid as primary payer less the appropriate co-pay.

Coordination of Benefits should be automatic through your Pharmacy Benefit Manager if the prescription is filled at a network pharmacy and the participant uses their ID Card.

Specialty Medications

Specialty medications require prior authorization and are limited to a 30-day supply per fill. The Plan has adopted a preferred drug program for select specialty drugs. The preferred drug program requires members filling specialty prescriptions for the first time to try a preferred medication. If you choose a nonpreferred specialty drug without first trying the preferred medication, you may be responsible for the full cost of the non-preferred medication.

Compound Medications

Compound medications which cost $500 or more must be pre-authorized. Compound medications are limited to one fill per 25 days.

PHARMACY BENEFIT LIMITATIONS/EXCLUSIONS

The following are not covered by the Plan:

- Therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use. Benefits may be provided for these items under the Major Medical portion of this Plan.
- No more than a 100-day supply or 100- quantity unit supply in any one prescription initial fill or refill. Any prescription initial fill or refill in excess of the number specified by the Physician or allowed by law, or any refill dispensed after one year from the order of the Physician or the maximum time allowed by law if less than one year ; shall be considered void as dictated by the applicable State Board of Pharmacy.
- Drugs labeled "Caution - limited by federal law to investigational use," or Experimental drugs, even though a charge is made to the individual.
- Prescriptions which an eligible person is entitled to receive without charge from any governmental program.
- Immunization agents, biologicals, blood or blood plasma.
- Charges for the administration or injection of any medication. Administration or injection charges may be eligible under the Major Medical portion of this Plan.
- Medication which is taken or administered, in whole or part, while the person is confined in a Hospital or other health care facility.
- Prescriptions which an eligible person is entitled to receive without charge under any workers' compensation or similar law.
- Non-legend drugs, other than insulin on prescription.
- Experimental or Investigational treatment or procedures.
- Anti-obesity drugs and formulas, except if morbidly obese.
- Care provided by a government health plan or for which there would be no cost if the Member did not have coverage. If the Member is entitled to benefits under a state-sponsored medical assistance program, benefits under the Plan will be paid to the state.
- Expenses Incurred for care provided by the Member or Member's spouse's immediate or extended family.
- Care received for an Illness that is a result of war, engaging in a riot or insurrection or from an intentionally self-inflicted injury.
- An accidental injury that occurs while working for pay or profit.
- A sickness for which the Member can receive benefits under any Worker's Compensation or similar law.

DENTAL BENEFITS

Benefits are available for the services and supplies described in this section which are furnished in connection with the diagnosis and treatment of a covered dental condition when such services and supplies meet all of these requirements:

1. They must be, in the Plan's judgment, dentally necessary. That is, they must be:
   a. Essential to, consistent with and provided for the diagnosis or the direct care and treatment of disease, accidental injury or condition harmful or threatening to your dental health;
   b. Consistent with standards of good dental practice within the organized dental community; and
   c. Not primarily for the convenience of you or your dentist.
2. The fact that the covered services were furnished, prescribed or approved by a Dentist does not in itself mean that the services were dentally necessary.
3. They must not be excluded from coverage under this Plan.
4. They must be furnished by a Dentist, except that they may also be provided by a licensed dental hygienist or other individual performing within the scope of his or her license as allowed by law. These services must be rendered under the supervision and guidance of the Dentist.

The Covered Person is responsible for furnishing all diagnostic evaluative material, such as study models, dental x-rays and charts to the Plan so that it may determine available benefits.

Alternative Benefits
To determine benefits available under this Plan, the Claims Administrator considers alternative procedures or services carrying different fees which are, in the Plan's judgment, consistent with acceptable standards of dental practice. In all cases where there is an alternative course of treatment carrying different fees, the Plan will only provide benefits for the treatment carrying the lesser fee. If you and the Dentist decide upon a more costly treatment, then you are responsible for the additional charges beyond those for the less costly alternative treatment.

Calendar Year Deductible
Covered dental services are classified as Preventive, Basic and Major. Preventive services are not subject to any deductible. However, a deductible does apply to Basic and Major services. A deductible is the amount of expense a Covered Person must incur for Basic and Major services and supplies. The deductible amount for each Covered Person is shown on the Summary of Benefits. The amount credited toward the deductible will not exceed the allowable charge for the covered service or supply. Any amount used to satisfy this deductible will not be used to satisfy any other deductible under the Plan.

However, this Plan limits the Calendar Year deductible for families. This deductible amount is shown on the Summary of Benefits. Only the amounts used to satisfy each enrolled family member's deductible will contribute toward the family's total deductible.

Benefit Payment Percentages
Benefits for Preventive services are available to a Covered Person before satisfaction of the Calendar Year deductible. After the Covered Person satisfies the required deductible for Basic and Major services, dental benefits are provided at the following percentages of allowable charges each Calendar Year, up to the dental benefit maximum. The maximum amount of dental benefits available to any one Covered Person in a Calendar Year is shown on the Summary of Benefits. Charges for dental services or supplies that exceed what is covered under this benefit are not covered under this benefit are not covered under other benefits of the Plan.

Allowable Covered Expenses
All dental benefits are subject to allowable covered expense guidelines. The allowable covered expense is determined by Usual Customary and Reasonable guidelines. The Member must pay any amount over Usual Customary and Reasonable charges.

Pre-Treatment Plan
For specialist care and any other dental care expected to cost $1,000 or more, ask the Dentist to prepare a treatment plan and send it to the address shown on the Plan ID card.

The Member and the Dentist will receive an explanation of benefits (EOB) that details the benefits payable under the Plan. The pre-determination of benefits is valid for ninety (90) days.

What is covered?
If the Plan pays benefits at less than 100%, the Member must pay the remaining percentage of covered services.

Services must be necessary for the diagnosis, prevention or correction of dental disease, defect or injury. Services must be recommended or prescribed by a licensed Dentist or Doctor, or performed by a dental assistant or dental hygienist working under the direct supervision of a Dentist.

The Plan covers only the least costly procedure that will produce satisfactory results. Expenses are covered only if incurred and completed while a Member is covered for these dental benefits.

Preventive Care
In accordance with the Summary of Benefits, the Plan will pay for the following diagnostic and preventive services:

1. Oral examinations, limited to two examinations each Calendar Year.
2. Diagnostic services, including examinations and diagnostic x-rays, as follows:
    a. Full mouth series of at least 14 films including bitewings, if needed (limited to once in any 3-calendar year period);
    b. Panoramic film, maxilla and mandible (in place of item a.; also limited to once in any 3-calendar year period)
    c. Bitewing films (limited to a maximum set of four films in one visit; limited to two preventative sets in any calendar year);
    d. Intraoral periapical or occlusal x-rays single films;
    e. Extra oral superior or inferior maxillary film.
3. Topical fluoride application for Covered Persons under age 20, limited to two treatments in each Calendar Year. Topical application of fluoride to the prepared portion of a tooth prior to placement of a final restoration and fluoride for use in prophylaxis paste and/or in restorative materials is not covered.
4. Prophylaxis limited to two treatments each Calendar Year. Curettage and scaling performed in conjunction with, and on the same day as, a prophylaxis will be deemed to be included within the prophylaxis procedure.
5. Sealants for Covered Persons under age 20, limited to use on permanent teeth.

Basic Care
In accordance with the Summary of Benefits, Basic Care includes:

- Extractions and alveolectomy at the time of tooth extraction.
- Amalgam, silicate, acrylic, and composite fillings. Silicate, acrylic, and composite fillings are covered only for teeth in front of the first bicuspid.
- Dental surgery.
- X-ray and lab procedures required for dental surgery.
- General anesthesia required for dental surgery.
- Care for relief of dental pain.

- Drugs that require a Dentist's written prescription, including medication given at the Dentist's office.
- For Members age 14 and under, space maintainers for missing primary teeth and habit-breaking appliances, including the re-cementing of space maintainers.
- Consultations required by the attending Dentist.
- Relines and rebases to existing dentures.
- Endodontic and periodontal Care.

Major Care
In accordance with the Summary of Benefits, Major Care includes:

- Crowns, inlays and onlays.
- Fixed bridge restorations.
- Removable partial or complete dentures.
- Implants
- Repairs to existing dentures.
- Initial placement of full or partial dentures or bridgework, including abutments, but only if they are needed to replace natural teeth pulled after coverage begins.
- Replacement of existing full or partial dentures, bridgework or crowns; or the addition of teeth, inlays, onlays, crowns or gold restorations to these appliances only if:
  - The existing appliance cannot be repaired or restored to use; and
  - The Member has been covered at least 12 months.
  - At least five years have passed since the last placement; or
  - The replacement:
    - Replaces an existing temporary appliance that was placed after the date on which the Member became covered; and
    - Is placed within twelve (12) months after a temporary appliance was placed; or
  - The replacement:
    - Is needed because of the pulling of additional natural teeth or accidental injury to natural teeth (except for chewing injuries) while covered; and
    - Is completed within twelve (12) months of the extraction or Accidental Injury.

If a Member has a partial denture, and a natural tooth adjacent to that denture is pulled while the Member is covered, the addition of another tooth to the Member's denture is covered.

DENTAL BENEFIT LIMITATIONS/EXCLUSIONS

The following are not covered by the Plan:

- Dental appliances, which have been lost, mislaid or stolen.
- Night Guards.
- Dental care that is cosmetic in nature or does not have ADA endorsement.
- Dental care provided to correct any birth defect or developmental malformation that does not interfere with function.
- Care of craniofacial muscle disorders and temporomandibular disorders. TMJ is covered under the medical plan.
- That part of any covered dental expense that is payable under any other section of this booklet, unless:
    - benefits are payable under both this dental benefit and any medical benefits; and
    - it is to the Member's advantage to have benefits paid under dental benefits rather than under medical benefits.
- Dental care that is cosmetic in nature.
- Services not necessary for the diagnosis, prevention or care of dental disease, defect or injury.
- Dental care provided for dietary planning for the control of dental disease or for plaque control or for oral hygiene instructions.
- Customized dental procedures.
- Crowns for teeth that are restorable by other means or for the purpose of periodontal splinting.
- Take-home fluoride solutions.
- Local analgesics.
- Orthodontic Treatment.
- Experimental or Investigational treatment or procedures.
- Broken appointments.
- Care provided by a government health plan or for which there would be no cost if the Member did not have coverage. If the Member is entitled to benefits under a state-sponsored medical assistance program, benefits under the Plan will be paid to the state.
- Expenses Incurred for care provided by the Member or Member's spouse's immediate or extended family.
- Care received for an Illness that is a result of war, engaging in a riot or insurrection or from an intentionally self-inflicted injury.
- An accidental injury that occurs while working for pay or profit.
- A sickness for which the Member can receive benefits under any Worker’s Compensation or similar law.

