PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
FOR THE

KODIAK ISLAND BOROUGH SCHOOL DISTRICT
EMPLOYEE HEALTH CARE PLAN

HIGH DEDUCTIBLE HEALTH PLAN

EFFECTIVE: JULY 1, 2015
To Our Valued Employees –

Welcome to the Kodiak Island Borough School District Employee Health Care Plan!

We are pleased to provide you with this comprehensive program of medical, dental, prescription drug and vision coverage.

With the exception of very large medical claims which the Plan is protected by insurance, all Plan expenses are directly paid by the Kodiak Island Borough School District Employee Health Care Plan. The major portion of the Plan cost is provided by your employer and is supplemented by the contributions you make to participate. This means that through careful use of the Plan, you, as a consumer of health care, can have a direct impact on the cost of our Plan which will benefit both you and your employer by allowing us to continue to provide this high quality level of benefits.

The plan offers Coordinated Care and Case Management through CareLink, our Coordinated Care Administrator. These are programs designed to assist you in understanding and becoming involved with your medical plan of care. CareLink advocates patient involvement in choosing a medical plan of care. Coordinated Care begins with the pre-notification process. Pre-notification of certain services is strongly recommended, but not required by the Plan.

If you have an ongoing medical condition or catastrophic Illness, a Case Manager may be assigned to monitor you and to work with your attending Physician and you to design a treatment plan and coordinate appropriate Medically Necessary care.

If you have any questions regarding either your Plan’s benefits or the procedures necessary to receive benefits, please call our Claims Administrator, Employee Benefit Management Services, Inc. at (800) 777-3575 or (406) 245-3575 or visit them on the web at www.ebms.com.

We wish you the best of health.

Kodiak Island Borough School District Employee Health Care Plan
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INTRODUCTION

This document is a description of the Kodiak Island Borough School District Employee Health Care Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

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

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

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, exclusions, limitations, definitions, eligibility and the like. Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all.

Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims, or lack of coverage.

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

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

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

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

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

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

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

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

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

Plan Exclusions. Shows what charges are not covered.


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

Third Party Recovery Provision. Explains the Plan’s rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.
COBRA Continuation Coverage. Explains when a person’s coverage under the Plan ceases and the continuation options which are available.
SCHEDULE OF BENEFITS

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator’s determination that: care and treatment is Medically Necessary; that charges are reasonable and customary (as defined as an Allowable Charge); that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Pre-notification of certain services is strongly recommended, but not required by the Plan. Pre-notification provides information regarding coverage before the Covered Person receives treatment, services or supplies. A benefit determination on a Claim will be made only after the Claim has been submitted. A pre-notification of services by CareLink is not a determination by the Plan that a Claim will be paid. All Claims are subject to the terms and conditions, limitations and exclusions of the Plan at the time services are provided. A pre-notification is not required as a condition precedent to paying benefits, and can only be appealed under the procedures in the Care Management Services Section. A pre-notification cannot be appealed under the Plan’s Internal and External Claims Review Procedures.

This Plan has entered into an agreement with certain Hospitals, which are called Network Providers. Because these facilities have agreed to charge reduced fees to persons covered under this Plan, the Plan can afford to reimburse a higher percentage of their fees for inpatient services. This Plan will utilize the Aetna Signature Administrators℠ Network and Multi-Plan Network.

Therefore, when a Covered Person uses a Network facility for inpatient Hospital or outpatient surgical services, that Covered Person will receive a higher payment from the Plan than when a Non-Network facility is used for inpatient Hospital or outpatient surgical services. This does not apply to Physician charges. Additional information about this option, as well as a list of Network Providers will be given to Plan Participants, at no cost, and updated as needed.

Please Note: If there is a Network Hospital within fifty miles of the Covered Person’s residence (including college students and summer residences), that facility must be used to receive the higher benefit percentage for inpatient charges. Otherwise, if a Network facility is not available within 50 miles, the use of a closer provider will be covered at the higher benefit percentage. Use of Network Providers in emergency care is not required.

High Deductible Health Plan

A qualified High Deductible Health Plan (HDHP) with a Health Savings Account provides comprehensive coverage for high cost medical events and a tax-advantaged way to help build savings for future medical expenses. The Plan gives you greater control over how health care benefits are used. A HDHP satisfies certain statutory requirements with respect to minimum deductibles and out-of-pocket expenses for both single and family coverage. These minimum deductibles and limits for out-of-pocket expenses’ limit are set forth by the U.S. Department of Treasury and will be indexed for inflation in the future.

Only those Employees covered under a qualified High Deductible Health Plan (HDHP) are eligible to contribute to a Health Savings Account (HSA).

If a Member has coverage under this Plan and another plan, the other plan would also need to be a qualified HDHP in order for the Member to contribute to an HSA.
Deductibles payable by Plan Participants

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

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services. Each January 1st, a new deductible amount is required.

However, covered expenses incurred in, and applied toward the deductible in October, November and December will be applied to the deductible in the next Calendar Year as well as the current Calendar Year.

**Embedded Deductible:** This Plan has an “embedded” deductible, which means a covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to the Plan paying benefits for that individual.

However, the deductible amount for all members of that Family Unit will only be satisfied when the family deductible has been met for that Calendar Year or each individual member has satisfied his/her individual deductible amount.

**Deductibles, per Calendar Year**

- Per Covered Person.......................................................... $3,500
- Per Family Unit.............................................................. $7,000

**Maximum out-of-pocket payments, per Calendar Year**

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

**Preferred Facility**

- Per Covered Person .......................................................... $3,500
- Per Family Unit .............................................................. $7,000

**Non-Preferred Facility**

- Per Covered Person .......................................................... Unlimited
- Per Family Unit .............................................................. Unlimited

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

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

- Non-Preferred Facility Penalty
- Amounts over the Allowable Charge
FOLLOWING ARE OTHER MAXIMUMS ON INDIVIDUAL BENEFITS.

Inpatient Hospital Charges

Room and Board Daily limit ................................................................. the average semiprivate room rate
Intensive Care Unit Daily limit ............................................................ Hospital’s ICU Charge
Preferred Facility Reimbursement rate .............................................. 100% after deductible
Non-Preferred Facility Reimbursement rate ..................................... 60% after deductible

Emergency Room –

Medical Emergency ................................................................. 100% after deductible
Non-Medical Emergency:
  Preferred Facility Reimbursement rate .............................................. 100% after deductible
  Non-Preferred Facility Reimbursement rate ..................................... 60% after deductible

Outpatient Surgery Facility Charges

Preferred Facility Reimbursement rate .............................................. 100% after deductible
Non-Preferred Facility Reimbursement rate ..................................... 60% after deductible

Ambulance Service

Reimbursement rate ................................................................. 100% after deductible

Audio-Care (Hearing Aid) Benefit

Reimbursement rate ................................................................. 100% after deductible
Maximum Benefit each thirty-six (36) months ................................ $400

BridgeHealth Surgery Benefit™

BridgeHealth Network Reimbursement rate ........................................ 100%, after deductible
Per diem day 1 through 14 for Meals and incidentals per person .......... $50 per day
Per diem day 15 or more for Meals and incidentals per person .......... $125 per week

Please refer to the BridgeHealth Surgery Benefit™ listed in the Medical Benefit section for additional details.

Chemotherapy and Radiation Charges

Reimbursement rate ................................................................. 100% after deductible

Durable Medical Equipment

Reimbursement rate ................................................................. 100% after deductible
Home Health Care

Reimbursement rate ................................................................. 100% after deductible

Home Infusion Therapy

Reimbursement rate ................................................................. 100% after deductible

Hospice Care

Reimbursement rate ................................................................. 100% after deductible

Inpatient Rehabilitation Therapy

Preferred Facility Reimbursement rate ........................................... 100% after deductible
Non-Preferred Facility Reimbursement rate .................................... 60% after deductible
Lifetime maximum ..................................................................... 45 days

Note: The plan will consider additional days for a catastrophic event such as head or spinal cord injury or for treatment of a stroke.

Mental Disorders Treatment

Inpatient

Preferred Facility Reimbursement rate ........................................... 100% after deductible
Non-Preferred Facility Reimbursement rate .................................... 60% after deductible

Outpatient visits

Reimbursement rate ................................................................. 100% after deductible

Morbid Obesity

Reimbursement rate ................................................................. 100% after deductible
Lifetime maximum ..................................................................... $50,000

Occupational Therapy

Reimbursement rate ................................................................. 100% after deductible

Organ Transplant Coverage Limits

Covered Transplant Procedures:

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

Preferred Facility Reimbursement rate ........................................... 100% after deductible
Non-Preferred Facility Reimbursement rate .................................... 60% after deductible
A Preferred Facility under this provision is a Center of Excellence. A Center of Excellence is a licensed healthcare facility that has entered into a participation agreement with a national transplant network to provide approved transplant services to which the Plan has access. A Covered Person may contact CareLink to determine whether or not a facility is considered a Center of Excellence.

Orthotics

Reimbursement rate ................................................................. 100% after deductible

Outpatient Diagnostic X-ray and Lab Charges

Reimbursement rate ................................................................. 100% after deductible

Physical Therapy

Reimbursement rate ................................................................. 100% after deductible

Physician Services

Inpatient

Reimbursement rate ................................................................. 100% after deductible

Office visit

Reimbursement rate ................................................................. 100% after deductible

Surgical services

Reimbursement rate ................................................................. 100% after deductible

Second Opinions

Physician recommended:

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

Self-referral:

Reimbursement rate ................................................................. 100% after deductible

Pre-Admission Testing

Reimbursement rate ................................................................. 100% after deductible

Prescription Drug Benefit

Participants are required to pay 100% at the pharmacy and are then reimbursed any applicable amount.

Reimbursement rate ................................................................. 100% after deductible

If the Covered Person requests a brand name drug when a generic equivalent is available, the Covered Person will pay the brand name coinsurance and the difference in cost between the Generic Drug and the brand name drug.
Refer to the Prescription Drug Benefit section in this Plan Document for more information.

