

FY19 BENEFITS HANDBOOK

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ABOUT THIS HANDBOOK

This handbook summarizes benefit programs currently provided by the University of Alaska. Formal agreements and rules, including but not limited to plan documents, Regents' Policy and University Regulation, determine the actual benefits that will be provided to employees. If the provisions of this summary conflict with such documents, the formal agreements and rules will govern.

The method of delivery or the company through which a benefit program is provided may change from time to time. Specific services may not be duplicated or offered by the new benefit vendor.

Alaska insurance regulations also place certain stipulations on the manner in which insurance-related disputes may be addressed and settled. As a result, each vendor has an established dispute resolution procedure. In addition, because some products are fully underwritten and/or insured by a vendor, the sole remedy for any and all disputes will rest exclusively with that benefit vendor.

This Handbook is current as of July 1, 2018. Updates to the Handbook are made as needed to clarify or correct information. The most recent version of the Handbook can be found on the University of Alaska's benefits web site at www.alaska.edu/benefits/

Your Handbook contains the following sections:

Benefits in Brief Chart—a quick overview of your various benefits and how they interrelate.

Introduction—basic information about the benefit programs of the University.

Health Care—description of your comprehensive Medical, Dental, Pharmacy and Audio benefits, including information about eligibility and enrollment.

Pharmacy—description of your prescription drug benefit, including retail, mail order and specialty pharmacy.

Vision Care—description of the Vision Care Plan as provided by VSP

Health Savings Account (HSA)—for employees on the Consumer-Directed Health Plan (CDHP), an account to use tax-free funds for current or future health care expenses, administered by Bank of America.

Flexible Spending Accounts (FSA)—pay for eligible expenses with tax-free dollars, administered by ASIFlex.

Employee Assistance Program (EAP)—description of the benefits available to employees and their dependents.

Disability—explains how the Long Term Disability plan can replace a percentage of your income in the event you cannot work because of a medical disability.

Life Insurance Benefits—summarizes Life Insurance coverage, optional Supplemental Life Insurance benefits, and voluntary Accidental Death and Dismemberment benefits.

Retirement Benefits—outlines the state-affiliated retirement plans - The Teachers' Retirement System (TRS), and Public Employees' Retirement System (PERS). Also outlines the University of Alaska Optional Retirement Plan (ORP), the University of Alaska Pension Plan, and voluntary Tax-Deferred Annuities or 403(b) plans.

Other Benefits—provides information about the University's regulations and procedures concerning leaves, sabbaticals, holidays, and educational benefits.

If you have any questions about your benefits, please contact the human resources office at your local campus.

BENEFITS IN BRIEF

UA CHOICE HEALTH CARE PROGRAM

Regular employees (and their dependents, if enrolled) are eligible after a waiting period of approximately 30 days from hire date. Employees may waive coverage with proof of other insurance. The University of Alaska and employees both contribute to the cost of this program. The chart below shows what members pay when using the plan. This is in addition to the payroll health care deductions taken from employees' pay.

Benefit:	Consumer-Directed Health Plan (CDHP)	High Deductible Health Plan (HDHP)	750 Plan
Medical Care Deductible	\$1,500 per individual \$3,000 per family	\$1,250 per individual \$3,000 per family	\$ 750 per individual \$2,250 per family
Coinsurance (after the deductible)	20% for in-network services, 40% for out-of-network	20% for in-network services, 40% for out-of-network	20% for in-network services, 40% for out-of-network
Out-of-Pocket Maximum (includes the deductible)	\$5,000 per person, \$6,850 per family for in-network services; Out-of-Network Services do not apply to the maximum out-of-pocket limit.	\$5,000 per person, \$11,000 per family for in-network services; Out-of-Network Services do not apply to the maximum out-of-pocket limit.	\$4,250 per person, \$9,250 per family for in-network services; Out-of-Network Services do not apply to the maximum out-of-pocket limit.
Pharmacy Local retail and mail order benefits; non-network benefits also available	CDHP pharmacy benefit: After the deductible has been met, prescriptions are covered at 80% until the medical out-of-pocket maximum is met. This plan does not have copays.	HDHP and 750 Plan pharmacy benefits: <u>Local Network Pharmacy</u> (30 day supply) Generic Drugs \$10 copay Brand Name \$30 copay Non-preferred \$60 copay Specialty Drugs are \$100 for up to a 30-day supply only from specialty pharmacy Accredo or Walgreens Specialty. There is a \$1,000 individual and \$1,700 family annual out-of-pocket maximum for pharmacy benefits.	
	Note: Up to a 90-day supply of <i>generic drugs</i> available from a retail pharmacy with the applicable multiple of copay or cost. Does not apply to brand name drugs.		
Dental Care (\$2,000 maximum benefit per covered individual per year)	Preventive services 0% Basic expenses 20% Major expenses 50% \$50 annual deductible on basic and major expenses	Preventive services 0% Basic expenses 20% Major expenses 50% \$50 annual deductible on basic and major expenses	Preventive services 0% Basic expenses 20% Major expenses 50% \$25 annual deductible on basic and major expenses Orthodontia at 50% up to \$1,500 lifetime maximum
Vision Care	\$10 copay for exam, \$25 copay for glasses (lenses and frames), no copay for contacts. Exam every plan year, lenses and frames OR contacts every other plan year. Non-VSP provider benefits limited to allowances.		

PRE-TAX SPENDING ACCOUNTS (VOLUNTARY)

Program	Who Pays	Eligibility	Benefits
Health Care Flexible Spending Account (FSA)	You	Regular employees upon enrollment (at the time of hire, during open enrollment, or with “life event”).	Provides employees the opportunity to be reimbursed with their own tax-free contributions for health care expenses that are not covered by the health care program. Account balances must be used during the plan year, or the money is forfeited.
Dependent Care Flexible Spending Account (FSA)	You	Regular employees upon enrollment (at the time of hire, during open enrollment, or with “life event”).	Provides employees the opportunity to be reimbursed with their own tax-free contributions for dependent care expenses that are necessary to allow the employee (and his/her spouse, if married) to seek or retain employment. Account balances must be used during the plan year, or the money is forfeited.
Health Savings Account (HSA)	You	Employees enrolled in the Consumer-Directed Health Plan (CDHP).	Pre-tax savings account for health care expenses. Must be enrolled in CDHP to contribute to HSA. Unused funds roll over to future years and can be invested in a variety of mutual funds.

LIFE INSURANCE

Program	Who Pays	Eligibility	Benefits
Basic Life Insurance	The University	Regular employees from the initial day of employment	\$50,000 of group life insurance coverage is provided to all employees.
Supplemental Life	You	Regular employees upon enrollment (at the time of hire, during open enrollment, or with “life event”).	Available in amounts from \$25,000 to \$400,000, in increments of \$25,000, benefits are paid in a lump sum unless the beneficiary elects some other option. Evidence of Insurability required for amounts over \$200,000. For employees age 65 and over, the maximum amount of life insurance that they may elect is reduced, and elected amounts are reduced per the schedule. Participation is optional.
Accidental Death and Dismemberment	You	Regular employees upon enrollment (at the time of hire, during open enrollment, or with “life event”).	Pays benefits for accidental loss of life or limb. Coverage is also available for dependents. Participation is optional.

RETIREMENT BENEFITS

Program	Who Pays	Eligibility	Benefits
Public Employees' Retirement System (PERS) and Teachers' Retirement System (TRS)	You contribute a percent of your salary before taxes. Contribution rate is determined by date of hire. University contribution can change annually as determined by the State of Alaska Division of Retirement.	Eligible regular employees from initial day of employment. Employees hired on or after July 1, 2006 participate in a defined contribution (DC) plan. Employees hired before July 1, 2006 participate in a defined benefit plan (DB).	Retirement benefit based on date of hire with DC members having a cash account and DB members getting credit for salary and service. Complete details on all features of PERS and TRS are available at the State of Alaska Division of Retirement and Benefits Web site at doa.alaska.gov/drb
Optional Retirement Program (ORP)	You contribute a percentage of your pre-tax salary. University contribution is 14% if hired into an ORP-eligible position before July 1, 2005. If hired after July 1, 2005 your employer contribution rate is 12%.	Regular full-time and part-time faculty and officers/senior administrators must choose between the ORP and the state's retirement system programs within 30 days of being notified they are eligible to participate.	Retirement benefit based on total contributions and earnings. Contributions are placed in an individual tax-deferred account, chosen from a wide variety of investment options provided by four fund sponsors. Participants are fully vested in the employer contribution account after three calendar years; vesting in the employee contribution account is immediate. Vested account balances may be rolled over to another qualified plan or IRA at termination after a 45-day waiting period. Please see the UA Retirement Decision Guide for more information.
University of Alaska Pension Plan	The University contributes 7.65% of your first \$42,000 in gross wages.	Eligible employees from initial day of employment. Employees hired between July 1, 2006 and June 30, 2015 must have elected the ORP to be eligible for UA Pension.	Retirement benefit based on amount contributed and investment options selected. Vesting is immediate if hired before July 1, 2006; 3-year vesting if hired on or after July 1, 2006. Account balance may be withdrawn at termination after a 45-day waiting period.
Tax Deferred Annuity Plans (TDAs)	You.	All employees upon enrollment.	Supplemental savings for retirement and defer taxes on current income. Participation is optional.
Medicare	You and the University.	All employees hired after March 31, 1986.	Medicare benefits for disabled employees and for those age 65 and over.

OTHER BENEFITS *

Program	Who Pays	Eligibility	Benefits
Sick Leave	The University	Regular employees from initial day of employment, and extended temporary employees	Paid leave for illness, medical conditions, or doctors appointment. Leave accrues at 4.62 hours per pay period for full-time employees. See the Family Medical Leave (FML) section for more information.
Leave Share Program	Fellow University Employees Donate from Their Accrued Sick Leave	Regular employees who qualify for Family Medical Leave for a serious health condition and satisfy a required period of leave without pay.	If an employee has exhausted all of their annual leave and sick leave as a result of a catastrophic medical event, they may apply to the leave share program if they still qualify for Family Medical Leave for a serious health condition. Under this program other employees may donate a portion of their sick leave to the employee applying for leave share.
Family Medical Leave (Parental Leave)	You and the University, depending on whether you use sick leave, annual leave, leave without pay, or combinations of the above.	Employees meeting length of employment and hours worked requirements.	Leave for serious health care condition of you or a family member, to care for newborn infant or newly adopted child or for placement of a foster child, or to care for an injured service member or for a qualifying exigency related to a covered service member. See the Family Medical Leave (FML) section for more information.
Annual Leave	The University	Regular employees, except faculty. Faculty should see their collective bargaining agreement for information on Faculty Time Off (FTO).	Vacation time based upon years of service and part-time/full-time employment status. Accrual for a full-time employee is: First 5 years: 5.54 hrs per pay period 6-10 years: 6.46 hrs per pay period Over 10 years: 7.38 hrs per pay period
Holidays	The University	Regular employees. Hours paid based on part/full-time employment status.	Up to 12 paid holidays each calendar year. One additional personal holiday per fiscal year is granted to regular exempt and non-exempt non-represented employees.

*If you are a member of a collective bargaining unit, your benefits may differ. Please check your collective bargaining agreement (CBA).

OTHER BENEFITS

Program	Who Pays	Eligibility	Benefits
Long-term Disability	The University	Regular employees.	If you are hired and actively at work on the first day of the month coverage begins on that day. If you are hired and actively at work on any other day of the month, it starts the first of the following month. In conjunction with other available benefits, the program pays 60% of your base salary, to a maximum of \$3,000/month. Prior to being eligible for this program, an employee must have exhausted all of their sick leave and/or completed the 90-day waiting period, which ever is greater.
Worker's Compensation	The University	All employees from initial day of employment.	Compensation for on-the-job injury or illness. Provides coverage for medical expense and loss of compensation. Injury/illness form must be completed within 10 days after the initial injury of illness.
Leave of Absence	You	All employees who are granted leave by the University.	Unpaid leave for up to one year, with the possibility to extend to a second year.
Educational Benefits	The University	Regular employees and their dependents.	Employees are eligible for up to 16 tuition-free course credits and 8 approved non-credit course charges per academic year. No tuition fee is charged for courses taken by eligible dependents. (Graduate credits, however, are taxable. Self-supporting classes are not covered.)

Travel Accident (for work-related travel only)	The University	Regular employees on official UA travel.	Up to \$250,000 for accidental death or dismemberment while on work-related travel. Contact UA Risk Services for information on this coverage.
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INTRODUCTION

YOUR BENEFIT PROGRAM

In recognition of the diversity of the employee population, the University of Alaska has developed a benefit program that allows flexibility and choice. The health benefit program provides coverage for you and your family not only in case of illness, but also includes several provisions that focus on preventive care. The *UA Choice* health care plan offers you three options: the 750 Plan, the High Deductible Health Plan (HDHP) or the Consumer-Directed Health Plan (CDHP) with a Health Savings Account (HSA), at three different costs to you. Alternatively, if you have other medical coverage and don't need coverage through the University, you can opt out (with proof of other coverage) and avoid payroll deductions for health care.

You may enhance the 750 Plan or HDHP by selecting a medical flexible spending account. The basic life insurance benefit may be supplemented by purchasing the optional supplemental life insurance and/or accidental death and dismemberment coverage. The medical and dependent care flexible spending accounts, health savings account and life insurance plans are designed to allow employees the ability to increase their total benefit coverage. Please note that all optional plans are paid for by the employee and rates are set annually.

Employees may also augment the University retirement program by selecting from a number of Tax-Deferred Annuity plans in which they set aside tax-deferred funds from their salary for income during retirement. These funds would be in addition to any benefits from the state-affiliated retirement plans (PERS or TRS), the University's Optional Retirement Plan (ORP) or the UA Pension Plan.

BENEFIT CONSIDERATIONS

It is important that you carefully evaluate each of the *UA Choice* plans and the optional plans after considering your particular needs. Age, family status, health care requirements, career goals, years of service, pay, and financial objectives are factors that need to be considered when selecting your optional benefits.

Each year during the annual open enrollment period employees can make new benefit elections to reflect changes in their benefit needs. Except in cases of a major life event, the period designated for open enrollment is the only time that employees may make benefit elections or changes. If, however, during the plan year an employee experiences a major life event such as marriage, divorce, birth, adoption, death of a spouse or child, etc., they may be eligible to make a change in their benefit elections as long as the change is consistent with the life event. Please consult your regional campus human resources office if you experience a major life event during the plan year.

CAMPUS HUMAN RESOURCES OFFICE LOCATIONS

Contact your regional campus human resources office at the following addresses for questions about specific programs:

University of Alaska Fairbanks
Human Resources
University of Alaska Fairbanks
UAF Administrative Services Center
P.O. Box 757860
3295 College Road
Fairbanks, AK 99775-7860
907-474-7700

University of Alaska Anchorage
Human Resource Services
101 University Lake Building
3890 University Lake Drive
Anchorage, AK 99508
907-786-4608

University of Alaska Southeast
Human Resources
University of Alaska Southeast
11120 Glacier Highway
Juneau, AK 99801
907-796-6473

Statewide Administration
Statewide Office of Human Resources
University of Alaska
P.O. Box 755140
212 Butrovich Building
Fairbanks, AK 99775-5140
907-450-8200

YOUR ROLE IN CONTROLLING YOUR HEALTH PLAN COSTS

The University's health care program has many features that have been designed to provide for your health care protection. However, your wise and careful use of the program is key to the University's ability to continue to offer a comprehensive health care program.

The cost of the health care plan is shared between employees and the university, with the university currently paying 82% of the net plan cost. For the FY19 plan year, the university's contribution is projected to be approximately \$47.2 million, or \$14,776 per employee.

One of the most effective measures that you can take in your personal efforts to assist in controlling the cost of the health care program is to develop a healthy lifestyle. Unless you are one of the few really health-conscious individuals, your current lifestyle is almost certainly less healthy than it could be. Now is the time to modify it. You will benefit first of all by lowering your risk of developing a preventable illness. Heart disease, cardiovascular disease, and cancer are major costs to your health care program and are more easily prevented than cured. Second, as you become increasingly fit, you will feel better and will find that you are more able to enjoy life. Basic guidelines for healthy living are simple, and medical research shows convincingly that following these guidelines will improve your chances for a longer, healthier life:

- If you smoke or use tobacco, quit. Tobacco cessation programs are available to help you quit.
- If you drink, drink in moderation.
- Get some aerobic exercise, preferably 30 minutes daily but at least three to five times each week.
- Eat a well-balanced diet.
- Get plenty of rest, and try to schedule time for yourself.

To help employees improve their health by adopting a more healthy lifestyle, the University of Alaska promotes a wellness program to provide incentives, health resources, screening and activity tracking tools and participant-based activities. This program goes beyond the health plan to help employees and their spouse or partner develop a healthy lifestyle plan that meets their needs. In addition, all three *UA Choice* plans offer preventive benefits covered at 100 percent of allowable charges so employees and dependents can get the necessary age and gender specific screening tests, well-care checkups and immunizations needed to maintain good health.

The University has contracted with Premera Blue Cross Blue Shield of Alaska, also referred to as Blue Cross in this Handbook, for **claims processing and payment** of the medical, pharmacy and dental plan benefits. Vision care benefits are provided by VSP. Please contact your regional Human Resources office at the numbers on the previous page, Blue Cross at (800) 364-2982, or VSP at www.vsp.com or (800) 877-7195 if you have any questions regarding your benefit plan.

This plan complies with the 2010 federal health care reform law, called the Affordable Care Act (see Glossary of Terms). If Congress, federal or state regulators, or the courts make further changes or clarifications regarding the Affordable Care Act and its implementing regulations, including changes which become effective on the beginning of the plan year, this plan will comply with them even if they are not stated in this Handbook or if they conflict with statements made in this Handbook.

ELIGIBILITY

EMPLOYEE ELIGIBILITY

Regular full-time, regular part-time working at least 20 hours per week, and extended temporary employees of the University of Alaska may elect either the 750 Plan, the High Deductible Health Plan (HDHP) or the Consumer-Directed Health Plan (CDHP) options under the UA Choice Health Plan, or may elect to waive coverage with verification of other coverage. Please note that there are restrictions on who can enroll in and contribute to the Health Savings Account that is coupled with the CDHP.

Temporary employees who are expected to work at least 30 hours per week on a regular basis may be eligible for health care coverage as required by the Affordable Care Act. Work hours for all temporary employees will be tracked over a specified “look back” period of time (currently six months) to determine if their hours worked will qualify them for health coverage. If hours worked average 30 hours per week or more (130 hours per month), the employee will be notified by the university and provided an opportunity to enroll in coverage for a six month period. This six month period of coverage is called the “stability period,” and it follows a two month “administrative period” where eligibility is confirmed, coverage is offered and enrollment is processed.