VISION BENEFITS

If a Covered Person has Covered Expenses for vision services and supplies which are provided while the individual is covered under this Plan, payment will be made for such Covered Expenses if they meet all of the following requirements:

1. They must be prescribed by an ophthalmologist or Optometrist;
2. They must be furnished by an ophthalmologist, Optometrist or optician;
3. They must not be excluded from coverage under this Plan; and
4. They must be specified as covered under the Plan.

Any Deductible and coinsurance applied to other benefits in this Plan do not apply to this benefit.

Examinations
Benefits are available for one routine vision examination per Covered Person each Calendar Year. Covered routine examination services are:

1. Examination of the outer and inner parts of the eye;
2. Evaluation of vision sharpness (refraction);
3. Binocular balance testing;
4. Routine tests of color vision, peripheral vision and intraocular pressure; and
5. Case history, recommendations and prescriptions.

Frames
This benefit includes parts of frames and fitting the frames to the face. The Plan covers charges for one set of frames per Covered Person per 2 consecutive calendar years

Benefits will be provided for either eyeglasses (eyeglass lenses or frames) or contact lenses during the same Calendar Year, not both.

Lenses
When necessary to improve vision, benefits are available for two eyeglass lenses per Covered Person each Calendar Year. This includes single, bifocal or trifocal lenses. The Plan also covers charges for contact lenses (including disposable contact lenses) that a Covered Person elects in place of eyeglasses.

The allowable charge is the Usual Customary and Reasonable charge. The Covered Person is responsible for any charges that exceed the amount as well as for any charges in excess of stated benefit maximums and services and supplies not covered under this Plan. Charges for vision services or supplies that exceed what is covered under this benefit are not covered under other benefits of this Plan.

Benefits for the following are included in the maximum benefit for the type of lenses prescribed:

1. Special features, such as tinting or coating;
2. Fitting of eyeglass lenses to frames; and
3. Fitting contact lenses to the eyes.

VISION BENEFIT LIMITATIONS/EXCLUSIONS

The following are not covered by the Plan:

- Safety glasses.
- Radial keratotomy.
- Orthoptics, vision training, or medical or surgical treatment of the eye.
- Artificial eyes. (Artificial eyes, if medically necessary, are covered under the Medical Plan.)
- Experimental or Investigational treatment or procedures.
- Broken appointments.
- Care provided by a government health plan or for which there would be no cost if the Member did not have coverage. If the Member is entitled to benefits under a state-sponsored medical assistance program, benefits under the Plan will be paid to the state.
- Expenses Incurred for care provided by the Member or Member's spouse's immediate or extended family.
- Care received for an Illness that is a result of war, engaging in a riot or insurrection or from an intentionally self-inflicted injury.
- An accidental injury that occurs while working for pay or profit.
- A sickness for which the Member can receive benefits under any Worker’s Compensation or similar law.

PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of Rehn & Associates to provide certain claims processing and other technical services.

Plan Administrator

An individual or entity may be appointed by the Plan Sponsor to be the Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is dissolved, is otherwise unable to perform, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies and care are Experimental Treatments), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Covered Person is entitled to them. The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable or Usual Customary and Reasonable.

Duties of the Plan Administrator

- To administer the Plan in accordance with its terms;
- To determine all questions of eligibility, status and coverage under the Plan;
- To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
- To make factual findings;
- To decide disputes which may arise relative to a Covered Person's rights;
- To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
- To keep and maintain the Plan documents and all other records pertaining to the Plan;
- To appoint and supervise a claims administration organization to pay claims;
- To perform all necessary reporting;
- To establish and communicate procedures to determine whether a medical child support order is a QMCSO;
- To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
- To perform each and every function necessary for or related to the Plan’s administration.

Amending and Terminating the Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settler of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust Agreement (if any).

Such Amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents.

If the Plan is terminated, the rights of the Covered Persons are limited to expenses incurred before termination. Benefits under this Plan shall not vest. All Amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

HOW TO FILE CLAIMS

Medical, Dental and Vision Benefits
Members who present their ID card to their provider should not have to file a claim. The ID card contains all of the information that the providers will need to bill the Plan for the balance directly.

For other services, Members must file a claim with the Claims Administrator for reimbursement. Ask your Employer for a claim form or the member may access one through the KPBSD Benefits website, www.kpbsd.rehnonline.com. Once the claim has been processed and paid by the Claims Administrator, an Explanation of Benefits (EOB) will be sent to the Member displaying the paid information.

For expenses incurred outside the United State and Puerto Rico, the Member must pay the bill and file a claim.

HEALTH CLAIM PROCEDURES

The procedures outlined below must be followed by Covered Persons to obtain payment of health benefits under this Plan.

Health Claims
All participant questions regarding health claims should be directed to the Claims Administrator, Rehn & Associates. The Plan Administrator (KPBSD) shall be ultimately and finally responsible for providing full and fair review of the decision on such claims in accordance with the following provisions. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Covered Person is entitled to them. The responsibility to process claims in accordance with the Summary Plan Description may be delegated to the Claims Administrator; provided, however, that Rehn & Associates is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each Covered Person claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Administrator, in its sole discretion, shall determine that the Covered Person has not incurred a covered expense or that the benefit is not covered under the Plan, or if the Covered Person shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

The US Department of Labor (DOL) has established four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

Pre-Service Claims:
A "Pre-service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. Since this Plan is an indemnity plan the only “Pre-Service Claims” are the few services that must be pre-certified with the third-party Utilization Review company, as outlined in the Summary Plan Description. Pre-service claims are claims where pre-certified services are reviewed and a determination is made regarding the medical necessity of the service or the appropriate level of care. Pre-service claim determinations do not address Covered Person’s eligibility or plan coverage for specific service items.

A "Pre-service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Covered Person or the Covered Person’s ability to regain maximum function, or, in the opinion of a physician with knowledge of the Covered Person’s medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. This Plan does not require pre-certification of “Urgent Care Claims” as

established by the DOL.

It is important to remember that, if a Covered Person needs medical care for a condition which could seriously jeopardize his/her life, there is no need to contact the Plan for prior approval. The Covered Person should obtain such care without delay.

Further, if the Plan does not require the Covered Person to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." The Covered Person 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 Claims:
A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the Covered Person requests extension of the course of treatment beyond that which the Plan has approved.

If the Plan does not require the Covered Person to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Covered Person 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.

Post-service Claims:
A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

Where to File a Claim
Claims should be mailed or faxed to the following:

Kenai Peninsula Borough School District Health Care Plan
P O Box 5433
Spokane WA 99205
Phone: (800) 872-8979
Fax: (509) 535-7883

When Health Claims Must Be Filed?
Health claims must be filed with Rehn & Associates within 15 months from the date of service. Benefits are based upon the Plan's provisions at the time the charges were Incurred Charges are considered incurred when treatment or care is given or supplies are provided. Claims filed later than that date will be denied. Timely filing for corrected claims or additional documentation requests must be received within normal timely filing limits of 15 months from the date of service.

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by Rehn & Associates in accordance with the Plan's procedures. However, a Post-service Claim is considered to be filed when the following information is received by Rehn & Associates:

- The date of service;
- The name, address, telephone number and tax identification number of the provider of the services or supplies;
- The place where the services were rendered;
- The diagnosis and procedure codes;
- The amount of charges;
- The name of the Plan;
- The name of the covered employee; and

- The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. Rehn & Associates will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by Rehn & Associates within 45 days from receipt by the Covered Person of the request for additional information. Failure to do so may result in claims being declined or reduced.

Timing of Claim Decisions

The Plan Administrator shall notify the Covered Person, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

Pre-service Non-urgent Care Claims

- If the Covered Person has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
- If the Covered Person has not provided all of the information needed to process the claim, then the Covered Person will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Covered Person will be provided at least 45 days from receipt of the notification to submit additional information. The Covered Person will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Covered Person (if additional information was requested during the extension period).

Concurrent Claims

- Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Covered Person of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments, the Covered Person will be notified sufficiently in advance of the reduction or termination to allow the Covered Person to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
- Request by Covered Person Involving Non-urgent Care. If the Plan Administrator receives a request from the Covered Person to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).

Post-service Claims

- If the Covered Person has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
- If the Covered Person has not provided all of the information needed to process the claim, the Covered Person will be notified as to what specific information is needed. The Covered Person will be provided at least 45 days from receipt of the notification to submit the additional information. If additional information is requested during the initial processing period, then the Covered Person will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Covered Person will be notified of the determination by a date agreed to by the Plan Administrator and the Covered Person.

Extensions – Pre-service Non-urgent Care Claims

This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Extensions – Post-service Claims

This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods

The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Covered Person with a notice, either in writing or electronically containing the following information:

1. Information to identify the claim;
2. A reference to the specific portion(s) of the Summary Plan Description upon which a denial is based;
3. Specific reason(s) for a denial;
4. A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary;
5. A description of the Plan's review procedures and the time limits applicable to the procedures;
6. A statement that the Covered Person 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 Covered Person's claim for benefits;
7. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
8. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Covered Person, free of charge, upon request); and
9. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, or a statement that such explanation will be provided to the Covered Person, free of charge, upon request.
10. The ability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established by the Public Health Service Act Section 2793.