Preventive Care

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

Routine Well Care services and Women’s Preventive will be subject to age and developmentally appropriate frequency limitations as determined by the U.S. Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA), *unless otherwise specifically stated in this Schedule of Benefits*, and which can be located using the following websites:

http://www.uspreventiveservicestaskforce.org; and

http://www.hrsa.gov/womensguidelines

Routine Well Care services will include, but will not be limited to, the following routine services:

Office visits, routine physical exams, prostate screening, routine lab and x-ray services, immunizations, routine colonoscopy/flexible sigmoidoscopy, routine well child care examinations.

Women’s Preventive Services, will include, but will not be limited to, the following routine services:

Office visits, well-women visits, mammogram, gynecological exam, Pap smear, counseling for sexually transmitted infections, human papillomavirus (HPV) testing, counseling and screening for human immune-deficiency virus (HIV), interpersonal and domestic violence, contraceptive methods and counseling as prescribed, sterilization procedures patient education and counseling for all women with reproductive capacity (*this does not include birthing classes*), screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth.

Diabetic Education

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

Calendar Year maximum ................................................................. 3 visits

Nutritional Education Counseling Benefit

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

Calendar Year maximum ................................................................. 3 visits

Tobacco Cessation Counseling

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

Calendar Year maximum ................................................................. 3 visits
Prosthetics
Reimbursement rate ................................................................. 100% after deductible

Skilled Nursing Facility
Daily limit .................................................................................. the facility’s average semiprivate room rate
Reimbursement rate ................................................................. 100% after deductible
Calendar Year maximum ......................................................... 90 days

Speech Therapy
Reimbursement rate ................................................................. 100% after deductible

Spinal Manipulation/Chiropractic Services
Reimbursement rate ................................................................. 100% after deductible
Calendar Year maximum ......................................................... 20 visits

Note: Diagnostic Testing (X-ray & Lab) and Imaging Services (MRI, CT/PET Scans, etc.) are payable as described in the Schedule of Benefits and do not apply to the visit maximum per Calendar Year.

Substance Abuse Treatment
Inpatient services
Preferred Facility Reimbursement rate ...................................... 100% after deductible
Non-Preferred Facility Reimbursement rate ............................... 60% after deductible

Outpatient visits
Reimbursement rate ................................................................. 100% after deductible

Temporomandibular Joint (TMJ) and Myofascial Pain Dysfunction (MPD)
Reimbursement rate ................................................................. 100% after deductible

Well Newborn Nursery Care Limits
Preferred Facility Reimbursement rate ...................................... 100% after deductible
Non-Preferred Facility Reimbursement rate ............................... 60% after deductible

Wig after chemotherapy
Reimbursement rate ................................................................. 100% after deductible
Calendar Year maximum ......................................................... $300

All Other Eligible Charges
Reimbursement rate ................................................................. 100% after deductible
DENTAL BENEFITS

Calendar Year Deductible

per person .................................................................................................................. $50
per Family Unit .......................................................................................................... $150

The deductible applies to these Classes of Service:

   Class B Services – Basic
   Class C Services – Major

Dental Percentage Payable
(subject to Allowable Charges)

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

Maximum Benefit Amount

For Class A services, age 18 and under:

   Per person per Calendar
   Year......................................................................................................................... No maximum

For Class A services for Covered Persons age 19 and over; and Class B and C services for all Covered Persons:

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

The Kodiak Island Borough School District Employee Health Care Plan has contracted with Vision Service Plan to provide vision care services for you and your Dependents. An outline of the benefits is provided below.

BENEFITS

<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>Once a Calendar Year starting in January</td>
</tr>
<tr>
<td>Lenses</td>
<td>Once a Calendar Year starting in January</td>
</tr>
<tr>
<td>Frame</td>
<td>Every other Calendar Year</td>
</tr>
</tbody>
</table>

COPAYMENT *Copayment applies to in and out of network services

<table>
<thead>
<tr>
<th>Service</th>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>$20.00</td>
<td></td>
</tr>
<tr>
<td>Materials</td>
<td>$20.00</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>VSP Participating Provider</th>
<th>Non-Participating Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>Paid-in-Full (After copayment)</td>
<td>Up to $45.00 (After copayment)</td>
</tr>
<tr>
<td>Single Vision Lenses</td>
<td>Paid-in-Full (After copayment)</td>
<td>Up to $45.00 (After copayment)</td>
</tr>
<tr>
<td>Bifocal Lenses</td>
<td>Paid-in-Full (After copayment)</td>
<td>Up to $65.00 (After copayment)</td>
</tr>
<tr>
<td>Trifocal Lenses</td>
<td>Paid-in-Full (After copayment)</td>
<td>Up to $85.00 (After copayment)</td>
</tr>
<tr>
<td>Lenticular Lenses</td>
<td>Paid-in-Full (After copayment)</td>
<td>Up to $125.00 (After copayment)</td>
</tr>
<tr>
<td>Frame</td>
<td>A wide selection of attractive Frames are covered up to $165.00</td>
<td>Up to $47.00 (After copayment)</td>
</tr>
<tr>
<td>Contact Lenses (Instead of spectacle lenses and frame)</td>
<td>Paid-in-Full (After copayment)</td>
<td>Up to $210.00 (After copayment)</td>
</tr>
<tr>
<td>Necessary</td>
<td>Paid-in-Full (After copayment)</td>
<td>Up to $120.00 (After copayment)</td>
</tr>
<tr>
<td>Elective</td>
<td>Up to $120.00 (After copayment)</td>
<td>Up to $105.00 (After copayment)</td>
</tr>
</tbody>
</table>

THIS IS ONLY A SUMMARY

VISION SERVICE PLAN CUSTOMER SERVICE (800) 877-7195
Web site at http://www.vsp.com

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

Out-of-Network Providers:

If you wish to see an out-of-network provider, VSP will reimburse you up to the amount allowed under your plan’s out-of-network provider reimbursement rate. Be aware that your out-of-network provider reimbursement rate does not guarantee full payment, and VSP cannot guarantee patient satisfaction when services are received from an out-of-network provider. Since your plan allows such reimbursements, pay the entire bill when you see the out-of-network provider and gather the following information:
• The provider’s bill, including a detailed list of the services you received
• The covered Employee’s Identification number
• The covered Employee’s name, phone number and address
• The name of the organization that provides your VSP coverage
• Your name, date of birth, phone number and address
• Your relationship to the covered VSP Employee (such as “self, spouse, child, etc.”)

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

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

Out-of-Network Provider Claims:
Vision Service Plan
P.O. Box 997100
Sacramento, CA 95899-7100
ELIGIBILITY, FUNDING, EFFECTIVE DATE
AND TERMINATION PROVISIONS

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

ELIGIBILITY

Eligible Classes of Employees.

The following Classes of Employees:

(1) All Active Employees of the Employer. See the Defined Terms Section for definition of Active Employee.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

(1) Is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 30 hours per week and is on the regular payroll of the Employer for that work.

(2) Is a Part-Time, Active Employee of the Employer. An Employee is considered to be Part-Time if he or she normally works at least 15 hours per week and is on the regular payroll of the Employer for that work.

(3) Is in a class eligible for coverage.

If the Employee is not designated as a Full-Time Active Employee by the Employer at time of hire, the Employer may use a 12-month look-back measurement period to determine the Full-Time status as defined under the Plan. The Employee must average or be expected to average 30 hours of service each week during the Employee’s initial 12-month measurement period to be eligible for coverage.

An Employee’s initial measurement period begins the first day of the month following the date of hire, with an initial stability period commencing the first day of the second full calendar month following the initial measurement period. If there is a gap between the end of the Employee’s first stability period and the start of the Employer’s standard stability period, the Employee will remain eligible until the first day of the standard stability period as long as the Employee is actively working for the Employer.

The Employer’s standard 12-month measurement period begins each November, with a standard stability period commencing each January 1. Coverage is effective the first day of the stability period following the applicable measurement period.

For more information on benefit measurement periods, contact the Employer’s Human Resources Department

(4) Completes the employment Waiting Period of:

- 30 days for administrators, elected officials, exempt and certified Employees; or
- 60 days (within their work months) for classified employees
A “Waiting Period” is the time between the first day of employment and the first day of coverage under the Plan.

**Eligible Classes of Dependents.**

A Dependent is any one of the following persons:

1. A covered Employee’s Spouse, Domestic Partner, and children from birth to the limiting age of **26 years**, including adult dependent children.

   *If an otherwise eligible Dependent is not the covered Employee’s true tax dependent as defined by the Internal Revenue Service (IRS), benefits for that Dependent will NOT be provided on a tax-free basis and therefore, the Employee may be required to pay the cost of the benefits on an after-tax basis and the employee may be subject to additional tax consequences.*

   The term "Spouse" shall mean one man or one woman of the opposite sex recognized as the Covered Employee’s husband or wife (not including a common-law marriage). The Plan Administrator may require documentation proving a legal marital relationship.

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

   The Employee must provide the Employer with a Notice of Cancellation of Domestic Partnership within 31 days if the partnership as defined above terminates.

   Please be advised, the definition of “Dependent” for purposes of group health plan eligibility may not allow for tax-free benefits for all eligible “Dependents”. For more information questions or concerns, please contact your tax advisor.

   The term “children” shall include natural, legally adopted children of either the Employee or Spouse, or children placed with a covered Employee in anticipation of adoption. Step-children may also be included. Children of the Employee’s Domestic Partner may also be included as long as the natural parent remains in a Domestic Partner relationship with the Employee and resides in the Employee’s household.

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

   The phrase “child placed with a covered Employee in anticipation of adoption” refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term “placed” means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.
Any child of a Plan Participant who is an alternate recipient under a Qualified Medical Child Support Order (QMCSO) shall be considered as having a right to Dependent coverage under this Plan.

A participant of the Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

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

(2) A covered Dependent child who is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical disability and is primarily dependent upon the covered Employee for support and maintenance, unmarried and covered under the Plan when reaching the limiting age. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent’s reaching the limiting age, subsequent proof of the child’s Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year.

These persons are excluded as Dependents: other individuals living in the covered Employee’s home, but who are not eligible as defined; the legally separated or divorced former Spouse or cancelled/separated Domestic Partner of the Employee; or any person who is covered under the Plan as an Employee.