There is an initial “look back” or measurement period six months after the employee is hired. There are also two standard measurement periods each year to determine eligibility for the standard stability periods of January through June, and July through December. If the employee continues to work 30 or more hours per week in each subsequent standard measurement period, the employee’s health care coverage will continue as long as the employee remains employed, even if hours drop below 30 hours per week during the coverage or stability period.

ENROLLMENT WAITING PERIOD

Eligible employees have a 30-day election period in which to choose their preferred health plan and dependent coverage options. The health plan requires a waiting period of 30 days from your date of hire into a benefits-eligible position, or attaining extended temporary status, before coverage for the employee and eligible enrolled dependents is effective on the 31st day.

If you do not submit an enrollment form and/or if you do not opt out (waive coverage) within your 30-day election period, you will automatically be enrolled in the High Deductible Health Plan (HDHP) with employee-only coverage, effective the 31st day following your date of hire or eligibility. **Please Note:** to submit your enrollment form means it has been received by your regional human resources office.

Employees rehired after a break in service of less than 10 working days from a benefits-eligible position will be covered as of the date of rehire into a benefits-eligible position, with no additional waiting period. Breaks in service of 10 working days or longer require the waiting period to be satisfied again.

Enrollments based on a life event are effective on the day of the life event, as long as the enrollment form is turned in within the appropriate time frame.

Employees and eligible dependents who enroll during the annual open enrollment will have coverage effective the following July 1.

Temporary employees who are offered coverage because their hours meet the 30 hours per week average during the look back period will have a deadline to enroll on their offer letter, with a stated coverage begin date. Temporary employees who do not enroll are deemed to have waived coverage, whether or not they return their signed letter indicating they do not wish to enroll.

DEPENDENT ENROLLMENT TIME FRAMES

Eligible employees are not required to enroll their eligible dependents, but may choose to do so at the time of initial eligibility, open enrollment or in the case of a major life event as explained below. Coverage for dependents can only be elected within thirty (30) days of hire, within thirty (30) days after a major life event, or during open enrollment, with the exception of newborn or newly adopted children, in which case you are allowed 60 days.

In the case of a major life event, coverage begins on the date of the major life event. Coverage for a dependent elected at open enrollment will become effective on July 1.

DEPENDENT ELIGIBILITY

Employees are required to notify their regional human resources office as soon as a dependent loses eligibility status.

To be eligible for coverage as a dependent under this program, the family member must fit one of the following descriptions:

- The lawful spouse of the employee, unless legally separated
Please note: Provided all requirements are met as specified by the University of Alaska, wherever “spouse” is stated in the health care plan, a financially interdependent partner would also be included. Please contact your regional human resources office for details concerning financially interdependent relationships.
- A “child” 25 years of age or younger. A child is considered one of the following:
 - A natural offspring of either or both the employee or spouse
 - A legally adopted child of either or both the employee or spouse
 - A child for whom the employee has been granted court-appointed legal guardianship; there must be a court order signed by a judge, which grants guardianship of the child to the employee or spouse of the employee as of a specific date. When the court order terminates or expires, the child is no longer an eligible child
 - A child for whom the employee or spouse is under a domestic relations order to provide medical benefits as directed by a divorce decree, a medical child support order or other court-ordered dependent coverage
 - A foster child living with the employee; there must be a court or other order signed by a judge or state agency, which grants guardianship of the child to the employee or spouse of the employee as of a specific date. When the court order terminates or expires, the child is no longer an eligible child.
 - A child “placed” with the employee for the purpose of legal adoption in accordance with state law; placed for adoption means assumption and retention by the employee of a legal obligation for total or partial support of a child in anticipation of adoption of such child.

EVIDENCE OF ELIGIBILITY

The University of Alaska requires evidence of eligibility for all enrolled dependents. Supporting documents include birth certificate, marriage license, final adoption paperwork, tax returns showing claimed dependents, qualified medical child support orders, legal guardianship papers, etc. See your regional human resources office for more information on supporting documentation.

CONTINUED ELIGIBILITY FOR A DISABLED CHILD

Coverage may continue past the limiting age of 26 for a dependent child who cannot support himself or herself because of a developmental or physical disability. The child will continue to be eligible if all the following requirements are met:

- The child became disabled before reaching the limiting age of 26.
- The child is incapable of self-sustaining employment by reason of developmental disability or physical handi-

cap, and is chiefly dependent upon the employee for economic support and maintenance.

- The employee remains covered under this program.
- The employee's cost for dependent coverage continues to be paid.
- Within 30 days of the child reaching the limiting age, the employee must have completed and have on file with Blue Cross a "Request for Certification of Handicapped Dependent" status form.
- The employee has continued to provide Blue Cross with proof of the child's disability and dependent status when requested. Blue Cross will not ask for proof more often than once a year after the two-year period following the child's attainment of the limiting age.

Blue Cross must approve the request for certification before coverage can continue.

MAJOR LIFE EVENT

Outside of the annual open enrollment period, an employee may change an enrollment election (i.e., add or delete dependents, change level of coverage) only if there has been a major life event. The following are considered major life events:

- Marriage or divorce of the employee
- Death of the employee's spouse or a dependent
- Birth or adoption of a child by the employee
- Termination of employment (or the commencement of employment) of the employee's spouse
- Switching from part-time to full-time employment status or from full-time to part-time status by the employee or the employee's spouse
- Taking of an unpaid leave of absence by the employee or the employee's spouse
- A significant change in the health coverage of the employee or the employee's spouse attributable to the spouse's employment
- Gain or involuntary loss of health care coverage of your dependent

Changes (addition or deletion of dependents) will be limited to those that are both on account of a major life event and are consistent with that major life event. Enrollment changes are subject to the other terms and limitations of this program.

An eligible employee who previously elected not to enroll a dependent(s) in the plan when such coverage was previously offered, may enroll the dependent(s) in the plan at the same time a newly acquired dependent is enrolled.

INVOLUNTARY LOSS OF OTHER COVERAGE

If a dependent did not enroll in this program when first eligible, the dependent may later enroll outside of the annual open enrollment period if each of the following requirements are met:

- your dependent was covered under group health coverage or a health insurance program at the time coverage under the University of Alaska's program was previously offered;
- you declined coverage for your dependent under this program at the time this coverage was offered, and
- your dependent's coverage under the other group health coverage or health program was terminated as a result of:
 - loss of eligibility for the coverage (including, but not limited to, as a result of legal separation, divorce, death, taking an unpaid leave of absence, termination of employment, or reduction in hours of employment);

- termination of employer contributions toward such coverage, or
- your dependent was covered under COBRA at the time coverage under this program was previously offered and COBRA coverage has been exhausted.
- there is a significant change in the health coverage of your spouse attributable to their employment.

When the University of Alaska receives your completed enrollment form and any required contributions within 30 days of the date such other coverage ended, coverage under this program will be come effective on the day after the other coverage ended. If the University of Alaska does not receive your completed enrollment form within 30 days of the date prior coverage ended, refer to “Open Enrollment” below.

ENROLLMENT

After timely enrollment, coverage will become effective on the following dates:

- For the employee and enrolled family members, see the section on Enrollment Waiting Period
- For a spouse and eligible children acquired through marriage, on the date of marriage
- For a spouse and eligible children who have had a loss of other coverage, the day after other coverage ended
- For a newborn child, on the child’s date of birth
- For an adopted child, on the date the child is placed with the employee for the purpose of legal adoption
- For a child covered under a court-appointed legal guardianship order, the date the court grants legal guardianship to the employee or spouse
- For a child covered under a domestic relations order to provide medical benefits as directed by a divorce decree or other court order, the date of the order
- For a foster child, on the date the child is placed in the employee’s home

OPEN ENROLLMENT

An eligible dependent who is not enrolled when first eligible or who fails to maintain continuous coverage may enroll only during the University’s annual open enrollment period. To enroll, proper application must be made during the open enrollment period and coverage will become effective at the beginning of the new plan year (July 1).

RE-ENROLLMENT AFTER A LAPSE IN COVERAGE

If your coverage is reinstated after a lapse of time, the date your coverage begins again becomes your new effective date. All terms and conditions of the health care program will apply at the time of reinstatement. Please see the section on Enrollment Waiting Period for more information.

COST FOR EMPLOYEE AND DEPENDENT COVERAGE

Employees are required to share in the cost of their health care coverage. The cost for employee and dependent coverage is determined annually. See the benefits web site at www.alaska.edu/benefits for current plan rates.

DirectPath

The University of Alaska has partnered with DirectPath for member advocacy and price transparency services. DirectPath is here to help you be a better health care consumer, and to help with many health care and eligibility issues.

DirectPath is 100% confidential and available at no cost to you or your covered family members. They are totally independent of Premera Blue Cross or any other insurance company so can help you with claims issues, appeals, finding in-network providers and help selecting a health plan. A full range of services is available, including:

- providing cost and quality research for planned medical services
- help with reading and understanding your Explanation of Benefits (EOB)
- resolving claims and billing issues
- finding in-network providers, and help you make your appointment
- help with the Premera medical travel support benefit
- verifying coverage and assist with prior authorization and referrals
- resolving prescription drug issues, including the prior authorization process and help with mail order
- coordinating coverage with primary and secondary coverage
- help with life events and the related benefits changes available
- help selecting a health plan at open enrollment or after life events.

When you need to schedule an elective procedure (non-emergency) such as advanced imaging or a surgery, please call DirectPath and ask for a cost and quality report. Prices can vary widely even among local providers. Find out what your provider and others nearby will charge for the same service. You can also request a comparison with a provider in the Pacific Northwest to see if traveling for care might be a better option. Get cost and quality comparisons of up to three providers and then you can decide which provider to choose.

DirectPath is available by calling 866-253-2273, Monday through Friday 4 a.m. to 5 p.m., or Saturdays from 4 a.m. to 10 a.m. Alaska time, or by visiting www.advocacy.directpathhealth.com/university_of_alaska/ anytime. Scroll to the bottom of the web site for authorization forms to allow DirectPath to work on your behalf.

PRE-APPROVAL (PRIOR AUTHORIZATION)

Your coverage for some services depends on whether the service is approved by Premera before you receive it. This process is called pre-approval (formerly prior authorization).

A planned service is reviewed to make sure it is medically necessary and eligible for coverage under this plan. You will be notified in writing if the service is approved. Notification will be faxed to your provider with a copy mailed to you. If the services are not approved, you will be given the reasons why. If you disagree with the decision, you can request an appeal. See “When You Have An Appeal” in this Handbook, or call Premera customer service at (800) 364-2982.

There are three situations where pre-approval is required:

- Before you receive certain medical services and drugs, or prescription drugs
- Before you schedule a planned admission to certain inpatient facilities
- Before you get services from non-network providers in Alaska that you want covered at the in-network level. If there are no in-network providers within 50 miles of your home, non-network providers will be covered at the in-network level.

Exceptions: The following services are not subject to this pre-approval requirement, but they have separate requirements:

- Emergency hospital admissions, including admissions for drug or alcohol detoxification, do not require pre-approval, but you must notify Premera as soon as reasonably possible.
- Childbirth admission to a hospital, or admissions for newborns that need medical care at birth, do not require pre-approval, but you must notify Premera as soon as reasonably possible.

GETTING PRE-APPROVAL

Services from in-network providers: It is your in-network provider’s responsibility to get pre-approval. They can call the number listed on your ID card to request a pre-approval.

Services from non-network providers: It is your responsibility to get pre-approval for any of the services on the pre-approval list when you see a non-network provider. The non-network provider may agree to make the request for you, however, you should call Premera to make sure they have approved the pre-approval request in writing before you receive the services.

Certain services, devices and drugs need to be reviewed to make sure that they are medically necessary for you and meet this plan’s other standards for coverage. It is to your advantage to know in advance if the plan would not cover them.

PRE-APPROVAL FOR MEDICAL SERVICES

The following medical services require pre-approval:

- Certain prescription drugs. Please see the Pre-Approval for Prescription Drugs section below. You can also see the Pharmacy section at premera.com.

- Home medical equipment costing \$500 or more
- Injectable medications you get in a healthcare provider's office
- Inpatient Facility Admissions, including
 - Planned inpatient hospital care (surgical, non-surgical, behavioral health and/or substance abuse)
 - Admission to skilled nursing facility, long-term acute care hospital or a rehabilitation facility
 - All residential treatment program admissions
- Non-emergency ground air or ambulance transport
- Outpatient imaging tests including:
 - Contrast Enhanced Computed Tomography (CT) Angiography of the heart
 - Computed Tomography (CT) Scans
 - Echocardiograms
 - High Tech Ultrasounds
 - Magnetic Resonance Imaging (MRI)
 - Magnetic Resonance Angiography (MRA)
 - Magnetic Resonance Spectroscopy
 - Nuclear Cardiology
 - Positron Emission Tomography (PET and PET/CT)
- Prosthetics and orthotics other than foot orthotics or orthopedic shoes
- Reconstructive surgery, including repairs of defects caused by injury and correction of functional disorders
- Surgical, medical therapeutic, diagnostic and reconstructive procedures, including:
 - Abdominoplasty/Panniculectomy
 - Ablation therapy
 - Arthroplasty and arthroscopy of major joints such as the shoulder, hip, and knee
 - Artificial intervertebral disc (any level)
 - Blepharoplasty (eyelid surgery)
 - Bone anchored and implantable hearing aids
 - Breast surgeries such as implant removal, mastectomy for gynecomastia , prophylactic mastectomy, reduction mammoplasty
 - Cardiac devices; including implantation
 - Cardiac percutaneous interventions
 - Chemotherapy administration and radiation oncology
 - Cochlear implantation
 - Corneal remodeling
 - Cosmetic or reconstructive surgery usually done to change the appearance
 - Cryosurgical ablation/ablation of tumors
 - Deep brain stimulation
 - Esophageal sphincter procedures
 - Extracorporeal photophoresis
 - Facet Arthroscopy
 - Facility based sleep studies (polysomnography)
 - Gastric restrictive procedures
 - Genetic testing and analysis
 - Hyperbaric oxygen therapy

- Implantation or application of electric stimulator
- Intraspinous distraction devices
- Mitral valve repair
- Nasal/sinus surgery
- Nursing care in the home
- Panniculectomy
- Radiation therapy such as gamma knife, proton beam, intensity modulated radiation therapy (IMRT), intra-operative radiation therapy
- Radiofrequency tumor ablation
- Spine surgery/treatments, such as cervical spinal fusion and lumbar spinal fusion
- Surgeries related to gender assignment
- Surgeries related to sleep apnea
- Therapeutic apheresis
- Transcatheter occlusion or embolization for tumor destruction
- Transcranial magnetic stimulation (TMS)
- Upper gastrointestinal endoscopy
- Vascular embolization or occlusion for tumors, organ ischemia or infarction
- Vertebroplasty, kyphoplasty, or sacroplasty
- Vagus nerve blocking therapy
- Varicose veins and perforator veins (all procedures)
- Transplant and donor services

Premera will respond to your request for pre-approval within 72 hours of receipt of all information necessary to make a decision. If your situation is clinically urgent (meaning that your life or health would be put in serious jeopardy if you did not get treatment right away), you may ask for an expedited review. Expedited reviews are responded to as soon as possible, but no later than 24 hours after all information necessary to make a decision has been received. Premera will provide the decision in writing.

Pre-approvals are good for 30 calendar days. This 30-day period is subject to your continued coverage under the plan. If you don't get the service, drug or supply item within that time, you will have to ask Premera for another pre-approval. A pre-approval may not be retroactively denied unless it was based on materially incomplete or inaccurate information provided to us by you or your provider.

PRE-APPROVAL FOR PRESCRIPTION DRUGS

Certain prescription drugs must be pre-approved before you get them at a pharmacy, in order for the plan to provide benefits. Your provider can ask for a pre-approval by faxing a pre-approval form, found on the pharmacy section of the Premera Web site at www.premera.com, to Premera at the number on the form.

You can find out if a specific drug requires pre-approval by contacting Customer Service, or checking premera.com. If your prescription drug requires pre-approval, and you do not get pre-approval, your pharmacy will tell you that it needs pre-approval. You or your pharmacy should call your provider to let them know. Your provider can fax a pre-approval form to Premera for review.

You can buy the prescription drug before it is pre-approved, but you must pay the full cost. If the drug is approved after you bought it, you can send a manual claim for reimbursement. Reimbursement will be based on the allowable charge. See "How To File A Claim" for details.

The categories of drugs that require pre-approval are:

- Andrenergics
- Androgens, Estrogens, Hormones and related drugs
- Angiotensin II Receptor Blockers
- Anticholinergics and Antispasmodics
- Anticonvulsants
- Antidepressant agents
- Antipsoriatic/Antiseborrheic
- Antipsychotics
- Drugs with significant changes in product labeling
- Glaucoma drugs
- Growth hormones
- Headache therapy
- Hypnotic agents
- Hypoglycemic agents
- Insulin Therapy
- Interferons
- Intranasal steroids
- Lipid/Cholesterol lowering agents
- Miscellaneous analgesics
- Miscellaneous antineoplastic drugs
- Miscellaneous antivirals
- Miscellaneous gastrointestinal agents
- Miscellaneous neurological therapy drugs
- Miscellaneous psychotherapeutic agents
- Miscellaneous pulmonary agents
- Miscellaneous rheumatological agents
- Myeloid stimulants
- Narcotics
- Narcotics antagonists
- Newly FDA-approved drugs
- NSAIDS/Cox II inhibitors
- Proton pump inhibitors
- Smoking deterrents
- Specialty drugs
- Tetracyclines
- Topical acne agents

Please contact Customer Service at (800) 364-2982 or check premera.com for the detailed list of drugs requiring prior authorization.

CLINICAL REVIEW

Clinical review is a summary of medical and payment policies. These are used to make sure that you get appropriate and cost-effective care. Premera's policies include:

- Accepted clinical practice guidelines
- Industry standards accepted by organizations like the American Medical Association (AMA)
- Other professional societies
- Center for Medicare and Medicaid Services (CMS).

Premera's medical policies can be found online at www.premera.com.

You or your provider may request a copy of the criteria used to make a medical necessity decision. Please send your request to Care Management at the address below, or fax to 1-800-843-1114.

Pre-Approval
Premera Blue Cross Blue Shield of Alaska
PO Box 91059
Seattle, WA 98111-9159

Premera may deny payment for services that are not medically necessary or that are considered experimental or investigational. A decision by Premera may be appealed, see the "Your Questions, Complaints and Appeals" section. When there is more than one alternative available, coverage will be provided for the least costly among medically appropriate alternatives.

PLAN YEAR DEDUCTIBLE—MEDICAL

INDIVIDUAL DEDUCTIBLE

Each plan year you must satisfy a deductible before your Comprehensive Medical Benefits are payable. Deductible amounts for each plan in *UA Choice* are listed below.