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

Appeals of Adverse Benefit Determinations - Full and Fair Review of All Claims

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

1. Covered Persons at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination and 60 days to appeal a second adverse benefit determination.
2. Covered Persons the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

3. For 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. For a review that takes into account all comments, documents, records, and other information submitted by the Covered Person relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
5. That, 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 experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and
7. That a Covered Person will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim for benefits in possession of the Plan Administrator or the Claims Administrator; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances.

First Appeal Level - Requirements
The Covered Person must file the appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, the Covered Person's appeal must be addressed as follows:

Kenai Peninsula Borough School District Health Care Plan
Attention: Appeals Department
P O Box 5433
Spokane WA 99205

It shall be the responsibility of the Covered Person to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Covered Person;
2. The Employee/Covered Person's social security number or alternative Plan identification number (if applicable);
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in them being deemed waived. In other words, the Covered Person will lose the right to raise factual arguments and theories which support this claim if the Covered Person fails to include them in the appeal;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Covered Person has which indicates that the Covered Person is entitled to benefits under the Plan.

If the Covered Person provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on First Appeal
The Claims Administrator shall notify the Covered Person of the Plan's benefit determination on review within the following timeframes:
Pre-service Non-urgent Care Claims
Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the

appeal.

Concurrent Claims
The response will be made in the appropriate time period based upon 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.

Calculating Time Periods
The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on First Appeal
The Claims Administrator shall provide a Covered Person with notification, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. Information to identify the claim;
2. The specific reason or reasons for the denial;
3. Reference to the specific portion(s) of the Summary Plan Description on which the denial is based;
4. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
5. A statement that the Covered Person 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 Covered Person's claim for benefits;
6. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Covered Person upon request;
7. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, will be provided free of charge upon request;
8. A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary;
9. A description of the Plan's review procedures and the time limits applicable to the procedures;
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.

Furnishing Documents in the Event of an Adverse Determination
In the case of an adverse benefit determination on review, the Claims Administrator shall provide such access to, and copies of, documents, records, and other information described in items 4 through 7 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as appropriate.

Second Appeal Level - Adverse Decision on First Appeal; Requirements
Upon receipt of notice of the Plan's adverse decision regarding the first appeal, the Covered Person has 60 days to file a second appeal of the denial of benefits. The Covered Person again is entitled to a "full and fair review" of any denial made at the first appeal, which means the Covered Person has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the Covered Person's second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal." To file a second appeal in writing, appeal must be

addressed as follows:

Kenai Peninsula Borough School District
Attn: Health Plan Administrator
148 N. Binkley St.
Soldotna, AK 99669

Timing of Notification of Benefit Determination on Second Appeal
The Plan Administrator shall notify the Covered Person of the Plan's benefit determination on review within the following timeframes:

Pre-service Non-urgent Care Claims
Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second appeal.

Concurrent Claims
The response will be made in the appropriate time period based upon 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 second appeal.

Calculating Time Periods
The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal
The same information must be included in the Plan's response to a second appeal as a first appeal. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination
In the case of an adverse benefit determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in items 4 through 8 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.

External Review Procedure
For denied claims involving medical judgments or rescission, the Plan has an external review procedure that provides for a review conducted by a qualified Independent Review Organization (IRO). The Covered Person may request a review by an IRO within 4 months after the date of the notice of the Plan's adverse decision regarding the Second Appeal Level. If there is no corresponding day 4 months after the date of the notice on the Second Level 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 Covered Person's request for external review must be in writing and include all of the items set forth in 1-5 of the section above entitled Level 1 – Internal Review. The Plan is entitled to charge a fee of $25 to initiate an External Review, which must be paid when the Covered Person submits the Request for External Review Form to initiate the process.

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

Preliminary Review

Within 6 business days following the date of receipt of the external review request, the Covered Person will be provided a written notice stating whether the request is eligible for external review and if additional information is necessary to process the request. If the request is determined to be ineligible, the notice will include the reasons for ineligibility and provide contact information for the appropriate State or federal oversight agency. If additional information is require to process the external review request, the notice will describe the information needed and the Covered Person may submit the additional information within the 4 month filing period or within 48 hours of receipt of the notification, whichever is later.

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

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

Decision of IRO Final
The decision of the IRO is binding upon the Covered Person and the Plan, except to the extent other remedies may be available under applicable law. Before filing a lawsuit against the Plan, the Covered Person 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.

Appointment of Authorized Representative
A Covered Person is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan Administrator, in writing, to the contrary.

Physical Examinations
The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose condition, Illness or Injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition to coverage.

Autopsy
The Plan reserves the right to have an autopsy performed upon any deceased Covered Person whose condition, Illness, or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

Payment of Benefits
All benefits under this Plan are payable, in U.S. Dollars, to the covered Employee whose Illness or Injury, or whose covered Dependent's Illness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered Employee and in

the absence of written evidence to this Plan of the qualification of a guardian for his estate, this Plan may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of this Plan, is or was providing the care and support of such Employee.

Assignments

Benefits for medical expenses covered under this Plan may be assigned by a Covered Person to the provider; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

Non-U.S. Providers

Medical expenses for care, supplies, or services which are rendered by a provider whose principal place of business or address for payment is located outside the United States (a "Non-U.S. Provider") are payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:

1. Benefits may not be assigned to a Non-U.S. Provider;
2. The Covered Person is responsible for making all payments to Non-U.S. Providers, and submitting receipts to the Plan for reimbursement;
3. Benefit payments will be determined by the Plan based upon the exchange rate in effect on the incurred date;
4. The Non-U.S. Provider shall be subject to, and in compliance with, all U.S. and/or other comparable and applicable licensing requirements; and
5. Claims for benefits must be submitted to the Plan in English.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, or are not paid according to the Plan's terms, conditions, limitations or exclusions. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the Covered Person or dependent on whose behalf such payment was made.

A Covered Person, Dependent, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan, in consideration of such payments, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their state's health care practice acts, ICD-10 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions

shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, provider or other person or entity to enforce the provisions of this section, then that Covered Person, provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Medicaid Coverage

A Covered Person's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Covered Person. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as required by the state Medicaid program; and the Plan will honor any subrogation rights the state may have with respect to benefits which are payable under the Plan.

COORDINATION OF BENEFITS

Coordination of benefits is the order of payment when charges are eligible under two or more benefit plans. Coordination of benefits also occurs when the Covered Person is covered by the Plan and Medicare.

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

Allowable Charge

The Plan will consider only covered charges under the Plan as Allowable Charges.

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

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

No-Fault Limitations

When medical payments are available under vehicle insurance, the Plan will pay excess benefits only, without reimbursement for vehicle plan deductibles. The Plan will always be considered secondary and coordinate with benefits provided or required by any no-fault insurance statute whether or not a no-fault policy is in effect.

Benefit Plan Payment Order

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

1. Benefit plans that do not have a coordination of benefits provision will pay first
2. Benefit plans with a coordination of benefits provision will pay benefits up to the Allowable Charge as follows:
    a. The benefit plan which covers the person directly (that is, as an employee, member or subscriber) will determine benefits there under before benefits are considered under a benefit plan which covers the person as a dependent.
    b. The benefit plan which covers a person as an employee who is neither laid-off nor retired will determine benefits before a benefit plan which covers that person as a laid off or retired employee. The benefit plan which covers a person as a dependent of an employee who is neither laid-off nor retired will determine benefits there under before benefits are considered under a benefit plan which covers a person as a dependent of a laid-off or retired employee.
    c. The benefit plan which covers a person as an employee who is neither laid-off nor retired will determine benefits before benefits are considered under a benefit plan which covers that person as a laid off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
    d. The benefit plan which covers a person as an employee who is neither laid-off nor retired or a dependent of an employee who is neither laid-off nor retired will determine benefits before benefits are considered under a benefit plan which covers the person as a COBRA beneficiary.
    e. When a child is covered as a dependent and the parents are not separated or divorced, the following rules will apply:
        - The benefit plan of the parent whose birthday falls earlier in a year will determine benefits before benefits are considered under a benefit plan of the parent whose birthday falls later in that year;

- If both parents have the same birthday, the benefit plan which has covered the patient for the longer period of time will determine benefits before benefits are considered under the benefit plan which covers the other parent.

f. When a child's parents are divorced or legally separated, the following rules will apply:

- This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will determine benefits before benefits are considered under the benefit plan of the parent without custody.
- This rule applies when the parent with custody of the child has remarried. First, the benefit plan of the parent with custody determines benefits. Next, the benefit plan of the stepparent that covers the child as a dependent will determine benefits. Finally, the benefit plan of the parent without custody will determine benefits.
- This rule will be in place of items (1) and (2) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will determine benefits before benefits are considered under other plans that cover the child as a dependent.
- If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the benefit plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated or divorced.

g. When a child's parents were never married to each other, the rules as set out above in letter (e), will apply as long as paternity has been established.

h. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer period of time will determine benefits there under first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

3. Medicare will pay primary, secondary or last, as specified in applicable law.
4. If a Covered Person is under a disability extension from a previous benefit plan, that benefit plan will pay first and the Plan will pay second.

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.

MEDICARE

Applicable to Active Employees and Their Spouses Ages 65 and Over
An Active Employee and his spouse (ages 65 and over) may remain covered under this Plan or terminate coverage under this Plan. If such Employee remains covered under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is terminated by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

Applicable to All Other Eligible Covered Persons
To the extent required by federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payer. The Covered Person will be assumed to have full Medicare coverage (that is, both Part A & B) whether or not the Covered Person has enrolled for the full coverage. If the provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare approved expenses.

Services Delivered to End Stage Renal Disease ("ESRD") Beneficiaries Covered Under This Plan
If any Covered Person is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 18 months of Medicare entitlement (with respect to charges incurred on or after February 1, 1991 and before August 7, 1997), and for the first 30 months of Medicare entitlement (with respect to charges incurred on or after August 5, 1997), unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

This provision shall apply to all benefits provided under any section of this Plan.

