PUBLIC EDUCATION HEALTH TRUST BENEFIT BOOKLET

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Medical Plan Option: Plan F

TABLE OF CONTENTS

Introduction....1

Eligibility, Funding, Effective Date And Termination Provisions....4

- Eligibility....4
- Enrollment....7
- Timely Or Late Enrollment Of Dependents....8
- Open Enrollment Opportunity....8
- Special Enrollment Opportunities Or Waiver Of Coverage Events....9
- Effective Date....11
- Termination Of Coverage....12

Schedule Of Benefits....15

- Deductibles Payable By Plan Participants....16
- Medical Maximum Out-Of-Pocket Amounts....17
- Vision Service Plan Benefits....26
- Alternative Vision Benefit....28

Medical Benefit Descriptions....30

- Hospital Care....31
- Coverage of Pregnancy....31
- Skilled Nursing Facility Care....32
- Physician Care....33
- Home Health Care Services and Supplies....34
- Hospice Care Services and Supplies....34
- Other Medical Services and Supplies....34
- Acupuncture....34
- Ambulance....35
- Anesthetic....35
- Audio Care (Hearing Aid)....36
- Aetna Signature Administrators® Solution Hearing Discounts....36
- Cardiac Rehabilitation....37
- Chemotherapy....37
- Clinical Trials....38
- Coronary Artery Bypass Graft (CABG)....38
- Contact Lenses....39
- Contraceptives....39
- Diabetic Education....39
- Durable Medical Equipment....39
- Home Infusion Therapy....40
- Laboratory studies....40
- Mammography....40
- Massage Therapy....40
- Mental Disorder and Substance Abuse....40
- Injury to Mouth, Teeth and Gums....41
- Nutritional Counseling....43
- Obesity Interventions....44
- Occupational Therapy....44
- Organ Transplant....45
- Orthotics....48
- Physical Therapy....48
- PKU....49

Prescription Drugs 49
Preventive Care 49
Prosthetics 49
Reconstructive Surgery 49
Rehabilitation Therapy 50
Renal Dialysis Services 50
SAD Lights 50
Speech Therapy 50
Spinal Manipulation/Chiropractic Services 51
Sterilization Procedures 51
Surgical dressings 51
Surgical treatment of Morbid Obesity 51
Jaw Joint/TMJ 52
Tobacco Cessation Counseling 52
Transcarent Surgery Benefit 52
Transportation 53
Virtual Visits 56
Weight Management 56
Well Newborn Nursery/Physician Care 57
Wig after chemotherapy or radiation therapy 57
X-rays 57

Care Management Services 58

Utilization Management 58
Pre-Notification Determination And Review Process 59
Case Management 60
Maternity Management Program 61

Defined Terms 62

Plan Exclusions 73

Prescription Drug Benefits 77

Prescription Drug Benefit Schedule 77
Specialty Medication Benefits 79
Prescription Drug Benefit Description 80

How To Submit A Claim 88

Internal And External Claims Review Procedures 91

Initial Benefit Determination 92
Claims Review Procedure - General 93
Internal Appeal Procedure 94
External Review Procedure 96

Coordination Of Benefits.. 97

Third Party Recovery.. 105

Cobra Continuation Coverage 108

Responsibilities For Plan Administration 114

HIPAA Privacy Standards.. 120

General Plan Information 121

A Member/Employee 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.

INTRODUCTION

This **Public Education Health Trust** (the Plan) benefit booklet is a summary of the plan design your employer/association has selected. The Plan is a self-insured health and welfare benefit trust for public education employees in the State of Alaska. The Plan is governed by a board of trustees. Funding is derived from contributions from participating Employers and covered Members of the participating Employers.

The Participation Agreement, signed by your Employer or Association, sets forth the terms and conditions under which Employees are deemed eligible to receive health and welfare benefits, and may obtain coverage for themselves and their eligible Dependents under the Public Education Health Trust (the Plan).

The Plan Administrator has the exclusive right, power and authority, in its sole and absolute discretion, to administer and interpret the Plan and other Plan documents. The Plan Administrator has all powers reasonably necessary to carry out its responsibilities under the Plan including (but not limited to) the sole and absolute discretionary authority to:

- Administer the Plan according to its terms and to interpret Plan policies and procedures;
- Resolve and clarify inconsistencies, ambiguities and omissions in the Plan document and among and between the Plan document and other related documents;
- Take all actions and make all decisions regarding questions of coverage, eligibility and entitlement to benefits, and benefit amounts; and
- Process and approve or deny all claims for benefits.

The decision of the Plan Administrator on any disputes arising under the Plan, including (but not limited to) questions of construction, interpretation and administration shall be final, conclusive and binding on all persons having an interest in or under the Plan. Any determination made by the Plan Administrator shall be given deference in the event the determination is subject to judicial review and shall be overturned by a court of law only if it is arbitrary and capricious.

No oral interpretations can change the Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Any references within the Plan to a "day" limit will mean calendar days unless specifically stated as otherwise.

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

Public Education Health Trust 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.

If a participating Employer ceases to have a valid participation agreement with the Public Education Health Trust, the covered Member (and their Providers) will have 90 days to submit claims for themselves or any of their covered Dependents.

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

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan such as coordination of benefits, third party recovery, 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 is terminated, even if the expenses were incurred as a result of an Accident, Injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

Representations, Not Warranties. All statements made by the Plan and the Employer shall be considered representations and not warranties.

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

Before filing a lawsuit, the Claimant must exhaust all available levels of review as described in the Internal and External Review Procedures section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.

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

The Claims Administrator utilizes Aetna's Clinical Policy Bulletins (CPBs) to determine whether services and procedures are considered Medically Necessary and Experimental and/or Investigational under the Plan. The CPBs are based on peer-reviewed, published medical journals, a review of available studies on a particular topic, evidence-based consensus statements, expert opinions of health care professionals and guidelines from nationally recognized health care organizations. These CPBs are reviewed on a regular basis based upon a review of currently available clinical information.

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

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

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

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

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.

How to Submit a Claim. Explains the rules for filing claims and the claim appeal process.

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

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

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

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY

Eligible Classes of Members/Employees

A Member/Employee eligible for coverage under the Plan shall include only Members/Employees who:

- Are Employees of the Public Education Health Trust office; or
- Are Members of an Association who have a current Participation Agreement with Public Education Health Trust as administered by Public Education Health Trust office; or
- Are School Board Members who have a current Participation Agreement with Public Education Health Trust as administered by Public Education Health Trust office; or
- Are Employees of an Employer who has a current Participation Agreement with Public Education Health Trust as administered by Public Education Health Trust office; or
- Are Employees of a School District that has a current Participation Agreement with Public Education Health Trust as administered by Public Education Health Trust office.

Eligibility Requirements for Coverage

Eligibility for participation is determined by the Employer. The Trust requires a minimum of 15 hours during an average work week, and;

(1) Is a covered Member under a current Collective Bargaining Agreement entered into by a participating Public Education Union working in Alaska; and

(2) Completes any applicable Waiting Period as defined in the Collective Bargaining Agreement; A "Waiting Period" is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan not to exceed 90 days.

OR

(3) Meets the definition of eligible Employee as defined in the Policy and Procedures Manual/Personnel Policy (or as documented by payroll record) of the participating Employer; and

(4) Completes any applicable Waiting Period as defined in the Policy and Procedures Manual/Personnel Policy (or as documented by payroll record) of the participating Employer.

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

The Trust assumes no liability in Employer compliance with the Affordable Care Act. For more information on the measurement and stability periods elected by the Employer, you should contact your Employer's administrative office/human resources office.

Eligible Classes of Dependents

A Dependent is any one of the following persons:

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

The term "**Spouse"** shall mean a person recognized as the covered Member's husband or wife under the laws of the state in which the marriage was formalized. When a couple is legally separated, the spouse is not eligible for coverage. The Plan Administrator requires documentation proving a legal marital relationship.

The term "**Domestic Partner**" shall mean a person of either opposite sex or of the same sex meeting the following criteria: share an intimate, exclusive committed personal relationship of mutual caring; are not related by blood closer than permitted under marriage laws of the State of Alaska; are not 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/Spouse 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 notarized Statement of Financial Interdependence form, under penalty of perjury, that she or he is the other's Domestic Partner.

All references to Spouse will also be applicable to a Domestic Partner, unless otherwise indicated.

Please be advised, the definition of "Dependent" may not be the same definition as established by the Internal Revenue Code (IRC) for individuals that the covered Employee is permitted to pay qualified medical expenses from a Health Savings Account (HSA), or individuals that can be enrolled as an eligible Dependent for tax-free benefits (i.e., Domestic Partner or non-IRC Section 152 Dependent). There may be tax implications for the Employee if he or she enrolls certain eligible Dependent(s). The Employee should consult his or her tax advisor with any questions on the tax consequences of benefits for his or her eligible Dependent(s).

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

The term "**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. If a covered Member or his or her Spouse or Domestic Partner is the Legal Guardian of a child or children who has not attained the age of 18, these children may be enrolled in this Plan as covered Dependents. When a child reaches the limiting age of 18, end of guardianship, coverage will end on the last day of the birthday month.

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

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

The Plan Administrator requires documentation proving dependency of a child, including court-appointed legal guardianship, adoption or placement for adoption; birth certificates or initiation of legal proceedings severing parental rights.

(2) A covered Dependent child who is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, dependent upon the covered Member for over one-half of his or her financial support during the Calendar Year, is unmarried, and who is over the limiting age 26 years. 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.

Subsequent proof includes:

- A notarized letter confirming over one-half of the covered Dependent's financial support is provided by the covered Member; and
- Supplemental Security Income (SSI) determination letter provided by Social Security Administration (SSA)

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

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

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

Eligibility Requirements for Dependent Coverage. A family member of a Member will become eligible for Dependent coverage on the first day that the Member is eligible for Member coverage and the family member satisfies the requirements for Dependent coverage including all supporting documentation (e.g. marriage certificate, birth certificate, court-appointed legal guardianship, adoption or placement for adoption, Statement of Financial Interdependence form, or QMCSO).

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 is established each Plan Year.

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

ENROLLMENT

Enrollment Requirements. A Member who is initially eligible for coverage must enroll for coverage by filling out and signing an enrollment form available from the Employer or the Public Education Health Trust or at www.miBenefits.com.

To enroll his or her Dependent(s) for coverage, the covered Member is required to complete and sign an enrollment form with the required documentation within ***31 days*** after the person becomes initially eligible for the coverage. Any changes to the coverage election must be made within the same ***31 days*** after the person becomes initially eligible for the coverage, otherwise see the Timely or Late Enrollment section below.

Required documentation includes marriage certificate, birth certificate, court-appointed legal guardianship, Statement of Financial Interdependence form, QMCSO, or proof of placement for adoption.

For the addition of Dependents after the initial eligibility, see the Timely or Late Enrollment section below.

Fraud. Coverage may be retroactively canceled or terminated (rescission of coverage) if a Member acts fraudulently or intentionally makes material misrepresentations of fact to obtain Dependent coverage. It is a Member's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Member's responsibility to update any previously provided information or statements pertaining to Dependent eligibility. Failure to do so may result in Dependent coverage being canceled, and such cancellation may be retroactive.

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

A determination by the Plan that a rescission of Dependent coverage is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Dependent whose coverage is being rescinded will be provided a 30-day notice period as described under the Patient Protection and Affordable Care Act (PPACA). Claims incurred after the retroactive date of termination shall not be processed and/or paid under the Plan.

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

Any additional premiums required due to birth of a newborn will be effective the first of the month following the birth of the child. Should the newborn not be enrolled on a timely basis, and premium increases will be removed as of the first of the month following the first 31 days of coverage.

If both Parents are Members under the Plan, then the newborn may be auto enrolled under both parents for the first 31 days.

TIMELY OR LATE ENROLLMENT OF DEPENDENTS

(1) **Timely Enrollment** The enrollment of Dependents will be "timely" if the completed enrollment form and/or an add/change form with required documentation attached is received by the Plan Administrator:

- In the case of the loss of other coverage (including but not limited to termination of other coverage), completed enrollment form and/or an add/change form with required documentation must be received no later than ***31 days*** from the date of loss.
- In the case of acquiring a new Dependent (other than a Domestic Partner), completed enrollment form and/or an add/change form with required documentation must be received no later than ***90 days*** from the date of acquisition.

If a Domestic Partner is not enrolled with the Member when first eligible, a Domestic Partner is only eligible to enroll during open enrollment or as the result of loss of other coverage.

(2) **Late Enrollment** An enrollment is "late" if it is not made on a "timely basis" or during another opportunity to enroll for coverage. Late Enrollees and their Dependents who are not eligible to join the Plan during another opportunity to enroll for coverage may join only during open enrollment under this Plan, or;

If an individual loses eligibility for coverage as a result of a Member terminating employment or a general suspension of coverage under the Plan, then upon the Member 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 Dependent 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 on July 1 of the following Plan Year.***

OPEN ENROLLMENT OPPORTUNITY

Each year there is an annual open enrollment period during the month of May during which eligible Members may enroll themselves and any eligible Dependents under the Plan (including eligible Domestic Partners and their Dependents), or covered Members may change their and their covered Dependents benefit elections under the Plan.

Benefit choices made during the open enrollment period will become effective July 1 and remain in effect until the next July 1 unless there is another opportunity to enroll for coverage event or a change in family status

during the year (birth, death, marriage, a legal separation, divorce, adoption) or loss of other coverage.

Plan Fiscal Year – An enrollment/waiver will be considered timely if received by the Plan Administrator no later than prior to the beginning of the Plan's fiscal year. The Plan's fiscal year begins July 1st.

SPECIAL ENROLLMENT OPPORTUNITIES OR WAIVER OF COVERAGE EVENTS

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

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

OPPORTUNITIES FOR A MEMBER TO WAIVE, CHANGE PLAN OPTIONS, OR ENROLL FOR COVERAGE

(1) **Losing other coverage may create opportunities for a Member to enroll/change Plan options for coverage.** An Employee or Dependent (including Domestic Partners) who are eligible, but not enrolled in this Plan, may enroll/change Plan options if the loss of coverage meets **one of the following conditions:**

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

(b) The other coverage was COBRA coverage and the COBRA coverage was exhausted.

In order to enroll an Employee and/or Dependent during a Special Enrollment Period prompted by the loss of other coverage, the completed enrollment form and/or an add/change form with required documentation must be received by the Plan Administrator within ***31 days*** from the date of loss. Coverage will then be effective the first of the month following the receipt of the required documentation.

If the Dependent (including Domestic Partners) loss of the other coverage was a result of 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) **Acquiring a newly eligible Dependent may create opportunities for a Member to enroll/change plan options for coverage.** If:

A person becomes a Dependent of the Member through marriage, birth, adoption, or placement for adoption, or legal guardianship then the Dependent may be enrolled under this Plan.

If the Employee is not enrolled at the time of the event, the Employee must enroll during this Special Enrollment Period in order for his or her eligible Dependents to enroll.

In order to enroll a Dependent and/or Employee during a Special Enrollment Period due to acquiring a newly eligible Dependent, the completed enrollment form and/or an add/change form with required documentation must be received by the Plan Administrator within **90 days** from the date of acquisition.

In the case of birth, adoption, or placement for adoption, or legal guardianship, the Spouse (**not** including Domestic Partners) of the covered Employee may also be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

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

(a) In the case of marriage, coverage will be effective the first of the month following the receipt of the required documentation as long as it is received within ***90 days*** from the date of marriage.

(b) In the case of a Dependent's birth, as of the date of birth as long as required documentation is received within ***90 days*** from the date of birth;

(c) In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption as long as required documentation is received within ***90 days*** from the date of adoption or placement for adoption;

(d) In the case of Legal Guardianship appointment, the date of the Legal Guardianship appointment as long as required documentation is received within ***90 days*** from the date of the Legal Guardianship appointment.

If the Member changes Plans after acquiring a new dependent due to birth, adoption or placement for adoption or Legal Guardianship, coverage under the new plan option will be effective the first of the month following the receipt of the required documentation as long as it is received within ***31 days*** from the date of birth, adoption or placement for adoption, or legal guardianship.

Note: Domestic Partners will not be eligible for coverage under the acquiring a newly eligible Dependent provision.

(3) **Contribution Changes.** If there is a 10% or more increase to the Member's cost of coverage (as determined by the participating Employer) due to a change in the Employer's contribution as the result of an Employee's FTE status, the Member will have the opportunity to waive the Member's coverage or enroll in a lower cost Plan option for himself or herself and his or her covered Spouse, Dependents, and/or Domestic Partner.

If there is a 10% or more decrease to the Member's cost of coverage (as determined by the participating Employer) due to a change in the Employer's contribution as the result of an Employee's FTE status, the Member will have the opportunity to enroll in coverage or enroll in a higher cost Plan option for himself or herself and his or her covered Spouse, Dependents, and/or Domestic Partner.