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

If both mother and father or Domestic Partner are Employees, their children will be covered as Dependents of the mother or father, but not of both.

**Eligibility Requirements for Dependent Coverage.** A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

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

**FUNDING**

**Cost of the Plan.** Kodiak Island Borough School District shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

**ENROLLMENT**
**Enrollment Requirements.** An Employee must enroll for coverage by filling out and signing an enrollment application. The covered Employee is required to enroll for Dependent coverage also.

**Enrollment Requirements for Newborn Children.** A newborn child of a covered Employee is not automatically enrolled in this Plan. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollments" following this section, the enrollment will be considered a Late Enrollment, there will be no payment from the Plan and the parents will be responsible for all costs.

**TIMELY OR LATE ENROLLMENT**

(1) **Timely Enrollment** – The enrollment will be “timely” if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible (or 90 days in the case of birth, adoption or placement for adoption) for the coverage, either initially or under a Special Enrollment Period.

If two Employees (mother and father or Domestic Partner) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee (with no Waiting Period) as long as coverage has been continuous.

(2) **Late Enrollment** – An enrollment is “late” if it is not made on a “timely basis” or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the plan during a Special Enrollment Period may join only during open enrollment.

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

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins the first day of the month following enrollment.

(3) **Open Enrollment** – Every **November 15th through December 15th**, the annual open enrollment period, covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them or Employees and their Dependents, who are Late Enrollees, will be able to enroll in the Plan.

Benefit choices made during the open enrollment period will become effective **January 1st** and remain in effect until the next open enrollment period unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied, coverage Waiting Periods (if applicable under this Plan) will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective **January 1st**.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

Plan Participants will receive detailed information regarding open enrollment from their Employer.
(4) **Enrollment Following a Benefit Measurement Period.** Employees who were determined to be Full-Time Active Employees during the applicable measurement period (and their eligible Dependents) may enroll in the Plan the first day of the first full calendar month of the following stability period.

**SPECIAL ENROLLMENT RIGHTS**

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her Dependents (including their Spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing toward the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the Employer stops contributing toward the other coverage).

In the case of a marriage, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the marriage or 31 days after the date an Affidavit of Domestic Partnership is executed.

In the case of a birth, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 90 days after the birth, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator.

**SPECIAL ENROLLMENT PERIODS**

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. This means that any Pre-Existing Condition will be determined on the basis of the look back period prior to the Enrollment Date, and the period of the Pre-Existing Conditions Limitation will start on the Enrollment Date.

(1) **Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent, who is otherwise eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to each of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.

(d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, as described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.
For purposes of these rules, a loss of eligibility occurs:

(i) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (e.g., part-time employees).

(ii) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(iii) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(2) Dependent beneficiaries. If:

(a) The Employee is a participant under this Plan or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period; and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may also be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

For marriage, the Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

For Domestic Partners, the Dependent Special Enrollment Period is a period of 31 days and begins on the date the Affidavit of Domestic Partnership is executed. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

For birth adoption or placement for adoption, the Dependent Special Enrollment Period is a period of 90 days and begins on the date of the birth, adoption, or placement for adoption. To be eligible
for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 90-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) In the case of marriage, the first day of the first month following the date of marriage;

(b) In the case of a Dependent's birth, as of the date of birth; or

(c) In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(d) In the case of a Domestic Partner, as of the date the Affidavit of Domestic Partnership is executed.

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

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

- The eligible person ceases to be eligible for Medicaid or Children’s Health Insurance Program (CHIP) coverage; or

- The eligible person becomes newly eligible for a premium subsidy under Medicaid or CHIP.

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

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

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

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the exact day, but no more than the 91st day the Employee satisfies all of the following:

1. The Eligibility Requirement.

2. The Active Employee Requirement.

3. The Enrollment Requirements of the Plan.

Active Employee. An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.
Effective Date of Dependent Coverage. A Dependent’s coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

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

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

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

1. The date the Plan is terminated;
2. The date the covered Employee's Eligible Class is eliminated;
3. The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes or, if applicable, the last day of the stability period for which the covered Employee met the required minimum hours of service established by the Employer. This includes death or termination of Active Employment of the covered Employee. (See the section entitled COBRA Continuation Coverage.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods;
4. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due;
5. If the Employee commits fraud or makes an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan’s discretion, or may immediately terminate coverage; or
6. As otherwise specified in the Eligibility section of this Plan.

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

Continuation During Periods of Leave of Absence. A person may remain eligible for a limited time if Active, full-time work ceases due to leave of absence. This continuance will end as follows:

For leave of absence: If the Employee is absent from work because of an approved sick leave, coverage will be continued while the Employee is receiving sick pay. However, if the Employee is on sick leave without pay, benefits may be continued provided the Employee pays full cost until coverage is terminated by the Employer. Please refer to section entitled Continuation During Family and Medical Leave.
If the Employee is absent from work because of an approved leave of absence without pay for any reason other than sickness or seasonal employment, coverage may be continued for a period of up to one year provided the employee pays the full cost until coverage is terminated by the Employer.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor, if, in fact, FMLA is applicable to the Employer and all of its Employees and locations. This Plan shall also comply with any other State leave laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State leave law is applicable to the Employer and all of its Employees. Leave taken pursuant to any other State leave law shall run concurrently with leave taken under FMLA, to the extent consistent with applicable law.

If applicable, during any leave taken under the FMLA and/or other State leave law, the Employer 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.

If Plan coverage terminates during the FMLA, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA and/or other State leave law. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example,

Rehiring a Terminated Employee. A terminated Employee who is rehired prior to the end of a 26 consecutive week period after the date of termination will have coverage reinstated the first day of the first calendar month following the date of rehire. Employees rehired after a break in service of 26 consecutive weeks or more will be treated as a new hire.

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

(1) The maximum period of coverage of a person under such an election shall be the lesser of:
   (a) The 24-month period beginning on the date on which the person’s absence begins; or
   (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

To elect this coverage or obtain more detailed information, contact the Plan Administrator. Continuation rights may apply under USERRA. In general, the same requirements for electing USERRA coverage must be
met as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and his or her Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation

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

1. The date the Plan or Dependent coverage under the Plan is terminated;
2. The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled COBRA Continuation Coverage);
3. The date a covered Spouse loses coverage due to loss of dependency status. (See the section entitled COBRA Continuation Coverage);
4. On the last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan. (See the section entitled COBRA Continuation Coverage);
5. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due;
6. If a Dependent commits fraud or makes an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage; or
7. As otherwise specified in the Eligibility section of this Plan.

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

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

DEDUCTIBLE

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

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

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

Deductible for a Common Accident. This provision applies when two or more Covered Persons in a Family Unit are injured in the same Accident. These persons need not meet separate deductibles for treatment of Injuries incurred in this Accident; instead, only one deductible for the Calendar Year in which the Accident occurred will be required for them as a unit.

BENEFIT PAYMENT

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

OUT-OF-POCKET LIMIT

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

COVERED CHARGES

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

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

Room charges made by a Hospital having only private rooms will be paid at the average private room rate.

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

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

*There is no coverage of pregnancy benefits for a covered Dependent child.*

The following services are available to all female Covered Persons and are payable as stated in the Schedule of Benefits, patient education and counseling for all women with reproductive capacity (does not include birthing classes), screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth.

**MATERNITY MANAGEMENT PROGRAM**

Maternity Management is an educational and empowerment program for eligible female Employees and Dependent Spouses.

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

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

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

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

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

(a) The patient is confined as a bed patient in the facility;

(b) The confinement starts within five (5) days of a Hospital confinement of at least fourteen (14) days;

(c) The attending Physician certifies that the confinement is Medically Necessary; and

(d) The attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

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

**Physician Care.** The professional services of a Physician for surgical or medical services.

(a) Charges for multiple surgical procedures will be a Covered Charge subject to the following provisions:
(i) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the reasonable and customary charge that is allowed for the primary procedures; 50% of the reasonable and customary charge will be allowed for each additional procedure performed through the same incision or during the same operative session. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(ii) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the reasonable and customary charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the reasonable and customary percentage allowed for that procedure; and

(iii) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 25% of the surgeon's reasonable and customary allowance.

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

(a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

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

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

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

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

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

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

(a) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled
Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

(b) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(c) **Audio Care (Hearing Aid)** Charges by a Physician for any audiometric examination only when performed following or in conjunction with a medical examination of the ear. Audiometric examination means a series of subjective tests by which a Physician determines which make and model of hearing aid will best compensate for the Covered Person’s loss of hearing. A follow-up visit, subsequent to obtaining the hearing aid, will be considered a covered expense.

Benefit includes eligible charges for:

- A hearing aid (monaural or binaural) of an approved function design, including ear molds and initial batteries, cords and other necessary equipment. **Note:** The hearing aid must be prescribed as a result of the examination.

- Rental charges for the use of a hearing aid instrument for a period up to but not exceeding 30 days in the event the Covered Person elects to return the hearing aid before actual purchase.

Physician certification and the examination charge for the examination must be submitted with the claim.

A certification from the Physician will not be necessary if the Covered Person purchases a replacement hearing aid covered by this benefit so long as the hearing aid being replaced was provided while covered by this benefit.

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

- Replacement of a hearing aid for any reason more often than once in a three-year period;

- Batteries or other ancillary equipment other than that obtained upon purchase of the hearing aid; and

- Repairs, servicing or alteration of hearing aid equipment.

(d) **Breast pump and breast pump supplies.** The purchase of a standard electric breast pump for initiation of breastfeeding (no more than 45 days prior to birth or within the first two (2) months following delivery) or a manual breast pump for continuation of breastfeeding (no more than 45 days prior to birth or within the first twelve (12) months following delivery) may be rented or purchased, with the cost not to exceed the purchase price of the equipment.

- Rental of a heavy duty/hospital grade breast pump may be considered Medically Necessary only for the period of time that a newborn remains inpatient in the Hospital. Purchase of a heavy duty/hospital grade breast pump is not considered a Covered Charge under this Plan.

- For all female Covered Persons using a breast pump from a prior Pregnancy, a new set of breast pump supplies may be covered with each subsequent Pregnancy.
Replacement of a standard electric breast pump may be covered up to once every three (3) Benefit Years if associated with a subsequent Pregnancy.