When this Provision Applies

A Covered Person may incur medical or other charges related to Injuries or Illness caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the Injuries or Illness. If so, the Covered Person may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be subrogated to all rights the Covered Person may have against that other person or Another Party and will be entitled to Reimbursement. In addition, the Plan shall have the first lien against any Recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supersedes any right that the Covered Person may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Covered Person procures or may be entitled to procure regardless of whether the Covered Person has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collect ability or responsibility, or otherwise. As a condition to receiving benefits under the Plan, the Covered Person agrees that acceptance of benefits is constructive notice of this provision.

The Covered Person must:

1. Execute and deliver a Subrogation and Reimbursement agreement;
2. Authorize the Plan to sue, compromise and settle in the Covered Person's name to the extent of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Covered Person's rights to Recovery when this provision applies;
3. Immediately reimburse the Plan, out of any Recovery made from Another Party, 100% of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collect ability or responsibility, or otherwise);
4. Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and
5. Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

When a Right of Recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other Illnesses or Injuries), the Covered Person will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the Injuries or Illness.

The Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other benefits for the Injuries or Illness before these papers are signed and things are done (for example, to obtain a prompt payment discount); however, in that event, the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Covered Person will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made whole and common fund doctrines. A Covered Person who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Covered Person who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because the Covered Person is not the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed.

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary.

Amount Subject to Subrogation or Reimbursement

Any amounts recovered will be subject to Subrogation or Reimbursement. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collect ability or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his charges and expenses.

When Recovery Includes the Cost of Past or Future Expenses

In certain circumstances, a Covered Person may receive a Recovery that includes amounts intended to be compensation for past and/or future expenses for treatment of the illness or injury that is the subject of the Recovery. This Plan will not cover any expenses for which compensation was provided through a previous Recovery. This exclusion will apply to the full extent of such Recovery or the amount of the expenses submitted to the Plan for payment, whichever is less. The Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

It is the responsibility of the Covered Person to inform the Plan Administrator when expenses are related to an Illness or Injury for which a Recovery has been made. Acceptance of benefits under this Plan for which the Covered Person has received a Recovery will be considered fraud, and the Covered Person will be subject to any sanctions determined by the Plan Administrator, in its sole discretion, to be appropriate. The Covered Person is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses that exceed the Recovery.

"Another Party": any individual or entity, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person's Injuries or Illness. Shall also include the party or parties who caused the Injuries or Illness; the insurer, guarantor or other indemnifier of the party or parties who caused the Injuries or Illness; a Covered Person's own insurer, such as uninsured, under insured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or entity that is liable or legally responsible for payment in connection with the Injuries or Illness.

"Recovery": any and all monies paid to the Covered Person by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the Injuries or Illness. Any Recovery shall be deemed to apply, first, for Reimbursement.

"Subrogation": the Plan's right to pursue the Covered Person's claims for medical or other charges paid by the Plan against Another Party.

"Reimbursement": "repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the injury or illness and for the expenses incurred by the Plan in collecting this benefit amount.

When a Covered Person Retains an Attorney

If the Covered Person retains an attorney, that attorney must sign the Subrogation and Reimbursement agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other illnesses or injuries. Additionally, the Covered Person's attorney must recognize and consent to the fact that the Plan precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his pursuit of Recovery. The Plan will not pay the Covered Person's attorneys' fees and costs associated with the Recovery of funds, nor will it reduce its Reimbursement pro rata for the payment of the Covered Person's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

An attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute

obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Covered Person's attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because neither the Covered Person nor his attorney is the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed.

When the Covered Person is a Minor or is Deceased

The provisions of this section apply to the parents, trustee, guardian or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the representative has access or control of the Recovery.

When a Covered Person Does Not Comply

When a Covered Person does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Covered Person to enforce the provisions of this section, then that Covered Person agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

GENERAL PROVISIONS

Clerical Error

Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made, unless the error or delay is discovered more than six months after the effective date of coverage, in which event no adjustment will be made.

Clerical errors, as defined below, shall be corrected and the plan coverage (benefits or eligibility) shall be determined using correct information.

Clerical error is any error which:

- Relates to the transmittal and/or communication of plan-related information;
- Is perfunctory or ministerial in nature;
- Is made by clerical-staff personnel (i.e., with limited or no authority over formal decisions);
- Involves claims processing, recordkeeping or underwriting functions;
- Is made by Plan Sponsor, Plan Administrator, Plan Supervisor or any Party of Interest to the Plan;
- Does not involve errors of judgment or involve the advance knowledge of how such error could unfairly be an advantage or disadvantage to any party thereto;
- Does not, except for the error, expand or contract coverage;
- Does not involve misconduct, misrepresentation, negligence, in competency or significantly poor administration of either the ceder or assumer as measured by industry, and
- Is promptly reported and rectified.

Curing an Employer/Plan Sponsor Error Regarding Eligibility

In the event the Employer/Plan Sponsor makes an error in the distribution of instructions to an eligible employee regarding eligibility and enrollment information, or in the receipt or processing of eligibility and enrollment information from an eligible employee, the eligible employee shall not be penalized with regard to enrollment or eligibility for benefits because the Employer's/Plan Sponsor's error in the administrative process.

If eligibility and enrollment information or instructions are not provided to the employee in a timely manner so that the employee has the full eligibility period to complete and return the enrollment information to the employer, the eligibility period (number of days) shall be counted from the date the information is provided to the employee. The Employer will be responsible for documenting the date when the enrollment information and/or instructions are provided to the employee.

If eligibility and enrollment information is properly provided to the eligible employee and submitted by the employee within the timeframe provided in the Plan, but the Employer fails to correctly and timely enroll the employee, the employee will not be penalized with regard to enrollment or eligibility for benefits because of the delinquency of the Employer. The Employer shall date stamp the receipt of the employee's enrollment information when it is submitted to the Employer / Plan Sponsor.

In the event enrollment information is not processed timely due to loss or an error by the Employer, the original effective date of coverage shall be used to enroll the employee, and the Employer shall document the nature of the loss of the original documents or the nature of the employer's error resulting in the untimely processing. The documentation by the employer and replacement or original documents including the payment of all required premiums for the coverage from the original effective date will correct the employer's error and constitute a cure.

Conformity with Applicable Laws
This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Summary Plan Description. It is intended that the Plan will conform to the requirements as it applies to employee welfare plans, as well as any other applicable law.

Interpretation
The use of masculine pronouns in this Summary Plan Description shall apply to persons of both sexes unless the context clearly indicates otherwise. The use of the words, “you” and “your” throughout this Summary Plan Description applies to eligible or covered Employees and, where appropriate in context, their covered Dependents.

Headings
The headings used in this Summary Plan Description are used for convenience of reference only. Covered Persons are advised not to rely on any provision because of the heading.

No Waiver or Estoppels
No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppels against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppels. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Payment of Plan Costs
The Plan Sponsor is responsible for funding the Plan and will do so as required by law. To the extent permitted by law, the Plan Sponsor is free to determine the manner and means of funding the Plan. The amount of the Covered Person’s contribution (if any) will be determined from time to time by the Plan Sponsor, in its sole discretion.

Protection against Creditors
No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Covered Person, the Plan Administrator in its sole discretion may terminate the interest of such Covered Person or former Covered Person, his or her spouse, parent, adult child, guardian of a minor child, brother or sister, or other relative of a Dependent of such Covered Person or former Covered Person, as the Plan Administrator may determine, any such application shall be a complete discharge of all liability with respect to such benefit payment.

Right to Receive and Release Necessary Information
For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Covered Person for benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action; however, the Plan Administrator at all times will comply with the Privacy Standards. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Statements; Fraud
The following actions by any Covered Person, or a Covered Person’s knowledge of such actions being taken by another, constitute fraud and may result in immediate termination of all coverage under this Plan for the entire Family of which the Covered Person is a member:

- Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a

Covered Person in the Plan;

- Attempting to file a claim for a Covered Person for services which were not rendered or drugs or other items which were not provided;
- Providing false or misleading information in connection with enrollment in the Plan; or
- Providing any false or misleading information to the Plan.

Workers' Compensation

This Plan excludes coverage for any Injury or Illness that is eligible for coverage under any workers' compensation policy or law regardless of the date of onset of such Injury or Illness. However, if benefits are paid by the Plan and it is later determined that a Covered Person received or is eligible to receive workers' compensation coverage for the same Injury or Illness, the Plan is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the Injury or Illness regardless of the amount or terms of any settlement the Covered Person receives from workers' compensation. The Plan will exercise its right to recover against the Covered Person. The Plan reserves its right to exercise its rights under this section and the section entitled "Recovery of Payment" even though:

- The workers' compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that the injury or illness was sustained in the course of or resulted from your employment;
- The amount of workers' compensation benefits due specifically to health care expense is not agreed upon or defined by the Covered Person or the workers' compensation carrier; or
- The health care expense is specifically excluded from the workers' compensation settlement or compromise.

You are required to notify the Plan Administrator immediately when a claim is filed for coverage under workers' compensation if a claim for the same Injury or Illness is or has been filed with this Plan. Failure to do so, or to reimburse the Plan for any expenses it has paid for which coverage is available through workers' compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the Plan for recovery and disciplinary action.

Alternate Course of Treatment

The Plan Administrator may, in its sole discretion, determine that a service or supply, not otherwise listed for coverage under this Plan, be included for coverage, if the service or supply is deemed appropriate and necessary, and is in lieu of a more expensive, listed covered service or supply.

If a Covered Person, in cooperation with his provider, elect a course of treatment that is deemed by the Plan Administrator, in its sole discretion, to be more extensive or costly than is necessary to satisfactorily treat the Illness or Injury, this Plan will allow coverage for the reasonable and appropriate value of the less costly or extensive course of treatment.

Not a Contract

This Summary Plan Description and any amendments constitute the terms and provisions of coverage under this Plan. The Summary Plan Description shall not be deemed to constitute a contract of any type between KPBSD and any Covered Person or to be consideration for, or an inducement or condition of, the employment of any employee. Nothing in this Summary Plan Description shall be deemed to give any employee the right to be retained in the service of KPBSD or to interfere with the right of KPBSD to discharge any employee at any time.