The Member must notify the Plan Administrator within ***31 days*** of the event.

(4) **Collective Bargaining Agreement** - Changes as the result of the ratification of a Collective Bargaining Agreement, a Member covered by such Collective Bargaining Agreement can waive the Member's coverage, or enroll in different coverage for himself or herself and his or her covered Spouse, Dependents, and/or Domestic Partner. Coverage will be effective the first of the month following the

receipt of the required documentation as long as it is received within ***31 days*** from the date of the ratification.

(5) **During open enrollment for the Covered Member's eligible Dependent Employer's plan.** Eligible Members may enroll themselves and any eligible Dependents under the Plan (not including eligible Domestic Partners and their Dependents), or covered Members may change their and their covered Dependents benefit elections under the Plan. Coverage will be effective the first of the month following receipt of the enrollment form and/or the add/change form.

(6) **When an Employer initially executes a Participation Agreement**, all Actively Employed participants of that Employer and effective only on the date that the Employer initially enrolls with the Public Education Health Trust as administered by the Public Education Health Trust.

(7) **Loss of a Dependent.** In the event that a Dependent is no longer eligible for coverage under this Plan, a Member may have the opportunity to change Plans or add a Dependent. The enrollment form or the add/change form must be received by the Plan Administrator within ***31 days*** from the date of the loss of Dependent coverage. Coverage under the new Plan will be effective the first of the month following the receipt of the required documentation.

(8) **Divorce/Termination of Domestic Partnership.** In the event that a Member has become divorced or terminates their Domestic Partnership, a Member may have the opportunity to change Plans or add a Dependent. The enrollment form or the add/change form must be received by the Plan Administrator within ***31 days*** from the date of the court order, divorce decree, or date of the termination of Domestic Partnership. Coverage will be effective the first of the month following the receipt of the required documentation.

(9) **Waiving Coverage -** A Member may also have the opportunity to **waive** coverage for himself or herself and thereby also waive their Dependent coverage because of other health insurance or group health plan coverage that becomes available, acquisition of new Dependent by marriage, execution of a financially interdependent relationship, birth, adoption or placement for adoption, a legal separation, divorce or death, or the ratification of the Collective Bargaining Agreement. The Member must notify the Plan Administrator within ***31 days*** of the event if coverage will be waived.

NOTE: If you participate in a Cafeteria Plan speak to your Human Resource Department for additional rules that may apply.

EFFECTIVE DATE

Effective Date of Member Coverage. A Member will be covered under this Plan as of the first day that the Member satisfies the eligibility requirements of the Plan.

Note: Funding must be received by the Plan Administrator.

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

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility and Enrollment Requirements are met, and any applicable premiums due to the addition of the Dependent are

paid, and the Member is covered under the Plan or as otherwise stated in the Enrollment section of this Plan.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)
Members and their Dependents who are otherwise eligible for coverage under the Plan but who are not enrolled can enroll in the Plan provided that they request enrollment in writing within 60 days from the date of the following loss of coverage or gain in eligibility:

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

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

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

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

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

TERMINATION OF COVERAGE

When coverage under this Plan terminates, Plan Participants may request a certificate that will show the period of creditable coverage under this Plan. Please contact the Claims Administrator for a copy of these procedures and further details.

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

- **(1)** The date the Plan is terminated.
- **(2)** The date the covered Member's participating Employer ceases to have a valid participation agreement with the Public Education Health Trust. Upon the date of termination, the covered Member (and their Provider) will have 90 days to submit claims for themselves or any of their covered Dependents.
- **(3)** The last day of the calendar month in which the covered Member ceases to be in one of the eligible classes. This includes death or termination of Active Employment of the covered Member (see the section entitled COBRA Continuation Coverage). It also includes a Member on disability or Leave of Absence, unless the Plan specifically provides for continuation during these periods.

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

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

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

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor and amended from time to time if, in fact, FMLA is applicable to the Employer and all of its Members 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 Members. 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 Member had been continuously employed during the entire leave period. The covered Member will still be required to make any applicable contributions to maintain coverage under the Plan.

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

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

(1) The maximum period of coverage of a person under such an election shall be the lesser of:

  (a) The 24-month period beginning on the date on which the person's absence begins; or

  (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

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

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of

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

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

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

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Member coverage under the Plan terminates for any reason including death (see the section entitled COBRA Continuation Coverage).

(3) The date a covered Spouse loses coverage due to loss of dependency status, including legal separation.

(4) On the last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan.

(5) On the last day of the calendar month that any child of a Plan Participant ceases to be an alternate recipient under a qualified medical child support order and is not otherwise an eligible Dependent as defined by the Plan.

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

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

SCHEDULE OF BENEFITS
FOR THE
Public Education Health Trust - Plan F

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.

PREFERRED FACILITIES AND AETNA SIGNATURE ADMINISTRATORS™ NETWORK:

Public Education Health Trust has negotiated significant fee reductions for covered services with Aetna Signature Administrators™ Network facilities and other direct provider contracts.

Additional information about the Aetna Signature Administrators™ Network and other direct provider contracts along with a list of current facilities and providers, can be obtained by visiting the web site at www.aetna.com/asa or www.pehtak.com.

When services are provided, it is required that the Covered Person use Preferred Providers and Facilities or the Plan's allowable reimbursement will be payable up to 125% of the Medicare equivalent rate. Further benefit reductions may apply. See the specific benefit below.

- ***The Plan does not consider the Alaska Native Medical Center or its providers, Alaska Regional Hospital or its providers or the Sutter Health Network facilities and providers a Preferred Provider. The Plan's allowable reimbursement will be payable up to 125% of the Medicare equivalent rate.***

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

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

Under the following circumstances, the higher Preferred Provider payment will be made for certain Non-Preferred services subject to the Plan's Allowable Charge:

- If a Covered Person obtains services from the nearest Hospital where professional and necessary treatment can be provided due to a Medical Emergency, as defined by the Plan, charges will be paid at the Preferred Provider benefit level.

- If a Covered Person obtains services at a Non-Preferred Facility because the Preferred Facility is not accepting new patients or the nearest Preferred Facility cannot provide the level of care required, the

charges at the Non-Preferred Facility will be paid at the Preferred Facility benefit level if sufficient substantiating documentation is provided by the nearest Preferred Facility.

- If the Covered Person utilizes a Non-Preferred Provider or Facility that is more than 50 miles from a Preferred Provider of the same specialty, this facility or provider will not be subject to the Non-Preferred Provider penalty when determining reimbursement.

- Services protected under the No Surprises Act (NSA) as follows:

  - Non-emergency services rendered by a Non-Preferred Provider at a Preferred Facility:
    - Provided the Covered Person has not provided Notice and Consent; and
    - Including the furnishing of equipment/devices, labs, imaging, telehealth, pre-operative and post-operative services regardless of being physically located at the Preferred Facility.

  - Emergency Services.

  - Non-Preferred air ambulance services.

  The NSA also prohibits Non-Preferred Providers from pursuing payment from the Covered Person for the difference between the Allowable Charge and the Non-Preferred Provider's billed charge for services, except for any applicable cost-sharing

Notice and Consent.

Exceptions to the NSA balance billing protections may apply when the Covered Person receives non-emergency services (other than ancillary services) from a Non-Preferred Provider, and gives written consent to receive those services as Non-Preferred Provider benefits. Ancillary services include anesthesiology, pathology, radiology, neonatology, assistant surgeons, hospitalists, intensivists, and items and services related to emergency medicine.

Deductibles/Copayments/Coinsurance payable by Plan Participants, per Calendar Year

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

Each **January 1st**, a new deductible amount is required.

Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges.

The deductible **will not** apply to the Medical maximum out-of-pocket amount.

A **copayment** is the amount of money that is paid each time a particular service is used.

Coinsurance is the percentage amount remaining after the Plan pays the reimbursement rate as shown in the Schedule of Benefits and is the Covered Person's responsibility. Coinsurance does not apply to the deductible and does not include copayment amounts.

Coinsurance is payable by the Covered Person until the Medical maximum out-of-pocket amount, as shown in

the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for any charges which do not apply to the Medical maximum out-of-pocket amount) for the remainder of the Calendar Year.

Prescription Drug copayments/coinsurance **will not** apply to the deductible and **will not** apply to the Medical maximum out-of-pocket amount, but will apply to the Prescription maximum out-of-pocket amount.

Claims must be received by the Claims Administrator within **365 days** of the date charges for the services were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims received later than that date will be denied.

If the Member's coverage terminates due to the covered Member's participating Employer ceasing to have a valid participation agreement with the Public Education Health Trust, the covered Member (and their Providers) will have 90 days following the date of termination to submit claims for themselves or any of their covered Dependents.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a Claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

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

Deductibles	***Preferred Provider & Facilities***	***Non-Preferred Provider & Facilities***
Per Covered Person	$1,500 per Calendar Year	
Per Family Unit	$3,000 per Calendar Year	

Medical Maximum out-of-pocket amounts, per Calendar Year

Except for any charges which do not apply, the Plan will pay the percentage of Covered Charges designated in the Schedule of Benefits until the following Medical maximum out-of-pocket amounts 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.

Medical Maximum Out-of-Pocket Amounts, per Calendar Year	***Preferred Provider & Facilities***	***Non-Preferred Provider & Facilities***
Per Covered Person	$3,000	unlimited
Per Family Unit	$6,000	unlimited
The Preferred Provider and Non-Preferred Provider Medical maximum out-of-pocket amounts do not apply to each other.		
Charges for the following do not apply to the Medical maximum out-of-pocket amounts: • Amounts for Covered Charges in excess of the Allowable Charge • Deductibles • Non-Preferred Facility and Provider Penalty • Prescription Copayments/Coinsurance • Prescription maximum out-of-pocket amounts		

- Discounts, coupons, Pharmacy discount programs or similar arrangements provided by drug manufacturers or Pharmacies to assist in purchasing Prescription Drugs.
- Vision Service Plan Benefits

FOLLOWING ARE OTHER MAXIMUMS ON INDIVIDUAL BENEFITS
COVERED CHARGES

<table>
<tr><th></th><th><u>Preferred
Provider & Facilities</u></th><th><u>Non-Preferred
Provider & Facilities</u></th></tr>
<tr><td colspan="3">[1] The first six (combined) Preferred Provider Primary Care Visits in a Calendar Year (other than outpatient Mental Disorder or Substance Abuse treatment), including acupuncture, chiropractor, massage therapy, physical therapy, occupational therapy, and speech therapy are eligible for a $25 copayment. Charges for the Primary Care Visit only are subject to the $25 office visit copayment and the copayment does not apply to the Deductible; thereafter, Covered Charges are subject to Deductible and Coinsurance or as otherwise stated in this Schedule of Benefits (does not apply to Specialists).

Non-Preferred Providers are not eligible for the office visit copayment, and all covered charges are subject to the Non-Preferred Provider reimbursement rates. All charges in excess of the Allowable Charge, excluding contracted or negotiated rates, are ineligible under the Plan and may be the responsibility of the Covered Person.</td></tr>
<tr><td colspan="3">[2] The first six (combined) Physician outpatient visits for Mental Disorder or Substance Abuse treatment in a Calendar Year with a Preferred Provider Physician are eligible for a $25 copayment and the copayment does not apply to the Deductible; thereafter, Covered Charges are subject to Deductible and Coinsurance or as otherwise stated in this Schedule of Benefits.

Non-Preferred Providers are not eligible for the copayment, and all covered charges are subject to the Non-Preferred Provider reimbursement rates. All charges in excess of the Allowable Charge, excluding contracted or negotiated rates, are ineligible under the Plan and may be the responsibility of the Covered Person.</td></tr>
<tr><td>Acupuncture[1]
(See limitations under the Medical Benefits section)</td><td>$25 copayment first six combined visits; thereafter, 80% after deductible</td><td>Allowable amount up to 125% of Medicare equivalent rate, after deductible</td></tr>
<tr><td colspan="3">Ambulance Service</td></tr>
<tr><td>- Ground Ambulance</td><td colspan="2">80% after deductible</td></tr>
<tr><td>- Air Ambulance
Pre-Notification is strongly recommended for Air Ambulance service.</td><td colspan="2">Allowable amount up to 125% of Medicare equivalent rate unless otherwise negotiated,
no deductible applies</td></tr>
<tr><td colspan="3">When medical evacuation services are provided, the Member or Physician/Facility should contact CareLink.

<u>Please refer to Ambulance listed in the Medical Benefit Descriptions section for additional Air Ambulance details or call (800) 228-9118 (U.S. Only) or (614) 582-9254.</u></td></tr>
<tr><td>Ambulatory Surgery Facility Charges</td><td>80% after deductible</td><td>Allowable amount up to 125% of Medicare equivalent rate, after deductible</td></tr>
</table>

	Preferred Provider & Facilities	***Non-Preferred Provider & Facilities***
Audio Care (Hearing Aid) Benefit	80% after deductible	
	$2,500 per ear maximum every 36 months.	
Note: Please refer to the Aetna Signature Administrators® solution hearing discounts under the Audio Care benefit listed in the Medical Benefit Descriptions section on how to access these services.		
Chemotherapy or Radiation Treatment	80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
Coronary Artery Bypass Graft (CABG)	80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
When provided by Providence Alaska Medical Center (PAMC) and/or NorthStarr Cardiothoracic Surgery, LLC	100%, no deductible applies	
Note: Please refer to the Coronary Artery Bypass Graft (CABG) benefit listed in the Medical Benefit Descriptions section for additional details.		
Durable Medical Equipment	80% after deductible	
Emergency Room	80% after deductible	
Home Health Care	80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
Home Infusion Therapy	80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
Hospice Care	80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
Inpatient Hospital Services	80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
Inpatient Rehabilitation Therapy *(See limitations under the Medical Benefits section)*	80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
	Maximum Benefit 180 combined days per Calendar Year for Inpatient Rehabilitation Therapy and Skilled Nursing Facility	
Massage Therapy[1] *(See limitations under the Medical Benefits section)*	$25 copayment first six combined visits; thereafter, 80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
	Maximum Benefit 20 visits per Calendar Year	

	Preferred Provider & Facilities	***Non-Preferred Provider & Facilities***
Mental Disorders Treatment/Counseling		
- Inpatient services	80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
- Outpatient visits[2]	$25 copayment first six combined visits; thereafter, 80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
Occupational Therapy[1] *(See limitations under the Medical Benefits section)*	$25 copayment first six combined visits; thereafter, 80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
Organ Transplant Coverage *Pre-notification is required*	80% after deductible	Not Covered
Note: *Covered Organ Transplant procedures, including travel and lodging, will only apply when the transplant recipient is using an Institute of Excellence (IOE) transplant facility. *Refer to the separate Organ Transplant benefit listed under the Medical Benefit Descriptions section for more information including applicable benefit limitations and maximums, including travel and lodging expenses.* ***Please contact CareLink toll-free at (866) 894-1505 to pre-notify or for more information.***		
- Transplant Travel Expenses maximum	Limited to $7,500 for an approved transplant up to $250 per day maximum	Not Covered
Orthotics	80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
	Foot orthotics: Maximum Benefit 1 pair per Calendar Year.	
Outpatient Diagnostic X-ray and Lab Charges / Imaging Services (MRIs, CT scans and PET scans)	80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
Physical Therapy[1]	$25 copayment first six combined visits; thereafter, 80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
	See limitations under the Medical Benefits section	
Sword Health (Virtual Physical Care)	100%, no deductible applies	
Note: *Please refer to the "Virtual Visits" benefit listed in the Medical Benefit Descriptions section for information on how to access Sword Health services.*		

	Preferred Provider & Facilities	***Non-Preferred Provider & Facilities***
Physician Services		
- Inpatient - Office visit ○ Primary Care Visit[1]	80% after deductible $25 copayment first six combined visits; thereafter, 80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
○ Specialist	80% after deductible	
- Surgical services	80% after deductible	
- Second Opinions • Physician recommended: • Self-referral	 100%, no deductible 80% after deductible	
Pregnancy	Payable per normal Plan provisions	Allowable amount up to 125% of Medicare equivalent rate, after deductible
Routine prenatal office visits	100%, no deductible **OR** *If global maternity fee:* 40% of Covered Charges of the global maternity fee will be paid at 100%, no deductible; thereafter, 80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
Note: *Please refer to the Coverage of Pregnancy benefit listed in the Covered Charges of the Medical Benefit Descriptions section for more information regarding routine prenatal office visits.*		
Preventive Care	100%, no deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible

	Preferred Provider & Facilities	***Non-Preferred Provider & Facilities***

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

- https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results
- www.cdc.gov/vaccines/schedules/index.html (routine immunizations)
- wwwnc.cdc.gov/travel/destinations/list (travel immunizations)

Routine Well Care Services will include, but will not be limited to, the following routine services:
Office visits, routine physical exams, routine lab and x-ray services, immunizations, routine colonoscopy/ flexible sigmoidoscopy, routine well child care examinations, tobacco/nicotine cessation counseling, diabetes education, and other screenings.