- Covered Charges for the purchase or rental of a breast pump and supplies will be payable subject to the Preventive Care benefits as shown in the Schedule of Benefits section. The Claims Administrator will require the following documentation: claim form with proof of purchase to include purchase price and item description.

Note: Breast pumps and breast pump supplies when purchased through a retail store (for example, through Target, Wal-Mart, Walgreens) will be considered payable only for the purposes of this benefit.

(e) **BridgeHealth Surgery Benefit™**

Kodiak Island Borough School District Employee Health Care Plan has contracted with BridgeHealth Medical, Inc. to provide BridgeHealth Surgery Benefit™ when a Covered Persons treating physicians recommends certain covered medical procedures (“Covered Services”) and they elect to receive treatment at certain medical providers participating in the BridgeHealth Network (“Providers”).

Covered Services may include, but not limited to comprehensive surgery benefits for planned major procedures such as:

- Heart Bypass and Valve Surgery
- Heart Pacemaker and Defibrillator Placement
- Knee and Hip Joint Replacement
- Shoulder Reconstruction and Other Major Orthopedic Procedures
- Spinal Fusion and Spinal Decompression
- Laparoscopic Prostate Surgery
- Tumor Treatment via CyberKnife

Covered Services include all medical costs incurred under the BridgeHealth Surgery Benefit™ will be payable as stated in the schedule of benefits, as well as:

(i) Round trip transportation for the Covered Person and one designated companion between the Covered Person’s home location and the location of the Provider where treatment is to be performed; and hotel accommodations near the Provider. All Transportation and Lodging must be reserved and scheduled through BridgeHealth Medical, Inc.

(ii) Per diem meals and incidentals allowance for the Covered Person and one companion while at the destination. The Covered Person’s per diem will not be paid during the required inpatient stay. This allowance shall be payable by BridgeHealth Medical, Inc. at initiation of the travel associated with such treatment up to the limits stated in the Schedule of Benefits.

Certain examinations, tests, treatments or other medical services may be required prior to or following travel under the BridgeHealth Surgery Benefit™. Any medical services performed by anyone not a Provider participating in the BridgeHealth Network, including such pre and post care, shall be subject to the coverage limits and other terms of the Health Plan.

The Plan shall remain responsible for BridgeHealth Surgery Benefit™ costs for changes required once travel and other accommodations have been made, as well as any
emergency or life-saving health services required as a result of any medical procedures or services received by the Covered Person.

Limitations and Disclosures:

(i) BridgeHealth Medical, Inc. is a Delaware corporation that communicates the availability of medical and surgical diagnostic, treatment and care services and coordinates the delivery of such services with travel, communication and other non-medical aspects of the interaction with the service providers to institutional healthcare purchasers and their Covered Persons. BridgeHealth Medical, Inc. does not provide any medical care or medical advice and does not evaluate or recommend any medical Providers or procedure.

(ii) The non-medical benefits provided under the BridgeHealth Surgery Benefit™ may be subject to taxation as income to the Covered Person; particularly any amounts paid to a Covered Person as meals and incidentals and travel benefits. BridgeHealth will provide appropriate documentation for benefits paid under the BridgeHealth Surgery Benefit™.

(iii) The BridgeHealth benefit is an alternate benefit and will be available when mutually beneficial to both the patient and the Plan including but not limited to locally available services. The Plan’s decision to allow this alternative benefits shall be determined on a case-by-case basis in conjunction with BridgeHealth, the treating provider, and the Covered Person. The Plan’s determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan Administrator to strictly enforce the provisions of the Plan.

BridgeHealth Medical, Inc. can be contacted at 1-800-680-1366 or visit their Web site at www.bridgehealthmedical.com.

(f) Cardiac rehabilitation as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(g) Radiation or chemotherapy and treatment with radioactive substances. The materials and services of technicians are included.

Pre-notification of services, by the Plan Participant, for cancer treatment services is strongly recommended. The pre-notification request to CareLink should include the Covered Person’s plan of care and treatment protocol. Pre-notification of services should occur at least seven (7) days prior to the initiation of treatment.

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

Toll Free in the United States: (866) 894-1505
Local Call in Billings, Montana: (406) 245-3575

A pre-notification of services by the Claims Administrator is not a determination by the Plan that claims will be paid. All claims are subject to the provisions of the Plan, including but not limited to medical necessity, exclusions and limitations in effect when services are provided. A pre-notification is not required as a condition to paying benefits.
and can only be appealed under the procedures in the Care Management Services Section. A pre-notification cannot be appealed under the Plan’s Internal and External Claims Review Procedures.

(h) **Clinical Trials.** Covered Charges will include charges made for routine patient services associated with clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:

- The clinical trial is registered on the National Institute of Health (NIH) maintained web site [www.clinicaltrials.gov](http://www.clinicaltrials.gov) as a Phase I, II, III, or IV clinical trial.
- The Covered Person meets all inclusion criteria for the clinical trial and is not treated “off-protocol.”
- The Covered Person has signed an Informed Consent to participate in the clinical trial. The Plan Administrator may request a copy of the signed Informed Consent;
- The trial is approved by the Institutional Review Board of the institution administering the treatment.
- Routine patient services will not be considered Experimental or Investigational and will include costs for services received during the course of a clinical trial, which are the usual costs for medical care, such as Physician visits, Hospital stays, clinical laboratory tests and x-rays that a Covered Person would receive whether or not he or she were participating in a clinical trial.

**Routine patient services do not include, and reimbursement will not be provided for:**

- The investigational service, supply, or drug itself;
- Services or supplies listed herein as Plan Exclusions;
- Services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs). This includes items and services provided solely to satisfy data collection and analysis and that are not used in direct clinical management of the Covered Person (e.g. monthly CT scans for a condition usually requiring only a single scan);
- Services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g. device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

(i) Initial **contact lenses** or glasses required following cataract surgery.

(j) **Contraceptives.** All Food and Drug Administration (FDA) approved contraceptive methods when prescribed by a Physician, including but not limited to intrauterine devices (IUDs), implants, injections, and any related Physician charges including insertion and removal when applicable.

Refer to the separate Prescription Drug Benefit of this Plan regarding prescription coverage of oral contraceptive medications, devices, transdermals, vaginal contraceptives, implantables and injectables, including Physician-prescribed over-the-counter (OTC) contraceptives for female Covered Persons.
(k) **Diabetes Education Benefit.** Outpatient self-management training and education for the treatment of diabetes, provided by a licensed health care professional with expertise in diabetes, up to the limits stated in the Schedule of Benefits.

(l) **Durable Medical Equipment (DME).** Charges for Durable Medical Equipment and supplies necessary for the maintenance and operation of the Durable Medical Equipment that meet all of the following criteria:

- Medically Necessary;
- Prescribed by a Physician for outpatient use;
- Is NOT primarily for the comfort and convenience of the Covered Person;
- Does NOT have significant non-medical uses (i.e. air conditioners, air filters, humidifiers, environmental control devices).

If more than one item of Durable Medical Equipment can meet a Covered Person’s needs, Plan benefits are only available for the least cost alternative as determined by the Plan Administrator. Benefits are not available for certain convenience or luxury features that are considered non-standard.

Rental of a Durable Medical Equipment item will be a Covered Charge up to a maximum of the lesser of 24 months or the warranty period of the item, commencing on the date the item is first delivered to the Covered Person.

A Durable Medical Equipment item may be purchased, rather than rented, with the cost not to exceed the actual acquisition cost of the item to the Covered Person if the Covered Person were to purchase the item directly. The acquisition cost of the item may be prorated over a 6 month period, subject to prior approval by the Plan Administrator.

Replacement of a Durable Medical Equipment item, rented or purchased, will be a Covered Charge limited to once every 4 calendar years.

- Subject to prior approval of the Plan Administrator, replacement for a *purchased* Durable Medical Equipment item may be available for damage beyond repair with normal wear and tear, when repair costs exceed the acquisition cost, or when a change in the Covered Person’s medical condition occurs sooner than the 4 calendar year period.

- Subject to prior approval of the Plan Administrator, replacement for a *rented* Durable Medical Equipment item may be available when a change in the Covered Person’s medical condition occurs sooner than the 4 calendar year period.

Repair of a Durable Medical Equipment item including the replacement of essential accessories such as hoses, tubing, mouth pieces, etc., are Covered Charges only when necessary to make the item serviceable and the total estimated repair and replacement costs do not exceed the acquisition cost of the item. Rental charges for a temporary replacement Durable Medical Equipment item are Covered Charges up to a maximum of two consecutive months. Requests to repair a Durable Medical Equipment item are not subject to the 4 calendar year limit.

The Plan Administrator may require documentation, including but not limited to the make and model number of the Durable Medical Equipment item, the acquisition cost to the provider, and documentation to support Medical Necessity.
(m) **Home Infusion Therapy.** The Plan will cover home infusion therapy services and supplies when they are Medically Necessary and are required for the administration of home infusion therapy regimen, when ordered by and are part of a formal written plan prescribed by a Physician and provided by an accredited home infusion therapy agency. The benefit will include all Medically Necessary services and supplies, including the nursing services associated with patient and/or alternative care giver training, visits to monitor intravenous therapy regimen, emergency care, administration of therapy and the collection, analysis and reporting of the results of laboratory testing services required to monitor response to therapy.

(n) Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome and Myofascial Pain Dysfunction.**

(o) **Laboratory studies.**

(p) **Mammography** (whether performed for an Illness or routine).

(q) **Massage Therapy.** Massage therapy will be considered an eligible expense when services are provided by a certified massage therapist working under the direction of a Physician and services are billed through the Physician’s office.

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

(s) Injury to or care of **mouth, teeth and gums.** Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be covered charges under Medical Benefits only if that care is for the following oral surgical procedures:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Emergency repair due to Injury to sound natural teeth. This repair must be made within 12 months from the date of an accident.
- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
- Excision of benign bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands or ducts.

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

(t) **Nutritional counseling and educational services.** Care, treatment, and services when provided by Physician, a registered dietician, or licensed nutritionist, up to the limits as stated in the schedule of benefits.