DEFINITIONS

Accident: an event that is sudden, unexpected, unintended and over which the Covered Person has no control and that is caused by a non-infectious source external to the body.

Accidental Injury: physical harm caused by a sudden and unforeseen event at a specific time and place. It is independent of Illness except for infection of a cut or wound.

Actively At Work or Active Employment: performance by the Employee of all the regular duties of his occupation at an established business location of the Participating Employer, or at another location to which he may be required to travel to perform the duties of his employment. An Employee shall be deemed Actively at Work on normal holidays or vacation days of the Participating Employer if the Employee is not Totally Disabled and if the Employee was Actively at Work on the last preceding regular working day. In no event will an Employee be considered Actively at Work if he is not physically able to perform all the duties of his employment or if he has effectively terminated employment.

Alcoholism and Drug Addiction: a condition, certified by a Physician, to be primarily alcoholism or drug dependency; provided, however, that any addiction from the use of tobacco shall not be included.

Allowable Charge: the amount allowed for any given service or supply.

1. For participating Hospitals, the Allowable Charge is the Hospital's billed charge for Medically Necessary covered services. For other participating providers, the Allowable Charge is the fee that the provider has agreed to accept as full payment for Medically Necessary covered services.

   The amount that participating providers have agreed to accept as full payment for Medically Necessary covered services is determined by the Plan's agreements with the providers. Participating providers will seek payment from the Plan when they furnish covered services to you. You will be responsible only for any applicable deductibles, co-payments, coinsurance, charges in excess of stated benefit maximums and charges for services or supplies not covered under this Plan.

   If a Covered Person obtains services at a facility within the Municipality of Anchorage other than Alaska Regional Hospital, the Allowable Charge will be the negotiated rate at Alaska Regional Hospital, and will be paid at 60% of the Allowable Charge. No breakpoint will apply. For inpatient services, the Allowable Charge shall be calculated as the per diem or case rate at Alaska Regional Hospital. For outpatient services, the Allowable Charge shall be calculated as the case rate at Alaska Regional Hospital or 50% of the billed charges if no case rate is available.

2. Non-participating providers: The Allowable Charge is either the fee that the Plan finds is the Usual Customary and Reasonable (UCR) rate for Medically Necessary covered services or the provider's charge, whichever is less. In no event will a provider's charge be more than what would have been charged in the absence of insurance.

   The Plan determines the UCR for a service by reviewing the range of charges and fees for the same or a similar service billed or accepted by providers within the geographical area where the service was performed. A UCR is established within said range by considering:

   a. The value of the particular service or category of services relative to other services based on published schedules and relative value studies.

   b. The level of skill and training of the provider with regard to the field of practices.

   c. When appropriate, the attending circumstances of a particular case, including but not limited to:

      - The time required to perform the service or procedure;
      - The severity of the condition being treated;
      - The complexity of the treatment of a particular case; or

- The newness of a particular service or procedure.

The UCR will be based on the 90th percentile of charges. However, if there is not sufficient statistical data within the geographical area where the service was performed upon which to base the assessment, the Plan may include a wider geographical area so that a statistically reliable base can be established.

For Medically Necessary Outpatient Dialysis Treatment, the Allowable Charge will be the provider's charge or the Usual and Reasonable Charge for Outpatient Dialysis Treatment, whichever is less. You are responsible for any amount that exceeds what the Plan determines to be the Allowable Charge. You are also responsible for any applicable deductibles, co-payments, coinsurance, charges in excess of stated benefit maximums and charges for services or supplies not covered under this Plan. These amounts will be reflected on the "Explanation of Benefits" the Plan sends to you.

Benefit Percentage: that percentage of Covered Expenses in excess of the Deductible amount, which the Employee pays. It is the basis used to determine any Out-of-pocket Expenses in excess of the annual Deductible which are to be paid by the Employee.

Birthing Center: a facility that meets the following requirements:

1. Is licensed by the department responsible for the licensing of such facilities in the geographical area in which it is located;
2. Has permanent facilities which are equipped and operated mainly for childbirth; and
3. Provides continuous service by Physicians, registered nurses or midwife nurse practitioners when a patient is in the center.

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

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

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

Claims Administrator: Rehn & Associates, 1322 N Post Street, Spokane, WA 99201

COBRA: Consolidated Omnibus Budget Reconciliation Act of 1985 as amended.

Company: Kenai Peninsula Borough School District.

Complications of Pregnancy

1. Conditions whose diagnoses are distinct from Pregnancy but adversely affected by Pregnancy or caused by Pregnancy. Such conditions include:
    a. Acute nephritis;
    b. Nephrosis;
    c. Cardiac decompensation;
    d. Hyperemesis gravidarum;
    e. Puerperal infection;
    f. Toxemia;
    g. Eclampsia;

   h. Missed abortions;
   i. Gestational diabetes; and
   j. Postpartum depression or psychosis.
2. A non-elective cesarean section surgical procedure;
3. Terminated ectopic Pregnancy; or
4. Spontaneous termination of Pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy do not mean:

- False labor;
- Occasional spotting;
- Prescribed rest during the period of Pregnancy;
- Similar conditions associated with the management of a difficult Pregnancy not constituting a distinct complication of Pregnancy; or
- Thrombophlebitis

Confinement: being a resident patient in a Hospital for at least 15 consecutive hours per day. Successive Confinement is considered one Confinement unless:

1. It is due to a different or unrelated Injury or Sickness causing the prior Confinement;
2. It is separated by 30 consecutive days when the Covered Person is not confined.

Convalescent Nursing Facility: a lawfully operated institution or that part of such an institution that meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an Inpatient basis, for a person convalescing from Injury or Illness, professional nursing services rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a Registered Nurse and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily activities;
2. Its services are provided for compensation from its patients and under the full-time supervision of a Physician or Registered Nurse;
3. It maintains a complete medical record on each patient;
4. It has an effective utilization review plan; and
5. It is not, other than incidentally, a place for rest, the aged, custodial or educational care.

The term shall also apply to expenses incurred in an institution referring to itself as a Skilled Nursing Facility, extended care facility, convalescent nursing home or any other similar designation.

Convalescent Period: a period of time commencing with the date of Confinement by the Covered Person to a Convalescent Nursing Facility. Such Confinement must meet both of the following conditions:

1. The Confinement must have been for a period of not less than three consecutive days; and
2. The convalescent Confinement must commence within 14 days after the Covered Person is discharged from a Hospital and both the Hospital and convalescent Confinements must have been for the care and treatment of the same Illness or Injury. Alternatively, the convalescent Confinement must be as an alternative to Hospitalization. The Plan may require that a Physician certify that the convalescent care is rendered as an alternative to Hospitalization.

Cosmetic Procedure: a procedure performed solely for the improvement of a Covered Person's appearance rather than for the improvement or restoration of bodily function.

Covered Expenses: expenses incurred by a Covered Person for any Medically Necessary treatment, service or supply that is not

specifically excluded from coverage elsewhere in this Plan.

Covered Person (also called Member): any person meeting the eligibility requirements for coverage as specified in this Plan and properly enrolled in the Plan as an Employee or Dependent.

Custodial Care: that type of care or service, wherever furnished and by whatever name called, that is designed primarily to assist a Covered Person, whether or not Totally Disabled, in the activities of daily living. Such activities include, but are not limited to, bathing, dressing, feeding, preparation of meals or special diets, housekeeping, assistance in walking or in getting in and out of bed, and supervision over medication that can normally be self-administered.

Deductible: a specified dollar amount of Covered Expenses that must be incurred during a Calendar Year before any other Covered Expenses can be considered for payment at the percentages stated in the Summary of Benefits of this Plan.

Dental Hygienist: an individual who works under the supervision of a Dentist and is currently licensed to practice dental hygiene by a governmental authority that has jurisdiction over the licensure and practice of dental hygiene.

Dentist: a licensed Dentist, dental surgeon or oral dental surgeon.

Dependent:

1. The Employee's legal spouse;
2. The Employee's child who meets all of the following conditions:
   - Is a natural child, stepchild, legally adopted child, a child placed for adoption with the Employee, or a child who has been placed under the legal guardianship of the Employee;
   - Is less than 26 years of age.
3. Covered dependent child who attains the limiting age while covered under the Plan shall remain eligible for medical benefits if ALL of the following exist at the same time:
   - He or she is mentally or physically handicapped;
   - He or she is incapable of self-sustaining employment;
   - He or she suffered the incapacity prior to attaining 20 years of age;
   - He or she is dependent on the covered Employee for at least 50% of his or her support and maintenance; and
   - He or she is unmarried.

   The Employee must furnish satisfactory proof to the Plan Administrator that the above conditions continuously exist on and after the date the limiting age is reached. The Plan Administrator may not request such proof more often than annually after two years from the date the first proof was furnished. If satisfactory proof is not submitted to the Plan Administrator, the Child's coverage shall cease on the date such proof is due.

The term Dependent excludes these situations:

- A spouse who is divorced from the Employee. Such spouse must have met all requirements of a valid divorce decree in the state granting such divorce; or
- Any person on active military duty.

Dependent Coverage: coverage under the Plan for benefits payable as a consequence of an Illness or Injury of a Dependent.

Diagnostic: a consultation, test, procedure, or instrument used to identify the nature or cause of an existing illness, disorder, or problem.

Effective Date: the date on which your coverage under this Plan begins. If you reenroll in this Plan after a lapse in coverage, the date that the coverage begins again will be your effective date.

Emergency: A sudden onset of a medical condition or accidental injury manifesting itself by acute symptoms or sufficient severity that the absence of immediate medical attention could reasonably result in one of the following:

1. Placing a participant's life in jeopardy;
2. Causing serious impairment to bodily functions;
3. Causing serious and permanent dysfunction of any bodily organ or part.

Employee: a person who works the minimum hours per week required by his Participating Employer or is an elected member of the KPBSD School Board.