A current list of U.S. Preventive Services Task Force (USPSTF) A and B Recommendations may be found at https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results
/. *Please note, all items listed may not be available until the next Plan Year that begins one year after the recommendation release date.*

Routine Well Care Services for men will include, but will not be limited to, the following routine services: Prostate screening.

Women's Preventive Services 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:

- https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results
- http://www.hrsa.gov/womens-guidelines

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)* preconception, screening for gestational diabetes in pregnant women, breastfeeding support, supplies, and counseling in conjunction with each birth.

Note: *Please refer to the Breast Pump benefit listed under the other medical services and supplies in the Medical Benefit Descriptions section for more information.*

	Preferred Provider & Facilities	***Non-Preferred Provider & Facilities***
Nutritional Education Counseling	100%, no deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
▪ Ages 6 through 17	Maximum Benefit 20 visits per Calendar Year	
▪ Ages 18 and over with a body mass index (BMI) of 30 kg/m^2 or higher)	Maximum Benefit 26 visits per Calendar Year	
Obesity Interventions • Ages 18 and over with a body mass index (BMI) of 30 kg/m^2 or higher)	100%, no deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
	Maximum Benefit 26 visits per Calendar Year	
Note: *Please refer to the Obesity Interventions benefit listed under the other medical services and supplies in the Medical Benefit Descriptions section for additional details.*		
Prosthetics	80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
Providence Express Care Clinics	$25 copayment	
Note: *Providence Express Care Clinics copayment will include the clinic charge only. All other Covered Charges will be payable per normal Plan provisions.*		
Renal Dialysis Services *(See additional information under the Medical Benefits section)*	Allowable amount up to 125% of Medicare equivalent rate after deductible	
Skilled Nursing Facility	80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
	Maximum Benefit 180 combined days per Calendar Year for Inpatient Rehabilitation Therapy and Skilled Nursing Facility	
Speech Therapy[1] *(See limitations under the Medical Benefits section)*	$25 copayment first six combined visits; thereafter, 80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
Spinal Manipulation / Chiropractic Services[1]	$25 copayment first six combined visits; thereafter, 80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
	Maximum Benefit 20 visits per Calendar Year	
Note: *Please refer to the Spinal Manipulation/Chiropractic Services benefit listed under the other medical services and supplies in the Medical Benefit Descriptions section for more information.*		

Substance Abuse Treatment		
- Inpatient services	80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
- Outpatient visits[2]	$25 copayment first six combined visits; thereafter, 80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
Surgical treatment for Obesity / Morbid Obesity	80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
Temporomandibular Joint (TMJ) and Myofascial Pain Dysfunction (MPD)	80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
Transcarent Surgery Benefit	100%, no deductible applies	Not Covered
- Per diem day 1 through 14 for Meals and incidentals per person	$45 per day	Not Covered
- Per diem day 15 or more for Meals and incidentals per person	$125 per week	Not Covered
- Recovery Benefit, Per Covered Person	$750 per incident	Not Covered
Note: Please refer to the Transcarent listed in the Medical Benefit Descriptions section for additional details.		
***mi*Choice Program**	100%, no deductible applies	Not Covered
Note: Elective surgeries that are not eligible with Transcarent Surgery Benefit maybe available under the *mi*Choice program. Please refer to *mi*Choice listed in the Medical Benefit Descriptions section for additional details.		
Urgent Care	Payable per normal Plan provisions	Payable per normal Plan provisions
Virtual Visits		
Providence Express Care Virtual	100% no deductible	
Teladoc Physician Consultations	100% no deductible	
Primary360/Virtual Mental Health (provided by Teladoc)	100% no deductible	
Sword Health (Virtual Physical Care)	100% no deductible	
All other providers	100% no deductible	Allowable amount up to 125% of Medicare equivalent rate, deductible waived
Note: *Please refer to the "Virtual Visits" benefit listed in the Medical Benefit Descriptions section for information on how to access Virtual Visit services.*		
Weight Management	80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible

Wig after Chemotherapy or Radiation Treatment	80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
	Maximum Benefit $300 per Calendar Year	
Well Newborn Nursery Care Limits	80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible
All Other Eligible Charges	80% after deductible	Allowable amount up to 125% of Medicare equivalent rate, after deductible

Vision services through VSP are for routine vision care. See an Aetna Signature Administrators provider for Medically Necessary vision care.

THIS IS ONLY A SUMMARY
VISION SERVICE PLAN CUSTOMER SERVICE (800) 877-7195
Web site at https://www.vsp.com/

VISION SERVICE PLAN BENEFITS

Public Education Health Trust has contracted with Vision Service Plan (VSP) to provide vision care services for you and your Dependents. Benefits are available for services as indicated by the reimbursement provisions below. Vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician; however, to receive the highest level of benefits services should be received from a VSP Provider.

YOUR COVERAGE WITH A VSP PROVIDER			
BENEFIT	**DESCRIPTION**	**COPAY**	
WELLVISION EXAM	Focus on your eyes and overall wellness	$0	Every Calendar Year
PRESCRIPTION GLASSES		$25	See below
Frames	• $225 allowance for a wide selection of frames • $245 allowance for featured frame brands • 20% savings on the amount over your allowance • $125 Costco and Walmart frame allowance	Included in Prescription Glasses copayment	Every other Calendar Year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses Polycarbonate lenses for Dependent children	Included in Prescription Glasses copayment	Every Calendar Year
Lens Enhancements	• Anti-reflective coating • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 35-40% on other lens enhancements	$0 $0 $80-$90 $120-$160	Every Calendar Year
Contacts (instead of glasses)	• $170 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every Calendar Year
ADDITIONAL PAIRS OF EYEWEAR			
Frames	• $225 allowance for a wide selection of frames • $245 allowance for featured frame brands • 20% savings on the amount over your allowance • $125 Costco and Walmart frame allowance	$25 for frame and lenses	Every other Calendar Year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses Polycarbonate lenses for Dependent children	Combined with frame copayment	Every Calendar Year
Contacts (instead of glasses)	• $170 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every Calendar Year

<table>
<tr><td rowspan="3">Extra Savings</td><td><u>Glasses and Sunglasses:</u>
Extra $20 to spend of featured frame brands. Go to vsp.com/special offers for details.
30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as the WellVision Exam or get 20% from any VSP provider within 12 months of your last WellVision Exam.</td></tr>
<tr><td><u>Retinol Screening:</u>
No more than a $29 copay for routine retinal screening as an enhancement to a WellVision Exam.</td></tr>
<tr><td><u>Laser Vision Correction:</u>
Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.
After surgery, use frame allowance (if eligible) for sunglasses from a VSP doctor.</td></tr>
<tr><td colspan="2">YOUR COVERAGE WITH AN OUT-OF-NETWORK PROVIDER</td></tr>
<tr><td colspan="2">Get the most out of your benefits and greater savings with a VSP network provider. Your coverage with out-of-network providers will be less or you'll receive a lower level of benefits. Visit VSP.com for Plan details.</td></tr>
<tr><td colspan="2">Exam – up to $50
Frame – up to $70
Single Vision Lenses - $50

Lined Bifocal Lenses – up to $75
Lined Trifocal Lenses – up to $100

Progressive Lenses – up to $75
Contacts – up to $105</td></tr>
<tr><td colspan="2">Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Alaska, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.</td></tr>
</table>

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria is satisfied and when prescribed by a vision provider. Prior review and approval by VSP is not required for a Covered Person to be eligible for necessary Contact Lenses.

When contact lenses are obtained, you are not eligible for lenses and frames again for one plan year.
Lens enhancements are not available from an out-of-network provider.

Additional Pairs of eyewear: A second pair enhancement allows you to get a second pair of glasses or contacts, subject to the same copays and frequencies as the first pair. There is no examination reimbursement on additional pairs.

Vision exam and material copayments will not apply to the Medical maximum out-of-pocket amount.

Mailing Address:
Vision Service Plan
P.O. Box 495918
Cincinnati, OH 45249-5918

ALTERNATIVE VISION BENEFIT

Alternative vision benefits are available to Covered Persons who are 50 miles or more from a VSP provider and have access to Prism Optical Traveling Eye Care providers (visit www.prismoptical.com for details).

Alternative vision benefits do not apply towards the medical deductible or medical maximum out-of-pocket amount and does not require a separate election.

VISION EXAM - Limited to once per Calendar Year	$0 copayment Benefits limited to $175
HARDWARE	
Eyeglasses	$25 copayment
Benefits are limited to the following per Calendar Year: Frames: $225 Lenses: $150 Progressive Lenses: $120 (above the Lenses benefit)	
Contacts (in lieu of glasses)	100%, no copayment applies
Benefits are limited to the following per Calendar Year: Fitting Exam $60 Contact Lenses $170	

<u>Out-of-Network, non-VSP Providers</u>:
If you wish to see an Out-of-Network provider, VSP will reimburse you up to the amount allowed under your plan's Coverage with Out-of-Network Providers. Be aware that your Out-of-Network provider reimbursement rate does not guarantee full payment, and VSP cannot guarantee patient satisfaction when your receive services from an Out-of-Network provider. Pay the entire bill when you see an Out-of-Network provider and gather the following information:

- The provider's bill, including a detailed list of the services you received
- The covered Member's ID number
- The covered Member's name, phone number and address
- The name of the organization that provides your VSP coverage
- Your name, date of birth, phone number and address
- Your relationship to the covered VSP Member (such as "self, spouse, child, etc.")

Claims must be filed with VSP within 365 days from the date of service.

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 495918
Cincinnati, OH 45249-5918

Exclusion and Limitations of Benefits:
Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. You may obtain details regarding frame brand availability from your VSP Provider or by calling VSP's Customer Care Division at (800) 877-7195.

This vision service plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following options, the Plan will pay the basic cost of the allowed lenses or frames, and you will be responsible for the options extra cost.

- Optional cosmetic processes.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Certain limitations on low vision care.

MEDICAL BENEFIT DESCRIPTIONS

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

Claims must be received by 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 received later than that date will be denied.

If the Member's coverage terminates due to the covered Member's participating Employer ceasing to have a valid participation agreement with the Public Education Health Trust, the covered Member (and their Providers) will have 90 days following the date of termination to submit claims for themselves or any of their covered Dependents.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a Claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

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

Before filing a lawsuit, the Claimant must exhaust all available levels of review as described in the Internal and External Review Procedures section, unless an exception under applicable law applies*. *A legal action to obtain benefits must be commenced within one year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.

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.

The deductible **will not** apply to the Medical maximum out-of-pocket amount.

Deductible for a Common Accident. This provision applies when two or more members 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 AND COINSURANCE

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person after the Covered Person has met his or her Calendar Year deductible and any coinsurance.

Benefit payment made by the Plan will be at the percentage rate shown in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

Once the Plan has made the applicable benefit payment, the remaining percentage owed is the Covered Person's "Coinsurance" responsibility. For example, if the Plan's reimbursement rate is 80%, the Covered

Person’s responsibility (or coinsurance) is 20%.

Coinsurance does not include any deductible or copayment amounts. Coinsurance will apply to the Medical maximum out-of-pocket amount.

MAXIMUM OUT-OF-POCKET AMOUNTS
Covered Charges are payable at the percentages shown each Calendar Year until the applicable Medical maximum out-of-pocket amount shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for any charges which do not apply to the Medical maximum out-of-pocket amount) for the rest of the Calendar Year.

When a Family Unit reaches the applicable Medical maximum out-of-pocket amount, Covered Charges for the Family Unit will be payable at 100% (except for any charges which do not apply to the Medical maximum out-of-pocket amount) for the rest of the Calendar Year.

MAXIMUM BENEFIT AMOUNT PER CALENDAR YEAR
The maximum benefit amount is the total amount of benefits that will be paid under the Plan for specific Covered Charges incurred by a Covered Person in a Calendar Year.

Dollar amounts listed as benefit maximums will accumulate across all Plans and benefit options offered under the Public Education Health Trust Employer Plans.

Day/visit limits listed under this Plan are a one-sum amount applicable to each individual regardless of the number of Public Education Health Trust Employer Plans that an individual may be a participant of.

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 payable at the average private room rate of that facility.

(2) **Coverage of Pregnancy**. The Allowable Charges for the care and treatment of Pregnancy are covered the same as any other Illness *and will be payable as stated in the Schedule of Benefits*.

Note: **Routine prenatal office visits** are payable as stated under the Pregnancy benefit as shown in the Schedule of Benefits section.

The following services will continue to be payable per normal Plan provisions:

Pregnancy-related ultrasounds, lab screenings (not otherwise specified), Complications of

Pregnancy (as defined under this Plan), delivery, and post-partum care.

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).

Maternity Management Program

The Maternity Management Program is an educational and empowerment program for eligible female Covered Persons.

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

A 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 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.

Maternity Management Program Notification:* *The Covered Person needs to notify CareLink during the first trimester of her Pregnancy.

The Covered Person will receive $100 from the Public Education Health Trust after satisfying all requirements.

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

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

(b) The confinement starts within five days of a Hospital-confinement;

(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 subject to the limits as stated in the Schedule of Benefits.

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

(a) Charges for multiple surgical procedures will be a Covered Charge subject to the following provisions:

(i) If multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Allowable Charge for the primary procedures; 50% of the Allowable Charge will be allowed for each additional procedure performed during the same operative session (with the exception of endoscopy with colonoscopy or multiple lesion/mole removals). Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

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

(iii) If bilateral surgical procedures are performed by one or more surgeons during the same operative session, benefits will be determined based on 150% of the Allowable Charge for the procedure unless the actual charge for both sides is less than this amount.

(iv) If multiple and bilateral surgical procedures are performed during the same operative session, and both the bilateral and surgical procedures are subjected to multiple procedure reduction; the bilateral adjustment will be applied first per item (iii) above.

The surgical procedure with the highest allowable reimbursement, after the bilateral adjustment, and any other surgical procedures will be reimbursed per items (i) and (ii) above accordingly.

(v) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 25% of the surgeon's Allowable Charge.

(b) Charges for anesthesia will be a Covered Charge subject to the following provisions:

(i) If anesthesia services are performed by one Physician, benefits will be determined based on the Allowable Charge that is allowed for the primary procedure(s).

(ii) If additional anesthesia services are performed by one Physician and one Certified Registered Nurse Anesthetists (CRNA) with medical direction, benefits will be determined based on 50% of the Allowable Charge for the Physician and 50% of the Allowable Charge for the CRNA.

(iii) If anesthesia services are performed by one CRNA only or no Physician services have been received, benefits will be determined based on the Allowable Charge

that is allowed for the primary procedure(s).

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

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

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

(6) **Home Health Care Services and Supplies**. Charges for home health care services and supplies are covered only for care and treatment of an Injury or Illness. 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 are payable as described in the Schedule of Benefits.

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

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

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

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

(a) **Acupuncture.** Charges by a Physician for acupuncture when deemed Medically Necessary, including but not limited to the following conditions:

- Acupuncture in lieu of other anesthesia for a surgical or dental procedure covered under this Plan.
- Chronic back pain (maintenance treatment is not covered)
- Headaches
- Pain due to osteoarthritis of the knee or hip
- Postoperative and chemotherapy and/or radiotherapy related nausea and vomiting
- Postoperative dental pain
- Pregnancy related nausea
- Temporomandibular disorders

In addition to the above list of covered conditions the Public Education Health Trust has adopted Category 1, of a list of diseases, symptoms or conditions for which acupuncture has been proven-through controlled trials to be an effective treatment.

- Allergic rhinitis (including hay fever)
- Biliary colic
- Depression (including depressive neurosis and depression following stroke)
- Dysentery, acute bacillary
- Dysmenorrhea, primary
- Epigastralgia, acute (in peptic ulcer, acute and chronic gastritis, and gastrospasm)
- Facial pain (including craniomandibular disorders)
- Hypertension, essential
- Hypotension, primary
- Induction of labor
- Leukopenia
- Low back pain
- Malposition of fetus, correction of
- Neck pain
- Periarthritis of shoulder
- Postoperative pain
- Renal colic
- Rheumatoid arthritis
- Sciatica
- Sprain
- Stroke
- Tennis elbow

The list can be found in the *Acupuncture: Review and Analysis of Reports on Controlled Clinical Trials*, a publication of the *World Health Organization (WHO)* or at http://apps.who.int/medicinedocs/pdf/s4926e/s4926e.pdf. *Coverage is subject to the terms and conditions, limitations and exclusions of the Plan at the time services are provided.* Acupuncture that may not otherwise be covered under this benefit may be allowed at the sole discretion of the Plan Administrator or its designee, if deemed Medically Necessary or if a significant loss of improvement in the Covered Persons condition would result without additional visits.

(b) **Ambulance**. Local Medically Necessary professional land or air ambulance service. A charge for this item will be a Covered Charge 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.

When deemed Medically Necessary, this Plan will provide benefits for return transportation for the Covered Person by professional land or air ambulance service to their home of record.