While some benefits have dollar maximums, others have different kinds of maximums, such as a maximum number of visits or days of care that can be covered. Allowable charges that apply to your individual plan year deductible don't count toward dollar benefit maximums. But if you receive services or supplies covered by a benefit that has any other kind of maximum, charges for those services or supplies that apply to your deductible are also applied to that benefit's maximum.

FAMILY DEDUCTIBLE

This program has a Comprehensive Medical Plan Year Deductible limit for families. If the total deductible for you and your family reaches a certain amount within one plan year, you will not be subject to any further deductible for that year. Family deductible limits are shown below.

<u>Plan Option</u>	<u>Individual Deductible</u>	<u>Family Deductible</u>
750 Plan	\$ 750	\$2,250
High Deductible Health Plan	\$1,250	\$3,000
Consumer-Directed Health Plan*	\$1,500	\$3,000

* Note that the individual and family deductibles work differently with the CDHP. If more than one person is covered, then the family deductible applies. No benefits for medical or pharmacy coverage are provided for any person until the *family deductible* has been satisfied.

The following features are applicable only for the 750 and High Deductible Health Plans:

COMMON ACCIDENT DEDUCTIBLE

If you and one or more of your insured dependents, or two or more of your insured dependents, incur covered medical expenses as a result of the same accident, the deductible will be applied only once during the plan year in which the accident occurs and the following plan year. In other words, no matter how many insured family members receive treatment for injuries from an accident, the deductible is the applicable individual deductible.

Because the deductible in the Consumer-Directed Health Plan is an aggregate deductible (there is no individual deductible if more than one person is enrolled), the common accident benefit does not apply.

FOURTH QUARTER DEDUCTIBLE CARRY FORWARD

Covered charges that are applied toward a deductible for services incurred during the last three months of a plan year may be carried over to reduce the deductible for the next plan year. This is also true for the family deductible. This feature is not available in the Consumer-Directed Health Plan because no benefits are payable until the full plan year deductible has been satisfied.

BENEFITS NOT SUBJECT TO THE MEDICAL DEDUCTIBLE

The following benefits are not subject to the comprehensive medical plan year deductible on any plan:

- Screening Mammography
- Wellness Provisions (Preventive Benefit)
- Dental Care (see the Dental Benefits section for information on dental deductibles)

The following benefits are not subject to the comprehensive medical plan year deductible on the **HDHP and 750 Plan** only:

- Diagnostic Mammography
- Pharmacy Benefits
- Audio Care
- Dialysis Benefit (only after the 90-day Medicare waiting period)

SCHEDULE OF BENEFITS—MEDICAL

The benefits of your health care plan are based on allowable charges for covered services and supplies. Please refer to the definition of Allowable Charge in the Glossary of Terms at the back of this Handbook.

Premera Blue Cross Blue Shield of Alaska has developed a broad network of providers in the state of Alaska called the *Alaska Heritage Network*. You may seek covered services from any provider licensed to provide the service. However, within Alaska, in order to receive the higher level of benefits available under this program for certain services, you must use a physician, hospital or hospital-based substance abuse treatment facility in the Network. For this purpose, a “physician” means a provider who is licensed by the state as a Doctor of Medicine and Surgery (M.D.), Doctor of Osteopathy and Surgery (D.O.) or Podiatrist (D.P.M.).

When you use a physician, hospital, or hospital-based substance abuse treatment facility in the Network, you will be responsible only for any applicable deductibles, copayments, coinsurance, out-of-pocket maximums, charges in excess of the stated benefit maximums, and charges for services and supplies not covered under the health care program. In addition, network providers will bill Blue Cross directly when they furnish covered services to you.

If you use a provider that doesn’t have a network agreement with Blue Cross, you’ll be responsible for amounts over the allowable charge. Amounts in excess of the allowable charge also don’t count toward the plan year deductible or as coinsurance. See the definitions of Allowable Charge in the Glossary of Terms section of this Handbook.

ANCHORAGE, FAIRBANKS AND JUNEAU

If you live in the greater Anchorage, Fairbanks or Juneau areas, the full network of Alaska Heritage providers is available (Alaska HeritagePlus network). For non-emergency physician services, hospital services and hospital-based chemical dependency services received in Alaska, you must use Alaska HeritagePlus network providers to receive the higher level of benefits provided under this program. After you satisfy your Plan Year Medical Deductible, the Plan will provide benefits for covered services as follows:

- **In-network Benefit Level:** benefits will be provided at 80 percent of allowable charges for covered services and supplies. This benefit level is also provided for non-network providers when Blue Cross has granted a benefit level exception for non-emergent care as explained below.
- **Out-of-network Benefit Level:** benefits will be provided at a constant 60 percent of allowable charges; out-of-pocket expenses do not accrue towards any out-of-pocket maximum. The allowable charge for out-of-network providers is 200% of Medicare, which could leave you with a significant out of pocket expense. Additional requirements may apply, please see the Allowable Charge definition in the Glossary of Terms (p. 125).

To locate a network provider in your area, please refer to the Blue Cross Heritage Network *Directory of Alaska Physicians and Other Providers*. If you have questions, please contact Blue Cross Customer Service at (800) 364-2982, your regional human resources office, or check the University of Alaska’s benefits web site at www.alaska.edu/benefits or Premera.com.

OUTSIDE ANCHORAGE, FAIRBANKS AND JUNEAU

If you live outside of the greater Anchorage, Fairbanks or Juneau areas, the network provider requirement in the state of Alaska applies to hospitals and hospital-based chemical dependency programs in Anchorage only. However, if you receive care outside of Alaska, you must use network providers to receive the higher level of benefits.

WHEN YOU ARE OUTSIDE ALASKA

For non-emergency physician, hospital and hospital-based chemical dependency services received in Washington, you'll receive the higher level of benefits when you use Heritage network providers. For the same services outside of Alaska and Washington, seek care from providers with preferred agreements with the local Blue Cross and/or Blue Shield Licensee.

When traveling or if eligible dependents are attending school outside the state of Alaska, it is imperative that you use preferred providers to obtain the higher level of benefits from your health care plan. See The BlueCard Program section of this Handbook for more information.

EMERGENCY SERVICES

Benefits for medical emergencies and accidental injuries will be provided at the higher level (80% of allowed charges) when you see any covered provider. Premera Blue Cross Blue Shield of Alaska will pay the allowable charge for these services and you'll only pay your applicable deductibles, coinsurance, copays, amounts that exceed the benefit maximums, amounts above the allowable charge for non-network providers and charges for non-covered services.

OUT-OF-NETWORK EXCEPTION FOR NON-EMERGENT CARE

If you require the services of a physician or hospital that is not in the Alaska Heritage network, you must call Blue Cross for prior authorization to receive the higher level of benefits. See "Services from Non-Network Providers" in the Prior Authorization section for more information. If you do not call Blue Cross for prior authorization beforehand, or if your request is denied, benefits will be provided at a constant 60 percent of allowable charges after you have met your deductible, with no maximum out-of-pocket limit.

If approved, the in-network cost share is applied to the out-of-network allowable charge, which is 200% of the Medicare allowed amount in Alaska or 125% of the Medicare allowed amount for out-of-state providers. Keep in mind this is much less than most providers charge. In addition to the cost-share, you will be required to pay any amounts over the allowable charge, which could be a significant share of the cost.

WAIVED SERVICES

Premera Blue Cross Blue Shield of Alaska may from time to time identify providers that they don't have agreements with who provide specific services for which you'll always receive the higher level of benefits. Waived services won't require an out-of-network exception, but may still require prior authorization. If you'd like more information on waived services, please call Customer Service at (800) 364-2982.

PROVIDER STATUS

Since a provider's agreement with Premera Blue Cross Blue Shield of Alaska is subject to change at any time, it is important to verify a provider's status. This may help you avoid additional out-of-pocket expenses. Please call Customer Service at (800) 364-2982 to verify a provider's status. If you are outside Alaska and Washington, or in Clark County, Washington, call (800) 810-BLUE (2583) to locate or verify the status of a provider.

If you are seeing a provider and their written agreement with Blue Cross is terminated while you are receiving pregnancy care or other active treatment, Blue Cross will consider the provider as if they still have an active agreement with Blue Cross for the purpose of that care until one of the following occurs:

- This program is terminated.
- The provider's status will change on the date the provider's medically necessary treatment of a terminal condition ends. "Terminal" means that the patient is expected to live less than one year from the date the provider's agreement is terminated.
- In all other cases, the provider's status will change on the last of three dates to occur:
 - The ninetieth day after the date the provider's agreement is terminated;
 - The date the current plan year ends; or
 - The date postpartum care is completed.

OUT-OF-POCKET MAXIMUMS

This provision offers extended protection for you and your family by placing maximum limits on your out-of-pocket costs for medical services (personal expenses for covered and allowable charges) when you use Alaska Heritage network providers. Once you have reached your out-of-pocket limit, benefits will be provided at 100 percent of allowable charges for covered services received by you from network providers during the remainder of that plan year.

If you live in the greater Anchorage, Fairbanks or Juneau areas where the full Alaska Heritage provider network applies, and you do not use a network provider or do not obtain a benefit level exception for non-emergent care for a non-network provider, your out-of-pocket expenses will not apply to any maximum out-of-pocket limit. Please see the Benefit Level Exception for Non-Emergent Care section of this Handbook.

Please Note: The 100 percent benefit level does not apply to the following benefits, which have their own specific benefit levels. Expenses incurred for these benefits do not accrue toward your medical out-of-pocket maximums, with the exception of any plan year deductibles:

- Dental Care Benefit
- Orthognathic Surgery Services
- Vision Care Benefit through VSP
- Pharmacy Drug Program for 750 Plan and HDHP
- Audio Care Benefit

In addition, amounts that exceed the benefit maximums under this program, and amounts for services and supplies not covered under this program **do not** accrue toward your individual or family medical coinsurance out-of-pocket maximum.

COINSURANCE

Coinurance is a defined percentage of allowable charges for covered services and supplies you receive. The benefit level provided by this plan and the remaining percentage you're responsible for are referred to as coinsurance. Your coinsurance for the covered services and supplies you receive is either 20% or 40% (plan pays 80% and 60%, respectively) depending on where you get care and the network status of your provider. See the "Schedule of Benefits-Medical" section for more information.

INDIVIDUAL MEDICAL OUT-OF-POCKET MAXIMUM

Based upon **covered** and allowable charges, the plan year maximum coinsurance that an individual would pay is shown in the tables below. During the plan year, after you pay the out-of-pocket maximum for covered medical services from network providers, any further **covered** and allowable medical expenses incurred by you from network providers would be reimbursed at 100 percent (subject to allowable charges) for the rest of that plan year. See the following tables for detail by plan option.

For the Consumer-Directed Health Plan (CDHP), the individual out-of-pocket maximum only applies if you are enrolled in employee only coverage. For any other type of enrollment (employee + spouse, employee + child(ren) or employee + family), the family out-of-pocket maximum applies and must be satisfied before the plan reimburses at 100 percent for any family member.

FAMILY MEDICAL OUT-OF-POCKET MAXIMUM

Based upon **covered** and allowable charges for services from network providers, the yearly maximum coinsurance for a family is shown in the tables below. During the plan year, if your family were to receive sufficient covered medical services from network providers to reach your coinsurance maximum, any further covered medical expenses incurred by your family from network providers would be reimbursed at 100 percent (subject to allowable charges) for the rest of that plan year. See the following tables for detail by plan option.

OUT-OF-POCKET MAXIMUMS BY PLAN OPTION

The medical out-of-pocket maximum coinsurance is the most you'll pay for covered in-network medical expenses after your deductible is satisfied. For the 750 Plan and High Deductible Health Plan, this maximum is for covered in-network medical expenses only; it does not include pharmacy, vision or dental coinsurance or copays. (The pharmacy plan has its own maximum out-of-pocket limit, see the Pharmacy Program section for more information.)

For the Consumer-Directed Health Plan, the maximum does include pharmacy expenses because they are treated as any other medical expense. Also, if you cover anyone else in addition to yourself on the CDHP, the family out-of-pocket maximum applies. The individual limit is for self-only coverage.

The maximum out-of-pocket you'll pay for covered and allowed in-network expenses is broken out by plan as follows:

Consumer-Directed Health Plan	Individual Limit	Family Limit
Deductible	\$ 1,500	\$ 3,000
Maximum Coinsurance	\$ 3,500	\$ 3,850
Total Out-of-Pocket Charges You'll Pay for the Plan Year	\$ 5,000	\$ 6,850

High Deductible Health Plan	Individual Limit	Family Limit
Deductible	\$ 1,250	\$ 3,000
Maximum Coinsurance	\$ 3,750	\$ 8,000
Total Out-of-Pocket Charges You'll Pay for the Plan Year	\$ 5,000	\$11,000

750 Plan	Individual Limit	Family Limit
Deductible	\$ 750	\$ 2,250
Maximum Coinsurance	\$ 3,500	\$ 7,000
Total Out-of-Pocket Charges You'll Pay for the Plan Year	\$ 4,250	\$ 9,250

MAXIMUM LIFETIME BENEFIT

The maximum lifetime benefit for any person insured under the University's health care plan is unlimited.

PREVENTIVE CARE BENEFIT

Our shared goal is a healthy and productive work force. The UA Choice Plan includes a Preventive Benefit that expands the medical care available to employees and their dependents. It allows you to decide what routine tests, screenings and immunizations are right for you and your family. The Preventive Benefit is available to you in addition to traditional diagnostic care.

Recent health care reform legislation has expanded the list of eligible preventive services. As a guide, we have published a list of these services and the suggested appropriate age guidelines on the University of Alaska's benefits web site at www.alaska.edu/benefits/health-plan/preventive-benefit.

Preventive services are a specific set of evidence-based services expected to prevent future illness. These services are based on guidelines established by government agencies and professional medical societies. The guidelines come from:

- Evidence-based items or services with a rating of "A" or "B" in the current recommendations of the U.S. Preventive Task Force (USPSTF). Also included are additional preventive care and screenings for women not described above in this paragraph as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control (CDC) and Prevention.
- Evidence-informed infant, child and adolescent preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

Please go to <https://www.healthcare.gov/coverage/preventive-care-benefits/> for more information. The agencies above may also change their guidelines from time to time. If this happens, this plan will comply with the changes. Some preventive services and tests have limits on how often you should get them. The limits are often based on your age and gender.

This Preventive Medical Care benefit covers routine exams and immunizations. Other medical services that qualify as preventive as shown above may also be covered under various other benefits of this plan.

For example, diagnostic colonoscopies are normally covered under the surgical services benefit. When these services meet the federal requirements for preventive medical services, however, the plan will provide benefits for them as stated below instead of as described in the benefit which normally covers the services. Removal and pathology (biopsy) related to polyps found during a screening procedure are covered as part of the preventive screening. Benefits include anesthesia services performed in connection with the preventive colonoscopy if the attending provider determines that anesthesia would be medically appropriate for the member.

Preventive health services as described above are covered at 100% of allowable charges, with no deductible, copay or coinsurance. The allowable charge for out-of-network providers is 200% of the Medicare fee schedule, which could leave you with an uncovered balance. Benefits are provided for routine and preventive services performed on an outpatient basis, and aren't subject to a plan year benefit limit. Examples of covered services include routine physical exams, well-baby and well-child exams, physical exams related to school or sports, and screening for depression.

Immunization benefits are provided at 100% of allowable charges. Covered services include, but are not limited to, flu shots, flu mist, pneumonia immunizations, whooping cough and adult shingles immunizations.

Services that are related to a specific illness, injury or definitive set of symptoms are covered under the non-preventive medical benefits of this plan.

WOMEN'S PREVENTIVE CARE

Benefits for women's preventive care, when they meet the federal guidelines as defined for women's health, aren't subject to the plan year deductible, coinsurance or copay, if any, when services are obtained from a physician or hospital in the Blue Cross network.

Examples of covered women's preventive care services include, but are not limited to:

- Contraceptive counseling, including generic and single-source (no generic alternative) brand name contraceptives, over-the-counter contraceptives with a written prescription, contraceptive devices, and sterilization services
- Breastfeeding counseling, including breast pump rental or purchase
- Maternity diagnostic screening
- Screening for gestational diabetes
- Counseling for sexually transmitted infections

A full list of preventive services is available at Premera.com, or by calling Premera Customer Service at (800) 364-2982, or on the benefits web site at www.alaska.edu/benefits/health-plan/preventive-benefit/

Please see the Medical Equipment and Supplies benefit for details on breast pump coverage. Please also see the Contraceptive Management and Sterilization, Diagnostic Services, Health Management and Obstetrical Care benefits for further detail.

FALL PREVENTION

Professional services to prevent falling for members who are 65 or older and have a history of falling or mobility issues are covered.

NUTRITIONAL COUNSELING

Healthy diet and eating habits assessment for members at risk for health conditions that are affected by diet and nutrition, and weight loss screening are covered.

PREVENTIVE CARE BENEFIT LIMITATIONS

In addition to "General Limitations and Exclusions," Preventive Medical Care benefits will not be provided for:

- charges that don't meet the federal guidelines for preventive services described at the start of this benefit. This includes services or items provided more often than as stated in the guidelines;
- dental examinations, treatment, the fitting of dental appliances or dentures, or other services provided by a dentist (except as specified under Dental Care Benefits);
- inpatient routine newborn exams while the child is in the hospital following birth (these services are covered under the Newborn Care benefit);
- routine vision and hearing examinations (except as specified under Vision Care Benefits and Audio Care Benefits);
- services that are related to a specific illness, injury, or definitive set of symptoms exhibited by the enrollee;
- physical exams for basic life or disability insurance; or
- work-related physical exams, work-related disability evaluations or medical disability evaluations.

CARE MANAGEMENT HEALTHCARE UTILIZATION

Care Management services work to help ensure that you receive appropriate and cost-effective medical care. Your role in the Care Management process is simple, but important.

This program's benefits require preauthorization for coverage of some services and planned procedures. You must be eligible on the dates of service and services must be medically necessary. We encourage you or your provider to call Customer Service to verify that you meet the required criteria for claims payment and to help Blue Cross identify admissions which might benefit from Personal Health Support Programs.

PERSONAL HEALTH SUPPORT PROGRAMS

Premera Blue Cross Blue Shield of Alaska offers participation in personal health support programs to help members with such things as managing complex medical conditions, a recent surgery, or admission to a hospital. Services include:

- Helping to overcome barriers to health improvement or following providers' treatment plan
- Coordinating care services, including access to care
- Helping to understand the health plan's coverage
- Finding community resources

Participation is voluntary. To learn more about Premera's personal health support programs, contact Blue Cross Customer Service at (800) 364-2982.

APPEALS REVIEW

Should you or your physician disagree with the Care Management determination, you may follow the appeal procedures explained in the "Your Questions, Complaints and Appeals" section of this handbook.