Enrollee: a person who is covered under this Plan as an Employee or Dependent; also called "you" and "your" in this booklet.

Experimental or Investigational Treatment: services, supplies, care and treatment which do not constitute accepted and appropriate medical practice considering the facts and circumstances of the case and by the generally accepted standards of a reasonably substantial, qualified, responsible, relevant segment of the appropriate medical community or government oversight agencies at the time services were rendered, as determined by the Plan Administrator as set forth below.

The Plan Administrator must make an independent evaluation of the Experimental or non-Experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. In addition to the above, the Plan Administrator will be guided by the following principles to determine whether a proposed treatment is deemed to be Experimental and/or Investigational:

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

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

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

Expenses related to off-label drug use (the use of a drug or a purpose other than that for which it was approved by the FDA) will be eligible for coverage when all of the following criteria have been satisfied:

1. The named drug is not specifically excluded under the General Limitations of the Plan; and
2. The named drug has been approved by the FDA; and
3. The off-label drug use is appropriate and generally accepted by the medical community for the condition being treated; and
4. If the drug is used for the treatment of cancer, the American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information or the Compendia-Based Drug Bulletin recognize it as an appropriate treatment for that form of cancer.

Expenses for drugs, devices, services, medical treatments or procedures related to an Experimental and/or Investigational treatment (related services) and complications from an Experimental and/or Investigational treatment and their related services are excluded from coverage, even if such complications and related services would be covered in the absence of the Experimental and/or Investigational treatment.

Final determination of Experimental and/or Investigational, Medical Necessity and/or whether a proposed drug, device, medical treatment or procedure is covered under the Plan will be made by and in the sole discretion of the Plan Administrator.

Family: a covered Employee and his covered Dependents.

FMLA: Family and Medical Leave Act of 1993, as amended.

FMLA Leave: a leave of absence, which the Participating Employer is required to extend to an employee under the provisions of the FMLA.

Full-time Employment: a basis whereby an Employee is employed, and is compensated for services, by the Participating Employer for at least the number of hours per week stated in the eligibility requirements. The work may occur either at the usual place of business of the Participating Employer or at a location to which the business of the Participating Employer requires the Employee to travel.

HIPAA: Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Care Agency: a public or private agency or organization that specializes in providing medical care and treatment in the home. It must meet all of the following conditions:

1. It is primarily engaged in providing skilled nursing and other therapeutic services and is duly licensed, if required, by the appropriate licensing authority;
2. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one Physician and at least one Registered Nurse to govern the services provided and it must provide for full-time supervision of such services by a Physician or Registered Nurse;
3. It maintains a complete medical record on each individual; and
4. It has a full-time administrator.

Hospice: a health care program providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons who are Terminally Ill.

Hospice Care: care rendered as part of a Hospice Care Program to a Terminally Ill Covered Person by or under arrangements with a Hospice Care Agency.

Hospice Care Agency: an agency or organization that meets all of the following tests:

1. Has Hospice Care available 24 hours a day;

2. Is licensed as such by the jurisdiction it is in;
3. Provides:
    a. Skilled nursing services;
    b. Medical social services;
    c. Psychological and dietary counseling; and
4. Provides or arranges for other services which will include:
    a. Services of a Physician;
    b. Physical or Occupational Therapy;
    c. Part-time or home health aide services consisting of primarily caring for a Terminally Ill family member; and
    d. Inpatient care in a facility when needed for pain control and other acute and chronic symptom management.

Hospice Care Program: a written plan of Hospice Care, which:

1. Is established by and periodically reviewed by:
    a. A Physician attending the Covered Person; and
    b. Appropriate personnel of a Hospice Care Agency;
2. Is designed to provide palliative and supportive care to Terminally Ill persons; and
3. Includes an assessment of the medical and social needs, and a description of the care to be rendered to meet those needs.

Hospital: an institution that meets all of the following conditions:

1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an Inpatient basis at the patient's expense;
2. It is constituted, licensed and operated in accordance with the applicable laws of the jurisdiction in which it is located;
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an Illness or an Injury;
4. Such treatment is provided for compensation by and under the supervision of Physicians with continuous 24-hour nursing services by Registered Nurses;
5. It qualifies as a hospital or a psychiatric hospital and is licensed by the appropriate state authority; and
6. It is not, other than incidentally, a place for rest, the aged, or a nursing home.

Illness or Sickness: a bodily disorder, disease, physical sickness, mental infirmity, functional nervous disorder, Chemical Dependency, Pregnancy or Complications of Pregnancy of a Covered Person. A recurrent Illness will be considered one Illness.

Concurrent Illnesses will be considered one Illness unless the concurrent Illnesses are totally unrelated. All such disorders that exist simultaneously which are due to the same or related causes shall be considered one Illness. For purposes of medical benefits only, Illness or Sickness shall include Alcoholism and Drug Addiction.

Incurred: the date when a Covered Expense is incurred, services are rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not incurred upon commencement of the first stage of the procedure or course of treatment.

Injury: a condition due, directly and independently of all other causes, to an Accident.

Inpatient: the classification of a Covered Person when that person is admitted to a Hospital, Hospice or Convalescent Nursing

Facility for treatment, and charges are made for Room and Board to the Covered Person as a result of such admission.

Licensed Practical Nurse: an individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

Medical Emergency: a sudden onset of a medical condition or Accidental Injury manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result, in the Plan's judgment, in one of the following:

1. Placing the Enrollee's life in jeopardy;
2. Causing serious impairment to bodily functions; or
3. Causing serious and permanent dysfunction of any bodily organ or part.

Medical Facility: a Hospital, Skilled Nursing Facility, state approved chemical dependency treatment facility or Hospice.

Medically Necessary: treatment which is generally accepted by medical professionals in the United States as proven, effective and appropriate for the condition based on recognized standards of the health care specialty involved.

- "Proven" means the care is not considered Experimental/Investigational, meets a particular standard of care accepted by the medical community and is approved by the Food and Drug Administration (FDA) for general use.
- "Effective" means the treatments beneficial effects can be expected to outweigh any harmful effects. Effective care is treatment proven to have a positive effect on your health, while addressing particular problems caused by disease, Injury, Illness, or a clinical condition.
- "Appropriate" means the treatment's timing and setting are proper and cost effective.

Medical treatments which are not proven, effective and appropriate are not covered by the Plan. All criteria must be satisfied. When a Physician recommends or approves certain care it does not mean that care is Medically Necessary.

Medicare: the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

Member (also called Covered Person): any person meeting the eligibility requirements for coverage as specified in this Plan and properly enrolled in the Plan as an Employee or Dependent.

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

Non-participating Provider: a provider that meets one of the two requirements at the time the services are rendered:

1. The provider is in a class of providers to which the Plan offers participating agreements, but has not signed such an agreement; or
2. The provider is in a class of providers to which the Plan does not offer participating agreements.

Nurse Midwife: a Registered Nurse who is licensed as a midwife by the state in which the services are provided.

Obstetrical Care: care furnished during pregnancy (ante partum, delivery and postpartum) including voluntary termination of pregnancy or any condition arising from pregnancy, except for Complications of Pregnancy. This includes the time during pregnancy and within 45 days following delivery.

Occupational Therapy: a program of care that focuses on the physical, cognitive and perceptual disabilities that influence the patient's ability to perform functional tasks. The therapist evaluates the patient's ability to use his fingers and hands (fine motor

skills), perceptual skills, cognitive functioning and eye hand coordination. Therapy sessions may also involve physical movement exercises. Functional tasks also may be used. The therapist may also perform splinting of the patient's arms or hands and may provide the patient with special equipment. Therapy which is intended to address primarily vocational rehabilitation issues (i.e., return to work skills) will not be considered a Covered Expense under this Plan.

Optometrist: a licensed optometrist.

Oral Surgery: maxillofacial surgical procedures limited to:

1. Excision of neoplasm's including benign, malignant and pre-malignant lesions, tumors and cysts;
2. Incision and drainage of abscess;
3. Surgical procedures involving accessory sinuses, salivary glands and ducts; and
4. Removal of impacted teeth.

Orthodontics: that branch of dentistry which deals with the development, prevention and correction of irregularities of the teeth and bite (malocclusion). Malocclusion is the abnormal position and contact of the upper and lower teeth which may affect chewing or cause facial, jaw and/or joint pain.

Orthotic Appliance: an external device placed on or within the body to correct a defect in form or function of the human body.

Out-of-pocket Expense: the total dollar amount the Covered Person will be required to pay, excluding the Deductible, for Covered Expenses under the Plan.

Outpatient: the classification of a Covered Person when that Covered Person receives medical care, treatment, services or supplies at a clinic, a Physician's office at a Hospital, if not a registered bed patient at that Hospital, an outpatient psychiatric facility or an Outpatient Chemical Dependency Treatment Facility.

Participating Provider: a provider which, at the time the services are rendered, has a participating agreement in effect with the Plan to furnish care to Enrollees.

Period of Dental Treatment: all treatment performed in the oral cavity during one or more sessions as the result of the same initial diagnosis, and shall include any complications arising during such treatment.

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

Physician: a legally licensed health care practitioner acting within the scope of the license of the state in which services are provided, including, but not limited to, a medical or dental doctor or surgeon, chiropractor, osteopath, podiatrist, certified consulting Psychologist or psychiatrist. The term "Physician" also includes a Nurse Midwife, a nurse practitioner, licensed marital family therapist, licensed clinical social worker, licensed professional counselor (LPC) and a social worker with the degree "MSW." The Plan Administrator may, in its sole discretion, determine whether a provider of health care services may be considered for coverage of services provided to a Covered Person.

Plan: Kenai Peninsula Borough School District.

Plan Administrator: Kenai Peninsula Borough School District.

Plan Sponsor: Kenai Peninsula Borough School District.

Plan Year: the period of time beginning January 1st and ending December 31st of each year.

Pregnancy: that physical state which results in childbirth, abortion or miscarriage.