Pre-notification of services by the Plan Participant, Physician, or facility, for air ambulance (and air facility to facility transportation) services is strongly recommended. Pre-notification of services should occur at the earliest available opportunity prior to the initiation of transportation.

For pre-notification of services, call (800) 228-9118.

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

(d) **Audio Care** (Hearing Aid) Charges by a Physician for any audiometric examination. Audiometric examination means subjective tests by which a Physician determines which make and model of hearing aid will best compensate for the Covered Person's loss of hearing. A follow-up visit, subsequent to obtaining the hearing aid, will be considered a Covered Charge.

Benefit includes Covered Charges for:

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

The following supplies and services are not covered by this benefit:

- Replacement of a hearing aid for any reason more often than as stated in the Schedule of Benefits;
- Batteries or other ancillary equipment other than that obtained upon purchase of the hearing aid; and
- Repairs, servicing or alteration of hearing aid equipment.

AETNA SIGNATURE ADMINISTRATORS® SOLUTION HEARING DISCOUNTS

Aetna Signature Administrators® solution hearing discounts is a program designed to assist Covered Persons to save on hearing aids, exams, and follow-up services.

Call (866) 344-7756 (Hearing Care Solutions)
or (877) 301-0840 (Amplifon Hearing Health Care, formerly HearPO®)
or
http://www.aetna.com/docfind/cms/assets/pdf/Great_Savings_on_Hearing_Aids.pdf

(e) **Breast pump, breast pump supplies, lactation support and counseling.**

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.

Unless purchased through the Providence Maternity Boutique, coverage of breast pumps is limited to $325. Members must submit a claim form and proof of purchase for reimbursement. If purchased through Providence Maternity Boutique, the Trust will provide a certificate for coverage.

The Claims Administrator will require the following documentation: claim form with proof of

purchase, which includes purchase price and item description.

A standard electric breast pump for initiation of breastfeeding may be bought rather than rented, with the rental cost not to exceed the limit of the actual purchase price.

Please contact the Plan Administrator for additional assistance.

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 Medically Necessary or 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 will be covered with each subsequent pregnancy.

Replacement of a standard electric breast pump may be covered up to once every 36 months if associated with a subsequent pregnancy.

Lactation support and counseling
Covered Charges include inpatient and outpatient comprehensive prenatal and postnatal lactation support and counseling for female Covered Persons for the duration of the breastfeeding. Services must be rendered by a Physician acting within the scope of their license or certification under applicable State law.

(f) **Cardiac rehabilitation** deemed Medically Necessary, provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion, coronary bypass surgery, or other cardiac condition; (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) **Chemotherapy or radiation 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* must include the Covered Person's Plan of Care and treatment protocol. Pre-notification of services should occur at least 15 days prior to the initiation of treatment.

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

Toll Free in the United States: (866) 894-1505

A pre-notification of services by CareLink is not a determination by the Plan that claims will be paid. All claims are subject to the provisions of the Plan, including but not limited to Medical Necessity, Exclusions and limitations in effect when charges are incurred. See Plan provisions for Care Management services for additional details. 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 determination cannot be appealed

under the Plan's Internal and External Claims Review Procedures.

(h) **Clinical Trials.** Covered Charges will include only those 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 Institutes of Health (NIH) maintained web site 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 or its designee 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) **Coronary Artery Bypass Graft (CABG).** Medically Necessary charges incurred for the care and treatment due to a coronary artery bypass graft.

Coronary Artery Bypass Graft (CABG) services when provided by Providence Alaska Medical Center (PAMC) and/or NorthStarr Cardiothoracic Surgery, LLC will be a bundled episode payment which will include the following Covered Charges during the

Episode Period:

- An index procedure of Coronary Artery Bypass Graft (CABG) surgery.
- Routine care appropriate to the index procedure during the Episode Period.
- Treatment of complications related to the index procedure arising during the stay or during the Episode Warranty Period following the inpatient discharge, including readmissions and revision procedures because of complications associated with the original procedure.

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

(k) **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. Contraceptive medications including Physician-prescribed over-the-counter (OTC) contraceptives for female Covered Persons, when prescribed by a Physician, are covered under the Prescription Drug Benefit of this Plan.

Complications arising in connection with any contraceptive method, other than follow-up and management of side effects, counseling for continued adherence, and device removal will be payable per normal Plan provisions.

(l) **Diabetes Education.** Outpatient self-management training and education for the treatment of diabetes, provided by a licensed health care professional with expertise in diabetes.

(m) **Durable Medical Equipment**. Rental of durable medical or surgical equipment if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator. Medically Necessary Durable Medical Equipment will be allowed for the first three months; after which claims will be reviewed for continued Medical Necessity.

NOTE: Blood Glucose Monitors are eligible under both Medical Benefits and Prescription Drug Benefits, when deemed Medically Necessary. The test strips are only eligible under the Prescription Drug Benefits when the blood glucose monitor's test strips communicate directly with the insulin pump or are available on the Premium Formulary.

(n) **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.

(o) **Laboratory studies.** Covered Charges for diagnostic lab testing and services, excluding shipping and handling charges.

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

(q) **Massage Therapy**. Massage therapy for a documented physical impairment, functional limitation or disability due to disease, trauma, or abnormal congenital condition, by a Physician or massage therapist up to the Calendar Year maximum stated in the Schedule of Benefits.

Massage therapists must:

- Have the appropriate certification and/or State Occupational Licensure for the state in which the massage therapy services are rendered; and,
- Bill his or her services through a Physician's office, when there is no State Occupational Licensure for a massage therapist in the state where services are rendered.

When a Physician's office is not available within 50 miles, a traveling massage therapist meeting the criteria above may provide services even when not provided in the Physician's office.

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

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

Note: *Counseling and other services are also available for Members and their families at no cost through the SupportLinc Member Assistance Program (MAP), which provides confidential assistance when needing help dealing with problems and managing change.*

Please contact SupportLinc MAP for all mental health and substance abuse services at (888) 881-LINC (5462). Information can also be found on the Public Education Health Trust Web site at http://www.pehtak.com.-

(s) ***mi*Choice Program.** This Plan is designed to provide a broad range of coverage and to reduce the overall cost and increase the quality of health care to both the Plan and to the Covered Persons under this Plan. The *mi*Choice Program is a decision-making tool to assist Covered Persons in making better choices for select inpatient and outpatient services. The success of this program will be achieved through the proper engagement of Covered Persons.

To receive the *mi*Choice Program benefit, a Covered Person must contact a *mi*Choice Healthcare Navigator prior to treatment and must utilize a *mi*Choice recommended facility for the proposed treatment.

Utilizing the *mi*Choice Program

A Covered Person whose Physician has recommended an inpatient or outpatient service should contact the *mi*Choice Healthcare Navigator toll-free at (866) 326-7340 to discuss the *mi*Choice Program services available.

A *mi*Choice Healthcare Navigator will assist the Covered Person by providing cost and quality information for recommended facilities available so that the Covered Person can make an informed decision and utilize a recommended facility when his or her procedure is performed.

If a *mi*Choice recommended facility is chosen the following benefits are also available in conjunction with the procedure:

1. Round trip air (coach) transportation for the Covered Person and one companion between the Covered Person's residence and the *mi*Choice facility where treatment will be performed and hotel accommodations near the facility.
   Air transportation and lodging must be coordinated in advance through the *mi*Choice Healthcare Navigator to be eligible for reimbursement.

2. 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.

3. A $750 recovery benefit to offset other expenses related to medical travel is available to the covered Employee when the covered Employee or any covered Dependent participates in the *mi*Choice Program.

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

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

2. Emergency repair due to Injury to sound natural teeth. This repair must be started within 12 months from the date of an accident.

3. Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

4. Excision of benign bony growths of the jaw and hard palate.

5. External incision and drainage of cellulitis.

6. Incision of sensory sinuses, salivary glands or ducts.

7. Removal of impacted teeth by an oral surgeon or Physician.

8. Dental treatment related to a congenital medical condition.

9. Medically Necessary Orthognathic Surgery and associated Hospital or facility charges. Orthognathic surgery is surgery to correct the position of the jaws in relation to each other. *Orthognathic surgery for cosmetic purposes is not covered under the Plan.*

Benefits will be provided for the following Medically Necessary indications:

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

2. Medically Necessary bone grafts where there is a lack of adequate maxillary or mandibular bone depth or thickness sufficient to securely integrate with a root-like implant to support the mechanical stress of chewing.

3. Medically Necessary extractions (removal of teeth) due to radiation and heart disease. This service includes local anesthesia, routine post-operative care, and associated implants or dentures.

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

a. The general anesthesia must be administered by an anesthesiologist, a certified Registered Nurse anesthetist, or another licensed health care professional, not the attending dental provider.

b. The Covered Person's mental or physical condition prohibits the service being done in an office setting. The determination will be based on medical necessity and include at least one of the following:

    i. A covered Dependent child five years of age or under; or

ii. A medical or mental condition that requires monitoring during dental procedures such as, but not limited to:

    1. Coronary disease;
    2. Asthma;
    3. Chronic Obstructive Pulmonary Disease (COPD);
    4. Heart Failure; or
    5. Developmental disability; or

iii. When Medically Necessary for complex oral surgical procedures with a greater than average incidence of life threatening complications, such as excessive bleeding or airway obstruction; or

iv. When non-dental systemic conditions for which the Covered Person is under current medical management (verified by appropriate medical documentation) and which currently are not in optimal control and, therefore, may increase the risk of serious complications; or

v. When there is removal of impacted teeth; or

vi. When there is extraction of five or more teeth on the same day; or

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

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease, and preparing the mouth for the fitting of or continued use of dentures, unless specifically stated as a Covered Charge under this Medical Benefit Descriptions section.

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

- Emergency "pain management" for dental purposes will be paid under the Medical Benefits of this Plan.
- Emergency "dental treatment" (extraction, abscess drainage, etc.) will be paid under the Dental Plan, if elected.

(u) **Nutritional Education Counseling.** Care, treatment, and services when provided by health care provider acting within the scope of his or her license. Nutritional education counseling benefits are limited to the Calendar Year visit maximum shown in the Schedule of Benefits. A visit for nutritional education counseling is considered care and treatment provided at a Hospital or Physician's office.

This benefit will not include nutritional supplements, gym memberships, or dues for participation in weight loss programs (e.g., Weight Watchers, Jenny Craig, etc.) *whether or not prescribed by a Physician.*

(v) **Obesity Interventions.** This benefit is being provided consistent with the Affordable Care Act preventive services requirement. Covered Charges include Physician-directed intensive, multicomponent behavioral interventions for weight management for Covered Persons age 18 and older with a body mass index (BMI) of 30 kg/m^2 or higher.

Intensive, multicomponent behavioral interventions for weight management will include:

- Group and individual sessions of high intensity *(up to the limits as shown in the Schedule of Benefits section)* encompassing the following:
  - Behavioral management activities such as setting weight loss goals
  - Improving diet or nutrition and increasing physical activity
  - Addressing barriers to change
  - Self-monitoring
  - Strategizing how to maintain lifestyle changes

Non-surgical care and treatment **will not** be a covered benefit except as may be specifically described as a benefit by this Plan.

Surgical treatment for Obesity/Morbid Obesity is covered under the "Surgical treatment for Obesity/Morbid Obesity" benefit.

This benefit ***will not*** *include* nutritional supplements, gym memberships, or dues for participation in weight loss programs (e.g., Weight Watchers, Jenny Craig, etc.) whether or not prescribed by a Physician.

(w) **Occupational therapy** by a health care provider acting within the scope of his or her license up to an Episode of Care maximum. Ongoing therapy must be ordered by a Physician, result from an Injury or Illness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy, or supplies used in occupational therapy.

The Plan will require a documented Plan of Care for service in excess of 20 visits. Once the Episode of Care maximum has been met or the Covered Person has reached any additional approved visit maximum established, no additional occupational therapy benefits will be provided for that condition.

Pre-notification of services, by the Plan Participant, for occupational therapy services in excess of 20 visits is strongly recommended. The pre-notification request to the Claims Administrator must include the Covered Person's Plan of Care.

Occupational therapy that may not otherwise be covered under this benefit may be allowed at the sole discretion of the Plan Administrator or its designee if deemed Medically Necessary or if a significant loss of improvement in the Covered Person's condition would result without additional visits such as but not limited to the case of neurological disease or neurological injuries (e.g., Parkinson's disease, cerebral palsy, multiple sclerosis, or cerebral vascular accident/incident).

(x) **Organ transplant.** Medically Necessary charges incurred for the care and treatment due to an organ or tissue transplant that is not considered Experimental or Investigational.

Institute of Excellence (IOE)
This is a facility that is contracted with Aetna to furnish particular services and supplies to you in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE.

Transplant Expenses

Once it has been determined that you or one of your dependents may require an organ transplant, you, or your physician should call CareLink pre-notification department to discuss coordination of your transplant care. In addition, you must follow any pre-notification requirements. Organ means solid organ; stem cell; bone marrow; and tissue.

Expenses listed below are payable only within the Institute of Excellence (IOE) network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure you require. A transplant will be covered only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any treatment or service related to a transplant that is provided by a facility that is not specified as an IOE network facility, even if the facility is considered as a Preferred Facility for other types of services, will not be covered. Please read each section carefully.

Covered Transplant Expenses

Covered transplant expenses include the following:

- Charges for activating the donor search process with national registries.

- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your biological parent, sibling, or child.

- Inpatient and outpatient expenses directly related to a transplant.

- Charges made by a **Physician** or transplant team.

- Charges made by a **Hospital**, Ambulatory facility or **Physician** for the medical and surgical expenses of a live donor, when the recipient is covered under this plan, and only to the extent not covered by another plan or program.

- Related supplies and services provided by the **IOE** facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

Covered transplant expenses are typically incurred during the four phases of transplant care

described below. Expenses incurred for one transplant during these four phases of care will be considered one Transplant Occurrence.

A "**Transplant Occurrence"** is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date you are discharged from the **Hospital** or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

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

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

2. Pre-transplant/Candidacy Screening: Includes human leukocyte antigen (HLA) typing/compatibility testing of prospective organ donors who are immediate family members.

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

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

For the purposes of this section, the following will be considered to be one Transplant Occurrence:

- Heart
- Lung
- Heart/ Lung
- Simultaneous Pancreas Kidney (SPK)
- Pancreas
- Kidney
- Liver
- Intestine
- Bone Marrow/Stem Cell transplant
- Multiple organs replaced during one transplant surgery
- Tandem transplants (Stem Cell)
- Sequential transplants
- Re-transplant of same organ type within 180 days of the first transplant
- Any other single organ transplant, unless otherwise excluded under the Plan

The following will be considered to be more than one Transplant Occurrence:

- Autologous Blood/Bone Marrow transplant followed by Allogenic Blood/Bone Marrow transplant (when not part of a tandem transplant)
- Allogenic Blood/Bone Marrow transplant followed by an Autologous Blood/Bone Marrow transplant (when not part of a tandem transplant)
- Re-transplant after 180 days of the first transplant
- Pancreas transplant following a kidney transplant
- A transplant necessitated by an additional organ failure during the original transplant surgery/process.
- More than one transplant when not performed as part of a planned tandem or sequential transplant (e.g., a liver transplant with subsequent heart transplant).

Limitations

The transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient Transplant Occurrence.
- Services and supplies furnished to a donor when recipient is not a Covered Person.
- Home infusion therapy after the Transplant Occurrence.
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing Illness.
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing Illness.
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the Plan Administrator or its designee.

Transplant Travel Expenses

Transplant travel expenses are available if the Covered Person is receiving an approved organ transplant and he or she normally resides more than 50 miles from the transplant facility, the Plan will pay for the following services incurred during the transplant benefit period subject to the maximum benefit as specifically stated in the Schedule of Benefits.

A. Transportation expenses related to actual travel, to and from the facility or for the following individuals:

   - The Covered Person; and
   - One adult to accompany the Covered Person.
   - Transportation expenses include commercial transportation (coach class only).

B. Reasonable lodging and meal expenses incurred for the Covered Person, and one adult companion who is accompanying the Covered Person, only while the Covered Person is receiving transplant-related services at a facility up to the maximum benefit per day as stated in the Schedule of Benefits.

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.

(y) **Orthotics.** 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 Illness. Replacement orthotic appliances will not be allowed unless the current appliance is not functional.

Note: Foot orthotics are subject to the limits as stated in the Schedule of Benefits.

(z) **Physical therapy** by a health care provider acting within the scope of his or her license.

The ongoing therapy must be deemed Medically Necessary, non-maintenance care with regard to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

The Plan will require a documented Plan of Care for services in excess of 20 visits. Once the Episode of Care maximum has been met or the Covered Person has reached any additional approved visit maximum established, no additional physical therapy benefits will be provided for that condition.