24-HOUR NURSELINE

Because your healthcare needs don't have a schedule, Premera Blue Cross offers peace of mind with the 24-hour NurseLine. Call 800-841-8343 to speak to a registered nurse about your non-emergency healthcare concerns.

Nurses will listen to your concerns, answer your questions and offer advice about many health-related topics, including pre-natal care. Their healthcare advice can help you to understand and better manage your condition, as well as provide peace of mind about what to expect or do about your health condition.

Nurses are trained to ask the right questions, listen to your concerns, and help you determine where and when to seek treatment for an injury or illness. The nurse provides healthcare advice based on your symptoms and other relevant health conditions or history.

All calls to the NurseLine are free, confidential and available 24 hours a day, 7 days a week.
800-841-8343

VIRTUAL CARE TELEMEDICINE

Premera covers virtual care so you can “visit” a doctor anytime and anywhere. Premera has partnered with Teladoc® to give you immediate and convenient access to care wherever you are. Avoid the long drive and wait times you might experience at an urgent care center or emergency room. In remote Alaska locations, members will especially appreciate access to care that might otherwise be miles away.

When you have a virtual visit with a Teladoc board-certified physician, you pay the deductible and in-network charge consistent with a face-to-face office visit. The charge for Teladoc® virtual care visits is considerably less than most office or emergency room visits.

Common conditions handled by virtual care providers include cold and flu symptoms, nasal congestion and sinus problems, bronchitis, respiratory infections, allergies and ear infections, to name a few.

PRIMARY CARE PROVIDER VS. TELADOC®

Virtual care is not meant to replace your relationship with your primary care provider (PCP) or to replace all in-person face-to-face visits. It is an expansion of the plan’s service delivery options. In some cases, it can also help you avoid a trip to the emergency room for non-emergent care.

PCPs and other local providers: If your doctor offers consultation, diagnosis, treatment advice and prescriptions by phone, video, or other online media that is real-time communication between your doctor and you, Premera reimburses for virtual care when medically appropriate at the standard deductible and coinsurance level.

Teladoc®: In case you need acute care when your regular doctor or other local provider is not available or doesn’t offer virtual service, Premera’s contract with Teladoc allows you access to care when and where you need it. Teladoc physicians consult, diagnose, and can even prescribe medication at the member’s in-network level.

HOW DOES IT WORK?

There are four simple steps to set up your account and use the Teladoc virtual care service.

- **Register and set up your account.** It’s quick and easy online. Visit teladoc.com/premeraAK and click on “Set up account.” You’ll fill out a health history—similar to the history a patient fills out in a doctor’s office. This can be done online or on the phone at 855-332-4059. You can also register your covered family members. To save time later, you can also identify your primary care doctor and your preferred pharmacy.
- **Consult a physician anytime.** When you want a consult with a Teladoc board-certified physician, you can make contact by phone, online video, e-mail, or other online media. A doctor calls back right away or at a time you request.

Teladoc doctors offer consultation similar to what a patient gets in a face-to-face office visit. The doctor checks the caller’s health history and discusses symptoms. Consistent care protocols help them diagnose. Physicians can send a prescription to your preferred pharmacy if it’s medically necessary.

- **Easily check benefits and pay.** Your eligibility and benefits are checked in real-time, which means Teladoc knows what deductible and coinsurance apply. You can pay via credit or debit card, HSA card or PayPal.
- **Continuity of care with your local doctor.** If you provide the name of your primary care doctor, Teladoc sends a record of the consult by fax or electronic medical record transfer.

Virtual care can improve access to care, especially in remote areas where in-network providers are hard to find. This service can improve quality, save you time and money and help contain health plan costs.

OUT-OF-AREA CARE

As a member of the Blue Cross Blue Shield Association (“BCBSA”), Premera Blue Cross Blue Shield of Alaska has arrangements with other Blue Cross and/or Blue Shield Licensees (“Host Blues”) for care outside Premera’s Service Area. These arrangements are called “Inter-Plan Arrangements.” Premera’s Inter-Plan Arrangements help you get covered services from providers within the geographic area of a Host Blue.

The BlueCard Program® is the Inter-Plan Arrangement that applies to most claims from Host Blues’ network providers. The Host Blue is responsible for its network providers and handles all interactions with them. Other Inter-Plan Arrangements apply to providers that are not in the Host Blues’ networks (non-network providers). This “Out-of-Area Care” section explains how the plan pays both types of providers.

Your getting services through these Inter-Plan Arrangements does not change covered benefits, benefit levels, or any stated eligibility requirements of this plan. Claims for prescription drugs are processed directly by Premera, not through an Inter-Plan Arrangement.

BLUECARD® PROGRAM

Whenever a claim is processed through the BlueCard® Program, the amount you must pay for covered services is calculated based on the lower of:

- The provider’s billed charges for your covered services; or
- The allowable charge that the Host Blue makes available to us. Please see the Glossary of Terms section for a definition of “allowable charge.”

Often, this allowable charge is a discount that reflects an actual price that the Host Blue pays to the provider. Sometimes, it is an estimated price that takes into account a special arrangement with a single provider or a group of providers. In other cases, it may be an average price, based on a discount that results in expected average savings for services from similar types of providers.

Host Blues may use a number of factors to set estimated or average prices. These may include settlements, incentive payments, and other credits or charges. However, no further adjustments will be applied retroactively to the price of a claim that has already been paid.

Clark County Providers

Services in Clark County, Washington are processed through the BlueCard® Program. Some providers in Clark County, Washington do have contracts with Premera. These providers will submit claims directly to Premera, and benefits will be based on Premera’s allowable charge for the covered service or supply.

TAXES, SURCHARGES AND FEES

A law or regulation may require a surcharge, tax or other fee to be added to the price of a covered service. If that happens, Premera will add that surcharge, tax or fee to the allowable charge for the claim.

NON-NETWORK PROVIDERS

It could happen that you receive covered services from providers outside Premera’s service area that do not have a contract with the Host Blue. In most cases, the amount you pay for such services will be based on Premera’s allowable charge for these providers or the pricing requirements under applicable law. In these situations, you may

owe the difference between the amount that the non-network provider bills and this plan's payment for the covered services as set forth above.

BLUE CROSS BLUE SHIELD GLOBAL® CORE

If you're outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (the "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global® Core. Blue Cross Blue Shield Global® Core is unlike the BlueCard Program in the BlueCard service area in some ways. For instance, although Blue Cross Blue Shield Global® Core helps you access a provider network, you will most likely have to pay the provider and send Premera the claim yourself in order for the plan to reimburse you. Please see the "How to Submit a Claim" section for more information on submitting claims. However, if you need hospital inpatient care, the service center can often direct you to hospitals that will not require you to pay in full at the time of service. In such cases, these hospitals also send in the claim for you.

If you need to find a doctor or hospital outside the BlueCard® service area, need help submitting claims or have other questions, please call the service center at 1-800-810-BLUE (2583). The center is open 24 hours a day, seven days a week. You can also call collect at 1-804-673-1177.

FURTHER QUESTIONS?

If you have questions or need more information about the BlueCard® Program, please call Premera Customer Service Department. To find a provider outside the Premera service area, go to www.premera.com or call 1-800-810-BLUE (2583). You can also get Blue Cross Blue Shield Global® Core information by calling the toll-free phone number.

COVERED SERVICES AND SUPPLIES

This section of your handbook describes the specific benefits available for covered services and supplies. Benefits are available for a service or supply described in this section when they meet all of these requirements:

- It must be furnished in connection with the diagnosis or treatment of a covered illness or accidental injury.
- It must be, in the judgment of Premera Blue Cross Blue Shield of Alaska, medically necessary and must be furnished in a medically necessary setting. Inpatient care is only covered when you require care that couldn't be provided in an outpatient setting without adversely affecting your condition or the quality of care you would receive.
- It must be prescribed by a physician, as defined in this handbook.
- It must not be excluded from coverage under the health care program.
- The expense for the service or supply must be incurred while you are covered under the health care program and after any applicable waiting period required under this program is satisfied.
- It must be furnished by a provider that is covered under the applicable benefit.

Medical and payment policies are used to administer the terms of the plan, as follows:

- Medical policies are generally used to further define medical necessity or investigational status for specific procedures, drugs, biologic agents, devices, level of care or services.
- Payment policies define Premera's provider billing and payment rules. Premera's policies are based on accepted clinical practice guidelines and industry standards accepted by organizations like the American Medical Association (AMA), other professional societies and the Center for Medicare and Medicaid Services (CMS).

HOSPITAL INPATIENT CARE

Covered costs include hospital room and board; intensive and coronary care units; plus services and supplies, such as diagnostic services, surgical dressings, and drugs, furnished by and used while confined in a hospital.

Please Note: When covered inpatient diagnostic services are furnished and billed by an inpatient facility, they are only eligible for coverage under the applicable inpatient facility benefit. All "Hospital Inpatient Care" services are subject to the health care plan's deductibles and out-of-pocket maximums.

HOSPITAL INPATIENT LIMITATIONS

In addition to "General Limitations and Exclusions," hospital inpatient care benefits will not be provided for the following:

- Hospital admissions for diagnostic purposes only, unless the services cannot be provided without the use of inpatient hospital facilities, or unless your medical condition makes inpatient care medically necessary
- Any days of inpatient care that exceed the length of stay that is, in the judgment of Premera Blue Cross Blue Shield of Alaska, medically necessary to treat your condition

HOSPITAL OUTPATIENT CARE

Covered costs include emergency, procedure, operating, and recovery rooms; plus services and supplies, such as surgical dressings, and drugs, furnished by and used while at a hospital for services that are furnished to an enrollee

who is not confined as a full-time inpatient. For benefit information on diagnostic services done while at the hospital, see the Diagnostic Services benefit.

Please Note: All “Hospital Outpatient Care” services are subject to the health care plan’s deductibles and out-of-pocket maximums.

SKILLED NURSING FACILITY

This benefit is only provided when you are at a point in your recovery where inpatient hospital care is no longer medically necessary, but skilled care in a skilled nursing facility is. Your attending physician must actively supervise your care while you are confined in the skilled nursing facility.

Covered costs include services and supplies, including room and board, furnished by and used while confined in a skilled nursing facility for up to 100 days in any one plan year.

SKILLED NURSING CARE LIMITATIONS

In addition to “General Limitations and Exclusions,” this benefit will not be provided for the following:

- Custodial care
- Care that is primarily for senile deterioration, mental deficiency or mental retardation
- Substance abuse

AMBULATORY SURGICAL CENTER

Services and supplies furnished by and used while at the center, such as surgical dressings and drugs are covered.

PHYSICIANS’ SERVICES

Home, office, emergency room, and inpatient visits; therapeutic injections including allergy testing and allergy injections; surgery; anesthesia administration, cornea transplantation, skin grafts and transfusion of blood or blood derivatives are covered. Sexual reassignment surgery if medically necessary and not for cosmetic purposes. Also included in this benefit are colonoscopies and other scope insertion procedures performed for screening of colorectal cancer, and prostate and cervical cancer screening examinations, unless they qualify as preventive services described in the Preventive Medical Care (Wellness) benefit.

Anesthesia or sedation and postoperative care is covered when medically necessary. Benefits include anesthesia services performed in connection with the preventive colonoscopy if the attending provider determines that anesthesia would be medically appropriate for the member. Please see “Diagnostic Services” for coverage of preventive diagnostic services.

ASSISTANT SURGEON

Benefits are only provided for services of an assistant surgeon when medically necessary. Assistant surgeons are not involved in the pre-operative or post-operative care and only assist during a surgical procedure at the direction of the primary surgeon. Benefits allowed for an assistant surgeon are based on their participation in this one element of your care and will be their billed charges or 20% of the primary surgeon’s allowable charge, whichever is less.

MULTIPLE SURGICAL PROCEDURES

If multiple or bilateral surgical procedures are performed during the same operative session, benefits will be provided based on the allowable charge for the first or major procedure, and one-half the allowable charge for eligible secondary procedures.

MENTAL HEALTH SERVICES

For inpatient, residential and outpatient mental health care of psychiatric conditions, and outpatient visits to manage or reduce the effects of a psychiatric condition, including treatment of eating disorders (such as anorexia nervosa, bulimia, or any similar condition), benefits will be provided according to the medical schedule of benefits. Covered services include:

- Individual, family or group therapy
- Lab and testing
- Take-home drugs you get in a facility
- Biofeedback for generalized anxiety disorders
- Physical, speech and occupational therapy provided to treat psychiatric conditions, such as autism spectrum disorders
- Applied behavior analysis (ABA) for the treatment of autism spectrum disorders. Services must be provided by a provider who is licensed or certified by the appropriate state agency.

“Outpatient therapeutic visit” (outpatient visit) means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards as defined in the **Physician’s Current Procedural Terminology**, as published by the American Medical Association.

MENTAL HEALTH CARE LIMITATIONS

In addition to “General Limitations and Exclusions,” this benefit will not be provided for the following:

- substance use disorders such as alcoholism or drug addiction (see below for substance abuse benefits);
- psychological treatment of sexual dysfunctions, including impotence and frigidity;
- EEG feedback or neurofeedback services, and biofeedback that is deemed experimental or investigational;
- psychological and neuropsychological testing and evaluations, and other psychological services related to chronic pain care (see the Neurodevelopmental Therapy benefit);
- Outward Bound, wilderness, camping or tall ship programs or activities; or
- mental health evaluations for purposes other than evaluating the presence of or planning treatment for covered mental health disorders, including, but not limited to, custody evaluations, competency evaluations, forensic evaluations, vocational, educational or academic placement evaluations.

SUBSTANCE ABUSE

This benefit covers inpatient, residential and outpatient visits to manage or reduce the effects of substance abuse, including individual, family or group therapy, lab and testing, and take-home drugs you get in a facility. Covered services must be medically necessary and furnished by a provider who is licensed or certified by the state to provide these services.

Medically necessary detoxification is covered in any medically necessary setting. Detoxification in the hospital is covered under the Emergency Room Care and Hospital Inpatient Care benefits.

In determining whether services for substance abuse treatment are medically necessary, Premera Blue Cross Blue Shield of Alaska will use the current edition of the **Patient Placement Criteria for the Treatment of Substance-Related Disorders**, as published by the American Society of Addiction Medicine.

SUBSTANCE ABUSE TREATMENT LIMITATIONS

In addition to “General Limitations and Exclusions,” this benefit will not be provided for the following situations:

- voluntary support groups, such as Alanon or Alcoholics Anonymous;
- treatment of alcohol or drug use or abuse that does not meet the definition of substance abuse as stated in the Glossary of Terms of this Handbook;
- court-ordered services or services related to deferred prosecution, deferred or suspended sentencing, or to driving rights, unless such services are medically necessary;
- halfway houses, quarterway houses, recovery houses, and other sober living residences; or
- Outward Bound, wilderness, camping or tall ship programs or activities.

CLINICAL TRIALS

This plan covers the routine costs of a qualified clinical trial. Routine costs mean medically necessary care that is normally covered under this plan outside the clinical trial. Benefits are based on the type of service you get. For example, benefits for an office visit are covered under the Professional Visits And Services benefit and lab tests are covered under the Diagnostic Services benefit.

A qualified clinical trial is a trial that is funded and supported by the National Institutes of Health, the Center for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veterans Affairs.

You or your provider should call customer service before you enroll in a clinical trial. Customer Service can help you verify that the clinical trial is a qualified clinical trial. You may also be assigned a nurse case manager to work with you and your provider. See “Case Management” for details.

CONTRACEPTIVE MANAGEMENT AND STERILIZATION SERVICES

Benefits for female contraceptive management and sterilization aren’t subject to your plan year deductible, coinsurance or copays, unless services are performed by a physician or hospital not in the network. For these providers, benefits are subject to the plan year deductible, coinsurance or copays. Benefits for male sterilization are covered as any other medical procedure and are subject to deductible and coinsurance. Benefits include the following services and supplies:

- Office visits and consultations related to contraception;
- Injectable contraceptives and related services
- Implantable contraceptives (including hormonal implants) and related services;
- Emergency contraception (oral or injectable); and
- Sterilization procedures. When sterilization is performed as the secondary procedure, associated service such as anesthesia, facility expenses will be subject to your deductible and coinsurance and will not be reimbursed under this benefit.

PREScription CONTRACEPTIVES DISPENSED BY A PHARMACY

Prescription contraceptives (including emergency contraception) and prescription barrier devices, such as diaphragms and cervical caps, dispensed by a licensed pharmacy are covered under the Prescription Drugs benefit. Your normal cost-share is waived for these devices and generic and single-source (no generic available) brand name birth control drugs when you get them from a participating pharmacy.

Women's over-the-counter contraception including birth control devices *with a written prescription*, such as sponges, female condoms or spermicides (foams, gels, creams, film, suppositories, etc) are covered as above. Over-the-counter contraceptives for men are excluded.

CONTRACEPTIVE MANAGEMENT AND STERILIZATION SERVICES LIMITATIONS

In addition to "General Limitations and Exclusions," this benefit will not be provided for nonprescription contraceptive drugs, supplies or devices (except emergency contraceptive methods); hysterectomy (covered on the same basis as other surgeries, see the Surgical Services benefit), sterilization reversal; testing, diagnosis and treatment of infertility, including assisted reproduction services, procedures, supplies and drugs.

DIAGNOSTIC SERVICES

Administration and interpretation of diagnostic imaging and scans (including X-rays and EKGs), pathology, and routine and preventive laboratory tests are covered.

Cancer screening tests are covered, to include at a minimum:

- annual tests for prostate cancer for high risk men under 40 and all men over 40 years of age, or as recommended by a physician;
- annual cervical cancer pap smears for women 18 years of age and older, or as recommended by a physician; and
- screening tests for colorectal cancer for high risk individuals under age 50 and all individuals over age 50, or as recommended by a physician. Removal and pathology (biopsy) related to polyps found during a screening procedure are covered as part of the preventive screening. Coverage for colonoscopy and sigmoidoscopy includes medically necessary sedation. Benefits include anesthesia services performed in connection with the preventive colonoscopy if the attending provider determines that anesthesia would be medically appropriate for the member.
- BRCA genetic testing for women at risk for certain breast cancers.

Preventive diagnostic services are laboratory and imaging services that meet the federal guidelines for preventive care services as stated in the "General Preventive Benefit" under "Wellness Provisions." When the federal guidelines for preventive care services are met, these preventive diagnostic services will not be subject to the deductible or coinsurance.

Please Note: When covered inpatient diagnostic services are furnished and billed by an inpatient facility, they are only eligible for coverage under the applicable inpatient facility benefit. When covered outpatient diagnostic services are billed by an outpatient facility or emergency room and received in combination with other hospital or emergency room services, benefits are provided under the Hospital Outpatient or Emergency Room Services benefits.

