Public Education
HEALTH TRUST

PUBLIC EDUCATION HEALTH TRUST BENEFIT BOOKLET

EFFECTIVE: JULY 1, 2026

*Dental Plan Option: Plan A **without** Orthodontia*

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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 *both* levels of review as described in the *Dental Claims* Procedures section. A legal action to obtain benefits must be commenced within one year of the date of the *notice* of *the Plan Administrator's determination* on the *second* level of review.

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.

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.

Dental Care Benefits. Explains when the benefit applies and the types of charges covered.

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

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 over the limiting age of 26 years old and Totally Disabled.

A Member who is initially eligible for coverage with a Dependent who is over the limiting age of 26 years and who is Totally Disabled may also enroll their Dependent. Totally Disabled Dependent are 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 and is unmarried. For additional information, refer to the Totally Disabled definition in the Defined Terms section of this Benefit Booklet.

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.

Totally Disabled dependents, who are 26 years old or older, are not eligible for enrollment during a Special Enrollment Opportunity.

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. The enrollment form or the add/change form must be received by the Plan Administrator within 31 days from the effective date of coverage following the Covered Member's eligible Dependent Employer's open enrollment.

(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, add a Dependent, or remove 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. Changes under the new Plan will be effective the first of the month following the timely 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, or remove 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. Changes will be effective the first of the month following the timely 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, loss of coverage, in coordination with open enrollment, 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. Changes will be effective the first of the month following the timely receipt of the notification.

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 Providers) 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 A

*** Note: Participation in the Dental Benefits of this Plan is available as a separate election.**

AMERITAS CLASSIC PLUS NETWORK:

Public Education Health Trust has contracted with Ameritas Classic Plus Network to provide significant fee reductions for covered dental services. Utilization of an Ameritas Classic Plus Network provider will result in better benefits for you.

Additional information about the Ameritas Classic Plus Network provider network can be obtained by visiting their website at https://dentalnetwork.ameritas.com/classic or www.pehtak.com.

Calendar Year deductible:

Per Covered Person	$50
Per Family Unit	$150

The deductible applies to these Classes of Service:
Class B Services – Basic
Class C Services – Major

Dental Percentage Payable – subject to Usual and Reasonable Charge:

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

Maximum Benefit Amount:

For Class A, B and C services for *all* Covered Persons:

Per Covered Person per Calendar Year	$2,000

DENTAL BENEFITS

Participation in the Dental Benefits of this Plan requires a separate enrollment election.

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

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.

Before filing a lawsuit, the Claimant must exhaust both levels of review as described in the Dental Claims Procedures section. A legal action to obtain benefits must be commenced within one year of the date of the notice of the Plan Administrator's determination on the second level of review.

DEDUCTIBLE

Deductible Amount. This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the deductible shown in the Schedule of Benefits. Deductible does not apply towards Class A services.

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

BENEFIT PAYMENT

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

MAXIMUM BENEFIT AMOUNT

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

DENTAL CHARGES

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

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

An eligible dental charge for inlays, onlays, laboratory-processed labial veneers, crowns, bridges, partial and completed dentures will be payable on the seat or delivery date.

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

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

The following are deemed service start dates:

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

The following are deemed service completion dates:

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

COVERED DENTAL SERVICES

Class A Services:
Preventive and Diagnostic Dental Procedures

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

All Covered Persons:

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

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

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

(4) Fluoride treatments for covered Dependent children under age 19. Limit of two fluoride treatments per Covered Person each Calendar Year.

(5) Sealants for Covered Persons ages 17 and under. Limit of one per permanent tooth per Covered Person every five Calendar Years.

(6) Emergency palliative treatment for pain.

(7) All other dental x-rays.

(8) Space maintainers for covered Dependent children under age 20.

Class B Services:
Basic Dental Procedures

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

(2) Periodontics (gum treatments).

(3) Endodontics (root canals).

(4) Extractions. This service includes local anesthesia and routine postoperative care.

(5) Repair and re-cementing bridges, crowns or inlays.

(6) Fillings.

(7) Nitrous Oxide, not limited to extractions.

(8) General anesthetics or IV sedation when an oral surgeon performs a tooth extraction or upon demonstration of Medical Necessity.

(9) Antibiotic drugs.

Class C Services:
Major Dental Procedures

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

(2) Installation of crowns; limited to once every five years, unless Medically or Dentally Necessary.

(3) Installing precision attachments for removable dentures.