This benefit will not include weight loss medications or nutritional supplements whether or not prescribed by a Physician.
(u) Occupational therapy by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(v) Organ transplant benefits. Medically Necessary charges incurred for the care and treatment due to an organ or tissue transplant, which are not considered Experimental or Investigational, are subject to the following criteria (and are subject to the limits as stated in the Schedule of Benefits):

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

- Organ transplant benefit period: A period of 365 continuous days beginning five (5) days immediately prior to an approved organ transplant procedure. In the case of a bone marrow transplant, the date the transplant begins will be defined as either the earlier of the date of the beginning of the preparatory regimen (marrow ablation therapy) or the date the marrow/stem cells is/are infused.

- Organ procurement limits. Charges for obtaining donor organs or tissues are Covered Charges under the Plan only when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The donor benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:
  
  (i) Evaluating the organ or tissue;

  (ii) Removing the organ or tissue from the donor; and

  (iii) Transportation of the organ or tissue from within the United States or Canada to the facility where the transplant is to be performed.

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

As soon as reasonably possible, but in no event more than ten (10) days after a Covered Person’s attending Physician has indicated that the Covered Person is a potential candidate for a transplant, the Covered Person or his or her Physician must contact CareLink at (866) 894-1505.

- In the event a Preferred Provider transplant facility is utilized, benefits will be payable at the Preferred Provider benefit level.

- In the event a Preferred Provider transplant facility is unavailable and the providing transplant facility is a Center of Excellence facility, benefits will be payable at the Preferred Provider benefit level.

- In the event a non-Preferred Provider transplant facility is utilized and the providing transplant facility is not a Center of Excellence facility, benefits will be payable at the non-Preferred Provider benefit level.

There is no obligation to the Covered Person to use either a Preferred Provider or a Center of Excellence facility; however, benefits for the transplant and related expenses will vary depending upon whether services are provided by a Preferred Provider or a non-Preferred Provider and whether or not a Center of Excellence facility is utilized.
A **Center of Excellence** is a licensed healthcare facility that has entered into a participation agreement with a national transplant network to provide approved transplant services, at a negotiated rate, to which the Plan has access. A Covered Person may contact CareLink to determine whether or not a facility is considered a Center of Excellence.

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

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

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

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

**Special Transplant Benefits**
Under certain circumstances, there may be special transplant benefits available when the group health plan and/or a Covered Person participates in a special transplant program and/or contracts with a specific transplant network. Therefore, it is very important to contact CareLink at (866) 894-1505 as soon as reasonably possible so that the Plan can advise the Covered Person or his or her Physician of the transplant benefits that may be available.

**Transplant Exclusions**
Coverage for the following procedures, when Medically Necessary, will be provided under the regular medical benefits provision under this Plan, subject to any Plan provisions and applicable benefits limitations as stated in the Schedule of Benefits.

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

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

(x) **Physical therapy** by a licensed physical therapist.
(y) **Prescription** Drugs (as defined). *Outpatient Prescription Drugs will be payable under the separate Prescription Drug Benefit section of this Plan.*

(z) Routine **Preventive Care.** Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits. Routine well care is care by a Physician that is not for an Injury or Sickness.

(a1) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.

(b1) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered covered charges.

   This mammoplasty coverage will include reimbursement for:

   (i) Reconstruction of the breast on which a mastectomy has been performed,

   (ii) Surgery and reconstruction of the other breast to produce a symmetrical appearance, and

   (iii) Coverage of protheses and physical complications during all stages of mastectomy, including lymphedemas,

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

(c1) Charges for **Rehabilitation therapy** up to the limits stated in the Schedule of Benefits. Services must be Medically Necessary to restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an accidental injury, illness, or surgery.

   **Inpatient Care.** Services must be furnished in a specialized rehabilitative unit of a Hospital and billed by the Hospital or be furnished and billed by a rehabilitation facility approved by the Plan. This benefit only covers care the Covered Person received within 24 months from the onset of the Injury or Illness or from the date of the surgery that made rehabilitation necessary. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physiatrist (a Physician specializing in rehabilitative medicine).

(d1) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either:

   (i) Surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than frenectomy) of a person;

   (ii) An Injury; or

   (iii) A Sickness.

(e1) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O., or D.C., subject to Medical Necessity and non-maintenance care, up to the limits as stated in the Schedule of Benefits.

(f1) **Sterilization** procedures. Sterilization procedures for female Covered Persons will be payable as shown under the Preventive Care benefit as shown in the Schedule of Benefits section.
The following charges will be payable per normal Plan provisions:

- **Hysterectomies; and**
- **Sterilization procedures for male Covered Persons.**

**g1)** **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

**h1)** **Tobacco Cessation Counseling.** Care and treatment for tobacco cessation counseling, up to the limits as stated in the Schedule of Benefits.

**i1)** **Transportation.** This Plan will provide benefits for round trip transportation by commercial airline (coach class only) or ferry from the place where the Illness or Injury occurred to the nearest Hospital where professional treatment can be obtained.

Benefits for non-emergency medical travel may be payable for transportation by commercial airline (coach class only, with a 14-day advanced or super-saver fare pre-approved) or ferry from the place where the Illness or Injury occurred to the nearest hospital where professional treatment can be obtained. All non-emergency travel must be pre-approved by the Claims Administrator using the “Non-Emergency Medical Travel Request Form”) or no benefits will be provided. The Non-Emergency Medical Travel Request Form is available from the Claims Administrator.

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

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

Transportation benefits are subject to the following limitations:

**i)** The Illness or Injury must be a life endangering situation that requires immediate transfer to a Hospital that has special facilities for treating the condition; or

**(ii)** Surgery or a condition exists which cannot be performed locally. In that case, transportation benefits in any one Calendar Year will be limited to:

- One visit and one follow-up visit which is pre-authorized as a condition requiring therapeutic treatment which cannot be provided locally; or

- One pre- or post-surgical visit and one visit for the actual surgical procedure which cannot be provided locally.

If the patient is a child under 18 years of age, the transportation charges of a parent or Legal Guardian accompanying the child will be allowed.
(j1) Coverage of **Well Newborn Nursery/Physician Care.**

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

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

The benefit is limited to Allowable Charges for nursery care for the newborn child while Hospital confined as a result of the child’s birth.

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

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

**Charges for Routine Physician Care.** The benefit is limited to the Allowable Charges made by a Physician for the newborn child while Hospital confined as a result of the child’s birth.

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

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

(l1) Diagnostic **x-rays.**
CARE MANAGEMENT SERVICES

UTILIZATION MANAGEMENT

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

Pre-notification of certain services is strongly recommended, but not required by the Plan. Pre-notification provides information regarding coverage before the Covered Person receives treatment, services and/or supplies. A benefit determination on a Claim will be made only after the Claim has been submitted. A pre-notification of services by CareLink is not a determination by the Plan that a Claim will be paid. All Claims are subject to the terms and conditions, limitations and exclusions of the Plan at the time services are provided. A pre-notification is not required as a condition precedent to paying benefit, and can only be appealed under the procedures in this Care Management Services Section. A pre-notification cannot be appealed under the Plan’s Internal and External Claims Review Procedures.

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

- Inpatient admissions to a Hospital
- Inpatient admissions to free-standing chemical dependency, mental health, and rehabilitation facilities
- Cancer treatment plan of care, administered on an inpatient or outpatient basis
- Inpatient or outpatient surgeries relating to, but not limited to, hysterectomies, back surgery, or bariatric surgery; and
- Outpatient services as follows:
  - Dialysis
  - Genetic testing
  - Injectables
  - Home Health Care
  - Hospice
  - Durable Medical Equipment (DME) over $2,000

All Claims are subject to the terms and conditions, limitations and exclusions of the Plan at the time services are provided.

The Physician or Covered Person should notify CareLink at least seven (7) days before services are scheduled to be rendered with the following information:

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

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

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

Contact the Care Management administrator at:

CareLink (406) 245-3575 or (866) 894-1505
Monday through Friday, 6:00 a.m. to 7:00 p.m. (Mountain Time)

PRE-ADMISSION AND POST DISCHARGE CARE CALLS

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

PRE-NOTIFICATION DETERMINATION AND REVIEW PROCESS

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

The Physician and Covered Person will be provided notice of the Plan’s determination. If the pre-notification request is denied, written notice will provide the reason for the adverse pre-notification determination.

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

CareLink
Attn: Appeals
7400 West Campus Rd.
New Albany, OH 43054

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

CASE MANAGEMENT

If a Covered Person has an ongoing medical condition or catastrophic Illness, a Case Manager may be assigned to monitor this Covered Person, and to work with the attending Physician and Covered Person to design a treatment
plan and coordinate appropriate Medically Necessary care. The Case Manager will consult with the Covered Person, the family, and the attending Physician in order to assist in coordinating the plan of care approved by the Covered Person’s attending Physician and the Covered Person.

This plan of care may include some or all of the following:

- Individualized support to the patient;
- Contacting the family to offer assistance for coordination of medical care needs;
- Monitoring response to treatment;
- Evaluating outcomes; and
- Assisting in obtaining any necessary equipment and services.

Case Management is not a requirement of the Plan. There are no reductions of benefits or penalties if the Covered Person and family choose not to participate.

Each treatment plan is individualized to a specific Covered Person and is not appropriate or recommended for any other patient, even one with the same diagnosis. All treatment and care decisions will be the sole determination of the Covered Person and the attending Physician.

MATERNITY MANAGEMENT PROGRAM

Maternity Management is an educational and empowerment program for eligible female Employees and Dependent Spouses. There is no coverage of Pregnancy for a Dependent child.