In addition to "General Limitations and Exclusions," this benefit will not be provided for the following:

- Diagnostic surgeries and scope insertion procedures, such as colonoscopies or endoscopies which are covered under the "Physician's Services" benefit, unless they meet the standards for preventive medical services described in the Preventive Medical Care (Wellness) benefit
- Allergy testing (see the "Physician's Services" benefit)

DIAGNOSTIC AND SCREENING MAMMOGRAPHY

This benefit is **not** subject to the plan year deductible or coinsurance on the 750 Plan or HDHP. Benefits are provided for screening and diagnostic mammography as follows:

- a baseline mammogram and annual mammogram screenings thereafter, regardless of age; and
- as recommended by a physician for an enrollee with symptoms, a history of breast cancer, or whose parent or sibling has a history of breast cancer.

Only preventive screening mammography is covered with no deductible or coinsurance on the CDHP.

MASTECTOMY AND BREAST RECONSTRUCTION SERVICES

Benefits are provided for mastectomy necessary due to illness or accidental injury. For any enrollee electing breast reconstruction in connection with a mastectomy, in a manner determined in consultation with the attending physician and the patient, this benefit covers:

- reconstruction of the breast on which mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prosthesis; and
- physical complications of all stages of mastectomy, including lymphedemas.

DIALYSIS

When you have end-stage renal disease (ESRD), you may be eligible to enroll in Medicare. If eligible, it is important to enroll in Medicare as soon as possible. When you enroll in Medicare, this plan and Medicare will coordinate benefits. In most cases, this means that you will have little or no out-of-pocket expenses.

Medicare has a waiting period, generally the first 90 days after dialysis starts. During this waiting period, benefits are subject to the same calendar year deductible and coinsurance, if any, as you would pay for outpatient services for other covered medical conditions. After Medicare's waiting period, the deductible and coinsurance, if any, are waived for network and non-network providers. Network providers are paid according to their provider contracts. The amount non-network providers are paid for dialysis after Medicare's waiting period is 200% of the Medicare-approved amount in Alaska, or 125% of the Medicare-approved amount in Washington State and through Blue Card, even if you do not enroll in Medicare.

If the dialysis services are provided by a non-network provider and you do not enroll in Medicare, then you will owe the difference between the non-network provider's billed charges and the payment made by the plan for covered services. See the "Allowable Charge" definition in the Glossary of Terms section of this Handbook.

FOOT CARE

Benefits are provided for routine medically necessary foot care for a member with impaired blood flow to the legs and feet when the complexity of the conditions puts the member at risk and care requires the services of a medical professional. Examples of these conditions include arteriosclerosis of the extremities, Buerger's disease, chronic thrombophlebitis of lower extremities, peripheral neuropathies and peripheral vascular disease.

TRANSPLANTS

This benefit covers medical services only if provided by “Approved Transplant Centers.” Please see the transplant benefit requirements later in this section for more information about approved transplant centers.

The Transplants benefit is not subject to a separate benefit maximum other than the maximums for transport and lodging. Specific services under this benefit have individual benefit maximums so it’s important to read this entire section to understand this benefit.

COVERED TRANSPLANTS

Solid organ transplants and bone marrow/stem cell reinfusion procedures must not be considered experimental or investigational for the treatment of your condition. (Refer to the Glossary of Terms for the definition of “Experimental/Investigational Services.”) Premera Blue Cross Blue Shield of Alaska reserves the right to base coverage on all of the following:

- Solid organ transplants and bone marrow/stem cell reinfusion procedures must be medically necessary and meet Blue Cross’ criteria for coverage. The medical indications for the transplant, documented effectiveness of the procedure to treat the condition, and failure of medical alternatives are all reviewed.
- The types of solid organ transplants and bone marrow/stem cell reinfusion procedures that currently meet Blue Cross’ criteria for coverage are:
 - heart
 - heart/double lung
 - single lung
 - double lung
 - liver
 - kidney
 - pancreas
 - pancreas with kidney
 - bone marrow (autologous and allogenic)
 - stem cell (autologous and allogenic)

Please Note: For the purposes of this plan, the term “transplant” does not include: cornea transplantation, skin grafts, or the transplant of blood or blood derivatives (except for bone marrow or stem cells). Benefits for such services are provided under other benefits of this program.

- Your medical condition must meet the plan’s written standards, which are found online at www.premera.com or by calling Premera Blue Cross Customer Service at (800) 364-2982.
- The transplant or reinfusion must be furnished in an approved transplant center. (“Approved transplant center” is a hospital or other provider that has developed expertise in performing solid organ transplants, or bone marrow or stem cell reinfusion.) Premera Blue Cross Blue Shield of Alaska has agreements with approved transplant centers in Alaska and Washington, and has access to a special network of approved transplant centers around the country. Whenever medically possible, you will be directed to an approved transplant center that has contracted for transplant services.
- Of course, if none of Premera Blue Cross Blue Shield of Alaska’s centers or the network centers can provide the type of transplant you need, benefits will be provided for your transplant furnished by another transplant center.

TRANSPLANT SERVICES AND SUPPLIES

This benefit covers the services and supplies listed below for all covered transplants:

- **Recipient Costs**—Transplant and reinfusion-related expenses, including the preparation regimen for a bone marrow or stem cell reinfusion. Also covered are anti-rejection drugs administered by the transplant center during the inpatient or outpatient stay in which the transplant was performed.
- **Donor Costs**—Covered donor services include the selection, removal (harvesting) and evaluation of the donor organ, bone marrow or stem cell; transportation of donor organ, bone marrow, and stem cells, including the surgical and harvesting teams; donor acquisition costs such as testing and typing expenses; and storage costs for bone marrow and stem cells for a period of up to 12 months.
- **Transportation and Lodging Expenses**—Covered transportation and lodging incurred by the transplant recipient and companion(s) are limited to \$7,500 per transplant. The transplant recipient must reside more than 50 miles from the approved transplant center, unless medically necessary treatment protocols require the member to remain closer to the transplant center. Travel and lodging expenses will be based on current IRS guidelines on the date(s) the expenses were incurred.
- **Travel** is reimbursed between the patient’s home and the approved transplant center for round trip (air, train or bus) coach class transportation costs. If traveling by car, mileage, parking and toll costs are reimbursed.
 - Mileage expenses are reimbursed at 19 cents per mile per trip;
 - Surface transportation and parking are limited up to \$35 per day, per person;
 - Ferry transportation expenses are limited to \$50 per person, each way.
- **Lodging** expenses for a transplant recipient and companion for hotel lodging away from home are limited to \$50 per day, per person.

Companion travel and lodging expenses are covered if the companion must, as a matter of medical necessity, accompany the member. If the member receiving the transplant is a minor child under the age of 19, one companion is automatically permitted. A second companion will only be permitted if medically necessary. Reimbursement amounts are subject to change due to IRS regulations. Please refer to the IRS website, www.irs.gov, for additional information. The information in this benefit should not be assumed as tax advice.

TRANSPLANT LIMITATIONS

In addition to “General Limitations and Exclusions,” this benefit will not be provided for the following:

- services and supplies that are payable by any government, foundation, or charitable grant, including services performed on potential or actual living donors and recipients, and on cadavers;
- donor costs for a solid organ transplant or bone marrow or stem cell reinfusion that isn’t covered under this benefit or for a recipient who is not a member; however, complications and unforeseen effects from a member’s organ or bone marrow donation will be covered under this program as any other illness;
- donor costs for which benefits are available under other group or individual coverage;
- nonhuman or mechanical organs, unless Blue Cross determines they are not experimental or investigational according to the criteria stated under “Glossary of Terms;”
- personal care items, meals, alcohol, tobacco, car rentals, souvenirs, entertainment, phone calls, and costs for people other than you and your covered companions;
- anti-rejection drugs, except those administered by the transplant center during the inpatient or outpatient hospital stay in which the transplant is performed. Outpatient prescription drugs are covered under your Pharmacy Drug Benefit.
- Planned storage of blood for more than 12 months against the possibility it might be used at some point in the future.

REHABILITATION THERAPY, CHRONIC PAIN CARE, AND NEURODEVELOPMENTAL THERAPY

Inpatient care is only covered when services cannot be done in a less intensive setting.

REHABILITATION THERAPY

Services must be medically necessary to restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an accidental injury, illness, or surgery.

Inpatient Care

Services must be furnished in a specialized rehabilitative unit of a hospital and billed by the hospital or be furnished and billed by another rehabilitation facility approved by Premera Blue Cross Blue Shield of Alaska. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physician specializing in rehabilitation medicine.

Outpatient Care

The following services are covered when furnished and billed by a hospital, another rehabilitation facility approved by Premera Blue Cross Blue Shield of Alaska, a physician (M.D. or D.O.), or a physical, occupational, or speech therapist:

- physical, speech, and occupational therapy services, including cardiac rehabilitation; and
- neurological and psychological tests and evaluations required to prescribe an appropriate treatment plan. This includes any later reevaluations to make sure that the treatment is achieving the desired medical results. For these services, a psychologist, psychological associate, or licensed clinical social worker is covered in addition to the providers listed above.
- outpatient physical therapy is limited to 45 visits per plan year; additional visits may be available based on medical necessity; and
- massage therapy is limited to 26 visits per year.

Chronic Pain Care

The Inpatient and Outpatient Rehabilitation Therapy Benefits also cover services that are medically necessary to treat intractable or chronic pain.

Neurodevelopmental Therapy

Neurodevelopmental therapy must be medically necessary to restore and improve function, or to maintain function where, in the judgment of Blue Cross, significant physical deterioration would occur without the therapy.

- **Inpatient Care**—Services must be furnished and billed by a hospital or by another rehabilitation facility approved by Blue Cross.
- **Outpatient Care**—The following services are covered when furnished and billed by a hospital, another rehabilitation facility approved by Blue Cross, a physician (M.D. or D.O.), or with a physician's referral, by a physical, occupational, or speech therapist:
 - physical, speech, and occupational therapy services, including cardiac rehabilitation, are limited to a maximum of 45 visits in a plan year; and
 - neurological and psychological tests and evaluations required to prescribe an appropriate treatment plan. This includes any later reevaluations to make sure that the treatment is achieving the desired medical results. For these services, a psychologist, psychological associate, or licensed clinical social worker is covered in addition to the providers listed above.

Physical, speech and occupational therapy provided for treatment of psychological conditions, such as autism spectrum disorders, are covered as described under the Mental Health Care benefit.

REHABILITATION THERAPY, CHRONIC PAIN CARE, AND NEURODEVELOPMENTAL THERAPY LIMITATIONS

In addition to “General Limitations and Exclusions,” this benefit will not be provided for the following situations:

- nonmedical self-help, such as “Outward Bound” or “Wilderness Survival;” recreational, vocational, or educational therapy; work hardening, or exercise programs;
- social or cultural therapy;
- acupressure or services of a massage therapist, except as supervised and billed by a physician (M.D. or D.O.), physical therapist, or chiropractor;
- treatment which is not actively engaged in by the ill, injured, or impaired enrollee;
- gym or swim therapy; and
- custodial care, except habilitative services under the Neurodevelopmental Therapy Benefit.

THERAPEUTIC NUCLEAR MEDICINE

Services and supplies furnished in connection with radium, radioisotope, and X-ray therapy are covered.

HOME HEALTH CARE

To be covered, the home health care services must be part of a written plan of treatment prescribed, periodically reviewed, and approved by a physician (M.D. or D.O.), and it must begin within seven days after discharge from a hospital as an inpatient. In the plan of care, the physician must certify that confinement in a hospital or skilled nursing facility would be required without home health care services. Medically necessary home health care must be rendered and billed by a home health agency that is Medicare-certified as such or is licensed or certified as such by the state in which it operates.

Covered services include home care by one or more of the following agency employees up to a maximum of 130 intermittent visits per enrollee each plan year:

- a registered or licensed practical nurse;
- a licensed or registered physical therapist;
- a certified respiratory therapist;
- a speech therapist certified by the American Speech, Language, and Hearing Association;
- a licensed occupational therapist;
- a licensed clinical social worker;
- a master of social work; or
- a home health aide who is directly supervised by one of the above providers (performing services prescribed in the plan of care to achieve the desired medical results).

HOME HEALTH CARE LIMITATIONS

In addition to “General Limitations and Exclusions,” this benefit will not be provided for the following:

- social services;
- services of family members or volunteers;
- nonmedical services, such as spiritual, bereavement, legal, or financial counseling;
- normal living expenses, such as food, clothing, and household supplies;

- housekeeping services, except for those of a home health aide as prescribed by the plan of care;
- transportation services;
- charges in excess of the average wholesale price shown in the *Pharmacist's Red Book* for prescription drugs, insulin, and intravenous drugs and solutions;
- over-the-counter drugs, solutions, and nutritional supplements;
- drugs and solutions received while you are an inpatient;
- services provided to someone other than the ill or injured enrollee;
- services, supplies, or providers not in the written plan of care or not named as covered in this Benefit;
- custodial care;
- dietary assistance, such as "Meals on Wheels," or nutritional guidance; or
- services provided during any period of time in which the enrollee is receiving hospice care benefits of this program.

HOSPICE CARE

To be covered, hospice care services must be furnished and billed by a hospice agency that is Medicare-certified as such or licensed or certified as such by the state in which it operates, and must be part of a written plan of care prescribed and periodically reviewed by a physician (M.D. or D.O.). This physician must certify that the enrollee is terminally ill and that hospital or skilled nursing home confinement would be required in the absence of the hospice plan of care. The plan of care shall also describe the services and supplies for the palliative care and medically necessary treatment to be provided to the enrollee.

The Hospice Care benefit also covers palliative care for members facing serious, life-threatening conditions but who are not in imminent danger of death, including expanded access to home-based care and care coordination. Participation in palliative care is usually approved for 12 months at a time, and may be extended based on the member's specific condition.

Benefits for a terminally ill member shall not exceed six months of covered hospice care. Covered hospice services include only the services and supplies listed below:

- In-home intermittent hospice visits by one or more of the following hospice employees:
 - registered or licensed practical nurse;
 - licensed physical therapist;
 - certified respiratory therapist;
 - American Speech, Language, and Hearing Association-certified speech therapist;
 - licensed occupational therapist;
 - licensed clinical social worker;
 - master of social work; or
 - home health aide who is directly supervised by one of the above providers (performing services prescribed in the plan of care to achieve the medically desired results).
- Inpatient hospice care up to a maximum of ten days, including inpatient services and supplies used while you're a hospice inpatient, such as solutions, medications or dressings, when ordered by the attending physician
- Respite care up to a maximum of 240 hours, to relieve anyone who lives with and cares for the terminally ill member.

HOSPICE CARE LIMITATIONS

In addition to "General Limitations and Exclusions," this benefit will not be provided for the following:

- Charges in excess of the average wholesale price shown in the “Pharmacist’s Red Book” for prescription drugs, insulin, and intravenous drugs and solutions
- Over-the-counter drugs, solutions and nutritional supplements
- Drugs and solutions received while you’re an inpatient, except for covered inpatient hospice care
- Services provided to someone other than the ill or injured member
- Services of family members or volunteers
- Services, supplies or providers not in the written plan of care or not named as covered in this benefit
- Custodial care, except for hospice care services
- Non-medical services, such as spiritual, bereavement, legal or financial counseling
- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care; and transportation services
- Dietary assistance, such as “Meals on Wheels,” or nutritional guidance

LICENSED AMBULANCE SERVICE

Benefits are provided for medically necessary licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat your condition, when any other mode of transportation would endanger your health or safety. Medically necessary services and supplies provided by the ambulance are also covered. Benefits are also provided for transportation from one medical facility to another, as necessary for your condition. This benefit only covers the member that requires transportation.

SPECIAL TRANSPORT (AIR/SURFACE TRANSPORTATION)

Please Note: This travel benefit is intended to allow you access to health care services when no local option exists. See the “Medical Travel Support” section of this Handbook for additional travel benefits.

Benefits for transportation will be provided to the nearest in-network provider or facility equipped to furnish special care deemed medically necessary for treatment of injury or illness if the injury or illness is life-endangering, if surgery is required that cannot be performed locally, or if a condition exists that cannot be treated locally. Transportation may be by air, ambulance, railroad, or commercial airlines on a regularly scheduled flight.

Travel in personal vehicles is not covered. Tickets obtained through mileage plans or other rewards programs are not covered.

Air fare for three round trips per plan year by the patient will be allowed for any one condition. If the patient is a minor age 17 or younger, air fare will be paid for one accompanying parent or guardian for each trip.

The attending physician must certify the necessity of any charges for special transportation. Although prior approval by Premera Blue Cross Blue Shield of Alaska is not required before benefits can be provided, you or your physician are encouraged to contact Blue Cross to see if the proposed travel will meet the requirements of this benefit.

HOME MEDICAL AND RESPIRATORY EQUIPMENT/MEDICAL SUPPLIES

Durable medical equipment, prosthetics, orthotics and medical supplies (including sales tax for covered items) are eligible expenses as follows:

- **Home Medical and Respiratory Equipment**—Rental, not to exceed the purchase price, is covered when medically necessary and prescribed by a physician for therapeutic use in direct treatment of a covered illness or

injury. Blue Cross may also provide benefits for the initial purchase of equipment, in lieu of rental. Examples of medical equipment are a wheelchair, a hospital-type bed, traction equipment, ventilators, diabetic equipment and light boxes.

- In cases where there is an alternative type of equipment that is less costly and serves the same medical purpose, Blue Cross will provide benefits only up to the lesser amount.
- Repair or replacement of home medical and respiratory equipment medically necessary due to normal use or growth of a child is covered.
- **Medical Supplies, Orthotics And Orthopedic Appliances**
 - Medical supplies and orthopedic appliances such as braces, rib belts, crutches and diabetic supplies.
 - Orthotics for the feet (shoe inserts), including impression casting, and related supplies, devices, and shoes are covered. Benefits are limited to a plan year maximum of \$350.
 - Benefits are provided for vision hardware for the following medical conditions of the eye: corneal ulcer, bullous keratopathy, recurrent erosion of the cornea, tear film insufficiency, aphakia, Sjorgren's Disease, congenital cataract, corneal abrasion and keratoconus.

HOME MEDICAL AND RESPIRATORY EQUIPMENT/MEDICAL SUPPLIES LIMITATIONS

In addition to "General Limitations and Exclusions," this benefit will not be provided for the following:

- special or extra-cost convenience features;
- items such as exercise equipment or weights;
- over-the-counter orthotic braces, such as knee braces, compression stockings that do not require a prescription;
- non-wearable external defibrillator, trusses and ultrasonic nebulizers;
- blood pressure cuffs or monitor (even if prescribed by a physician);
- orthopedic appliances prescribed primarily for use during participation in sports, recreation, or similar activities;
- whirlpools, whirlpool baths, portable whirlpool pumps, sauna baths, and massage devices;
- over-bed tables, elevators, vision aids, enuresis alarms and telephone alert systems;
- structural modifications to your home or personal vehicle; or
- eyeglasses, contact lenses and other vision hardware for conditions not listed as a covered medical condition, including routine eye care (see the Vision Care section for these benefits).