Pre-notification of services, by the Plan Participant, for physical therapy services in excess of 20 visits is strongly recommended. The pre-notification request to the Claims Administrator must include the Covered Person's Plan of Care.

Physical therapy that may not otherwise be covered under this benefit may be allowed at the sole discretion of the Plan Administrator or its designee if deemed Medically Necessary or if a significant loss of improvement in the Covered Persons condition would result without additional visits such as but not limited to the case of neurological disease or neurological injuries (e.g., Parkinson's disease, cerebral palsy, multiple sclerosis, or cerebral vascular accident/incident).

Physical Care Program (virtual)
Public Education Health Trust has contracted with Transcarent to give members access to SWORD, a virtual physical care program to treat back, joint and muscle pain.

The program is available to Covered Persons age 18+. Pre-approval is not required. Covered services include all program and digital therapy kit costs. There is no limit to the number of conditions treated with virtual physical care.

To get started, visit join.swordhealth.com/PEHT/guide and schedule a video call with a physical therapist. Your dedicated physical therapist will design a personalized exercise program for you to do at home. You will receive a digital therapy kit that includes a complimentary tablet and motion sensors to guide and track your movement. Your physical

therapist monitors your exercise session results and provides you feedback to achieve your goals.

(aa) **PKU Dietary Formula**. Dietary formula which is Medically Necessary for the treatment of phenylketonuria (PKU), not to exceed an order for five cases in any calendar month. If more than five cases are required for use in any Calendar month, benefits will be provided for the additional formula once deemed Medically Necessary.

(bb) **Prescription** Drugs (as defined).

Note: *Please refer to the Specialty Medication Benefits section of this booklet for additional information regarding outpatient and Pharmacy specialty medications.*

(cc) Routine **Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

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

(ee) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

Pre-notification of services, by the Plan Participant, for reconstructive surgery is strongly recommended. The pre-notification request to the Claims Administrator must include the Covered Person's Plan of Care.

This abnormal congenital conditions coverage will include reimbursement for:

(i) Surgical care and treatment for an abnormal congenital condition which is:

(a) Present at the time of birth; or
(b) May not be known at birth but is diagnosed after developmentally appropriate milestones have not been met; or
(c) The abnormal congenital condition symptoms become present.

(ii) Surgery must be Medically Necessary to restore function or appearance related to the abnormal congenital condition.

(iii) Care and treatment will be subject to the terms and conditions, limitations, and exclusions of the Plan at the time services are provided.

Examples of an abnormal congenital condition are cleft lip or palate, club foot, septal defect of heart, undescended testicle, and arteriovenous malformation.

Mammoplasty coverage will include reimbursement for:

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

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

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

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

(ff) **Rehabilitation therapy**. Services must be Medically Necessary to restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an accidental Injury, Illness, or surgery.

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

(gg) **Renal Dialysis Services**. Renal dialysis visits are paid as stated in Schedule of Benefits.

For renal dialysis treatments associated with an inpatient hospitalization, the Plan Administrator has the discretionary authority to negotiate a contract rate or other discounting arrangement on the entire inpatient claim.

Renal dialysis visits shall include dialysis, facility services, supplies, and medications provided during treatment. Laboratory testing and Physician visits will be payable per normal Plan provisions.

Medicare Part B Coverage
For additional coverage options under the Medicare program, visit www.medicare.gov or call toll-free (800)-MEDICARE ((800) 633-4227). For more information on Medicare Part B premiums, visit www.socialsecurity.gov, the local Social Security office or call Social Security at (800) 772-1213.

Once eligible for Medicare, this plan is only primary for 30 months. Please see the Coordination With Medicare section found in the *Coordination of Benefits* section for more information.

(hh) **SAD Lights.** Seasonal Affective Disorder (SAD) lights, when deemed Medically Necessary.

(ii) **Speech therapy** by a health care provider acting within the scope of his or her license. Therapy must be ordered by a Physician and follow either:

- Surgery for correction of a congenital condition of the oral cavity, throat or nasal complex of a person;

- An Injury; or
- An Illness. This may include, but is not limited to, Dyslexia, Autism Spectrum Disorders/Pervasive Developmental Disorders, or a developmental delay which is a consequence of a temporary Illness or trauma.

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

(jj) **Spinal Manipulation/Chiropractic services** by a health care provider acting within the scope of his or her license, will be payable up to the Calendar Year maximum as stated in the Schedule of Benefits.

Once the Calendar Year maximum has been met or the eligible Covered Person has reached any approved visit maximum established, no additional spinal manipulation/chiropractic service benefits will be provided.

(kk) **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.*

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

(mm) **Surgical treatment for Obesity/Morbid Obesity**. Coverage includes Medically Necessary surgical charges for Morbid Obesity, as defined by this Plan, (including complications) as stated in the Schedule of Benefits.

The measurement of Body Mass Index (BMI) of 40+ as defined under this Plan or a BMI of 35 or greater with any co-morbid conditions that are expected to improve, reverse, or be limited by this surgical treatment and which must be documented in a record or letter of medical necessity must demonstrate the diagnosis of Morbid Obesity.

A pre-notification of services, by the Plan Participant is strongly recommended for either inpatient or outpatient surgical procedures and will require the following documentation including, but not limited to, a written treatment plan or Plan of Care by the attending Physician and documentation that all required medical criteria in advance of any surgical treatment has been met. Please contact the Claims Administrator for further information regarding pre-notification procedures and requirements.

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 charges are incurred. 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 determination cannot be appealed under the Plan's Internal and External Claims Review Procedures.

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

(oo) **Tobacco/Nicotine cessation counseling.** Care and treatment for tobacco/nicotine cessation counseling as described in the Preventive Care section in the Schedule of Benefits. *Physician-prescribed tobacco/nicotine cessation products and medications are covered under the Prescription Drug Benefits of this Plan. Reference the Prescription Drug Benefits section of this Plan document to understand limitations and eligibility criteria.*

(pp) **Transcarent Surgery Benefit**

Public Education Health Trust has contracted with Transcarent to provide *Transcarent Surgery Benefit* when a Covered Person's treating physicians recommends certain covered medical procedures ("Covered Services") and they elect to receive treatment at certain medical providers participating in the Transcarent Network ("Providers").

The Covered Person's request must be pre-approved before benefits are payable. 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
- Laparoscopic Prostate Surgery
- Shoulder Reconstruction and Other Major Orthopedic Procedures
- Spinal Fusion and Spinal Decompression
- Tumor Treatment via CyberKnife
- Weight-Loss Surgery

Covered services include all medical costs incurred under the *Transcarent Surgery Benefit* will be payable as stated in the Schedule of Benefits, as well as:

1. 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 Transcarent.

2. 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 Transcarent at initiation of the travel associated with such treatment up to the limits stated in the Schedule of

Benefits.

3. A travel benefit, payable by Transcarent to the Covered Person to offset other expenses related to medical travel as stated in the Schedule of Benefits.

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

The Public Education Health Trust shall remain responsible for *Transcarent 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:

1. Transcarent 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. Transcarent does not provide any medical care or medical advice and does not evaluate or recommend any medical Providers or procedure.

2. The non-medical benefits provided under the Transcarent 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. Transcarent will provide appropriate documentation for benefits paid under the Transcarent Surgery Benefit.

3. The Transcarent 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 benefit shall be determined on a case-by-case basis in conjunction with Transcarent, the treating provider, and the Covered Person. The Plan's determination to provide the benefit in one instance shall not obligate the Plan to provide the same or similar alternative benefit 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.

Transcarent can be contacted at (855) 265-2874 or visit their Web site at **www.Transcarent.com**. Important Note: Public Education Health Trust's unique access code is **TVIBF**. This code will be needed to register and/or log into your account.

(qq) Transportation.

Emergency Transportation

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.

This Plan will provide benefits for return transportation for the Covered Person by commercial airline (coach class only) or ferry to their home of record if previously transported by an air ambulance to the nearest Hospital where professional treatment could be obtained.

This Plan will provide benefits for round trip transportation by commercial airline (coach class only) or ferry for the parent or Legal Guardian of a Covered Person who is a child under 18 years of age and is transported by an air ambulance to the nearest Hospital where professional treatment could be obtained.

Please refer to Ambulance listed in the Medical Benefit Descriptions section for additional Air Ambulance details or call (800) 228-9118.

Non-Emergency Transportation

All non-emergency travel must be pre-approved.

Benefits for non-emergency medical travel may be payable for transportation by commercial airline (**coach class only, with at least a 14-day advanced fare**) or ferry from the place where the Illness or Injury occurred to the nearest area where necessary professional treatment can be obtained unless the Plan Administrator finds a longer trip is necessary. For reimbursement consideration, commercial airline flights may only be scheduled for departure two days in advance of the first appointment or two days after the last appointment related to the condition being treated. Consideration for additional days may be given upon approval by the Plan Administrator.

All non-emergency commercial travel must be pre-approved by the Plan Administrator using the "Public Education Health Trust Non-Emergency Medical Travel Request Form" or no benefits will be provided.

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

This Plan will provide benefits for return transportation for the parent or Legal Guardian of a Covered Person who is a child under 18 years of age or the Spouse by commercial airline (coach class only) or ferry to their home of record if previously transported by an air ambulance to the nearest Hospital where professional treatment could be obtained.

Pre-notification of this return transportation will not be required.

The *Public Education Health Trust Non-Emergency Medical Travel Request Form* is available from **http://www.pehtak.com** and upon approval the Plan Administrator will provide the *Public Education Health Trust Non-Emergency Medical Travel Completed Form* to the Plan Participant for their Physician to complete.

If a Covered Person requires transportation as outlined above, the Physician must provide written certification and detailed medical documentation of the existing condition in

advance of the trip. The Plan Administrator will then determine how much of the transportation charges, if any, are eligible for coverage under the Plan.

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

Non-emergency transportation charges will only be allowed for a patient who is a Covered Person, except for the following circumstances:

- If the patient is a Covered Person under 18 years of age, then the transportation charges of a parent or Legal Guardian accompanying the covered child will also be allowed; or

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

After the travel has occurred, a "Public Education Health Trust Non-Emergency Medical Travel Completed Form," must be submitted with the boarding passes and signed off by the attending Physician or no benefits will be provided.

(rr) **Virtual Visits.** 24/7 Physician consultations, which provide access to licensed, U.S.-based Physicians by phone, secure e-mail, video and mobile app at any time of the day. Physicians offer diagnoses, medical advice, treatment recommendations and can even prescribe medications over the phone.

Plan Participants may use any of the following services:

Providence Express Care Virtual: Visit https://www.providence.org/our-services/urgent-care

Teladoc Physician Consultations: Call (800) 835-2362 or visit www.Teladoc.com.

Telehealth services not incurred through Providence Express Care Virtual or Teladoc Physician Consultations will be a Covered Charge subject to the same deductible, copayment, or coinsurance requirements that apply to comparable health services provided in person.

Teladoc is now offering **Primary360/Virtual Mental Health**, a convenient way to access virtual primary care and annual checkups so you can become your healthiest self. This program offers:

- Annual checkups and wellness by phone or video.
- Dedicated time with your doctors to talk through your medical history, challenges, and needs.
- A personalized Care Plan so you can beat your health goals.
- Referrals, prescriptions and lab orders as needed.

Physical Care Program (virtual)
Public Education Health Trust has contracted with Transcarent to give members access to SWORD, a virtual physical care program to treat back, joint and muscle pain.

The program is available to Covered Persons age 18+. Pre-approval is not required. Covered services include all program and digital therapy kit costs. There is no limit to the number of conditions treated with virtual physical care.

To get started, visit join.swordhealth.com/PEHT/guide and schedule a video call with a physical therapist. Your dedicated physical therapist will design a personalized exercise program for you to do at home. You will receive a digital therapy kit that includes a complimentary tablet and motion sensors to guide and track your movement. Your physical therapist monitors your exercise session results and provides you feedback to achieve your goals.

(ss) **Weight management.** Coverage includes non-surgical Physician-directed care and treatment for weight management, nutritional instruction, or dietary control for treatment of Obesity and Morbid Obesity, as defined by this Plan.

***Note**: Surgical treatment of Obesity/Morbid Obesity is covered under the "Surgical treatment for Obesity/Morbid Obesity" benefit.*

This Plan will not cover nutritional supplements, gym memberships, or dues for participation in weight loss programs (e.g., Weight Watchers, Jenny Craig, etc.) whether or not prescribed by a Physician.

(tt) Well Newborn Nursery/Physician Care.

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 the Allowable Charge 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).

Routine Physician Care. The benefit is limited to the Allowable Charge 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.

(uu) Wig. Charges associated with the initial purchase of a wig after chemotherapy or radiation treatment. Benefits are subject to the limits as stated in the Schedule of Benefits.

(vv) X-rays. Charges for diagnostic x-rays and imaging services.

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

Pre-notification of certain services is strongly recommended. 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 in effect at the time services are received. A pre-notification cannot be appealed under the Plan's Internal and External Claims Review Procedures.*

Air Ambulance *Pre-notification of services by the Covered Person, Physician, or facility, for air ambulance (and air facility to facility transportation) services is strongly recommended.* Pre-notification should occur at the earliest available opportunity prior to the initiation of transportation by contacting CareLink to coordinate and pre-negotiate Allowable Charges.

- The Plan's allowable reimbursement will be 125% of the Medicare equivalent rate, unless otherwise negotiated and charges in excess of this amount will be considered patient-responsibility and will not apply towards satisfaction of the Covered Person's Medical maximum out-of-pocket amount.

  Note: Covered Persons are not responsible for the excess charges over the Allowable Charge for services protected by the No Surprise Act.

- For pre-notification of services, call (800) 228-9118.

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 administered on an inpatient or outpatient basis;
- Outpatient Diagnostic Services including, but not limited to, MRI/MRA, PET, CT;
- 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

These procedures apply to the Plan's pre-notification of services for treatments reviewed under the Plan's Utilization Management program. Please note that pre-notification determinations provide information about coverage before the Covered Person receives treatment, services, and/or supplies and are not considered a Claim for benefits. Pre-notification determinations can only be appealed under the procedures in this Care Management Services section before services are provided. All Claims are subject to the terms and conditions, limitations and exclusions of the Plan in effect at the time the services are provided.

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

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

If there is an emergency admission to the Hospital, the Covered Person, Covered Person's family member, Hospital, or attending Physician should notify CareLink within **two 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 (other than Air Ambulance Pre-notification) at:

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

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 **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. In the case of an adverse pre-notification determination, written notice will provide the reason for the adverse pre-notification determination.

The Plan offers a one-level review procedure for adverse pre-notification determinations. The request for reconsideration must be submitted in writing within **30 days** of the receipt of the adverse pre-notification determination and must 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 **30 days** of the receipt of the request for reconsideration.

CASE MANAGEMENT

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

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

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

Case Management occurs when services are beneficial to both the patient and the Plan.

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

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

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

Continuing Treatment Claims. If the Covered Person is undergoing a course of treatment for a specific Illness or Injury as documented by a Plan of Care that was previously approved for a *specific period* of time or *number* of treatments, and it is Medically Necessary to extend treatment for that Episode of Care, the treating Physician or Covered Person is ***strongly encouraged to request*** a Pre-notification of services by the Plan. Claims beyond the approved number of visits will not be a covered benefit of this Plan. An appeal for denial of continuing treatment can be made under the post-service or pre-service timeframes, whichever applies.

MATERNITY MANAGEMENT PROGRAM

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

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

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

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

***Maternity Management Program Notification:* The Covered Person needs to notify CareLink during the first trimester of her Pregnancy.**

The Covered Person will receive $100 from the Public Education Health Trust after satisfying all requirements.

DEFINED TERMS

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

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

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

Adverse Benefit Determination shall mean any of the following:

(1) A denial in benefits, in whole or in part;
(2) A reduction in benefits;
(3) A rescission of coverage;
(4) A termination of benefits; or
(5) A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.

Allowable Charge. Allowable Charge means the amount for a treatment, service, or supply that is the negotiated amount established by a provider network arrangement or other discounting or negotiated arrangement.

In the absence of any such arrangement, Allowable Charge means an amount that does not exceed billed charges for the same treatment, service, or supply furnished in the same geographic area by a provider of like service as follows:

1) **Non-Preferred Providers and Facilities located beyond 50 miles from a Preferred Provider and Facility:** an amount equivalent to the **80th percentile** of a commercially available database, or such other cost or quality-based reimbursement methodologies as may be available and adopted by the Plan.

2) **Alaska Native Medical Center or its providers, Alaska Regional Hospital or its providers or Sutter Health Network facilities and providers:** an amount payable up to 125% of the Medicare equivalent rate for that service.

    a. For inpatient or outpatient facility claims where a Medicare equivalent rate is not available, a per diem rate of $500 will be applied.

    b. For all other Covered Charges where a Medicare equivalent rate is not available, an amount equivalent to the **70th percentile** of a commercially available database, or such other cost or quality-based reimbursement methodologies as may be available and adopted by the Plan.