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

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

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

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

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

**Allowable Charge** means the charge for a treatment, service, or supply that is the lesser of: 1) the charge made by the provider that furnished the care, service, or supply; 2) the negotiated amount established by a discounting or negotiated arrangement other than the Aetna network; 3) the reasonable and customary charge for the same treatment, service, or supply furnished in the same geographic area by a provider of like service as further described below; or 4) an amount equivalent to the following:

1. For specialty drugs, the lesser of average wholesale price (AWP) minus 10% or the amount set by the Plan’s prescription drug service vendor;

2. For inpatient or outpatient facility claims, an amount equivalent to 200% of the Medicare equivalent allowable.

The reasonable and customary charge shall mean an amount equivalent to the 95\textsuperscript{th} percentile (90\textsuperscript{th} percentile for anesthesia) of a commercially available database, or such other cost or quality-based reimbursement methodologies as may be available and adopted by the Plan. If there are insufficient charges submitted for a given procedure, the Plan will determine an Allowable Charge based upon charges made for similar services. Determination of the reasonable and customary charge will consider the nature and severity of the condition being treated, medical complications or unusual circumstances that require more time, skill or experience, and the cost and quality data for that provider.

For Covered Charges rendered by a Physician, Hospital or Ancillary Provider in a geographic area where applicable law dictates the maximum amount that can be billed by the rendering provider, the Allowable Charge shall mean the amount established by applicable law for that Covered Charges.

For Covered Charges rendered by a Physician, Hospital, or Ancillary Provider that is a contracted provider with the Aetna network, the negotiated rate of that preferred provider arrangement shall be the Allowable Charge.

The Plan Administrator or its designee has the **ultimate discretionary authority** to determine an Allowable Charge, including establishing the negotiated terms of a provider arrangement as the Allowable Charge even if such negotiated terms do not satisfy the lesser of test described above.

**Active Employee** is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time or part-time basis.

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

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

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

**Calendar Year** means January 1st through December 31st of the same year.
COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Cosmetic Dentistry means dentally unnecessary procedures.

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

Covered Person is an Employee or Dependent who is covered under this Plan.

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

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

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

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

Employer is Kodiak Island Borough School District.

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

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

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

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

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

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

3. Except as provided under the Clinical Trial benefit in the Medical Benefits section of the Covered Charges section, if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise
under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

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

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

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

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

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

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

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

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

- An approved Christian Science Sanitarium or institution which has been approved by the Committee on Christian Science Nursing Homes of the Mother Church, The First Church of Christ Scientist in Boston, Massachusetts; however, no benefits shall be payable by this Plan for confinement for spiritual guidance or rest in any such institution.

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

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

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

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

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

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

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

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

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

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

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

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

**Morbid Obesity** is a serious disease associated with a high incidence of medical complications and a significantly shortened life span. The current clinical standard measure for Morbid Obesity is a BMI (Body Mass Index) of 40+. The BMI is a factor produced by dividing a person’s weight (in kilograms) by his/her height squared (in meters).

**No-Fault Auto Insurance** is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.
Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician’s office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient’s home.

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

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Dentist (D.D.S. or D.M.D.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist, Naturopathic Doctor (N.D.) Advances Registered Nurse Practitioner (A.R.N.P.) or Licensed Clinical Social Worker (L.C.S.W.), and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

This definition will also include a Christian Science Practitioner authorized by the Mother Church, First Church of Christ Scientist, in Boston Massachusetts when prescribed by a Medical Doctor (M.D.) or Doctor of Osteopathy (D.O.).

Plan means Kodiak Island Borough School District Employee Health Care Plan, which is a benefits plan for certain employees of Kodiak Island Borough School District and is described in this document.

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

Plan Year is the 12-month period beginning on July 1 and ending June 30.

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

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

Sickness is:

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

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

1. It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

2. Its services are provided for compensation and under the full-time supervision of a Physician.

3. It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

4. It maintains a complete medical record on each patient.
(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

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

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

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

**Temporomandibular Joint (TMJ) syndrome** is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment may include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

**Total Disability (Totally Disabled)** means: In the case of an **Active Employee**, the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Sickness.

**Total Disability (Totally Disabled)** means: In the case of a **Dependent Child**, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.
PLAN EXCLUSIONS

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

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

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

1. **Audio Care/Hearing Aids.** Care, services, or treatment for audio care/hearing aids, except as specifically stated as a benefit of this Plan.

2. **Coding Guidelines.** Charges for inappropriate coding in accordance to the industry standard guidelines in effect.

3. **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan.

4. **Counseling.** Charges marital, social, sexual, or lifestyle counseling.

   Note: Counseling for these and other services are available through the Employee assistance program, which provides Employees and their families with confidential assistance when needing help dealing with problems and managing change.

   Please contact Magellan Health Service at 562-2812 (Local) or 800-478-2812 (Toll Free)

5. **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care, except as specifically stated as a benefit of this Plan.

6. **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Allowable Charge.

7. **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

8. **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.

9. **Eye care.** Radial keratotomy or other eye surgery to correct near-sightedness. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting, except as specifically stated in the Schedule of Benefits. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

10. **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease). This includes foot-support supplies, devices and shoes, unless such items are deemed Medically Necessary.

11. **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

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

(14) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(15) **Illegal acts.** Charges for services received as a result of an Injury, Illness and/or Sickness resulting from or occurring during the commission of a violation of law by the Covered Person, including but not limited to, a felony, a misdemeanor, and/or engaging in an illegal occupation. This exclusion does not apply to minor traffic violations. The Plan Administrator has full discretion to determine what constitutes a minor traffic violation. Under no circumstances will operating a motor vehicle while under the influence of alcohol or drugs (illegal drugs and/or Prescription Drugs), or a combination thereof, or operating a motor vehicle with a blood alcohol content (BAC) above the legal limit, be considered a minor traffic violation. For this exclusion to apply, it is not necessary that a fine be imposed or criminal charges be filed, or if filed, that a conviction result or that a sentence be imposed. This exclusion does not apply if the Injury, Illness, and/or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(16) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence.

(17) **Infertility.** Care and treatment for infertility, artificial insemination or in vitro fertilization.

(18) **Mailing or Sales Tax.** Charges for mailing, shipping, handling, conveyance and sales tax.

(19) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(20) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(21) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(22) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(23) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Medically Necessary charges for Morbid Obesity will be covered, up to the limits as stated in the Schedule of Benefits.

(24) **Occupational.** Care and treatment of an Injury or Sickness that is occupational – that is, arises from work for wage or profit including self-employment.

(25) **Personal comfort items.** Personal comfort items, patient convenience items, or other equipment, such as, but not limited to, air conditioners, air purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first aid supplies and nonhospital adjustable beds.

(26) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.
(27) **Pregnancy of daughter.** Care and treatment of Pregnancy and Complications of Pregnancy for a Dependent daughter only.

(28) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person’s physical condition to make the original device no longer functional.

(29) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.

(30) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(31) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(32) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

(33) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(34) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except as specifically stated as a benefit of this Plan.

(35) **War.** Any charge that is due to a declared or undeclared act of war or caused during service in the armed forces of any country.
PREScription Drug Benefits

Pharmacy Drug Charge
Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. Navitus Health Solutions is the administrator of the Pharmacy drug plan.

Participants are required to pay 100% at the pharmacy and are then reimbursed any applicable amount.

Any one prescription is limited a 90-day supply.

This plan requires the pharmacist to fill the prescription with a generic product whenever it is available, unless the prescription is written as Dispense as Written. If the prescription is not specified as Dispense as Written and the prescription is filled with a name brand prescription at the Plan participant’s request, then the coinsurance plus the difference between the cost of the generic drug and the brand name drug will be charged.

If a drug is purchased from a non-participating Pharmacy, or a participating Pharmacy when the Covered Person’s ID card is not used, the Covered Person must pay the entire cost of the drug at the Pharmacy, will not receive a discount and will have to submit the receipt Navitus Health Solutions for processing. The prescriptions will be processed up to the participating pharmacy Allowable Charge at 100%, less any coinsurance listed in the Schedule of Benefits. The contracted rate will not be applied to compound drugs, urgent/emergency claims, or foreign claims, the applicable copayment as shown in the Schedule of Benefits will apply.

If a drug is purchased and this Plan is, secondary the Covered Person will be required to submit the prescription receipt to Navitus Health Solutions for reimbursement. Reimbursement is up to the participating pharmacy Allowable Charge minus any applicable copayment as shown in the Schedule of Benefits.

miRx Mail Order Drug Benefit Option
The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer Covered Persons significant savings on their prescriptions. The mail order pharmacy is subject to change.
Any one prescription is limited to a 90-day supply.

Specialty Pharmacy
Navitus SpecialtyRx works with a specialty partner to offer services with the highest standard of care. Covered Persons will get one-on-one service with skilled pharmacists. They will answer questions about side effects and give advice to help Covered Persons stay on course with treatment. Navitus SpecialtyRx, delivery of specialty medications is free, and right to the Covered Person or prescriber’s office. Local courier service may be available for emergency, same-day medication needs.

Tablet (Pill) Splitting Program
Tablet splitting can help lower the cost of daily medication. “Tablet splitting” means a higher strength tablet is cut in half to provide the prescribed dose of medication. For example, if the Covered Person’s Physician prescribes Lipitor 10 mg tablets, the Covered Person can speak with his/her Physician or pharmacist about obtaining 20 mg tablets then cut them in half to receive the 10 mg dosage. Tablet splitting is safe when done on appropriate medications. Tablet splitting is available for a defined list of medications.

Covered Prescription Drugs

Note: Some quantity limitations and/or prior authorizations may apply.
(1) All drugs prescribed by a Physician that require a prescription either by federal or state law, except insulin or any other drugs not covered under this Plan.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin when prescribed by a Physician.

(5) Injectable drugs.

(6) Diabetic supplies including insulin syringes/needles, glucose sticks, urine tablets, lancets, test strips, insulin pumps and pump supplies.

(7) Renova, Retin A and Accutane.

The following will be covered at 100%, no deductible required for formulary drugs.

Benefits may be subject to prescription formulary and/or quantity limitations. Non-formulary prescriptions may be payable subject to the applicable prescription copayment as shown in the Schedule of Benefits. Contact the Claims Administrator to request coverage of the medication as a non-formulary medical exception.


(2) Physician-prescribed folic acid for all female Covered Persons with reproductive capacity.

(3) Physician-prescribed contraceptives methods (Food and Drug Administration (FDA) approved) including but not limited to oral contraceptive medications, transdermals, devices (diaphragms, cervical caps, and intra-uterine devices (IUDs)), vaginal contraceptives, implantables, injectables, female condoms, spermicides, and sponges for all female Covered Persons with reproductive capacity.