BREAST PUMPS

This benefit covers the purchase of standard electric breast pumps. Rental of hospital-grade breast pumps is also covered when medically necessary. Purchase of hospital-grade breast pumps is not covered.

When you use an in-network supplier, benefits for covered breast pumps are not subject to your plan year deductible and coinsurance. For suppliers not in the network, benefits are subject to the plan year deductible and out-of-network coinsurance. For further information, please see the Preventive Care benefit.

PROSTHETIC DEVICES

Devices to replace all or part of an absent body limb or to replace all or part of the function of a permanently inoperative or malfunctioning body organ are covered.

Benefits will only be provided for the initial purchase of a prosthetic device, unless the existing device cannot be repaired, or replacement is prescribed by a physician because of a change in your physical condition.

Benefits will be provided for the purchase of a wig or hairpiece to replace hair lost due to an accident or radiation therapy or chemotherapy for a covered condition. Benefits will be limited to one wig or hairpiece per plan year, up to a plan year maximum of \$350.

PROSTHETIC DEVICES LIMITATIONS

In addition to “General Limitations and Exclusions,” this benefit will not be provided for the following:

- electronic prostheses, penile prostheses, or devices directly related to an organ transplant; or
- prosthetics, intraocular lenses, appliances or devices requiring surgical implantation. These items are covered under the Surgical Services benefit. Items provided and billed by a hospital are covered under the Hospital Inpatient Care or Outpatient Care benefits.

OBSTETRIC CARE

Pregnancy, childbirth, and related conditions are covered the same on the same basis as any other condition for all female members. Covered services include screening and diagnostic procedures during pregnancy, and related genetic counseling, when medically necessary for prenatal diagnosis of congenital disorders. Plan benefits are also provided for medically necessary services and supplies related to home births.

Certain preventive diagnostic obstetrical services that meet the federal guidelines as defined for women’s health are covered as stated in the Preventive Care benefit when you see a network provider. A full list of preventive services is available on the benefits web site at www.alaska.edu/benefits, or by calling Premera customer service.

Please Note: Attending provider as used in this benefit means a physician, a physician’s assistant, a certified nurse midwife (C.N.M.), a licensed midwife or an advanced registered nurse practitioner (A.R.N.P.). If the attending provider bills a single fee that includes prenatal, delivery or postpartum services received on multiple dates of service, this plan will cover those services as it would any other surgery.

Inpatient hospital services and related inpatient medical care following childbirth as determined to be necessary by the attending provider, in consultation with the mother, will be provided up to:

- 48 hours after a vaginal birth; or
- 96 hours after a cesarean birth.

If it is determined that the length of stay will exceed the above limitations, Blue Cross recommends that the hospital contact Care Management at (800) 722-4714 for discharge planning and potential case management.

Helpful information about pregnancy and proper prenatal care is available by calling the 24-Hour NurseLine at (800) 841-8343. Please see 24-Hour NurseLine in the Care Management section of this handbook.

ROUTINE NEWBORN CARE

Benefits for routine hospital nursery charges and related inpatient well-baby care for a newborn dependent child are provided up to:

- 48 hours after a vaginal birth; or
- 96 hours after a cesarean birth.

Benefits are also provided for routine circumcision up to six months following birth.

Newborn children born to dependent daughters are not eligible for coverage.

If it is determined that the length of stay will exceed the above limitations, Blue Cross recommends that the hospital contact Care Management at (800) 722-4714 for discharge planning and potential case management.

Please Note: Benefits for care of an ill baby are provided under the child's coverage, subject to his or her own Comprehensive Medical Calendar Year Deductible and out-of-pocket requirements.

The University requests that you enroll your newborn as soon as possible from the date of birth. Enrollments after 60 days from date of birth will not be accepted until the next open enrollment period. Please contact your regional human resources office for assistance with enrolling your newborn.

NEWBORN HEARING EXAMS AND TESTING

This benefit provides for one screening hearing exam for newborns up to 30 days after birth. Benefits are also provided for diagnostic hearing tests, including administration and interpretation, for children up to age 24 months if the newborn hearing screening exam indicates a hearing impairment.

PKU DIETARY FORMULA

A dietary formula that is medically necessary for the treatment of phenylketonuria (PKU) is covered.

ACUPUNCTURE

Benefits are provided for acupuncture services when medically necessary to relieve pain, induce surgical anesthesia, or to treat a covered illness, injury or condition. Acupuncture benefits aren't subject to a calendar year benefit maximum.

BLOOD TRANSFUSIONS

The cost of blood and blood derivatives are covered when medically necessary.

CHIROPRACTORS' SERVICES

The services of a chiropractor (D.C.) operating within the scope of his or her license are covered on the same basis as for any covered physician providing medically necessary services.

Please Note: Chiropractic benefits are limited to a maximum of 26 visits per plan year.

HEALTH MANAGEMENT

These services are provided at 100% of allowable charges. Benefits for health education services and nicotine dependency programs are not subject to a calendar year maximum.

HEALTH EDUCATION

Benefits are provided for outpatient health education services to manage pain or cope with a covered condition like heart disease, diabetes, or asthma.

NICOTINE DEPENDENCY PROGRAMS

Benefits are provided for nicotine dependency programs. You pay for the cost of the program and send proof of payment to Blue Cross along with a reimbursement form. The plan will provide benefits as stated above in this benefit. Claim forms are available on the university's benefits web site at www.alaska.edu/benefits, or you can request one from Blue Cross Customer Service.

SKILLED NURSING CARE

Services of a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.) are covered for the purpose of performing skilled nursing care. Covered services include the following:

- visiting nursing care of not more than two hours per day for the purpose of performing specific skilled nursing tasks; or
- private duty nursing care of greater than two hours per day, if Blue Cross determines that visiting nursing care is not adequate to treat your condition

SKILLED NURSING CARE LIMITATIONS

In addition to "General Limitations and Exclusions," this benefit will not be provided for the following services:

- all or that part of any nursing care that does not require the skills of an R.N. or L.P.N.;
- any nursing care, given while the member is an inpatient in a health care facility, that could safely and adequately be furnished by the facility's general nursing staff if it were fully staffed; or
- private duty nursing provided by a state-licensed Advanced Nurse Practitioner (ANP) that is employed privately to provide one-on-one care in your home and not through a home health agency, hospital, or other such institution.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDERS

Benefits for medical services and supplies for the treatment of temporomandibular joint (TMJ) disorders are provided on the same basis as any other medical condition. This benefit covers inpatient and outpatient facility and professional care, including professional visits. Covered services include the following:

- Inpatient and outpatient professional services, including surgery
- Outpatient surgical facility services
- Inpatient facility services

Medical services and supplies are those that meet all of the following requirements:

- reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case;
- effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food;
- not experimental or investigational, as determined according to the criteria stated under "Definitions," or primarily for cosmetic purposes.

ORTHOGNATHIC SURGERY (JAW AUGMENTATION OR REDUCTION)

When medically necessary criteria are met, benefits for upper and/or lower jaw augmentation or reduction (orthognathic and/or maxillofacial) surgery is provided at a constant 80 percent of allowable charges, up to a lifetime benefit maximum of \$25,000.

WEIGHT LOSS SERVICES

NON-SURGICAL WEIGHT MANAGEMENT

Benefits for non-surgical weight management are covered on the same basis as any other covered condition, subject to the applicable benefits, limitations and exclusions. Non-Surgical Weight Management benefits include, but aren't limited to, coverage of the following outpatient medical services:

- Behavioral health visits
- Nutritional/dietician visits
- Physical Therapy visits (subject to the 45 visits per plan year limit)
- Physician visits
- Prescription drugs
- Related lab and diagnostic services

SURGICAL TREATMENT OF MORBID OBESITY

Coverage is available for bariatric procedures listed as medically necessary, when conservative measures have proven ineffective. Examples of conservative measures include but aren't limited to covered services under the Non-Surgical Weight Management benefit, diet and exercise programs.

To qualify for the surgical treatment for morbid obesity benefit, the member must meet the three criteria stated in Premera's medical policy on bariatric surgery. A summary of these criteria is shown below. Please see the Bariatric Surgery medical policy at www.Premera.com. Click the link to Medical Policies at the bottom of the landing page.

- The member must be diagnosed as morbidly obese with a Body Mass Index (BMI) greater than 40; or
- Overweight with a BMI greater than 35 with at least one of the following conditions, including but not limited to:
 - Established coronary heart disease
 - Other atherosclerotic disease
 - Type 2 diabetes that is not controlled by drug therapy
 - High blood pressure that is not controlled by medical management
 - Sleep apnea documented as moderate or severe
- During the 2 years immediately before the surgery, the member has actively taken part in a weight-loss program that is supervised by a physician and that lasted at least 6 months in a row. The program must be documented in the member's medical records.
- A licensed mental health provider has evaluated the member to establish emotional stability and ability to cope with surgical limitations

For specific surgical treatment benefit information, please see the Hospital Inpatient Care, Hospital Outpatient Care and Surgical Services benefits.

The surgical treatment of morbid obesity benefit is subject to a lifetime benefit maximum of \$25,000 for covered

services, including but not limited to surgery, anesthesia, facility and other charges directly related to surgical care. Medically necessary treatment of surgical complications do not accrue toward this benefit maximum.

WEIGHT LOSS SERVICES BENEFIT LIMITATIONS

In addition to the “General Limitations and Exclusions,” this benefit will not be provided for the following services:

- Procedures or treatments that are experimental or investigational (please see the Glossary of Terms)
- Liposuction or surgical removal of excess abdominal, arm or other skin unless medically necessary
- Over-the-counter medications for weight loss
- Liquid diet or fasting programs
- Other food replacement and nutritional supplements
- Membership in diet programs
- Exercise programs and health clubs
- Wiring of the jaw

URGENT CARE CENTER

Care you get in a freestanding urgent care center is covered. Urgent care centers have extended hours and are open to the public. You can go to an urgent care center for an illness or injury that needs treatment right away. Examples are minor sprains, cuts and ear, nose and throat infections. Covered services include the doctor’s services.

URGENT CARE CENTER LIMITATIONS

In addition to the “General Limitations and Exclusions,” this Urgent Care Center benefit doesn’t cover hospital urgent facility care. For urgent care centers attached to or part of a hospital, please see the emergency services benefit for details.

TRAVEL SUPPORT BENEFIT

Premera Blue Cross Blue Shield of Alaska offers a medical travel support benefit to members who reside in Alaska. Note this is a different benefit from the special transport benefit described in Covered Services and Supplies. This benefit is subject to your plan year deductible and coinsurance.

The travel support benefit uses pre-approved medical facilities chosen to provide quality care at more affordable prices. You also have access to a national network of quality medical facilities through the Blue Cross and Blue Shield Association's BlueCard Program. Contact Premera Blue Cross for information on covered facilities.

This benefit requires pre-approval. First you need to talk to your doctor to learn if traveling is safe for you. If your doctor says it's safe for you to travel, call the Premera Travel Desk at (800) 364-2994 to get started. Once approved, Premera will help to make your appointments, transfer medical records, and introduce you to their travel partners. They can help make your reservations for round trip airfare, ground transportation and hotel lodging. These travel expenses are partly covered for you and your travel companion, as described below. If you prefer, you can make your own travel arrangements but be sure to get your travel and procedure approved before making plans.

APPROVED TRAVEL EXPENSES

Benefits are provided for travel costs for members who reside in Alaska only for specified non-emergent medical procedures performed at in-network Blue facilities. Please contact Customer Service for assistance with the process. You will need preapproval for this benefit and will need to obtain an authorization number to use when filing the claim.

- One round trip airfare by a licensed commercial carrier for the member and one companion per episode.
- Air transportation expenses for the member and a companion from the member's home in Alaska to and from the medical facility where services will be provided. Air travel expenses cover unrestricted, flexible and fully refundable round trip airfare from a licensed commercial carrier.
- Surface transportation, car rental, taxi cab fares and parking fees for the member and a companion between the hotel and the medical facility where services will be provided, limited to \$35 per day.
- Mileage expenses for the member's personal automobile are reimbursed at 17 cents per mile per trip.
- Ferry transportation expenses for the member and a companion from the member's home community, limited to \$50 per person each way.
- Lodging expenses at commercial establishments (hotels and motels) for the member and a companion while traveling between home and the medical facility where services will be provided, limited to \$50 per day per person.

Please Note: Companion travel and lodging expenses are only covered if they must, as a matter of medical necessity or safety, accompany the member. The full price for these expenses must be paid in advance and a claim for reimbursement must be submitted. If the member using the Medical Travel Support benefit is a child under age 19, one companion is automatically permitted, however a second companion will be permitted only if medically necessary.

Reimbursement rates are based on IRS guidelines for the date(s) the expenses were incurred. Reimbursement amount are subject to change due to IRS regulations. Please refer to the IRS website, <http://www.irs.gov>, for additional information. The information in this benefit should not be assumed as tax advice.

Air travel and lodging arrangements can be made by Premera's travel partner or by the member.

Expenses must be incurred while the member is covered under the plan.

BEFORE AND AFTER YOUR CARE

When you travel for approved care, you will first have an appointment to meet with the doctor, followed by the surgery or procedure. After your procedure, you should talk with your doctor to see when it is safe to travel home.

If you develop complications after your procedure, you will be allowed to return for follow-up treatment with the surgeon who performed the procedure, if a local surgeon and/or the surgeon who performed the procedure do not feel it is medically appropriate to provide the care locally. As always, talk to your doctor to learn if traveling is safe for you.

HOW TO FILE A CLAIM

To make a claim for travel expenses covered under this benefit, please complete a Medical Travel Support Claim Form. A separate form is necessary for each patient and each carrier or transportation service utilized.

If your stay extended past the recommended travel duration guidelines, you must include a statement or letter from your physician attesting to the medical necessity of the extension.

Be sure to attach the following documentation:

- Boarding pass or a copy of the ticket from the airline or other transportation carrier, indicating name(s) of the passenger(s), dates of travel, origination and final destination points, and receipts with total cost
- Receipts for all covered travel expenses
- The Utilization Management Authorization number provided to you when your travel was approved

Credit card statements or other payment statements are not acceptable forms of documentation.

MEDICAL TRAVEL SUPPORT LIMITATIONS AND EXCLUSIONS

In addition to “General Limitations and Exclusions,” this benefit will not be provided for the following services:

- Travel that is not pre-authorized; you must contact Premera and have authorization for this benefit
- Travel to facilities outside the network
- International travel
- Airline charges and fees for booking changes
- Reimbursement for mileage rewards or frequent flier coupons
- Travel for ineligible medical procedures, such as regular office visits, preventive or routine care, outpatient rehabilitation
- Lodging at any establishment that is not a hotel or motel
- Using a mobile home, RV or travel trailer for lodging or travel
- Meals and personal care items
- Pet care, except for service animals
- Phone service and long distance calls

PHARMACY PROGRAM

The pharmacy benefit provides coverage for medically necessary prescription drugs, prescriptive oral agents for controlling blood sugar levels, glucagon emergency kits, allergy emergency kits and insulin when prescribed for your use outside of a medical facility and dispensed by a licensed pharmacist in participating mail order or retail pharmacies licensed by the state in which the pharmacy is located. For the purposes of this plan, a prescription drug is any medical substance that, under federal law, must be labeled as follows: “Caution: Federal law prohibits dispensing without a prescription.” It does not include any drugs labeled, “Caution—limited by federal law to investigational use.”

This program also provides coverage for the following:

- Prenatal and fluoridated vitamins
- Prescription contraceptive drugs and devices (e.g. oral drugs, diaphragms and cervical caps)
- Compounded medications of which at least one ingredient is a covered prescription drug
- PKU Dietary Formula
- Drugs for the treatment of nicotine dependency, including over the counter (OTC) nicotine patches, gum or lozenges purchased through a retail pharmacy
- Inhalation spacer devices and peak flow meters
- Hypodermic needles/syringes and alcohol swabs used for self-administered injectable prescription medications, and other disposable diabetic supplies such as test strips, testing agents and lancets.

To receive benefits for prescription drugs at a network pharmacy, just show your Premera ID card and pay your share of the cost (either a copayment for the 750 Plan and HDHP, or deductible and coinsurance for the CDHP) for the prescription. The pharmacist will electronically file the balance of the claim with Express Scripts. You don't have to file a claim form and you don't have to wait to be reimbursed. If you are covered by an additional program you may submit your receipt for your share of the cost for reimbursement from the secondary carrier. If your secondary carrier is also Premera/Express Scripts, complete a Secondary Coverage Prescription Claim Form and send it, along with your receipt for the primary coverage, to Premera for processing. Forms are available through the university's benefits Web site at www.alaska.edu/hr/forms/hr_benefits/.

MAXIMUM MEDICATION SUPPLY

When you purchase prescriptions at a participating (network) pharmacy, you will receive a maximum 30-day supply, unless the drug maker's packaging limits the supply in some other way. This 30-day supply limitation is typical of most prescription drug programs because it reduces waste and conforms with standard physician prescribing patterns. The plan also allows you to obtain up to 90 days' of generic medications at a local pharmacy for up to three times the standard copay. If you are taking a prescription for a long-term or chronic condition, you should consider using the Home Delivery Mail Service Pharmacy, the mail service pharmacy which allows you to purchase up to a 90-day supply at significant savings.

GENERIC DRUGS

One of the most important ways that you can help keep program costs down over time is by utilizing generic drugs whenever possible. The generic version of a drug is made from the same chemical compound as its brand name counterpart. Generic drugs are manufactured according to the same standards as brand name drugs and have the FDA's approval for safety and effectiveness, yet generic drugs cost a fraction of the price of their brand name coun-

terparts. The use of generic drugs offers a simple and safe alternative to help reduce your medication costs. You can ensure that you will receive the generic product when it is available by asking your doctor to write your prescription for the generic or by indicating generic substitution is allowed.

Under this program (including the Home Delivery Mail Service Pharmacy) generics will be used in all situations except in the following cases:

- there is no generic equivalent;
- the pharmacy is unable to provide the generic equivalent at the time the prescription is filled; or
- the physician, employee or dependent requests the name brand drug and member pays the difference in the cost between the generic and name brand drug.

PRESCRIPTION DRUG FORMULARY

The pharmacy program uses a specific list of covered prescription drugs, sometimes referred to as a formulary. Premera’s Pharmacy and Therapeutics Committee, which includes medical practitioners and pharmacists from the community, frequently reviews current medical studies and pharmaceutical information. The committee then makes recommendations on which drugs are included in the drug lists, which are updated quarterly based on these recommendations. The formulary includes both generic and brand name drugs. For the most current formulary information please check the web site at Premera.com and select Pharmacy from the Member Services tab. Click on the Rx Search tool and select the Preferred B3 drug list for the 750 and High Deductible Plans, or the Preferred A1 drug list for the Consumer-Directed Health Plan. You can also call Premera Customer Service for a complete list of this plan’s covered drugs.