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

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

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

(7) Rebasing or relining of removable dentures.

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

(a) The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.

(b) The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed.

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

(10) Occlusal Guards.

EXCLUSIONS

A charge for the following is not covered:

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

(2) **Bone grafting.** Charges for bone grafting. However, this may be a covered charge under a medical plan.

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

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

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

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

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

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

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

(10) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining dental 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

(11) **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.

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

(13) **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.

(14) **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.

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

(16) **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.

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

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

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

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

(21) **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).

(22) **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.

(23) **Orthodontics.**

(24) **Orthognathic surgery.** Surgery to correct malposition in the bones of the jaw.

(25) **Personalization.** Personalization of dentures.

(26) **Plan design.** Charges excluded or limited by the Plan design as stated in this Plan Document.

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

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

(29) **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.

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

(31) **Temporomandibular joint (TMJ) syndrome .** All diagnostic and treatment services related to the treatment of jaw joint problems, including TMJ syndrome.

(32) **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.

HOW TO SUBMIT A CLAIM

When services are received from a health care provider, a Plan Participant should show his or her Ameritas/**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 (CDT) codes from his or her dental 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 **302277**)
- 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

WHERE TO SUBMIT CLAIMS

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

Ameritas
P.O. Box 82520
Lincoln, NE 68501-2520
(800) 487-5553

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.***

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.

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.

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

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

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

Cosmetic Dentistry means dentally unnecessary procedures.

Covered Charge(s) means those Medically or Dentally 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.

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

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.

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) 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.

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

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

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.

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

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

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

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.

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

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 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.

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.

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.

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

The Plan will pay benefits on the basis of the actual charge billed if it is less than the Usual and Reasonable Charge.

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

DENTAL CLAIMS PROCEDURES

A Claim means a request for a Plan benefit, made by a 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 for benefits is not a Claim that has been previously submitted, denied, appealed, and re-denied upon appeal.

> A "Claim" is a **Post-Service Claim** under the terms of the Plan. A **Post-Service Claim** means a Claim for covered medical services that have already been received by the Plan Participant.

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. The Plan Administrator shall have full responsibility to adjudicate all claims and to provide a full and fair review of the initial claim determination in accordance with the following Claims review procedure.

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

For the purposes of this section, **Claimant** means the Plan Participant or the Plan Participant's authorized representative. A Claimant may appoint an authorized representative to act upon his or her behalf with respect to the Claim. Contact the Claims Administrator for information on the Plan's procedures for authorized representatives. A Claimant does not include a healthcare provider simply by virtue of an assignment of benefits.

An Adverse Benefit Determination shall mean a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. An inquiry regarding eligibility or benefits without a Claim for benefits is not a Claim and, therefore, cannot be appealed.

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. If the Claims Administrator requires an extension due to circumstances beyond the Plan's control, the Claims Administrator will notify the Claimant of the reason for the delay within the initial 30-day period. A benefit determination on the Claim will be made within 15 days of the date the notice of the delay was provided to the Claimant. If additional information is necessary to process the Claim, the Claims Administrator will request the additional information from the Claimant within the initial 30-day 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. A benefit determination on the Claim will be made within 15 days of the Plan's receipt of the additional information.

Notice of Adverse Benefit Determination

The Plan shall provide written or electronic notice of the determination on a Claim in a manner meant to be understood by the Claimant. If a Claim is denied in whole or in part, notice will include the following:

(1) Information to identify the claim involved. Specific reason(s) for the denial.

(2) Reference to the specific Plan provisions on which the denial was based.

(3) Description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is necessary.

(4) Description of the Plan's Claims review procedures and the time limits applicable to such procedures.

(5) 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:

(6) 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).

(7) 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.

(8) Identification of medical or vocational experts, whose advice was obtained on behalf of the Plan in connection with a Claim.

If the Claimant does not understand the reason for the Adverse Benefit Determination, the Claimant should 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 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 either an appropriate Plan representative or the Claims Administrator on the Plan's behalf, who is neither the individual who made the Initial Benefit Determination, nor a subordinate of that individual. The review will 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 the Initial Benefit Determination.

- If the Adverse Benefit Determination was based in whole or in part upon medical judgment, including determinations on whether a particular treatment, drug, or other item is Experimental and/or

Investigational, or not Medically Necessary, the Plan Administrator or its designee will consult with a health care professional who has the appropriate training and experience in the applicable field of medicine; was not consulted in the Initial Benefit Determination; and is not the subordinate of the initial decision-maker. The Plan may consult with vocational or other experts regarding the Initial Benefit Determination.