Prescription Drug: any medical substance, the label of which, under the Federal Food, Drug and Cosmetic Act, as amended, is required to bear the legend, "Caution: Federal law prohibits dispensing without a prescription." It does not include any drugs labeled, "Caution: limited by federal law to investigational use."

Preventative or Routine Care: care emphasizing priorities for prevention of illness or disease. Care may also provide early detection and early treatment of conditions that are asymptomatic. Generally includes regularly scheduled physical examinations, immunizations, vaccinations, and screening tests. Not Diagnostic or focused in nature for specific existing illness or symptom.

Provider: Physician, or other practitioner or facility defined or listed herein, or approved by the Plan Administrator.

Psychiatric Conditions: any conditions listed, at the time you receive services, as a mental disorder in the current edition of "Diagnostic and Statistical Manual of Mental Disorders," except for conditions of substance use.

Psychologist: a licensed Psychologist or psychological associate.

Qualified Treatment Facility: only a facility, institution or clinic duly licensed, primarily established and operating within the scope of its license. Treatment must be provided for the cause for which benefits are payable under the provision of the Plan referring to a Qualified Treatment Facility.

Registered Nurse: an individual who has received specialized nursing training, is authorized to use the designation of "R.N.," and is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

Room and Board: all charges by whatever name called which are made by a Hospital, Hospice, or Convalescent Nursing Facility as condition of occupancy. Such charges do not include the professional services of Physicians or intensive nursing care by whatever name called.

Semiprivate: a class of accommodations in a Hospital or Convalescent Nursing Facility in which at least two patient beds are available per room.

Skilled Nursing Facility: an institution or a distinct part of one that is operating pursuant to the law for such an institution. In addition the Plan requires that:

1. Its main purpose is to provide 24-hour-a-day accommodations and skilled nursing care for patients recovering from Sickness or Injury;
2. It is not used mainly as a place for the aged, or a place for rest;
3. It is approved by the appropriate state authority and/or approved by Medicare;
4. It is under the full-time supervision of a Physician or Registered Graduate Nurse;
5. The patient's plan of care is prescribed by a Physician and updated at least every 30 days;
6. It has an agreement to have Physician's services available when needed;
7. It maintains adequate medical records for all patients;
8. It has written transfer agreement with at least one Hospital; and
9. It is approved as such by Medicare.

Speech Therapy: a program of care that evaluates the patient's motor speech skills, expressive and receptive language skills and

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

Terminally Ill: a medical prognosis of six months or less to live.

Third Party Administrator: a non-risk bearing company that pays claims, collects and pays premium and provides administrative services on behalf of the Employer.

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

Usual Customary and Reasonable: actual fees for services and supplies that are reasonably necessary for the care and treatment of a Sickness or Injury, but only to the extent that such fees are reasonable. The Plan determines the UCR for a service by reviewing the range of charges and fees for the same or a similar service billed or accepted by providers within the geographical area where the service was performed. A UCR is established within said range by considering:

1. The value of the particular service or category of services relative to other services based on published schedules and relative value studies.
2. The level of skill and training of the provider with regard to the field of practices.
3. When appropriate, the attending circumstances of a particular case, including but not limited to:
    - The time required to perform the service or procedure;
    - The severity of the condition being treated;
    - The complexity of the treatment of a particular case; or
    - The newness of a particular service or procedure.

The UCR will be based on the 90th percentile of charges. However, if there is not sufficient statistical data within the geographical area where the service was performed upon which to base the assessment, the Plan may include a wider geographical area so that a statistically reliable base can be established.

GENERAL PLAN INFORMATION

Name of Plan:	Kenai Peninsula Borough School District Health Care Plan
Plan Sponsor:	Kenai Peninsula Borough School District
Plan Administrator: (Fiduciary)	Mr. Dave Jones
Plan Sponsor ID No. (EIN):	92-0030923
Plan Year:	January 1st through December 31st
Plan Type:	Medical, Dental, Vision and Pharmacy
Claims Administrator:	Rehn & Associates 1322 N Post Place Spokane WA 99201 Telephone: (509) 534-0600 Toll Free: (800) 872-8979 Fax: (509) 535-7883
Group Number:	863906
Participating Employer(s):	Kenai Peninsula Borough School District
Agent for Service of Legal Process:	Dave Jones, Director of Human Resources Kenai Peninsula Borough School District 148 N Binkley Street Soldotna, AK 99669
Type of Administration:	The Plan Administrator administers this Plan with the assistance of Rehn & Associates, a claims administration organization.
Contributions:	The Plan Sponsor and Employees make contributions. Contributions are calculated and based upon the estimated monthly cost of operating the Plan, and are allocated based upon the cost of Employee and Dependent Coverage.
Requirements	Eligibility requirements, termination provisions, circumstances which may result in disqualification, denial or loss of benefits, the procedure to follow in presenting claims for benefits and the remedies regarding claims which are denied in whole or in part as described in this Plan Document.

PRIVACY STANDARDS / HIPAA SECURITY

The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") set the following standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards"):

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

a. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);
b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
e. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);
f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);
g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
j. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

   The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

   - Human Resources Manager
   - Staff designated by Human Resources Manager
   - City Manager
   - Finance Director

The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or Rehn & Associates, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

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

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

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

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

<u>Health Information Technology for Economic and Clinical Health (HITECH) Act</u>

The Plan will comply with all applicable requirements of final Regulations issued by the Department of Health and Human Services pursuant to Subtitle D of the HITECH Act and any authoritative guidance issued pursuant to that Act, if and as they become applicable to the Plan. If there is any conflict between the requirements of Subtitle D of the HITECH Act, and any provision of this Plan, applicable law will control. Any amendment or revision or authoritative guidance relating to Subtitle D of the HITECH Act is hereby incorporated into the Plan as of the date that the Plan is required to comply with such guidance.

Notice of Privacy Practices

The Group Health Plan is required by law to maintain the privacy of protected health information ("PHI") and to provide individuals covered under the Group Health Plan with notice of its legal duties and privacy practices with respect to PHI in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). PHI is information that may identify you and that relates to your past, present or future physical or mental health or condition, health care services provided to you, or payment for health care services provided to you. This Notice of Privacy Practices ("Notice") is provided for the Group Health Plan and applies with respect to each benefit in which you are enrolled.

The Notice describes how the Group Health Plan and its Plan Administrator may use and disclose PHI to carry out treatment, payment or health care operations and for other specified purposes that are permitted or required by law. The Notice also describes your rights with respect to PHI about you.

The Group Health Plan is required to follow the terms of this Notice. We will not use or disclose PHI about you without your written authorization, except as described in this Notice. We reserve the right to change our practices and this Notice and to make the new Notice effective for all Personal Health Information (PHI) we maintain. If we materially change our practices and this Notice, a revised Notice will be distributed or sent to you if you are still participating in the Group Health Plan at that time. If you have any questions, please contact the Group Health Plan Privacy Official at Kenai Peninsula Borough School District, 148 N. Binkley St., Soldotna, AK 99669, (907)714-8888.

YOUR INDIVIDUAL RIGHTS

You have the following rights with respect to PHI the Group Health Plan maintains about you:

Receive a copy of the Notice. You have the right to receive a paper copy of this Notice at any time, even if you have previously agreed to receive the Notice electronically, by contacting the Privacy Official. A copy of this Notice is also available on Health Care Plan Website.

<u>Request a restriction on certain uses and disclosures of Personal Health Information (PHI)</u>

You have the right to request additional restrictions on our use or disclosure of PHI about you by sending a written request to the Privacy Official. In your request you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want to limits to apply – for example, disclosures to your spouse. We are not required to agree to the requested restrictions.

<u>Inspect and obtain a copy of Personal Health Information (PHI)</u>

You have the right to access and copy PHI about you contained in a designated record set for as long as the Group Health Plan maintains the PHI. The designated record set usually will include enrollment, payment, claims and case management record systems maintained by or for the Group Health Plan. To inspect or copy PHI about you, you must send a written request to the Privacy Official. We may charge you a fee for the costs of copying, mailing, and supplies that are necessary to fulfill your request. We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to PHI about you, you may request that the denial be reviewed.

<u>Request an amendment of Personal Health Information (PHI)</u>

If you feel that PHI, we maintain about you, is incomplete or incorrect, you may request that we amend it. You may request an amendment for as long as we maintain the PHI. To request an amendment, you must send a written request to the Privacy Official. You must include a reason that supports your request. In certain cases, we may deny your request for an amendment – for example, if the PHI was not created by us or is not part of the information kept by or

for the Group Health Plan. If we deny your request for amendment, you have the right to file a statement of disagreement with the decision and we may give a rebuttal to your statement.

Receive an accounting of disclosures of PHI

You have the right to receive an accounting of the disclosures we have made of PHI about you for most purposes other than treatment, payment, or health care operations. The accounting will exclude certain disclosures, such as disclosures made directly to you, disclosures you authorize, disclosures to family members and other persons involved in your care, and disclosures for other notification purposes. The right to receive an accounting is subject to certain other exceptions, restrictions, and limitations. To request an accounting, you must submit a request in writing to the Privacy Official. You may ask for disclosures made up to six years before your request. The first accounting you request within a 12-month period will be provided free of charge, but you may be charged for the cost of providing additional accountings. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time.

Request Communications of PHI by Alternative Means or At Alternative Locations

You have the right to request and to receive (if the request is reasonable) confidential communications of PHI by alternative means or at alternative locations. For instance, you may request that we contact you about medical matters only in writing or at a different residence or post office box. To request confidential communications of PHI about you, you must submit a request in writing to the Privacy Official. Your request must state how or where you would like to be contacted and must include a clear statement that communicating PHI by the usual means or at the usual location would endanger you. We will accommodate reasonable requests to the extent practicable.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated, we will not disclose your health information other than with your written authorization. If you authorize us to use or disclose your health information, you may revoke that authorization in writing at any time.