Please note: certain categories of drugs are excluded; see “Pharmacy Limitations” for more information on excluded drugs. See the “Prior Authorization” section for information on drugs requiring prior authorization.

The 750 Plan and the High Deductible Health Plan use a four-tiered benefit plan. This means there are four tiers of copays with Tier 1 drugs being Generic, Tier 2 are Preferred Brand Name drugs, Tier 3 are Non-Preferred Brand drugs, and Tier 4 are Specialty Drugs. As a general rule, generics cost less; however, there are some individual cases where even generics can cost a lot. For a better understanding of your cost, log in to the Premera portal and go to Pharmacy Services under My Premera Plan. Then select “Compare prescription costs” to log in to MyRxChoices at Express Scripts.

PRESCRIPTION DRUG COPAYMENT (750 PLAN AND HDHP)

Each member on the 750 Plan and the HDHP must pay a copay for each separate new prescription or refill. A “copay” is a fixed up-front dollar amount that you’re required to pay for each prescription drug purchase. If purchased at a participating pharmacy, the amount you’ll pay will be as follows:

Per Prescription or Refill	Generic Drug Copayment	Brand Name Drug Copayment	Non-Preferred Brand Drug Copayment
Network Pharmacy (up to 30-day supply)	\$10 for generic drugs	\$30 for brand name	\$60 copay for non-preferred brand name
Home Delivery Mail Service (up to 90-day supply)	\$20 for generic drugs	\$60 for brand name	\$120 copay for non-preferred brand name
Specialty Drugs (See Specialty Pharmacy section)		\$100 for up to 30 day supply	

When available, a generic drug will be dispensed in place of a brand name drug. In the event a generic equivalent is not manufactured, the brand name copayment will apply. Generic drugs may also be obtained in up to 90 day quantities with the applicable multiple of copay (30 days for \$10, 60 days for \$20, and 90 days for \$30).

Note: If you or your doctor request a brand name drug when a generic equivalent is allowed by law and available, in addition to the brand name copayment you will be required to pay the difference in price between the brand name drug and the generic equivalent.

PREVENTIVE DRUG LIST (750 PLAN AND HDHP)

The 750 Plan and the High Deductible Health Plan offer a list of preventive generic drugs that are covered at 100% with no copay, like other preventive medical services. The preventive drug list is called the PV1 List and is available on the UA benefits Web site at www.alaska.edu/benefits/pharmacy-benefits.

PRESCRIPTION DRUGS ON CDHP

The Consumer-Directed Health Plan treats prescription drugs as any other medical expense, subject to the deductible and coinsurance. Use the drug cost comparison tool at MyRxChoices to find the most cost effective drug for your needs, as well as the savings available by mail order.

The CDHP also has a preventive drug benefit that covers many generic and some brand-name medications at 100% with no deductible or coinsurance, like any other preventive medical service. The drug list for this benefit, called the PV3 List, is available on the UA benefits web site at www.alaska.edu/benefits/pharmacy-benefits/.

OUT-OF-POCKET MAXIMUM

Pharmacy plan copays on the 750 Plan and HDHP are limited to an individual out-of-pocket maximum of \$1,000 per person, with a family maximum of \$1,700, per plan year. This is a separate out-of-pocket maximum from the medical plan maximum, and is not combined with any other plan limits.

Pharmacy costs on the CDHP are subject to the plan's medical deductible and out-of-pocket maximum like any other covered medical expense.

REFILLS

Benefits for refills will be provided only when you have used three-fourths (75 percent) of the current supply. The 75 percent is calculated based on the number of units and days' supply dispensed in the 180 days preceding the last refill.

SPECIAL FEATURES OF THE PHARMACY NETWORK PROGRAM

The University of Alaska uses Premera Blue Cross Blue Shield to access the pharmacy network of their partner, Express Scripts. These pharmacies have agreed to provide University of Alaska plan participants discounts equal to or greater than any available when purchasing the medication for cash. The pharmacy network program also includes some important quality and cost-saving features such as:

- drug utilization review;

- tablet splitting program; and
- clinical pharmacy management (step therapy, prior authorization and quantity limits).

More information on each of these features is provided below.

DRUG UTILIZATION REVIEW

Your drug benefit includes a special computerized real-time monitoring service. When you have a prescription filled at a network pharmacy (including the Home Delivery Mail Service Pharmacy mentioned later in this section), your prescription will be analyzed for certain types of potential problems related to:

- interactions with other drugs you are taking;
- inappropriate drugs, based on your age;
- unusually high or low drug dosage; and
- drug duplication or excessive use.

This monitoring is based on information stored from previous prescriptions you have had dispensed from a network pharmacy. If any of these potential problems arise, a message is transmitted to your pharmacist before the drug is dispensed. The pharmacist may consult with you and may want to contact your physician to resolve any questions about the appropriateness of a particular drug.

TABLET SPLITTING PROGRAM

The Tablet Splitting Program reduces your out-of-pocket costs for certain prescription medications. Participation in the program is voluntary. When you participate, selected drugs are dispensed at double strength, and then the individual tablets are split by you into half-tablets for each use. Premera will provide you with a tablet splitter. The drugs eligible for the program have been selected because they are safe to split without jeopardizing quality or effectiveness.

Because the drugs are dispensed at double strength and will be split, they will be dispensed at one-half the normal dispensing limits listed above. Members on the 750 Plan and HDHP will pay one-half the normal copay for retail or mail order drugs included in the program. Members on the CDHP will have lower out-of-pocket costs because the double-strength tablets are less expensive than twice the quantity of single-strength tablets.

Contact Premera customer service at (800) 364-2982 to find out which drugs are eligible for tablet splitting.

STEP THERAPY PROGRAM, PRE-APPROVAL AND QUANTITY LIMITS

In certain circumstances, the plan may limit benefits to a specific dispensed days' supply, drug or drug dosage appropriate for a usual course of treatment. The plan may also limit benefits for certain drugs to specific diagnoses or pharmacies.

In making these determinations, Premera considers medical necessity criteria, the recommendations of the manufacturer, the circumstances of the individual case, U.S. Food and Drug Administration Guidelines, published medical literature and standard reference compendia.

The Step Therapy program (also called Generic Step Therapy) is designed to encourage the use of lower-cost generics and preferred brand-name drugs to help reduce pharmacy costs for both employees and the University of Alaska.

Step Therapy requires that a cost effective generic alternative be tried first before a non-preferred brand drug is covered. In order for a non-preferred brand medication to be covered, the plan requires you to have used a 30-day supply of a generic alternative in the same drug class within the last 24 months, or your medical provider will need to get pre-approval for the non-preferred drug to be covered.

Some drugs are part of Premera's Pre-Approval Program, meaning you may need to meet certain requirements before your prescription is covered. Medications for certain conditions, such as migraines, diabetes, high blood pressure or asthma, may require pre-approval. If you have a prescription requiring pre-approval, your doctor will need to submit information that will be reviewed prior to the drug being dispensed. See the Pre-Approval section of this Handbook for more information.

Quantity Limits are in place for some drugs that treat conditions such as migraines, severe pain and erectile dysfunction.

These programs are limited to a certain number of drugs. For an up-to-date listing, check the Premera.com web site and select Drugs Requiring Approval under Pharmacy link in the Member Services tab.

MAINTENANCE DRUGS

The pharmacy plan encourages the use of mail order for maintenance drugs by charging a higher copay for the third and future refills of preferred and non-preferred brand name medications when filled at a retail pharmacy. After two refills at a retail pharmacy, the regular copay will be doubled unless you use the Mail Service Pharmacy. A list of maintenance drugs can be found on the benefits web site at www.alaska.edu/benefits/pharmacy-benefits. Drugs that could be damaged by freezing and generic drugs are exempt from the Mail Service requirement.

PHARMACIES OUTSIDE ALASKA

Your identification card will also be honored at more than 62,000 participating independent and chain pharmacies located in the other 49 states, Puerto Rico, and the District of Columbia that have contracts with Express Scripts. When you show your Premera identification card, you will only have to pay your plan's applicable copayment or deductible/coinsurance at time of purchase.

If you do not show your identification card at a network pharmacy or if you use a non-participating pharmacy, you will have to submit the claim as described below in the "Non-Participating Retail Pharmacy" section. You will be reimbursed up to the amount charged by a participating pharmacy, less the applicable copayment or deductible/coinsurance. The Premera Prescription Claim Form is available through the university's benefits Web site at www.alaska.edu/benefits. To confirm the status of a pharmacy, ask the pharmacist or call the 24 hour pharmacy locator number on the back of your ID card.

NON-PARTICIPATING RETAIL PHARMACY

If you fill a prescription at a non-participating pharmacy, you will be reimbursed up to the amount allowed at a participating pharmacy, less your applicable copayment or amount applied to deductible and coinsurance. You will be responsible for the full retail cost of the prescription at the time the pharmacist issues your medication; you will not receive the discounted price of a participating pharmacy. To be reimbursed, you will need to submit a Prescription Claim Form to Express Scripts at the address on the form. Forms are available through the university's benefits Web site at www.alaska.edu/benefits/pharmacy-benefits.

COORDINATION OF BENEFITS FOR PRESCRIPTION DRUG CLAIMS

To file a claim for coordination of benefits for secondary coverage you will need to submit a Secondary Insurance Prescription Claim Form to Premera Blue Cross at the address on the form. The form is available through the university's benefits Web site at www.alaska.edu/benefits/pharmacy-benefits. Be sure to include any receipts or explanations of benefits you received from the primary coverage.

EXPRESS SCRIPTS HOME DELIVERY (MAIL ORDER PHARMACY)

Express Scripts Home Delivery allows employees and their dependents to fill maintenance prescriptions at less cost than through a retail pharmacy. If you take prescription medication on an ongoing basis and/or you have a prescription that will need a 30-day to a 90-day supply, you can order that prescription (and refills) by mail. Up to a 90-day supply of covered medications may be purchased through the mail service program, unless the drug maker's packaging limits the supply in some other way. The cost to you is the copayment shown in the Prescription Drug Copayment table for the 750 Plan and HDHP per prescription or refill. When you receive your medication in the mail, you will only receive a bill for your copayment amount, and Express Scripts will be billed directly for the balance.

CDHP enrollees benefit from Home Delivery by getting a 90-day supply of medication for a reduced price. Use the cost comparison tool at MyRxChoices, available by logging in to Premera.com, select Pharmacy Services and click on the Compare Prescription Costs link.

ORDERING FROM EXPRESS SCRIPTS HOME DELIVERY

The easiest way to get started with the mail order benefit is to go to Premera.com, select Online Pharmacy and download the Express Scripts Home Delivery Mail-Order Form. Complete instructions are available under the Mail Order Prescriptions link. You will only need to complete this form for your first order. Obtain a new prescription written for a 90-day supply with refills as needed for a year. Be sure to allow at least two weeks for your initial prescription order. Have your doctor write you a prescription for a local fill, in addition to the mail order prescription, so you have adequate medication on hand. Mail your prescription drug claims to:

Express Scripts
PO Box 747000
Cincinnati, OH 45274-7000

Your prescription drug order will be processed and mailed to you via First Class Mail or UPS, along with instructions for future prescriptions and/or refills. Refills can be ordered over the phone or online at Express Scripts' MyPharmacyPlus. For more information about the Express Scripts Home Delivery, call member services at 800-391-9701.

SPECIALTY PHARMACY

Patients with complex, chronic medical conditions need the necessary care management to monitor their condition. Premera's Specialty Pharmacy is a program that provides that attention, working one-on-one with patients, managing their treatment. Specialty Pharmacy provides a full complement of specialized drugs and services for patients with complex or rare conditions such as hepatitis C, cancer, hemophilia, RSV, Crohn's disease, multiple sclerosis, rheumatoid arthritis, growth deficiency, organ transplants, and HIV/AIDS.

If you are taking medications for a complex, chronic medical condition, contact Accredo, an Express Scripts Specialty Pharmacy toll-free at 1-877-244-2995 to enroll. You can ask an Accredo representative to call your provider for a new prescription, or your provider can call Accredo directly.

The first fill of a specialty medication may be obtained at a local retail pharmacy. Future refills are filled through Specialty Pharmacy and are subject to the applicable copay or deductible and coinsurance per 30-day fill.

PHARMACY LIMITATIONS

In addition to “General Limitations and Exclusions,” this benefit will not be provided for the following:

- Drugs and medicines that may be lawfully obtained over the counter (OTC) without a prescription. OTC drugs are excluded even if prescribed by a practitioner, unless otherwise stated in this benefit. Examples of such excluded items include, but aren’t limited to, non-prescription drugs and vitamins, food and dietary supplements, herbal or naturopathic medicines and nutritional and dietary supplements (e.g. infant formulas or protein supplements)
- Non-prescription contraceptive methods (e.g. jellies, creams, foams or devices)
- Drugs for the purpose of cosmetic use, or to promote or stimulate hair growth (e.g. for wrinkles or hair loss)
- Fertility drugs, regardless of their intended use
- Replacement of lost or stolen medication
- Therapeutic devices or appliances (including, but not limited to, hypodermic needles, syringes, support garments, and other nonmedical substances), except for insulin needles/syringes and other disposable diabetic supplies
- Any prescription or refill that is in excess of the quantity specified, or that is dispensed after one year from the date the prescription was written
- Any claim or demand for injury or damage arising in connection with the manufacturing, compounding, dispensing, or use of any prescription drug
- Drugs for experimental or investigational use

Prescription drugs covered under this benefit on the 750 Plan and HDHP are not eligible for Comprehensive Medical Benefits.

This pharmacy program benefit is intended to provide coverage for prescription drugs and insulin when dispensed by a pharmacy. Although the following drugs, services, and supplies are not available under the pharmacy program, they may be available elsewhere in this plan:

- Immunization agents; biological sera, such as rabies serum
- Biologicals, blood or blood derivatives
- Any infusion therapy drugs or solutions
- Injectables or other prescriptions requiring parenteral administration or use (other than insulin)
- Services other than prescription drugs
- Administration or injection of any drug
- Drugs delivered or administered by the prescriber
- Take-home prescription drugs dispensed and billed by a medical facility

DENTAL CARE BENEFITS

INTRODUCTION

Benefits are available under the dental care section of the benefit program for services and supplies furnished in connection with the diagnosis and treatment of a covered dental condition if such services and supplies meet all of these requirements:

- They must not be excluded from coverage under this program.
- They must be furnished by a dentist, except that they may also be provided by a dental hygienist or other individual performing within the scope of his or her license as allowed by law. These services must also be rendered under the supervision and guidance of the dentist.
- They must be dentally necessary. A service is dentally necessary if, in the judgment of Blue Cross, it meets all of the following requirements:
 - Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of a disease, accidental injury, or condition harmful or threatening to the enrollee's dental health
 - Consistent with standards of good dental practice within the organized dental community
 - Not primarily for the convenience of the enrollee or the enrollee's dentist

Please Note: The fact that the covered services were furnished, prescribed, or approved by a dentist does not in itself mean that the services were dentally necessary.

The deductibles and out-of-pocket maximums from the comprehensive medical benefit section of your benefit plan do not apply to the dental care benefit.

You are responsible for furnishing to Blue Cross all diagnostic evaluative material, such as study models, dental X-rays, and charts that Blue Cross may require to determine available benefits. Benefits will only be provided for dental services that can be verified as covered services based on the diagnostic material Blue Cross has been furnished. Blue Cross will not provide benefits for those dental services which it is unable to verify as covered services when any necessary materials are not furnished upon request.

ESTIMATE OF BENEFITS

Your dentist may submit an estimate of benefits request to Blue Cross for any proposed dental service or series of dental services for which the total charge will exceed \$500. It is also important that any cast or porcelain restorations, prosthetic appliances, or periodontal surgeries be sent for an estimate of dental benefits. Within 72 hours after Blue Cross receives the fully documented request, Blue Cross will determine whether the service meets the standard for coverage under this program. Estimates are valid for six months.

Blue Cross strongly recommends that you request an estimate of dental benefits so that benefit questions are answered before your course of treatment begins. If your dentist makes a major change in the treatment plan, he or she should submit a revised plan.

Blue Cross' estimate is conditioned on the provisions of this program and your eligibility for coverage at the time the service is rendered. If Blue Cross finds the proposed treatment to be dentally necessary, they will not reverse that decision unless the information on which their decision was based is later found to be materially incomplete or inaccurate. The decision to deny, reduce, or end benefits for an otherwise covered service because the service is not dentally necessary will be made by a Blue Cross employee or consultant who is a licensed dental care provider.

ALTERNATIVE BENEFITS

To determine benefits available under this program, Blue Cross considers alternative procedures or services carrying different fees and are, in the judgment of Blue Cross, consistent with acceptable standards of dental practice. In all cases where there is an alternative course of treatment that is less costly, Blue Cross will only provide benefits for the treatment carrying the lesser fee. If you and your dentist decide upon a more costly treatment, then you are responsible for the additional charges beyond those for the less costly alternative treatment.

PLAN YEAR DEDUCTIBLE (750 AND HIGH DEDUCTIBLE HEALTH PLANS ONLY)

Covered dental services are classified as Type A, Type B, or Type C. Type A covered services (Preventive) are not subject to any deductible. However a deductible does apply to Type B and Type C covered services. A deductible is the amount of expense you must incur for Type B and Type C covered services and supplies in each plan year before benefits are payable under this program for those services and supplies. For each enrollee, this deductible amount is either \$25 (for the 750 Plan option), or \$50 (for the High Deductible and Consumer-Directed Health Plan options). The amount credited toward the deductible will not exceed the allowable charge for the covered service or supply, and will not apply to any other deductible under the health care program.

COVERED DENTAL EXPENSES

Dental benefits are provided for each enrollee according to the plan option in effect at the time services are rendered, up to the dental benefit plan year maximum of \$2,000.

Type Of Covered Service	750 Plan	HDHP	CDHP
Deductibles:			
Type A - Preventive Care Expenses	\$0	\$0	\$0
Type B - Other Basic Expenses	\$25	\$50	\$50
Type C - Major Dental Expenses	\$25 (combined with Basic Expenses)	\$50 (combined with Basic Expenses)	\$50 (combined with Basic Expenses)
Coinsurance (the percent of allowable charge you are responsible for):			
Type A - Preventive Care Expenses	0%	0%	0%
Type B - Other Basic Expenses	20%	20%	20%
Type C - Major Dental Expenses	50%	50%	50%

The dental benefits of this program are based on allowable charges for dentally necessary covered services. The percentage of an allowable charge that you are responsible for is called coinsurance. Please refer to the “Glossary of Terms” section for a detailed explanation of Allowable Charge.