The Plan Administrator will provide free of charge upon request by the Claimant, reasonable access to and copies of, documents, records, and other information as described in Items 5 through 8 under "Notice of Adverse Benefit Determination".

First Level of Claims Review

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

Qualify Control
℅ Ameritas
P.O. Box 82657
Lincoln, NE 68501-2657
Attn: Claims Appeals

An appeal will not be deemed submitted until it is received by the Claims Administrator. **Failure to appeal the initial Adverse Benefit Determination within the 180 day period will render that determination final.**

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

Second Level of Claims Review

If the Claimant does not agree with the Claims Administrator's determination from the first level review, the Claimant may submit a second level appeal in writing within 60 days of the Claimant's receipt of the Notice of Determination from the first level of review, along with any additional supporting information to:

Plan Administrator
℅ PEHT
2550 Denali St., Suite 1614
Anchorage, AK 99503
Attn: Claims Appeals

An appeal will not be deemed submitted until it is received by the Plan Administrator**. Failure to appeal the determination from the first level of review within the 60 day period will render that determination**

final.
The second level of review will be done by the Plan Administrator. The Plan Administrator will review the information initially received and any additional information provided by the Claimant, and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Plan Administrator will send a written or electronic Notice of Determination for the second level of review to the Claimant within 30 days of receipt of the appeal. The determination by the Plan Administrator upon review will be final, binding, and conclusive and will be afforded the maximum deference permitted by law.

If upon review, the *Adverse Benefit* Determination *remains* the *same and* the Claimant *still does* not *agree* with the determination, the Claimant *has the right to bring* an *action for benefits*. **Before filing a lawsuit, the Claimant must exhaust both levels of review as described in this section**. **A legal action to obtain benefits must be commenced within one year of the date of the notice of the Plan Administrator's determination on the second level of review.**

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 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.

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 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. Other government benefits, as permitted by law. This does not include Medicare, Medicaid, or a government plan that by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan;

7. The medical benefits coverage in automobile "no-fault" and traditional automobile "fault" type contracts;
8. Any third-party source, including but not limited to, automobile or homeowners liability insurance, umbrella insurance and premises liability insurance, whether individual or commercial, or on an insured, uninsured, under-insured or self-insured basis.

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

Allowable Charge(s). For a charge to be allowable it must be a Usual, Customary, and Reasonable charge and at least part of it must be covered under this Plan. (See "Usual and Reasonable Charge" in the Defined Terms section.)

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

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

Automobile limitations. When any medical benefits coverage is available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles.

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

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

(B) Plans with a coordination provision will pay their benefits up to the Allowable Charge.

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

(1) The benefits of the plan which covers the person directly (that is, as a Member, 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.

(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.

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.

PLEASE NOTE: Benefits will be suspended for the month until payment has been received.

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 Benefit Booklet 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 Benefit Booklet 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.

PLEASE NOTE: Benefits will be suspended for the month until payment has been received.

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
HealthBenefitsSupport@wexinc.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 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, 2026

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

Ameritas
P.O. Box 82520
Lincoln, NE 68201-2520
(800) 487-5553

TRUSTEES:

Shelby Beck
2550 Denali St.
Suite 1614
Anchorage, Alaska 99503

Kathy Bell
2550 Denali St.
Suite 1614
Anchorage, Alaska 99503

Jessica Cook
2550 Denali St.
Suite 1614
Anchorage, Alaska 99503

Kari Konrath - Bera
2550 Denali St.
Suite 1614
Anchorage, Alaska 99503

Laura Mulgrew
2550 Denali St.
Suite 1614
Anchorage, Alaska 99503

Michael Robbins
2550 Denali St.
Suite 1614
Anchorage, Alaska 99503

Monica Southworth
2550 Denali St.
Suite 1614
Anchorage, Alaska 99503

PLAN NAME: Public Education Health Trust

PLAN OPTION: Dental Plan A without Orthodontia

EFFECTIVE DATE: July 1, 2026

RESTATEMENT DATE: July 1, 2026

I, Rhonda Prowell-Kitter, (Name) certify that I am the Plan Administrator (Title)

for the above named Plan, and further certify that I am authorized to sign this Benefit Booklet. I have read and agree with the above referenced Benefit Booklet and am hereby authorizing its implementation as of the restatement date stated above.

Signature: 

Date: June 25, 2026