3) **Non-Preferred Providers and Facilities located within 50 miles from a Preferred Provider and Facility**: an amount payable up to 125% of the Medicare equivalent rate for that service.

   a. For inpatient or outpatient facility claims where a Medicare equivalent rate is not available, a per diem rate of $500 will be applied.

   b. For all other Covered Charges where a Medicare equivalent rate is not available, an amount equivalent to the **70th percentile** of a commercially available database, or such other cost or quality-based reimbursement methodologies as may be available and adopted by the Plan.

4) **Air ambulance services:** an amount equivalent up to 125% of the Medicare reimbursement for transportation provided.

In the event the Non-Preferred Provider disputes the Plan's Allowable Charge for any claim subject to the No Surprises Act (NSA) through the Independent Dispute Resolution (IDR) process, the Allowable Charge may be determined by a Certified IDR Entity.

Physician, Facilities 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 those Covered Charges.

*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 result in an amount that is different than that set forth herein.*

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

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

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a homelike 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 fulltime 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.

Certified Independent Dispute Resolution (IDR) Entity means an entity responsible for conducting determinations under the No Surprises Act (NSA) that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

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

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

Complications of Pregnancy are determined as follows:

> These conditions are included before the Pregnancy ends: acute nephritis; ectopic Pregnancy; miscarriage; nephrosis; cardiac decompensation; missed abortion; hyperemesis gravidarum; and eclampsia of Pregnancy.
>
> Complications of Pregnancy will also mean other Pregnancy health related conditions that are as medically severe as those listed that would not typically happen in a normal Pregnancy and can affect the baby, mother (covered Member or covered Spouse) or both.

Cosmetic Dentistry means dentally unnecessary procedures.

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

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

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.

Emergency Services means the following:

(1) An appropriate medical screening examination (as required under section 1867 of the Social Security Act 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Medical Emergency; and

(2) Within the capabilities of the staff and facilities available at the Hospital (including Hospital outpatient department that provides Emergency Services) or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment (as are required under section 1867 of the Social Security Act 42 U.S.C. 1395dd), or as would be required under such section

if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

When furnished with respect to a Medical Emergency, Emergency Services shall also include an item or service provided by a Non-Preferred Provider (regardless of the department of the Hospital in which items or services are furnished) after the Plan Participant is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the provider determines that the Plan Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Plan Participant is in a condition to, and in fact does, give informed consent to the provider to be treated as a Non-Preferred Provider.

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 an employer who has a current Participation Agreement with the Public Education Health Trust as administered by the Public Education Health Trust office.

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

Episode of Care consists of all clinically related services for one Covered Person for an individually separate and distinct diagnostic condition starting from the onset of symptoms until treatment is complete.

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

(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 ongoing phase I or phase II clinical trials, is the research, experimental, study or

Investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

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

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

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

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

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

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

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

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is

licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: (1) it must be a formal written plan made by the patient's attending Physician that is reviewed at least every 30 days; (2) it must state the diagnosis; and (3) it must specify the type and extent of Home Health Care required for the treatment of the patient.

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

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

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

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

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

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

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

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

- A facility operating primarily for the treatment of Substance Abuse if it has received accreditation from Commission on Accreditation of Rehabilitation Facilities (CARF) or The Joint Commission (TJC) or if it meets these tests: maintains permanent and fulltime facilities for bed care and fulltime 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 fulltime psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

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

Independent Freestanding Emergency Department means a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services. Independent Freestanding Emergency Departments do not include Urgent Care Centers or Clinics.

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 lifesaving 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 timely enrollment eligibility period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Leave of Absence shall mean a period of time during which Employee must be away from his/her primary job with Employer, while maintaining the status of Employee during said time away from work, generally requested by an Employee and having been approved by his or her Employer, and as provided for in the Employer's rules, policies, procedures and practices where applicable.

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.

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 such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to 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.

Medical Record Review is the process by which the Plan, based upon a Medical Record Review and Claims Audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical 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 ultimate discretionary authority to decide whether care or treatment is Medically Necessary.

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

Member is an Employee who is covered by a current Collective Bargaining Agreement entered into by a participating Public Education Union working in Alaska; or an employee of a public education school district that has a participation agreement with the Public Education Health Trust, which is a benefits plan for certain Members of Employers who:

1. Are Employees of the Public Education Health Trust office; or

2. Are Members of an Association who have a current Participation Agreement with Public Education Health Trust as administered by Public Education Health Trust office; or

3. Are School Board Members who have a current Participation Agreement with Public Education Health Trust as administered by Public Education Health Trust office; or

4. Are Employees of an Employer who has a current Participation Agreement with Public Education Health Trust as administered by Public Education Health Trust office; or

5. Are Employees of a School District that has a current Participation Agreement with Public Education Health Trust as administered by Public Education Health Trust office.

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

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

The BMI is a factor produced by dividing a person's weight (in kilograms) by his/her height squared (in meters).

Myofascial Pain Dysfunction (MPD) is a syndrome of pain caused by spasm in the muscles and the pain may occur in a different part of the body than where the muscle is in spasm (referred pain).

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

Non-Preferred Provider/Non-Preferred Facility means a healthcare institution or healthcare provider who does not have a contractual relationship with the Plan or issuer, respectively, regarding reimbursement of items or services they provide.

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

Obesity is an abnormal accumulation of body fat, over an individual's ideal body weight. Obesity is associated with increased risk of Illness, disability, and death. The current clinical standard measure for Obesity in children and adolescents aged 6 to 18 years is defined as an age and gender-specific BMI equal to or greater than the 95th percentile and in adults a BMI equal to or greater than 30.

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

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

Plan means Public Education Health Trust.

Plan of Care is a written plan that describes the services being provided and any applicable short term and long term goals, specific treatment techniques, anticipated frequency and duration of treatment, and/or treatment protocol for the Covered Person’s specific condition. The Plan of Care must be written or approved by a Physician and updated as the Covered Person’s condition changes.

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

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

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

Preferred Provider/Preferred Facility means a healthcare institution or healthcare provider who has by contract agreed to provide services at discounted reimbursement rates. A single direct contract or case agreement between a health care Facility and a Plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

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 an Illness or Injury.

Primary Care Physician (PCP) shall mean a general practitioner, family practitioner, general internist, pediatrician, urgent care Physician, nurse practitioner, Physician's Assistant (P.A.), licensed professional counselor, licensed certified professional counselor, certified chemical dependency counselor, licensed clinical social worker, chiropractor, massage therapist, or acupuncturist providing services in a primary care setting.

Qualifying Payment Amount (QPA) means the median of the contracted rates recognized by the Plan or recognized by all Plans serviced by the Plan's Third-Party Administrator (if calculated by the Third-Party Administrator), for the same or a similar item or service provided by a provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a QPA, said amount will be determined by referencing an eligible third-party database in accordance with applicable law.

Recognized Amount means the lesser of a provider's billed charge or the Qualifying Payment Amount.

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 Illness. 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 fulltime supervision of a Physician.

(3) It provides 24-hour nursing services by licensed nurses, under the direction of a fulltime Registered Nurse (R.N.).

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

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

(7) It is approved and licensed by Medicare.

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

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

State Occupational Licensure means the appropriate state agency approval for the health care professional to engage in a given occupation upon the agency's finding that the applicant has attained the degree of competency, met all educational requirements necessary, and passed any required state and national certifying exams. A municipal, city, or business license will not meet the requirements for State Occupational Licensure.

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

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

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

- You lose the ability to safely and completely perform two activities of daily living without another person's assistance or verbal cueing; or

- You have a deterioration or loss in intellectual capacity and need another person's assistance or verbal cueing for your protection or for the protection of others.

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

Activities of daily living mean:

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

Urgent Care Services means care and treatment for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

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) **Administrative Costs.** Charges that are solely for and/or applicable to administrative costs of completing claim forms or reports or for providing records.

(2) **Broken Appointments.** Charges solely due to a Covered Person's failure to honor an appointment.

(3) **Claims not submitted within timely filing requirements.** See When To Submit Claims section for the requirements.

(4) **Coding Guidelines.** Charges for inappropriate coding in accordance to the industry standard guidelines in effect at the time services were received.

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

(6) **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.

(7) **Excess charges.** The part of an expense for care and treatment of an Injury or Illness that is in excess of the Allowable Charge.

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

(9) **Experimental/ Investigational or not Medically Necessary**. Care and treatment that is either Experimental/Investigational or not Medically Necessary.

(10) **Eye care.** Radial keratotomy or other eye surgery to correct nearsightedness. 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.

(11) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services, except for those Covered Persons within close proximity and who regularly utilize Canadian medical, vision and dental providers, such treatment must be a covered benefit under this Plan, be documented with a paid receipt, and be submitted to the Plan Administrator with the following information in writing, that is supplied with English translation:

- Name of Plan
- Member name and ID number

- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

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

(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 or radiation treatment.

(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 Illness or Injury occurring directly, or indirectly as a result of a serious criminal act, or a riot or public disturbance, or regardless of causation, if such Illness or Injury occurs in connection with, or while engaged in, or attempting to engage in, a serious criminal act, or a riot or public disturbance. For the purposes of this exclusion, the term "serious criminal act" shall mean any act or series of acts by the Plan Participant, or by the Plan Participant in concert with another or others, for which, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. For this exclusion to apply, it is not necessary that criminal charges be filed, or if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

Charges for services, supplies, care or treatment to a Plan Participant for an Injury or Illness which occurred as a result of that Plan Participant operating a motor vehicle while under the influence of alcohol or drugs (illegal drugs, legal drugs, and/or prescription drugs) or a combination thereof or operating a motor vehicle with a blood or breath alcohol content (BAC) above the legal limit. The arresting officer’s determination of inebriation, medical records, or other substantiating documentation will be sufficient for this exclusion. It is not necessary for this exclusion to apply that criminal charges be filed, or if filed, that a conviction result. Expenses will be covered for Injured Plan Participants other than the person operating the vehicle while under the influence or a BAC above the legal limit, and expenses may be covered for chemical dependency treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(16) **Immediate Family Member.** Services rendered by a member of the immediate Family Unit or person regularly residing in the same household, regardless of the classification of the relationship.

(17) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for male or female sexual or erectile dysfunction and/or inadequacy, except for diagnostic testing, a diagnosis of hypogonadism, or following surgical or cancer treatment that has damaged the nerves and arteries in the pelvic area.

(18) **Incarcerated.** Care, treatment, services, and supplies incurred and/or provided to a Covered Person by a government entity while housed in a governmental institution.

(19) **Infertility.** Care and treatment for infertility, artificial insemination or in vitro fertilization, except for diagnostic testing.

(20) **Intraoperative neuromonitoring (IONM) services.**

(21) **Mailing or Sales Tax.** Charges for mailing, shipping, handling, conveyance and/or sales tax except as may be allowed at the sole discretion of the Plan Administrator, if deemed Medically Necessary.

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

(23) **No obligation to pay**. Charges incurred for which the Plan has no legal obligation to pay including, but not limited to, never events (e.g. wrong surgery; wrong body part; wrong patient) and hospital acquired conditions (e.g. object left in surgery; blood incompatibility) as set forth in the then current Centers for Medicare and Medicaid Service (CMS) guidelines.

(24) **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 Illness.

(25) **Not Acceptable.** Charges that are not accepted as standard practice by the American Medical Association (AMA), American Dental Association (ADA), or the Food and Drug Administration (FDA).

(26) **Not specified as covered**. Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(27) **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 Illness, except as specifically stated as a benefit of this Plan. Medically Necessary charges for Morbid Obesity will be covered.

(28) **Occupational Injury.** Care and treatment of an Injury or Illness that is occupational – that is, arises from work for wage or profit and for which the Plan Participant is eligible to receive benefits under any Workers' Compensation or occupational disease law. This exclusion will apply if the Plan Participant was eligible to receive such benefits and failed to properly file a claim for such benefits or to comply with any other provision of the law to obtain such benefits.

(29) **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.

(30) **Plan design excludes**. Charges excluded by the Plan design as mentioned in this document.

(31) **Prohibited by Law.** Charges are excluded to the extent that payment under this Plan is prohibited by law.

(32) **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.

(33) **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.

(34) **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.

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

(36) **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.

(37) **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

PRESCRIPTION DRUG BENEFIT SCHEDULE

If applicable, this Plan will make a retroactive adjustment to a claim based on a discount, coupon, Pharmacy discount program or similar arrangement provided by drug manufacturers or Pharmacies to assist in purchasing Prescription Drugs.

Prescription Maximum Out-of-Pocket Amounts, per Calendar Year	
Per Covered Person	$3,000
Per Family Unit	$6,000

The Prescription Copayments/Coinsurance will apply to the Prescription maximum out-of-pocket amount and will not apply towards the medical maximum out-of-pocket amount.

Prescription Drug benefits are payable at the percentages shown below each Calendar Year until the Prescription maximum out-of-pocket amount is reached. Then, Prescription Drug benefits incurred by a Covered Person will be payable at 100% for the rest of the Calendar Year.

When a Family Unit reaches the applicable Prescription maximum out-of-pocket amount, Prescription Drug benefits for the Family Unit will be payable at 100% for the rest of the Calendar Year.

Prescription medication day supply
Prescription medications are available for up to a 34-day supply with one copayment/coinsurance. Prescriptions filled for 35 - 90 day supply will be charged the 90-day copayment/coinsurance. Specialty medications are only available for a 30-day supply.

Pharmacy Option – up to a 34-day supply

Copayment/Coinsurance, per Prescription

For Preferred name brand drugs........ 30% ($45 min/$70 max)

For Non-Preferred name brand drugs........ 30% ($70 min/$115max)

For Generic drugs........ 30% ($15 min/$35 max)

For compound drugs........ 30% ($15 min/$35 max)

Retail Pharmacy 35 to 90-day supply or Mail Order Prescription Drug Option 1 to 90-day supply

Copayment/Coinsurance, per Prescription

For Preferred name brand drugs........ 30% ($90 min/$140 max)

For Non-Preferred name brand drugs........ 30% ($140 min/$230 max)

For Generic drugs........ 30% ($30 min/$70 max)

For Compound drugs........ 30% ($30 min/$70 max)

If the Covered Person requests a brand name drug when a generic equivalent is available, the Covered Person will pay the brand name copayment/coinsurance and the difference in cost between the Generic Drug and

the brand name drug, regardless of whether the Physician has prescribed the brand name drug with "Dispense as Written" on the prescription (unless a brand name drug is deemed Medically Necessary through Prior Authorization).

Members will also have access to Optum's Critical Drug Affordability Program. Under this Program, critical medications which help protect against or manage chronic diseases or acute conditions may be more affordable. Medications must be on the formulary/drug list in order to qualify.

For further information please call **OptumRx Member Services** toll-free, 24 hours a day, 7 days a week at **(855) 395-2022**.

Visit our web site at www.optumrx.com.

Additional information regarding the Prescription Drug Benefit can be found in the following section.

SPECIALTY MEDICATION BENEFITS

Specialty medications are high-cost injectables, infused, oral, or inhaled medications prescribed in the treatment of chronic and life-threatening diseases including but not limited to: multiple sclerosis, rheumatoid arthritis, hepatitis C, hemophilia or Crohn's disease.

To access a *current* list of Specialty Pharmacy medications go to www.optumrx.com.
Please contact OptumRx at (855) 395-2022
for more information concerning
the Specialty Pharmacy Program or assistance to transfer your medications.

BENEFIT PAYMENT

Specialty Medication benefits are payable at the percentages shown below each Calendar Year until the Prescription maximum out-of-pocket amount is reached. Then, Specialty Medication benefits incurred by a Covered Person will be payable at 100% for the rest of the Calendar Year.

When a Family Unit reaches the applicable Prescription maximum out-of-pocket amount, Specialty Medication benefits for the Family Unit will be payable at 100% for the rest of the Calendar Year.

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

- Non-Contracted Specialty Pharmacy charges

Outpatient Specialty Medication – *(facility or Physician)*

Preferred *Facility or Physician*
Reimbursement rate, per Prescription.. 50% up to $600, no deductible applies

Non-Preferred *Facility or Physician*
Reimbursement rate, per Prescription .... Not Covered

Pharmacy Specialty Medications – 30-day supply

Specialty Pharmacy

Value Specialty drugs (Tier 1)
Reimbursement rate, per Prescription.. 25% up to $50, no deductible applies

Preferred Specialty drugs (Tier 2)
Reimbursement rate, per Prescription.. 25% up to $200, no deductible applies

Non-Preferred Specialty drugs (Tier 3)
Reimbursement rate, per Prescription.. 50% up to $600, no deductible applies

Non-Contracted Specialty Pharmacy
Reimbursement rate, per Prescription .... Not Covered

This benefit applies when a specialty medication charge is incurred for care and treatment of a Covered Person for:

(1) **Outpatient Specialty Medications.** Eligible outpatient specialty medications billed by a Preferred Facility or Physician are Covered Charges under the specialty medication benefit and are payable as stated in the Specialty Medication Benefits section, until the Prescription maximum out-of-pocket amount has been satisfied for the Calendar Year.