Refer to the Medical Benefits section of this Plan regarding additional coverage for intrauterine devices (IUDs), implantables, and injectables.

(4) Physician-prescribed breast cancer risk-reducing medications for asymptomatic women ages 35 years or older without a prior diagnosis of breast cancer and is at an increased risk for breast cancer and after a formal breast cancer risk assessment.

(5) Physician-prescribed aspirin to prevent cardiovascular disease (CVD) in adult men and women.

(6) Physician-prescribed iron supplements for asymptomatic covered Dependent children aged 6 to 12 months who are at increased risk for iron deficiency anemia.

(7) Physician prescribed fluoride supplements for covered Dependent children ages 19 years and under.

(8) Immunizations for influenza, pneumonia, tetanus, hepatitis, shingles, measles, mumps, HPV (human papilloma virus), pertussis, varicella, meningitis, and as designated by Navitus Health Solutions.
LIMITS TO THIS BENEFIT

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

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

EXCLUSIONS

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

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(3) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device. *These may be considered Covered Charges under the Medical Benefits section of this Plan.*

(4) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

(5) **FDA.** Any drug not approved by the Food and Drug Administration.

(6) **Growth hormones.**

(7) **Immunization.** Immunization agents or biological sera except as described as covered benefit under this Plan or offered by Navitus Health Solutions.

(8) **Impotence.** A charge for impotence medication.

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

(10) **Investigational.** A drug or medicine labeled: “Caution - limited by federal law to investigational use”.

(11) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(12) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(13) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

(14) **Obesity drugs.**

(15) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

(16) **Rogaine** (or similar drug) for topical application.
Vitamins, except for pre-natal vitamins.

HOW TO SUBMIT PHARMACY CLAIMS

For prescription claims questions or to obtain a claim form please call:

Navitus Health Solutions - toll-free 1 (866) 333-2757
or access www.ebms.com

Please submit prescription claim forms to:

Navitus Health Solutions
Operations Division – Claims
P.O. Box 999
Appleton, WI 54912-0999

Or fax ALL information to 1 (920) 735-5313 or toll free 1 (855) 668-8550
DENTAL BENEFITS

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

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

DEDUCTIBLE

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

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

BENEFIT PAYMENT

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

MAXIMUM BENEFIT AMOUNT

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

DENTAL CHARGES

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

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

COVERED DENTAL SERVICES

Class A Services:
Preventive and Diagnostic Dental Procedures

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

(1) Routine oral exams. This includes the cleaning and scaling of teeth. Limit of two exams per Covered Person each Calendar Year.

(2) Bitewing x-ray series. Limit of two per Covered Person each Calendar Year.

(3) One full mouth x-ray every 36 consecutive month period.

(4) Two fluoride treatments for covered Dependent children under age 20 each Calendar Year.
(5) Space maintainers for covered Dependent children under age 20.

(6) Emergency palliative treatment for pain.

(7) Sealants on permanent teeth for Dependent children under age 14.

(8) All other dental x-rays.

**Class B Services:**
**Basic Dental Procedures**

(1) Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts.

(2) Periodontics (gum treatments).

(3) Endodontics (root canals).

(4) Extractions. This service includes local anesthesia and routine post-operative care.

(5) Repair and recementing bridges, crowns or inlays.

(6) Fillings, other than gold.

(7) General anesthetics, upon demonstration of Medical Necessity.

(8) Antibiotic drugs.

**Class C Services:**
**Major Dental Procedures**

(1) Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.

(2) Installation of crowns.

(3) Installing precision attachments for removable dentures.

(4) Installing partial, full or removable dentures to replace one or more natural teeth. This service also includes all adjustments made during a six-month period following the installation.

(5) Addition of clasp or rest to existing partial removable dentures.

(6) Initial installation of fixed bridgework to replace one or more natural teeth.

(7) Rebasings or relining of removable dentures.

(8) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if one of these tests is met:

(a) The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.
(b) The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed.

(9) Implants. Charges for implants, including any appliances and/or crowns and the surgical insertion or

(10) Occlusal Guards

EXCLUSIONS

A charge for the following is not covered:

(1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.

(2) **Broken appointments.** Charges for broken or missed dental appointments.

(3) **Cosmetic.** Services or supplies which are primarily cosmetic in nature.

(4) **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.

(5) **Excluded under Medical.** Services that are excluded under Medical Plan Exclusions.

(6) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.

(7) **Medical services.** Services that, to any extent, are payable under any medical expense benefits of the Plan.

(8) **No listing.** Services which are not included in the list of covered dental services.

(9) **Orthodontia services.**

(10) **Personalization.** Personalization of dentures.

(11) **Replacement.** Replacement of lost or stolen appliances.

(12) **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.
HOW TO SUBMIT CLAIMS

When services are received from a health care provider, a Plan Participant should show his or her EBMS/ Kodiak Island Borough School District Identification card to the provider. Participating Providers may submit claims on a Plan Participant’s behalf.

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

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

- A copy of the itemized bill
- Group name and number (Kodiak Island Borough School District, Group 0000340)
- Provider Billing Identification Number
- Employee's name and Identification Number
- Name of patient
- Name, address, telephone number of the provider of care
- Date of service(s)
- Place of service
- Amount billed

Note: A Plan Participant can obtain a claim form from the Plan Administrator or the Claims Administrator. Claim forms are also available at http://www.ebms.com.
WHERE TO SUBMIT CLAIMS

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

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

WHEN CLAIMS SHOULD BE FILED

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

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

Upon termination of this Plan, all expenses incurred prior to the termination of this Plan, but not submitted to the Claims Administrator within 75 days of the effective date of termination of this Plan, will be excluded from any benefit consideration.

INTERNAL AND EXTERNAL CLAIMS REVIEW PROCEDURES

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

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

There are two types of claims.

Concurrent Care Determination

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

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

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

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

Initial Benefit Determination

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

Notice of Adverse Benefit Determination

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

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

If applicable:

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

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

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

**Claims Review Procedure - General**

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

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

- Take into account all comments, documents, records and other information submitted by the Claimant related to the claim, without regard as to whether this information was submitted or considered in a prior level of review.

- Provide to the Claimant, free of charge, any new or additional information or rationale considered, relied upon or created by the Plan in connection with the Claim. This information or new rationale will be provided sufficiently in advance of the response deadline for the final Adverse Benefit Determination so that the Claimant has a reasonable amount of time to respond.

- Consult with an independent health care professional who has the appropriate training and experience in the applicable field of medicine related to the Claimant’s Adverse Benefit Determination if that determination was based in whole or in part on medical judgment, including determinations on whether a treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary. A health care professional is “independent” to the extent the health care professional was not consulted on a prior level of review or is a subordinate of a health care professional who was consulted on a prior level of review. The Plan may consult with vocational or other experts regarding the Initial Benefit Determination.

**Internal Appeal Procedure**

**First Level of Internal Review**

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

Plan Administrator  
/o Employee Benefit Management Services, Inc. (EBMS)  
P.O. Box 21367  
Billings, Montana 59104  
Attn: Claims Appeals
An appeal will not be deemed submitted until it is received by the Claims Administrator. The Claimant cannot proceed to the next level of internal or external review if the Claimant fails to submit a timely appeal.

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

Second Level of Internal Review

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

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

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

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

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

External Review Procedure

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

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

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

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

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

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

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

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

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

1. Group or nongroup insurance contracts and subscriber contracts;
2. Uninsured arrangements of group or group-type coverage;
3. Group and nongroup coverage through closed panel plans;
4. Group-type contracts;
5. The medical components of long-term care contracts, such as skilled nursing care;
6. Medicare or other government benefits, as permitted by law. This does not include Medicaid, or a government plan that by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan;
7. The medical benefits coverage in automobile “no-fault” and traditional automobile “fault” type contracts;
8. Any third-party source, including but not limited to, automobile or homeowners liability insurance, umbrella insurance and premises liability insurance, whether individual or commercial, or on an insured, uninsured, under-insured or self-insured basis.

The term benefit plan does not include hospital indemnity, accident only, specified disease, school accident or non-medical long-term care coverage.

Allowable Charge(s). For a charge to be allowable it must be a usual, customary, and reasonable charge and at least part of it must be covered under this Plan. (See “Allowable Charge” in the Defined Terms section.)

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

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

Automobile limitations. When any medical benefits coverage is available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles.
**Benefit plan payment order.** When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(A) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(B) Plans with a coordination provision will pay their benefits up to the Allowable Charge. The first rule that describes which plan is primary is the rule that applies:

1. The benefits of the plan which covers the person directly (that is, as a Member/Employee, Retiree, or subscriber) (“Plan A”) are determined before those of the plan which covers the person as a Dependent (“Plan B”).
   For Qualified Beneficiaries, coordination is determined based on the person’s status prior to the Qualifying Event.

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

2. Unless there is a court decree stating otherwise for a Dependent child up to age 19, when a child is covered as a Dependent by more than one plan the order of benefits is determined as follows:

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

   - The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
   - If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

   When a child’s parents are divorced, legally separated or not living together, whether or not they have ever been married, these rules will apply:

   - A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent. If the financially responsible parent has no health care coverage for the Dependent child, but that parent’s spouse does, the plan of that parent’s spouse is the primary plan. This rule applies beginning the first of the month after the plan is given notice of the court decree.
   - A court decree may state both parents will be responsible for the Dependent child’s health care expenses. In this case, the plans covering the child shall follow order of benefit determination rules outlined above when the parents are married or living together (as detailed above);
   - If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are married or living together.
If there is no court decree allocating responsibility for the Dependent child’s health care expenses, the order of benefits are as follows:

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

When a child is covered as a Dependent under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined as if those individuals were parents of the child.

Unless specifically stated otherwise, court order and custody provisions apply up to age 19 for any Dependent child.

For a Dependent child who has coverage under either or both parents’ plans and also has his or her own coverage as a dependent under a spouse’s plan, Rule (5) applies. If the Dependent child’s coverage under the spouse’s plan began on the same date as the Dependent child’s coverage under either or both parents’ plans, the birthday rule shall apply to the Dependent child’s parents and the Dependent child’s spouse.