Authorization for Psychiatric Notes, Genetic Information, Marketing, & Sale

In general, and subject to specific conditions, we will not use or disclose psychiatric notes without your authorization; we will not use or disclose PHI that is genetic information for underwriting purposes; we will not sell your PHI, i.e. receive direct or indirect payment in exchange for your PHI, without your authorization; we will not use your PHI for marketing purposes without your authorization; and we will not use or disclose your PHI for fundraising purposes unless we disclose that activity in this Notice.

EXAMPLES OF HOW WE MAY USE AND DISCLOSE PHI

This Section describes the ways that the Group Health Plan may use and disclose your PHI. Generally, the Group Health Plan will only use and disclose your PHI as authorized by you or as required or permitted by law. Although not every specific use or disclosure is listed, the reasons for which the Group Health Plan is permitted or required by law to use or disclose your PHI generally will fall under one of the categories described below.

HIPAA generally does not take precedence over state or other applicable privacy laws that provide individuals with greater privacy protections. As a result, when a state law requires the Group Health Plan to impose stricter standards to protect your PHI, the Group Health Plan will follow state law rather than HIPAA. For example, where such laws have been enacted, the Group Health Plan will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse, chemical dependency, genetic testing, or reproductive rights.

For Treatment

The privacy rules allow covered entities to use and disclose PHI for treatment. Treatment means the provision, coordination, or management of health care and related services by one or more health care providers. For example, if you are referred to a specialist for treatment, we could share your PHI with the specialist to whom you have been referred so that he can become familiar with your medical condition.

For Payment

We may use and disclose your PHI for payment purposes and to otherwise fulfill our responsibilities for coverage and providing benefits. For example, we may use information submitted by health care providers to determine whether the

Group Health Plan covers the services provided and the amount of your copayment (if any). Additionally, we may provide you and the health care provider with an explanation of benefits. The explanation of benefits may include information that identifies you, as well as the health care provider and the cost of the services.

For Health Care Operations

We may use and disclose your PHI for health care operations including, but not limited to, underwriting, premium rating and other activities relating to obtaining or renewing contracts (including stop-loss insurance), disease management, case management, legal services, auditing functions, and general administrative activities. For example, the Group Health Plan may use information in your claims records to manage and administer the Group Health Plan. This information may be used in an effort to continually improve the quality and effectiveness of the health care coverage and administrative services provided under the Group Health Plan.

To the Group Health Plan Sponsor

We may disclose PHI to the Company in its role as Group Health Plan sponsor. The Company may not use and disclose the PHI other than as permitted or required by law and must comply with the same restrictions and conditions applicable to the Group Health Plan. PHI will be disclosed only to Benefits, Human Resources, Finance and IT personnel who need access to such information to fulfill their Group Health Plan administration duties. PHI received by these employees will be used exclusively for purposes of carrying out the Company's administrative functions with respect to the Group Health Plan. The Company may not use or disclose PHI for employment-related actions or in connection with any other employee benefit plan of the Company without your specific authorization.

To Business Associates

Some services are provided by the Group Health Plan through contracts with business associates. Examples include claims administration, case management and utilization reviews, pharmacy benefits management, vision benefits management, COBRA administration, and subrogation. When these services are contracted for, we may disclose PHI about you to our business associates so that they can perform the job we have asked them to do and bill the appropriate party for services rendered. To protect PHI about you, we require business associates to appropriately safeguard the PHI.

Communication with Individuals Involved in Your Care or Payment for Your Care

Persons responsible for Group Health Plan administration, using their professional judgment, may disclose to a family member or any person you identify, PHI relevant to that person's involvement in your care or payment related to your care. In addition to the above, we may use or disclose PHI for the following purposes:

Worker's Compensation

We may disclose PHI about you as authorized by and as necessary to comply with laws relating to worker's compensation or similar programs established by law.

Public Health Risks

As required by law, we may disclose PHI about you to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement

We may disclose PHI about you for law enforcement purposes as required by law or in response to a valid subpoena or other legal process.

As Required by Law

We must disclose PHI about you when required to do so by law. For example, we may disclose PHI in response to court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury or an administrative body authorized to require production of information; or under statutes or regulations that require the production of information (such as Medicare/Medicaid if payment is sought under such government programs).

Health Oversight Activities

We may disclose PHI about you to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, and inspections, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings

If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the requested PHI.

National Security and Intelligence Activities

We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Victims of Abuse, Neglect, or Domestic Violence

We may disclose PHI to government authorities, including social services and protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence. We must inform you (with certain exceptions) that such disclosure has been made.

Decedents

We may disclose PHI to coroners or medical examiners for the purpose of identifying a deceased person or determining cause of death and to funeral directors to carry out their duties.

Organ, Eye, or Tissue Donation

We may use or disclose PHI to organ procurement organizations or other entities for the purpose of facilitating organ, eye or tissue donation and transplantation.

Research

We may use or disclose PHI for purposes of research, subject to approval by institutional or private privacy review boards, and subject to assurances by the researcher regarding the treatment of PHI during research and that the PHI is necessary for the research purposes.

Specialized Government Functions

We may disclose PHI for specialized government functions, such as (1) about individuals who are Armed Forces personnel for activities deemed necessary by military command authorities for the proper execution of military missions, or (2) to correctional institutions or law enforcement officials having custody of an inmate if necessary for safety, security and other purposes of the correctional institution.

To Avert a Serious Threat to Health or Safety

We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Government Audits

We are required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the privacy rules.

For Distribution of Health-Related Benefits and Services

We may use or disclose your health information to provide you your health-related benefits and services that may be of interest.

OTHER USES AND DISCLOSURES OF PHI

The Group Health Plan will obtain your written authorization before using or disclosing PHI about you for purposes other than those provided for above or as otherwise permitted or required by law. You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing PHI about you, except to the extent that we have already taken action in reliance on the authorization.

Note about personal representatives. You may exercise your privacy rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or be allowed to take any action for you. Proof of such authority may include a notarized power of attorney for health care purposes or a court order of appointment as your conservator or guardian. In most cases, the parent of a minor child may be the child's personal representative (although certain exceptions apply).

The Group Health Plan retains the discretion to deny your personal representative access to your PHI if the Group Health Plan believes that (1) you have been or may be subject to domestic violence, abuse or neglect by such person; (2) treating such person as your personal representative could endanger you; or (3) the Group Health Plan determines, in its exercise of professional judgment, that it is not in your best interest to treat the person as your personal representative.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions or would like additional information about the Group Health Plan's privacy practices, you may contact the Privacy Official at (907) 714-8888 or at Kenai Peninsula Borough School District, 148 N. Binkley St., Soldotna, AK 99669, (907)714-8888. If you believe your privacy rights have been violated, you can file a complaint with the Privacy Official at the address indicated above or with the Office for Civil Rights of the United States Department of Health and Human Services (HHS). For information on filing complaints with HHS, please consult the HHS website: http://cms.hhs.gov/hipaa/hipaa2/default.asp. The Company and the Group Health Plan will not take any retaliatory action against you for filing a complaint.

PLAN AMENDMENTS

The following change has been made to the Kenai Peninsula Borough School District Health Care Plan:

Effective March 1, 2022 ***HRA Plan participants will be transitioned into the Prudent Rx Program for Specialty medications as described below, as well as being transitioned to CVS Caremark's exclusive Specialty pharmacy for Specialty medication prescriptions. HSA Plan enrollees will have no change to their current prescription benefits except for being transitioned to CVS Caremark's exclusive Specialty pharmacy for Specialty medication prescriptions, HSA enrollees are not eligible for the Prudent Rx program.***

PrudentRx Copay Program for Specialty Medications

In order to provide a comprehensive and cost-effective prescription drug program for you and your family, The Kenai Peninsula Borough School District has contracted with PrudentRx to offer the PrudentRx Copay Program for certain specialty medications. The PrudentRx Copay Program assists members by helping them enroll in manufacturer copay assistance programs. Medications in the specialty tier will be subject to a 30% co-insurance. However, enrolled members who get copay card for their specialty medication (if applicable), will have a $0 out-of-pocket responsibility for their prescriptions covered under the PrudentRx Copay Program.

Copay assistance is a process in which drug manufacturers provide financial support to patients by covering all or most of the patient cost share for select medications - in particular, specialty medications. The PrudentRx Copay Program will assist members in obtaining copay assistance from drug manufacturers to reduce a member's cost share for eligible medications thereby reducing out-of-pocket expenses. Participation in the program requires certain data to be shared with the administrators of these copay assistance programs, but please be assured that this is done in compliance with HIPAA.

If you currently take one or more medications included in the PrudentRx Program Drug List, you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication. All eligible members are enrolled in the PrudentRx program via an easy two-step process: 1) The first step of enrollment is already complete as your member information is on file with PrudentRx and 2) You need to call PrudentRx at 1-800-578-4403 within the next 5 days to register for any copay assistance available from drug manufacturers. You can choose to opt out of the program and you must call 1-800-578-4403 to opt-out. Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications – in that case, you must speak to someone at PrudentRx at 1-800-578-4403 to provide any additional information needed to enroll in the copay program. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take. If you do not return their call, choose to opt-out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer you will be responsible for the full amount of the 30% co-insurance on specialty medications that are eligible for the PrudentRx program.

If you or a covered family member are not currently taking, but will start a new medication covered under the PrudentRx Copay Program, you can reach out to PrudentRx or they will proactively contact you so that you can take full advantage of the PrudentRx program. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Copay Program.

The PrudentRx Program Drug List may be updated periodically by the Plan.

Copayments for these medications, whether made by you, your plan, or a manufacturer's copay assistance program, will not count toward your plan deductible.

Because certain specialty medications do not qualify as "essential health benefits" under the Affordable Care Act, member cost share payments for these medications, whether made by you or a manufacturer copayment

assistance program, do not count towards the Plan's out-of-pocket maximum. A list of specialty medications that are not considered to be "essential health benefits" is available. An exception process is available for determining whether a medication that is not an essential health benefit is medically necessary for a particular individual.

PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Copay Program.

If you have any questions regarding your benefits, please contact Stacey Cockroft (Vinson) at 907.714.8879 or svinson@kpbsd.k12.ak.us.