(2) **Pharmacy Specialty Medications**. Eligible specialty medications billed by a Contracted Pharmacy are Covered Charges under the specialty medication benefit and are payable as stated in the Specialty Medication Benefits section, until the Prescription maximum out-of-pocket amount has been satisfied for the Calendar Year.

This Plan offers a Specialty Pharmacy program for specialty medications that can provide Covered Persons with greater convenience, including express delivery, follow-up care calls, expert counseling, and superior service.

All prescriptions are subject to the terms, limitations, and exclusions as set forth in this Plan.

PRESCRIPTION DRUG BENEFITS DESCRIPTION

The Coordination of Benefits Provisions will not apply to prescriptions purchased at a Participating Pharmacy for Covered Persons who are double covered under two Public Education Health Trusts.

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

PHARMACY DRUG CHARGE

Participating Pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. OptumRx is the administrator of the Pharmacy drug plan.

PREMIUM FORMULARY

The Premium Formulary includes a list of medications that have received FDA approval as safe and effective, with the exception of DESI 5 and 6 products, which pre-date the development of the FDA approval process, and have been chosen by the OptumRx Pharmacy and Therapeutics (P&T) committee to be included in the list. The Premium Formulary excludes coverage for certain brand-name drugs offering no clear clinical advantage over less costly brand or Generic Drugs according to the P&T committee and some drugs are subject to Age and Quantity Limits.

Certain drugs that are listed on the Premium Formulary may not be covered under the Public Education Health Trust Prescription Benefit Plan due to Plan Exclusions. For example, lifestyle medications, including,

but not limited to, infertility medication is excluded on the Public Education Health Trust plan as infertility is not a covered benefit, but is listed on the Premium Formulary.

The Premium Formulary is posted on the Optum Rx website at www.OptumRx.com.

Tier 1 medications are listed in lowercase on the Premium Formulary. Tier 2 and Tier 3 medications are listed on the Premium Formulary in uppercase. Products showing E in the Tier column are Excluded under the Premium Formulary. Lower-cost options are available and covered.

PHARMACY COPAYMENT/COINSURANCE

The copayment/coinsurance is applied to each covered Pharmacy drug charge and is shown in the Schedule of Benefits. The copayment/coinsurance amount is a Covered Charge under the Prescription maximum out-of-pocket amount. Any one prescription is limited to a 90-day supply.

At select Participating Pharmacies, the Covered Person will be able to obtain a 35 to 90-day supply, per prescription, at the same copayment/coinsurance level as the mail order benefit (as shown in the Schedule of Benefits).

For additional information or a current list of these select Participating Pharmacies, please contact **OptumRx** ***or access the following Web site at*** **optumrx.com.**

If a drug is purchased from a Non-Participating Pharmacy, or a Participating Pharmacy when the Covered Person's ID card is not used, the Covered Person must pay the entire cost of the drug at the Pharmacy, will not receive a discount, and will have to submit the receipt to **OptumRx** for processing. The prescriptions will be processed at 100%, less any copayment/coinsurance listed in the Schedule of Benefits and subject to any quantity or coverage limitations.

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. Please contact OptumRx for more information concerning the mail order pharmacy.

> **Effective October 1, 2019**, the Plan will implement OptumRx's mandatory maintenance medication program. After the second, 30 day-supply, grace fill of a maintenance medication, a 90-day supply is required. Members can utilize mail order via Home Delivery 90 or fill their maintenance medication at a participating retail location which has the ability to dispense 90-day supplies.

MAIL ORDER COPAYMENT/COINSURANCE

The copayment/coinsurance is applied to each covered mail order prescription charge and is shown in the Schedule of Benefits. It is a Covered Charge under the Prescription maximum out-of-pocket amount. Any one prescription is limited to a 90-day supply.

PRIOR AUTHORIZATIONS

Certain prescriptions require prior authorization (approval before they will be covered). Types of prior authorizations include, but are not limited to:

- medications where a set amount is allowed within a set timeframe and an additional amount is requested within the same timeframe;
- where an age limitation has been reached and/or exceeded; or
- where appropriate utilization must be determined.

OptumRx administers the clinical Prior Authorization process on behalf of Public Education Health Trust.

To confirm whether a medication requires prior authorization and/or to request a prior authorization, the Covered Person or provider should call OptumRx's Clinical Member Services at (855) 395-2022. Monday through Friday 8 AM –12 AM CST and Saturday 8 AM – 5 PM CST (hours could vary during holidays).

Drug categories or medications that may require prior authorization include, but are not limited to:

1. Testosterone containing products (all forms)
2. Antiemetics
3. Antifungals
4. Cardiovascular Disease
5. Diabetic Products
6. Erythropoietins (Specialty medication)
7. Ophthalmic Immunomodulators
8. Pain Management
9. Topical Acne
10. Topical Analgesic Agents
11. Viral Hepatitis (Specialty medication)

STEP THERAPY PROGRAM

With the Step Therapy program, members need to try a Step 1 medication first, before a Step 2 medication may be covered. When you bring a prescription to the pharmacy, OptumRx's system will screen the medication to see if it is part of the Step Therapy program. If your prior pharmacy claims show you have tried a Step 1 medication in the recent past, the Step 2 medication may be filled. If not, the pharmacist will contact your doctor for more details.

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 (Federal legend drugs). This does not include any drugs not covered under this Plan.

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

(3) Insulin and diabetic medications and supplies such as disposable insulin syringes, glucagon, prescribed oral agents for controlling blood sugar and any of the devices listed above that are needed due to being visually impaired or legally blind. Members may receive a free glucose monitor through the **OptumRx** Free Meter Program.

NOTE: Blood Glucose Monitors are eligible under both Medical Benefits and Prescription Drug Benefits (through Free Meter Program), when deemed Medically Necessary. The test strips are only eligible under the Prescription Drug Benefits when the blood glucose monitor's test strips communicate directly with the insulin pump or are available on the Premium Formulary.

(4) Injectable drugs.

(5) Retin A and Accutane like products.

(6) Fluoride supplements.

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

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

Benefits may be subject to prescription formulary and/or quantity limitations. Non-formulary prescriptions may be payable subject to the applicable prescription copayment/coinsurance as shown in the Schedule of Benefits. Physician-prescribed medications as recommended by the U.S. Preventive Services Task Force (USPSTF) grades A and B recommendations will be covered at 100%, no prescription copayment/coinsurance will be required, and will only be available when utilizing a Participating Pharmacy.

Refer to the following link for more information regarding USPSTF grade A and B recommendations or contact the administrator of the pharmacy drug plan for more information regarding which medications are available. Note: Age and/or quantity limitations may apply:

https://www.uspreventiveservicestaskforce.org/uspstf/topic_search_results

Please note: the USPSTF grades A and B recommendations are subject to change as new medications become available and other recommendations may change. Coverage of new recommended medications will be available following the USPSTF grade A and B recommendation.

USPSTF grades A and B recommendations may include but are not limited to:

(1) Physician-prescribed **tobacco/nicotine cessation products**. Physician-prescribed generic nicotine replacement products (such as: nicotine patch, gum, lozenges) Physician-prescribed medications (such as: Zyban, Chantix).

To qualify, members must:

i. be age 18 or older
ii. Get a prescription for these products from their doctor, even if the product is sold over the counter (OTC)
iii. Fill the prescription at a network pharmacy.

Up to 180 days of treatment are covered at no cost each year. Maximum daily dose quantity limits apply.

Chantix Tablet, Nicotrol Inhaler and Nicotrol Nasal Spray prescription medications are covered after members have tried: 1) One over-the-counter nicotine product and 2) bupropion sustained-release (generic Zyban) separately.

(2) Physician-prescribed diabetes testing supplies (test strips, lancets, lancing devices and alcohol swabs).

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

(4) Physician-prescribed **contraceptive** methods (Food and Drug Administration (FDA) approved) including but not limited to generic 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.

(5) 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. A prior authorization is required to obtain the $0 copayment/coinsurance.

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

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

(8) Physician-prescribed **bowel prep agents for colorectal cancer screening** for adults 45years of age or older generic prescription bowel preparation agents. Applies to generic prescription bowel preparation agents only with a quantity limit of 1 bowel prep product per year.

(9) **Immunizations**. Certain vaccinations/immunizations as recommended by applicable federal law. Please note: Not all Pharmacies may be providing vaccinations/immunizations or may vary in what

they offer. It is important to check with the Pharmacy to determine availability, age restrictions, any prescription requirements or hours of service.

(10) **Statins.** Physician-prescribed statin medication including generic lovastatin for members ages 40-75 and generic simvastatin or atorvastatin for members ages 40-75 with an established high level of risk. A prior authorization is required to obtain the $0 copayment/coinsurance.

(11) **HIV PrEP.** For members who have a higher chance to become infected with human immunodeficiency virus (HIV) but are not yet infected, preventative medications are available at $0 cost share. Covered $0 cost medications: tenofovir tab 300mg (generic Viread), Truvada & Descovy (member must be unable to take Truvada before Descovy is covered) A prior authorization is required to obtain the $0 copayment/coinsurance.

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, insulin pumps and supplies, artificial appliances, braces, support garments, or any similar device. *These may be considered Covered Charges under the Medical Benefits section of this Plan.*

(4) Drugs used for cosmetic purposes including, but not limited to, certain anti-fungals, hair loss treatments, those used for pigmenting/depigmenting and reducing wrinkles.

(5) Drugs showing no clear clinical advantage over less costly brand or Generic Drugs are excluded from the Premium Formulary.

(6) Experimental. Experimental drugs and medicines, even though a charge is made to the Covered Person. This exclusion shall not apply to the extent that charges are for routine patient care associated with an approved clinical trial. (See "Clinical Trials" within the Covered Charges section of this Plan.)

(7) FDA. Any drug not approved by the Food and Drug Administration, **with the exception of DESI 5 and 6 products, which pre-date the development of the FDA approval process**.

(8) Growth hormones. A charge for growth hormones, except as Medically Necessary.

(9) Immunization. Immunization agents or biological sera, except as specifically stated as a benefit of this Plan.

(10) Impotence. A charge for impotence medication, except for confirmed diagnosis of benign prostatic hypertrophy, documented diagnosis of hypogonadism (via medical records), or for members with damaged nerves/arteries in the pelvic area following surgical or cancer treatment.

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

(11) Infertility. A charge for infertility medication.

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

(12) Investigational. A drug or medicine labeled: "Caution limited by federal law to investigational use".

(13) Medical exclusions. A charge excluded under Medical Plan Exclusions.

(14) No charge. A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs. In addition, discounts, coupons, Pharmacy discount programs or similar arrangements provided by drug manufacturers or Pharmacies to assist in purchasing Prescription Drugs will not be a Covered Charge under this Plan.

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

(16) Obesity drugs or nutritional/dietary supplements, except as stated as a benefit of this Plan.

(17) 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.

(18) Rogaine (or similar drug) for topical application.

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

(19) **Rx with OTC.** Prescription products when therapeutically acceptable over-the-counter (OTC) alternatives are available.

(20) Vitamins, except for pre-natal vitamins and other over-the-counter vitamin supplements that may be covered pursuant to preventive care mandate of PPACA, if prescribed by a Physician.

HOW TO SUBMIT PHARMACY CLAIMS

For a prescription drug claim form, call the PEHT office at (**907) 274-7526** or visit the website at **pehtak.com/forms**.

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

If the pharmacy provider is unable to submit the claim, the Plan Participant should request a receipt. To assist **OptumRx** in processing a claim, the following information must be provided when submitting the claim for processing:

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

WHERE TO SUBMIT PHARMACY CLAIMS

Claims for expenses should be submitted to the Claims Administrator at the address below:

OptumRx Claims Department
P.O. Box 65034
Dallas, TX 75265-0334

HOW TO SUBMIT A CLAIM

When services are received from a health care provider, a Plan Participant should show his or her EBMS/**Public Education Health Trust** 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) 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 (**Public Education Health Trust** Group **00350**)
- Provider Billing Identification Number
- Member's name and Identification Number
- Name of patient
- Name, address, telephone number of the provider of care
- Date of service(s)
- Place of service
- Amount billed

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

WHERE TO SUBMIT CLAIMS

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

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

WHEN CLAIMS SHOULD BE FILED

Claims must be received by the Claims Administrator within **365 days** of the date charges for the services were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims received later than that date will be denied.

If the Member's coverage terminates due to the covered Member's participating Employer ceasing to have a valid participation agreement with the Public Education Health Trust, the covered Member (and their Providers) will have 90 days to submit claims for themselves or any of their covered Dependents.

The Plan Participant must provide sufficient documentation (as determined by the Claims Administrator) to support a Claim for benefits. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

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

Balance-Billing.

In the event that a claim submitted by a Non-Preferred Facility and/or Provider is subject to a medical bill review or medical chart audit and some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Covered Person should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance-billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. Except for services protected by the No Surprises Act (NSA), balance-billing is legal in many jurisdictions, and the Plan has no control over Non-Preferred Facilities and/or Providers that engage in balance-billing practices.

In addition, with respect to services rendered by a Preferred Facility being paid in accordance with a discounted rate, it is the Plan's position that the Covered Person should not be responsible for the difference between the amount charged by the Preferred Facility and the amount determined to be payable by the Plan Administrator, and should not be balance-billed for such difference. Again, the Plan has no control over any Preferred Facility that engages in balance-billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Preferred Facility.

The Covered Person is responsible for payment of coinsurances, deductibles, and Medical maximum out-of-pocket amounts and may be billed for any or all of these.

Continuing Care Provision.

When a Covered Person is a receiving treatment from a Preferred Provider, and that provider's relationship with the Plan is terminated, not renewed, or otherwise ends for any reason (other than the Provider's failure to meet applicable quality standards or for fraud), the Covered Person has rights to elect Continuing Care from the former Preferred Provider.

The Plan shall notify the Covered Person in a timely manner that the Preferred Provider's contractual relationship with the Plan has terminated. If the Covered Person **elects in writing** to receive Continuing Care, benefits will apply under the same terms and conditions as would have applied had the termination not occurred. This Continuing Care Provision becomes available as of the date of the letter received by the Covered Person that the former Preferred Provider is no longer associated with the Plan. The Continuing Care Provision will cease 90 days after that date or when the Plan Participant ceases to receive Continuing Care, whichever occurs first.

Under the Continuing Care Provision, the former Preferred Provider or former Preferred Facility must: (1) accept reimbursement from the Plan and any applicable cost sharing from the Covered Person as payment in full; and (2) continue to adhere to all policies, procedures, and standards of care imposed by the Plan in the same manner as if the Preferred Provider termination had not occurred.

For purposes of this provision, a "Continuing Care" Covered Person is:

(1) undergoing a course of treatment for a serious and complex condition from a specific Preferred Provider;
(2) undergoing a course of institutional or inpatient care from a specific Preferred Provider;
(3) scheduled to undergo non-elective surgery from a specific Preferred Provider, including postoperative care;
(4) pregnant and undergoing a course of treatment for the Pregnancy from a specific Preferred Provider; or
(5) terminally ill and receiving treatment for such illness from a specific Preferred Provider.

Claims Audit for Non-Preferred Facility and/or Provider Claims.

In addition to the Plan's medical record review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The claim audit will be employed to identify charges billed in error and/or charges that are not Allowable Charges, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Allowable Charges or other applicable provisions, as outline in this booklet.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to an Allowable Charge, in accordance with the terms of this booklet.

Assignments.

Assignment by a Covered Person to the provider of the Covered Person's right to submit claims for payment to the Plan, and receive payment from the Plan, may be achieved via an assignment of benefits, if and only if the provider accepts said assignment of benefits as consideration in full for services rendered. If benefits are paid directly to the Covered Person – despite there being an assignment of benefits – the Plan shall be deemed to have fulfilled its obligations with respect to such payment, and it shall be the Covered Person's responsibility to compensate the applicable provider(s). The Plan will not be responsible for determining whether an assignment of benefits is valid; and the Covered Person shall retain final authority to revoke such assignment of benefits if a provider subsequently demonstrates an intent not to accept it as payment in full for services rendered. As such, payment of benefits will be made directly to the assignee unless a written request not to honor the assignment, signed by the Covered Person, has been received.

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

A Provider which accepts an assignment of benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this booklet.

Benefits due to any Preferred Facility will be considered "assigned" to such facility and will be paid directly to such facility, whether or not a written assignment of benefits was executed. Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, agrees to be bound by the terms of the Plan and agrees to submit claims for reimbursement in strict accordance with applicable law, ICD, and/or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer.

Clean Claim.

Clean Claim is one that can be processed in accordance with the terms of the Plan without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity, or any other matter that may prevent the charge(s) from being Covered Charges in accordance with the terms of this document.

Filing a Clean Claim.