(3) The benefits of a benefit plan which covers a person as a Member/Employee who is neither laid off nor retired or as a Dependent of a Member/Employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid-off or Retired Member/Employee. This rule does not apply if Rule (1) can be used to determine the order of benefits If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(4) The benefits of a benefit plan which covers a person as a Member/Employee who is neither laid off nor retired or a Dependent of a Member/Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary. This rule does not apply if Rule (1) can be used to determine the order of benefits.

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

(C) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D.

(D) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(E) The Plan will pay primary to Tricare to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year or Plan Year basis, as shown in the Schedule of Benefits section. This is called the claims determination period.
**Right to receive or release necessary information.** To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

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

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

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

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

Defined Terms

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

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

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

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

Right to Reimbursement

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

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

The Plan will not pay or be responsible for attorney fees and/or costs of recovery associated with a Covered Person pursuing a claim against a Third Party, unless the Plan agrees in writing to such a reduction in its equitable lien, or subject to the terms of a court order.
Right to Subrogation

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

The Covered Person agrees that the Plan is subrogated to any and all claims, causes of action or rights that the Covered Person may have now or in the future against a Third Party who has or may have caused, contributed, aggravated, and/or been responsible for the Covered Person’s Injury, Sickness, condition, and/or accident to the extent the Plan has paid benefits or has agreed to pay benefits. The Covered Person further agrees that the Plan is subrogated to any and all claims or rights that the Covered Person may have against any Recovery, including the Covered Person’s rights under the Plan to bring an action to clarify his rights under the Plan. The Plan may assert this Right of Subrogation independently of the Covered Person. The Plan is not obligated to pursue this right independently or on behalf of the Covered Person, but may choose to exercise this right, in its sole discretion.

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

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

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

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

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

(4) The Plan may, to the extent of any benefits paid by the Plan, exercise its Right of Subrogation directly against a Third Party who is or may be responsible; or

(5) The Plan may, to the extent of any benefits paid by the Plan which have not otherwise been reimbursed to the Plan, offset any future benefits otherwise payable under the Plan to the Covered Person or on the Covered Person’s behalf.

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

Right to Recover Benefits Paid in Error

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

Introduction

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”). COBRA Continuation Coverage can become available to you and other members of your family when group health coverage would otherwise end. You should check with your Employer to see if COBRA applies to you and your Dependents.

You may have other options available to you when you lose group health coverage. 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 that plan generally doesn’t accept late enrollees.

What is COBRA Continuation Coverage?

“COBRA Continuation Coverage” is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a “Qualifying Event.” After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a “Qualified Beneficiary.” You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage. Life insurance, Accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your Employer’s plan) are not considered for continuation under COBRA.

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

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

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

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

- Your Spouse dies;
- Your Spouse’s hours of employment are reduced;
- Your Spouse’s employment ends for any reason other than his or her gross misconduct;
- Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

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

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

- The parent-covered Member dies;
- The parent-covered Member’s hours of employment are reduced;
- The parent-covered Member’s employment ends for any reason other than his or her gross misconduct;
- The parent-covered Member becomes entitled to Medicare benefits (Part A, Part B, or both);
• The parents become divorced or legally separated; or
• The child is no longer eligible for coverage under the plan as a “Dependent child.”

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

When is COBRA Continuation Coverage available?

The Plan will offer COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment, reduction of hours of employment, death of the Covered Member, commencement of proceeding in bankruptcy with respect to the Employer, or the Covered Member’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the Plan Administrator must be notified of the Qualifying Event.

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice in writing to:

Plan Administrator
Kodiak Island Borough School District
722 Mill Bay Road
Kodiak, AK 99615
(907) 486-9278

Notice must be postmarked, if mailed, or dated, if emailed or hand-delivered on or before the 60th day following the Qualifying Event.

How is COBRA Continuation Coverage provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA Continuation Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Members may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

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

How long does COBRA Continuation Coverage last?

COBRA Continuation Coverage is a temporary continuation of coverage that generally last for 18 months due to the employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA Continuation Coverage can be extended, discussed below.

If the Qualifying Event is the death of the Covered Member (or former Member), the Covered Member’s (or former Member’s) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent child’s losing eligibility as a Dependent child, COBRA Continuation Coverage can last for up to a total of 36 months.
**Medicare extension of COBRA Continuation Coverage**
If you (as the Covered Member) become entitled to Medicare benefits, your Spouse and dependents may be entitled to an extension of the 18 month period of COBRA Continuation Coverage.

If you first become entitled to Medicare benefits, and later experience a termination or employment or a reduction of hours, then the maximum coverage period for Qualified Beneficiaries other than you ends on the later of (i) 36 months after the date you became entitled to Medicare benefits, and (ii) 18 months (or 29 months if there is a disability extension) after the date of the termination or reduction of hours. For example, if you become entitled to Medicare 8 months before the date on which your employment terminates, COBRA Continuation Coverage for your Spouse and children can last up to 36 months after the date of your Medicare entitlement.

If the first Qualifying Event is your termination of employment or a reduction of hours of employment, and you then became entitled to Medicare benefits less than 18 months after the first Qualifying Event, Qualified Beneficiaries other than you are not entitled to an extension of the 18 month period.

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

Notice of the disability determination must be provided in writing to the Plan Administrator 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 Summary Plan Description 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.

The notice must include the name of the Qualified Beneficiary determined to be disabled by the SSA and the date of the determination. A copy of SSA’s Notice of Award Letter must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator  
Kodiak Island Borough School District  
722 Mill Bay Road  
Kodiak, AK  99615  
(907) 486-9278

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

Notice of a second Qualifying Event must be provided in writing to the Plan Administrator 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 Qualifying Beneficiary is informed, through the furnishing of the Plan’s Summary Plan Description, of both the responsibility to provide the notice and the Plan’s procedures for providing such notice to the Plan Administrator.

The notice must include the name of the Qualified Beneficiary experiencing the second Qualifying Event, a description of the event and the date of the event. If the extension of coverage is due to a divorce or legal separation, a copy of the decree of divorce or legal separation must be provided within 30 days after the deadline to provide the notice.

You must provide this notice to:

Plan Administrator  
Kodiak Island Borough School District  
722 Mill Bay Road  
Kodiak, AK 99615  
(907) 486-9278

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

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

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

How Do I Pay for COBRA Continuation Coverage?

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

Yes. Instead of enrolling in COBRA Continuation Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation Coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

**Additional Information**

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

<table>
<thead>
<tr>
<th>Plan Administrator</th>
<th>COBRA Administrator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kodiak Island Borough School District</td>
<td>Employee Benefit Management Services, Inc.</td>
</tr>
<tr>
<td>722 Mill Bay Road</td>
<td>P.O. Box 21367</td>
</tr>
<tr>
<td>Kodiak, AK 99615</td>
<td>Billings, MT 59104</td>
</tr>
<tr>
<td>(907) 486-9278</td>
<td>(406) 245-3575 or (800) 777-3575</td>
</tr>
</tbody>
</table>

For more information about your rights under COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website). For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov).

**Current Addresses**

To protect your family’s rights, let the Plan Administrator (who is identified above) know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.
RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Kodiak Island Borough School District Employee Health Care Plan is the benefit plan of Kodiak Island Borough School District, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator. An individual may be appointed by Kodiak Island Borough School District to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Kodiak Island Borough School District shall appoint a new Plan Administrator as soon as reasonably possible.

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

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

1. To administer the Plan in accordance with its terms.
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
3. To decide disputes which may arise relative to a Plan Participant’s rights.
4. To prescribe procedures for filing a claim for benefits and to review claim denials.
5. To keep and maintain the Plan documents and all other records pertaining to the Plan.
6. To appoint a Claims Administrator to pay claims.
7. To perform all necessary reporting.
8. To establish and communicate procedures to determine whether a medical child support order is qualified.
9. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

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

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.
FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) With care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) By diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) In accordance with the Plan documents.

THE NAMED FIDUCIARY. A “named fiduciary” is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) The named fiduciary has violated its stated duties in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) The named fiduciary breached its fiduciary responsibility.

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

FUNDING THE PLAN AND PAYMENT OF BENEFITS. The cost of the Plan is funded as follows:

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

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

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

PLAN IS NOT AN EMPLOYMENT CONTRACT. The Plan is not to be construed as a contract for or of employment.

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

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

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.
The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

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

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

“Protected Health Information” (PHI) means individually identifiable health information, created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and is transmitted or maintained in any form or medium.

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

1. 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);

2. 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;

3. 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;

4. 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;

5. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

6. 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);

7. 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);

8. 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);

(9) 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

(10) 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:

(a) 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:

Superintendent
Director of Finance
Director of Accounting
Payroll Accountant
Assistant Payroll Accountant

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

(c) In the event any of the individuals described in subsection (a) 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 the Claims Administrator, 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 and any applicable Business Associate Agreement(s).

Other Disclosures and Uses of PHI

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

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

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

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

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

TYPE OF ADMINISTRATION

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

PLAN NAME

Kodiak Island Borough School District Employee Health Care Plan

TAX ID NUMBER: 92-6000106

PLAN EFFECTIVE DATE: July 1, 2006

PLAN YEAR BEGINS: July 1

PLAN YEAR ENDS: June 30

EMPLOYER INFORMATION

Kodiak Island Borough School District
722 Mill Bay Road
Kodiak, Alaska 99615
(907) 486-9278

PLAN ADMINISTRATOR

Kodiak Island Borough School District
722 Mill Bay Road
Kodiak, Alaska 99615
(907) 486-9278

NAMED FIDUCIARY

Kodiak Island Borough School District
722 Mill Bay Road
Kodiak, Alaska 99615

AGENT FOR SERVICE OF LEGAL PROCESS

Kodiak Island Borough School District
722 Mill Bay Road
Kodiak, Alaska 99615

CLAIMS ADMINISTRATOR

Employee Benefit Management Services, Inc.
P.O. Box 21367
Billings, Montana 59104
(406) 245-3575
Plan Name: Kodiak Island Borough School District Employee Health Care Plan

Option: HDHP

Effective: July 1, 2015

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

Signature: ______________________________

Print Name: Roger Studley

Date: December 21, 2015