A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this booklet and at other times prior to claim submittal) to ensure charges constitute Covered Charges as defined by and in accordance with the terms of the Plan. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Covered Person has failed to submit required forms or additional information to the Plan as well.

Internal and External Claims Review Procedures

A Claim is 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 or her Physician for a pre-notification of benefits on a medical treatment. Pre-notification of certain services is strongly recommended, but not required by the Plan. A pre-notification of services by CareLink is not a determination by the Plan that a Claim will be paid. A benefit determination on a Claim will be made only after the Claim has been submitted. A pre-notification is not required as a condition precedent to paying benefits, and cannot be appealed. Please refer to the Care Management Services section.

A Claimant may appoint an authorized representative to act upon his or her behalf with respect to a 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 Post-Service 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. Under the No Surprises Act, the Plan will have up to 30 calendar days to send a notice of denial of payment or an initial payment to the Non-Preferred Provider from the time the Claim is resubmitted with 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 (or a statement that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and that a copy will be provided free of charge to the Claimant upon request).

(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, or a statement that such explanation will be provided free of charge, upon request.

(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.

Note: When the dispute of a Claim payment or denial only involves payment amounts due from the Plan to the Non-Preferred Provider, and the provider has no recourse against the Plan Participant under the No Surprises Act, the payment dispute may only be resolved through open negotiation, or the Independent Dispute Resolution (IDR) process as outlined in the NSA. There may be instances when a Plan Participant may appeal a Claim through this section concurrently with a Non-Preferred Provider's payment dispute through the IDR process.

Internal Appeal Procedure

First Level of Internal Review

To appeal an Adverse Benefit Determination of a Claim, the Claimant must submit in writing, a request for a review of the Claim. 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 denial. The Claimant may include any additional supporting information, even if not initially submitted with the Claim. The written request for review must be submitted within:

- 15 days of the Claimant's receipt of a denial on a Concurrent Care Claim; or

- 180 days of the Claimant's receipt of a denial on a Post-Service Claim.

The written request for appeal should be addressed to:

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

A first level 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:

- 15 days of the receipt of the appeal for a Concurrent Care Claim; or
- 30 days of the receipt of the appeal for a Post Service Claim.

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. The written request for review of the first level of internal review must be submitted within:

- 15 days of the Claimant's receipt of the first level of internal review on a Concurrent Care Determination;
- 60 days of the Claimant's receipt of the first level of internal review on a Post-Service Claim.

The written request for appeal should be addressed to:

Public Education Health Trust
Attn: Claims Appeals
2550 Denali St.
Suite 1614
Anchorage, Alaska 99503

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:

- 15 days of the Plan's receipt of Claimant's second level appeal on a Concurrent Care Determination;
- 30 days of the Plan's receipt of Claimant's second level appeal on a Post-Service Claim.

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.

A request for external review may be granted only for Adverse Benefit Determinations that involve a:

- Determination that a treatment or service is not Medically Necessary.
- Determination that a treatment is Experimental or Investigational.
- Rescission of coverage, whether or not the rescission involved a Claim.
- Protection of cost-sharing and surprise billings as identified within the NSA.
- Application of treatment limits to a Claim for a Mental Disorder.

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 **six 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 year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable**.

COORDINATION OF BENEFITS

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

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

If this Plan is secondary and there is a direct contract in place between the participating provider and the Public Education Health Trust, this Plan, as secondary, shall pay the balance due under the applicable terms of that agreement.

In the case of deductibles, if this Plan is secondary to any other plan, this Plan may pay the balance minus the applicable deductible as stated in the Schedule of benefits to the extent not previously satisfied. The balance due, if any, is the responsibility of the Covered Person.

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

If this Plan is secondary to any plan that is not associated with the Public Education Health Trust, any applicable Preferred Facility direction will not apply and no benefit reduction will be imposed. If this Plan is secondary to any other plan, timely filing of claims will be extended to 18 months from the date of service.

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

1. Group or 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 reasonable and customary 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 Health Maintenance Organization (HMO) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network (preferred) 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 (preferred) 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 (preferred) 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, 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.

<u>Special rules</u>. If: (i) the person covered directly is a Medicare beneficiary (Part A and B), 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.

If: (i) the person covered directly is a Medicare beneficiary for Part B only, and (ii) Medicare is primary to Plan B, and (iii) Medicare is primary to Plan A (for example if the person is retired), THEN Medicare 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:

i. 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;

i. 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 the parent's spouse does, that parent's spouse's plan 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 who is neither laid off nor retired or as a Dependent of a Member 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. 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 who is neither laid off nor retired or a Dependent of a Member who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary. This rule does not apply if Rule (1) can be used to determine the order of benefits.

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

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

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

Claims determination period. Benefits will be coordinated on a Calendar Year 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.

Occasionally benefits are paid more than once; are paid based upon improper billing or a misstatement in a proof of loss or enrollment information; are not paid according to the Plan's terms, conditions, limitations or exclusions; or should otherwise not have been paid by the Plan. As such, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In which case the Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Claimant or Dependent on whose behalf such payment was made.

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

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

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, Provider, or other person or entity to enforce the provisions of this section, then that Covered Person, Provider, or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the outcome.

Further, Covered Persons and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Claimants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Covered Person(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising

from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1) In error;

2) Pursuant to a misstatement contained in a proof of loss or a fraudulent act;

3) Pursuant to a misstatement made to obtain coverage under this Plan;

4) With respect to an ineligible person;

5) In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or

6) Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Covered Person or by any of his covered Dependents if such payment is made with respect to the Covered Person or any person covered or asserting coverage as a Dependent of the Covered Person.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

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

Coordination With Medicare. Medicare Part A, Part B and Part D will be considered a plan for the purposes of coordination of benefits.

(A) For Working Aged

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

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

Per Medicare Secondary Payer Manual, Section 10.2 – Individuals Not Subject to the Limitation on Payment (Rev. 118, 04-28-16), the following are exceptions the Medicare secondary provision for working aged does not apply to:

- If the Member or Dependent Spouse is enrolled in Part B only;
- If the Member or Dependent Spouse is enrolled in Part A on the basis of a monthly premium;
- Domestic partners who are given "spousal" coverage by the Plan; or
- Former spouses who have Federal Employees Health Benefit coverage under the Spouse Equity Act.

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

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

- The Covered Person has no dialysis for a period of 12 consecutive months and then resumes dialysis, at which time the Plan will again become primary for a period of 30 months; or

- The Covered Person undergoes a kidney transplant:

    - If the transplant is successful, Medicare will remain primary payer and terminate 36 months after the successful transplant date; or

    - If the transplant is unsuccessful and dialysis is required, then the Covered Person can re-enroll in Medicare and the Plan will be primary for the second 30-month period after reenrollment.

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

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

In Summary (for entitlement reason - Aged):

When the Employee has Medicare:
- Employee – This Plan is primary, Medicare is secondary.
- Spouse – This Plan is primary.

When the Spouse has Medicare:

- Employee – This Plan is primary.
- Spouse – This Plan is primary, Medicare is secondary.

When the Employee does not have Medicare and is a Dependent on the Spouse's Plan:

- Employee – This Plan is primary, Spouse's plan is secondary.
- Spouse – Spouse's plan is primary, this Plan is secondary.

When the Employee has Medicare and is a Dependent on the Spouse's Plan:

- Employee – This Plan is primary, Medicare is secondary, and the Spouse's plan is tertiary.
- Spouse – Spouse's plan is primary, this Plan is secondary.

When the Spouse has Medicare, and the Employee is a Dependent on the Spouse's Retiree Plan:

- Employee – This Plan is primary, Spouse's plan is secondary.
- Spouse – This Plan is primary, Medicare is secondary, and Spouse's retiree plan is tertiary.

THIRD PARTY RECOVERY

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

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, Illness, 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, Illness, 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" (or similar legal theory) and/or the Recovery is called something other than a Recovery for healthcare, medical and/or dental expenses.

The Plan shall be entitled to recover 100% of the benefits paid and 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, is required by court order, or applicable law.

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

The Covered Person agrees that the Plan is subrogated to any and all claims, causes of action or rights that the Covered Person may have now or in the future against a Third Party who has or may have caused, contributed aggravated, and or be responsible for the Covered Person's Injury, Illness, 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:

- Cooperate fully with the Plan and its agents, regarding the Plan's rights under this section;
- Advise the Plan of any right or potential right to reimbursement and/or subrogation on the Plan's behalf;
- 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, Illness, condition, and/or accident, including any efforts by another individual to Recover on the Covered Person's behalf;
- Execute all assignments, liens, or other documents that the Plan or its agents may request to protect the Plan's rights under this section;
- Obtain the Plan's consent before releasing a Third Party from liability for payment of expenses related to the Covered Person's Injury, Illness, condition, and/or accident;
- 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;
- Agree not to impair, impede or prejudice in any way, the rights of the Plan under this section; and
- 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:

- The Plan may require the Covered Person as a condition of paying benefits for the Covered Person's Injury, Illness, condition, or accident, to execute documentation acknowledging the Plan's rights under this section;

- The Plan may withhold payment of benefits to the extent of any Recovery received by or on behalf of a Covered Person;
- The Plan may, to the extent of any benefits paid by the Plan, exercise its Right of Reimbursement against any Recovery received, or that will be received, by or on behalf of Covered Person; or
- The Plan may, to the extent of any benefits paid by the Plan, exercise its Right of Subrogation directly against a Third Party who is or may be responsible.
- The Plan may, to the extent of any benefits paid by the Plan which have not otherwise been reimbursed to the Plan and to the extent permitted by law, offset any further 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 procedure as deemed necessary and appropriate to administrate the Plan's rights under this section.

Right to Recover Benefits Paid in Error

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

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Waiver

The failure by the Plan Administrator to require performance of any provision and/or requirement set forth in this booklet shall not affect the Plan Administrator's right to require performance at any time thereafter.

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 may 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
Public Education Health Trust
2550 Denali St.
Suite 1614
Anchorage, Alaska 99503
(907) 274-7526

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.

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

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

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

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

How long does COBRA Continuation Coverage last?
COBRA Continuation Coverage 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
Public Education Health Trust
2550 Denali St.
Suite 1614
Anchorage, Alaska 99503
(907) 274-7526

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
Public Education Health Trust
2550 Denali St.
Suite 1614
Anchorage, Alaska 99503
(907) 274-7526

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:

(1) The date your Employer ceases to provide a group health plan to any Employee;

(2) The date the covered Member's participating Employer ceases to have a valid participation agreement with the Public Education Health Trust;

(3) The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;

(4) 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;

(5) 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

(6) 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 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.

Additional Information

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

Plan Administrator
Public Education Health Trust
2550 Denali St.
Suite 1614
Anchorage, Alaska 99503
(907) 274-7526

COBRA Administrator
UnifyHR
P.O. Box 6763
Fargo, ND 58108-6763
(800) 519-8366
COBRA@unifyhr.com

For more information about your rights under the Public Health Services Act, 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/agencies/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.

Current Addresses

To protect your family's rights let the Plan Administrator (who is identified above) informed of 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. Public Education Health Trust is the benefit plan of Public Education Health Trust, the Plan Administrator, also called the Plan Sponsor. An individual may be appointed by Public Education Health Trust to be Plan Administrator and serve at the convenience of Public Education Health Trust. If the Plan Administrator resigns, dies or is otherwise removed from the position, Public Education Health Trust shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator has the authority to, and does so allocate limited fiduciary duties to American Health Holdings, Inc. Those duties are limited to a review of and determination on a Plan Participant's request (or a request by the Plan Participant's treating provider) for a pre-determination of benefits prior to the occurrence of treatment or services. As part of those limited duties, American Health Holdings shall have the discretionary authority and ultimate decision-making authority to review the request and any submitted documentation, make a decision, respond to an appeal if the decision is to deny the request, and to maintain records related to its activities related to this decision. See the Care Management Services section for additional information.

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

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

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

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

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

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

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

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

(3) In accordance with the Plan documents.

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

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

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

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

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

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

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

If 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, the amount of overpayment may be deducted from future benefits payable.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION COMPLIANCE WITH HIPAA

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

(1) Protected Health Information. Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a Participant; the provision of health care to a Participant; or the past, present, or future payment for the provision of health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant. Protected health information includes information of persons living or deceased.

(2) Privacy Official. The Plan Administrator will be the Privacy Official for the Plan, responsible for the development and implementation of policies and procedures relating to the use and disclosure of PHI. The Privacy Official will also serve as the contact person for Participants and other Covered Persons who have questions, concerns, or complaints about uses and disclosures of their PHI

Access to PHI is Limited to Certain Employees.

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

(1) Non-Plan Personnel Have No Access to PHI. No other Members of the Plan Sponsor's workforce beyond personnel employed to administer the Plan shall be deemed to have a job-related need for access to PHI created or maintained by the Plan.

(2) Plan Personnel Access is the Minimum Necessary. Based on job duties, the size and nature of the Plan's operations and workforce, each Member of the Plan's workforce shall be entitled to access any and all PHI created or maintained by the Plan. PHI may include payment, claims administration, enrollment and eligibility information, which each Member of the Plan's workforce may be called upon to access, interpret, use for Plan operations, and disclose in accordance with the Plan's written privacy policy. The Members of the Plan's workforce designated as entitled to access PHI created or maintained by the Plan include to following job titles:

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

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

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

(1) Payment. Payment includes activities undertaken to obtain Plan contributions or to determine or fulfill the Plan's responsibility for provisions of benefits under the Plan, or to obtain or provide reimbursement for health care. Payment may include other Plan administrative functions, including but not limited to: (i) eligibility and coverage determinations including coordination of benefits and adjudication or subrogation of health benefit claims; (ii) risk adjusting based on enrollee status and demographic characteristics; and (iii) billing, claims, management, collection activities, obtaining payment under a contract for reinsurance and related health care data processing.

(2) Operations. Plan operations may include any of the following activities to the extent that they are related to Plan administration: (i) conducting quality assessment and improvement activities; (ii) reviewing Plan performance; (iii) underwriting and premium rating; (iv) conducting or arranging for medical review, legal services and auditing functions; (v) business planning and development; and (vi) business management and general administrative activities.

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

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

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

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

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

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

(1) Business Associate. A Business Associate is an entity that (i) performs or assists in performing a Plan function or activity involving the use and disclosure of protected health information (including claims processing or administration, data analysis, underwriting, etc.); or (ii) provides legal, accounting, actuarial, consulting, data aggregation, management, accreditation, or financial services, where the performance of such services involves giving the service provider access to PHI.

(2) Contractual Assurances. Prior to disclosing PHI to a Business Associate, the Plan shall obtain written assurances from the Business Associate that it shall comply with the same restrictions and conditions that apply to the Plan and Plan Sponsor as regards the use or disclosure of PHI.

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

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

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

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

Sponsor shall limit further uses and disclosures of such PHI to those purposes that make the return or destruction of the information infeasible.

The Plan provides each Covered Person access to a Notice of Privacy Practices. This Notice describes how the Plan uses and discloses your PHI. It also describes certain rights you have regarding this information. Copies of the Notice of Privacy Practices are available at: **http://www.pehtak.com.**

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

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

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

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f) (2) (iii), is supported by reasonable and appropriate security measures.

- Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and

- Report to the Plan any security incident of which it becomes aware.

AMENDING AND TERMINATING THE PLAN

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

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

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health plan and the administration is provided through a third party claims administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Members.

PLAN NAME

Public Education Health Trust

TAX ID NUMBER: 92-6027877

PLAN EFFECTIVE DATE: July 1, 1996

PLAN YEAR ENDS: June 30

PLAN ADMINISTRATOR

Plan Administrator
Public Education Health Trust
2550 Denali St.
Suite 1614
Anchorage, Alaska 99503
(907) 274-7526

AGENT FOR SERVICE OF LEGAL PROCESS

Plan Administrator
Public Education Health Trust
2550 Denali St.
Suite 1614
Anchorage, Alaska 99503
(907) 274-7526

Service of process may also be made on the Plan Administrator.

CLAIMS ADMINISTRATOR

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

TRUSTEES:

Tim Walters
2550 Denali St.
Suite 1614
Anchorage, Alaska 99503

Dan Polta
2550 Denali St.
Suite 1614
Anchorage, Alaska 99503

Kathy Bell
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Laura Mulgrew
2550 Denali St.
Suite 1614
Anchorage, Alaska 99503

Shelby Beck
2550 Denali St.
Suite 1614
Anchorage, Alaska 99503

PLAN NAME: Public Education Health Trust

PLAN OPTION: Plan F

EFFECTIVE DATE: July 1, 1996

RESTATEMENT DATE: July 1, 2024

I, Rhonda Prowell-Kitter, certify that I am the Plan Administrator
Name Title

for the above-named Plan, and further certify that I am authorized to sign this Amendment. I have read and agree with the above change to the Plan and am hereby authorizing its implementation as of the effective date stated above.

Signature:

Date: April 29, 2024