The dental benefits available under this section will be provided prior to any dental benefits which may be available under other provisions of this program.

TYPE A—PREVENTIVE CARE EXPENSES (NOT SUBJECT TO DENTAL DEDUCTIBLE)

- Oral examinations (two per year), which includes prophylaxis (cleaning, scaling, and polishing of teeth)

- Dental X-rays for diagnosis; also other x-rays not to exceed the following:
 - one full mouth series in a 36-month period; and
 - one set of bitewings (twice a year).
- Topical application of fluoride, for enrollees age 15 or younger
- Emergency palliative treatment
- Space maintainers
- Sealants, for enrollees age 15 or younger

TYPE B—BASIC EXPENSES

- Permanent fillings, consisting of silver amalgam, silicate, and composite resins; when dentally necessary, resin fillings will be allowed only for the front teeth; for other types of fillings, such as gold foils, the allowance will be limited to what would have been otherwise allowed for amalgam fillings
- Temporary fillings
- Extractions, including surgery to remove one of the following:
 - teeth partly or completely impacted in the bone of the jaw;
 - teeth that will not erupt through the gum;
 - other teeth that cannot be removed without cutting into bone;
 - the roots of a tooth without removing the entire tooth
- Oral surgery for diagnosis and treatment of cysts and abscesses
- General anesthetics given in connection with covered dental services
- Periodontal examinations, and treatment of diseased periodontal structures
- Endodontic treatment, including root canal therapy
- Injection of antibiotic drugs
- Repair and recementing of crowns, inlays, bridgework, and dentures
- Treatments of impactions and gingivectomies
- Relining and/or rebasing of dentures
- Tissue conditioning
- Occlusal analysis, adjustments, and guards
- Surgical dental implant and implant-related services (excluding implant abutment supported crowns or prosthetics over the implants) (dental benefit pre-determination is recommended)

TYPE C—MAJOR DENTAL EXPENSES

- Inlays, onlays, gold fillings, and crowns when, in the judgment of Blue Cross, amalgam or composite resin fillings would not adequately restore the teeth; this circumstance includes precision attachments for dentures
- Initial installation of dentures (including adjustments during the first six-month period following installation) and fixed bridgework (including inlays and crowns to form abutments)
- Initial placement of implant/abutment-supported crowns or prosthetics over implants
- Replacement of implant/abutment-supported crowns or prosthetics over implants that cannot be made serviceable and was seated at least five years prior to replacement
- Replacement inlays, onlays, crowns, dentures, and fixed bridgework, but only when one of the following is true:
 - the present inlay, onlay, crown, denture or bridgework cannot be made serviceable, and was seated at least five years prior to replacement;

- the replacement or addition of teeth is required to replace one or more additional teeth extracted after initial placement;
- reparation of the natural tooth structure (or natural tooth structure under the existing fixed bridgework) is required as a result of an accidental injury to that structure; or
- the present denture is an immediate, temporary one and cannot be made permanent; replacement by a permanent denture is needed; and it takes place within 12 months from the date the immediate temporary one was first installed.
- Labial veneers
- Temporary prosthetics

DENTAL LIMITATIONS

In addition to “General Limitations and Exclusions,” this benefit will not be provided for the following:

- Any services or supplies received when this benefit is not in effect or when you are not covered under this benefit (including bridges, dentures, crowns, or root canals fitted, prepared, started, or ordered before your effective date), except for prosthetic devices, crowns, or root canals that fulfill the following requirements:
 - were fitted, prepared, started, or ordered prior to the date your coverage under this benefit ended; and
 - were completed or seated, and delivered to you within 30 days after the date your coverage under this benefit ended.
- Services and supplies to increase or alter the vertical dimension
- Services and supplies provided by more than one dentist for the same dental procedure
- Services and supplies not customary and accepted by the dental profession in the states of Alaska or Washington
- Services and supplies for orthodontia under the Standard or Economy Plan options, except as provided for accidental injury, including casts, models, X-rays, photographs, examinations, appliances, braces, and retainers; however, this exclusion does not apply to extractions incidental to orthodontic services
- Services and supplies to treat congenital malformations, except when the patient is a dependent child
- Services and supplies for cosmetic or aesthetic purposes
- Myofunctional therapy, which means muscle training therapy or training to correct or control harmful habits
- Dietary planning for the control of dental caries, oral hygiene instruction, and training in preventive dental care
- Charges for broken appointments
- Extra dentures or other appliances, including replacements due to loss or theft
- Other than standard techniques used in the making of restorations or prosthetic appliances, such as personalized restorations or precision attachments
- Any drugs and medicines, including vitamins and food supplements, except as specified in this benefit; however, benefits may be available for fluoridated vitamins under other benefits of this program
- Dental services received from one of the following:
 - Dental or medical department maintained for employees by or on behalf of an employer
 - Mutual benefit association, labor union, trustee, or similar person or group
- Facility charges for dental procedures
- Any services or supplies connected with the diagnosis or treatment of temporomandibular joint (TMJ) disorders fractures and dislocations; however benefits may be available under Comprehensive Medical.

ORTHODONTIA (AVAILABLE ON 750 PLAN ONLY)

Benefits are available for the services and supplies described in this section subject to the following requirements:

- An existing orthodontic condition must be diagnosed as consisting of a handicapping malocclusion which is abnormal and which can be reduced or eliminated by correcting abnormally positioned teeth; and
- An expense for an orthodontic service or supply is incurred on the date the service is received or the supply is ordered.
- Any plan year deductibles, coinsurance and benefit maximums of other benefits under this plan don't apply to this benefit.

Covered services and supplies include

- diagnostic services and supplies, including examinations, x-rays, models, and photographs;
- active treatment, including initial and subsequent necessary appliances; and
- retention treatment, including necessary appliances.

Premiera Blue Cross Blue Shield of Alaska reserves the right to review your dental records, including x-rays, models and photographs, to determine if the requested services and supplies are within the limits of this benefit.

Benefits are provided at a constant 50 percent up to a lifetime maximum of \$1,500 per enrollee, or until the enrollee's total treatment plan, including retention treatment, is paid, whichever occurs first.

ORTHODONTIA LIMITATIONS

In addition to "Dental Limitations" and "General Limitations and Exclusions," this benefit will not be provided for the following:

- Any replacement or repair to any appliance
- Charges beyond the month of termination of orthodontic services if such services are terminated for any reason before completion
- Further orthodontic services and supplies, after completion of the initial treatment plan, unless this benefit's lifetime maximum hasn't been reached
- Services rendered by a dental care provider beyond the scope of his or her license or certification
- Orthognathic surgery (jaw augmentation or reduction), although benefits may be available under the medical plan
- Services provided by more than one dental care provider for the same dental procedure
- Expenses incurred for orthodontic services or supplies when this benefit isn't in effect or when you're not covered by this benefit

In all cases where there are alternative techniques of treatment which are, in Blue Cross' judgment, consistent with acceptable standards of dental practice, but which carry different charges, benefits will be provided only for the technique carrying the lesser charge.

The orthodontia benefits available under this section will be provided prior to any orthodontia benefits that may be available under other provisions of this plan.

VISION CARE BENEFITS

INTRODUCTION

Vision coverage is provided through VSP. VSP has an extensive nationwide network of doctors who agree to provide vision care and materials to participants at discounted rates. Finding a VSP network doctor is easy—visit *vsp.com*, select the Member portal, and click on “Find a Doctor” or call (800) 877-7195.

Once you are enrolled in the VSP plan, your personalized benefit information is available on *vsp.com*. Simply register at the site by entering your employee ID where indicated, and follow the steps to access your account. Your employee ID will be your VSP identification number; you will not receive a separate ID card. You can also check details such as your eligibility, date of your last eye exam and which VSP network doctor you used. All UA Choice plan options have the same vision benefit.

COVERED VISION SERVICES

There is no plan year deductible or coinsurance for vision benefits. Benefits for you or any of your covered dependents are payable according to the following schedule (plan year begins July 1):

Type Of Service	Benefit
Complete Vision Examination Once every Plan Year	VSP doctor: Paid in full after \$10 copay Non-VSP doctor: Up to a \$50 reimbursement after the \$10 copay
Lenses and Frames—Once every other plan year VSP Provider	Single vision, lined bifocal and trifocal lenses covered in full after \$25 copay, frame of your choice, up to \$150, plus 20% off any out-of-pocket costs
Non-VSP Provider	Reimbursement after \$25 copay as follows: Single vision lenses Up to \$50 Bifocal lenses Up to \$75 Trifocal lenses Up to \$100 Progressive lenses Up to \$75 Frames Up to \$70
OR Contact Lenses—Once every other plan year VSP Provider	Elective contact lenses up to a \$150 allowance for the cost of the contacts and contact lens exam with no copay. Available every other plan year.
Non-VSP Provider	Reimbursement up to \$105

EXTRA DISCOUNTS AND SAVINGS

When you go to a VSP network doctor, you will receive the following discounts:

- Average of 35 - 40% savings on all non-covered lens extras (such as scratch resistant and anti-reflective coatings)

- 30% discount when you purchase additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision exam, or 20% off from any VSP doctor within 12 months of your last eye exam
- 15% discount off the cost of your contact lens fitting and evaluation exam from a VSP network doctor;
- An average of 15% off the regular price of laser vision correction, or 5% off the promotional price, through a VSP network doctor. After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

Benefits renew every plan year for covered vision examinations, and every other plan year for eyeglasses (lenses and frames) or contacts. Benefits will be provided for either eyeglasses or contact lenses during the same benefit period, not both.

USING NON-VSP PROVIDERS

You may obtain eye care services from non-VSP providers. Reimbursement for services is according to the reimbursement benefits stated above. However, VSP cannot guarantee satisfaction or extend the additional discount towards materials or any options that you may choose.

When you obtain services and/or materials from a non-VSP provider, please follow these steps:

- Pay the non-VSP provider the full amount of the bill and request an itemized copy of the bill. The bill needs to show the charges for the eye exam and materials, including lens type.
- Log in to the VSP web site and click the link for “Out-of-Network Reimbursement” and follow the instructions to complete and then print the online form, or you can attach a sheet and include the following information with your receipt: Employee name and ID, patient’s name, date of birth and relationship to the employee.
- Send a copy of the itemized bill along with the completed Out-of-Network Reimbursement Form to:

VSP
PO Box 385018
Birmingham, AL 35238-0518

Please note that claims for reimbursement must be filed within one year of the date of service. You will be reimbursed according to the reimbursement schedule.

COORDINATION OF BENEFITS

If you have coverage as an employee and as a dependent, please let the VSP member doctor know at the time services are rendered, and provide the other coverage ID number. The doctor’s office will file the claims on your behalf.

If you choose to use a non-VSP provider, you will need to pay the full amount of the bill at the time of service, and submit your itemized copy of the bill as described above, being sure to reference both the primary and secondary ID numbers.

VISION LIMITATIONS

In addition to “General Limitations and Exclusions,” the following limitations will apply to this benefit:

- vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), or pleoptics;
- plano lenses;
- expenses associated with securing materials such as lenses and frames;

- medical or surgical treatment of the eyes; or
- replacement of lenses and frames furnished under this program (under a covered allowance), except at the normal intervals when services are available. Discounts on additional materials are provided on an unlimited basis for twelve months following an eye exam.

AUDIO CARE BENEFITS

INTRODUCTION

Benefits are available for the services and supplies described in this section that are furnished in connection with hearing loss.

The deductibles and out-of-pocket maximums of the comprehensive medical benefits in this program do not apply to this benefit.

In order to receive your audio care benefit, you must be examined by one of the following:

- a physician certified as an otolaryngologist or otologist; or
- an audiologist performing the examination at the written direction of a legally qualified otolaryngologist or otologist; the audiologist must either be legally qualified in audiology, or hold a Certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any applicable licensing requirements.

A “covered hearing aid” is an electronic hearing aid installed in accordance with a prescription written during a covered hearing examination as stated above.

COVERED SERVICES AND SUPPLIES

Benefits will be provided according to the medical schedule of benefits up to a maximum benefit of \$400 in a period of three consecutive plan years for the following:

- one audiometric (hearing) examination; and
- one hearing aid per ear
- hearing aid rental while the primary unit is being repaired

AUDIO LIMITATIONS

In addition to “General Limitations and Exclusions,” the hearing benefits of this program will not be provided for the following:

- any ear or hearing examination to determine the presence of disease or injury, for medical or surgical treatment or for drugs or medicines;
- batteries or other ancillary equipment other than that obtained upon purchase of the hearing aid;
- repairs, servicing, and alteration of hearing aid equipment purchased under this plan;
- expenses incurred after your coverage ends under this program unless a hearing aid was ordered prior to that date and was delivered within 30 days after the day coverage ended;
- services and supplies that were received prior to the enrollee’s effective date; and
- hearing aids furnished or ordered as a result of a hearing examination that occurred prior to the enrollee’s effective date.
- Hearing aid charges in excess of this benefit are not eligible for comprehensive major medical benefits.

HOW TO SUBMIT A CLAIM

AUTOMATIC CLAIMS SUBMISSION

Generally if you use a Blue Cross network provider, the provider will submit your claim directly to Blue Cross. On receipt of the claim from a network provider, Blue Cross will pay the provider directly—even if you pay the provider in-full up front for their service. The contracts between network providers and Blue Cross require all payments be sent directly to the provider.

If you are outside of Alaska and Washington and have received medical services from a hospital or other health care provider, your provider of care must bill the local Blue Cross and/or Blue Shield Licensee directly.

Blue Cross is available to answer questions regarding health insurance benefits and their payment. They can be reached by letter at:

Premera Blue Cross Blue Shield of Alaska
PO Box 327
Seattle, WA 98111-0327

Or you may phone toll free:

(800) 364-2982

If you are unable to resolve your questions directly with Premera, please contact DirectPath, your health care advocate. They can help you with benefits and claims questions, billing problems with providers and filing appeals. Call 866-253-2273 to contact DirectPath. See more information on page 15.

MANUAL CLAIMS FILING

If you choose to go to a non-network provider, or to a provider outside of Alaska and Washington for dental or vision services, you have the option to mark the claim form for direct payment to the provider or yourself. If you do not indicate on the claim form that you want the payment sent to you, Blue Cross will pay benefits to the hospital, doctor, dentist, or any other covered provider who served you.

Step 1

Complete a claim form. A separate claim form is necessary for each patient and each provider. Claim forms are available from Blue Cross, your regional human resources office, or on the University of Alaska benefits web page at <http://www.alaska.edu/benefits/>.

Step 2

Attach the itemized bill. The itemized bill must contain all of the following information:

- Names of the employee and the enrollee who incurred the expense
- Identification numbers for both the enrollee and the University of Alaska (these are shown on the enrollee's identification card)
- Name, address, and IRS tax identification number of the provider
- Information about other insurance coverage
- Date of onset of the illness or injury

- Diagnosis or ICD-9 code
- Procedure codes (CPT-4, HCPCS, ADA, or UB-92) for each service
- Dates of service and itemized charges for each service rendered
- If the services rendered are for treatment of an accidental injury, the date, time, location, and a brief description of the accident

Step 3

If you are also covered by Medicare, and Medicare is primary, you must attach a copy of the “Explanation of Medicare Benefits.”

Step 4

Check that all required information is complete. Bills received will not be considered claims until all necessary information is included. Be sure to sign the claim form in the space provided.

Step 5

Mail your claims to the following address:

Premera Blue Cross Blue Shield of Alaska
P.O. Box 91059
Seattle, WA 98111-9159

AIR OR SURFACE TRANSPORTATION CLAIMS

To make claim for covered air or ground transportation services, please follow these steps:

Complete an Air/Surface Transportation Claim Form, found online at Premera.com or the UA benefits web site under Health Plan, and Travel for Health Care. A separate claim form is necessary for each patient and each carrier or transportation service utilized. Include copies documentation as listed on the form. Incomplete forms or missing documentation will delay reimbursement.

Your claim must include a statement or letter from your physician attesting to the medical necessity of the services you received that required the air or surface travel. Mail your claim to the address shown in step 6, above.

Please Note: Credit card statements or other payment receipts are not acceptable forms of documentation. Travel in personal vehicles is not covered transportation.

SUBMISSION OF PHARMACY DRUG CLAIMS

To make a claim for covered pharmacy drugs, please refer to the “Pharmacy Drug Benefit” section of this handbook.

CLAIMS FILING TIMELINES

You should submit all claims within 90 days of the start of service or within 30 days after the service is completed. Blue Cross must receive claims within the following time limits:

- Within 365 days of discharge for hospital or other medical facility expenses, or within 365 days of the date on

which expenses were incurred for any other services or supplies

- For enrollees who have Medicare, claims must be filed within the above-mentioned 365-day time frame or within 90 days of the process date shown on the Explanation of Medicare Benefits, whichever is greater

Blue Cross will not provide benefits for claims they receive after the later of these two dates, nor will Blue Cross provide benefits for claims which were denied by Medicare because they were received past Medicare's submission deadline. Exceptions will be allowed when required by law or regulation.

CLAIMS PROCEDURE

Blue Cross will make every effort to process claims as quickly as possible. Claims for benefits will be processed under the following time frames;

- If the claim includes all of the information needed to process the claim, Blue Cross will process it within 30 calendar days of receipt.
- If more information is needed to process the claim, Blue Cross will tell you or the provider who submitted the claim that they need more information. They will make that request within 30 calendar days of receipt. You or your provider will have 45 days from the notice to provide the additional information. If the additional information is not received, Blue Cross will continue to notify you every 45 calendar days from the initial notice, until a decision is made about your claim.
- Once Blue Cross receives the additional information for your claim, they will process your claim within 15 days of the date they receive the information.
- Copayments are not considered claims. When a copay is the only amount the member must pay, this would not be considered a claim for benefits; however, an explanation of benefits is available and can be requested.

When your claim is processed, Blue Cross will send a written notice explaining how the claim was processed (an "Explanation of Benefits," or "EOB"). If the claim is denied in whole or in part, they will send a written notice that states the reason for the denial, and information on how to request an appeal of that decision.

DENIED CLAIMS

Blue Cross may deny benefits after you have filed a claim. The University of Alaska has also granted Blue Cross the discretionary authority to determine eligibility for benefits and to construe the terms used in this program. If your claim was denied, in whole or in part, the EOB will include the reasons for the denial and a reference to the provisions of this program on which it is based, as well as a description of additional information Blue Cross may need and why it is needed.

An adverse benefit determination means a decision to deny, reduce, terminate, or a failure to make payment. This includes:

- A decision regarding a member's eligibility in this plan
- A limitation on otherwise covered benefits
- A clinical review decision
- A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective
- When there is more than one alternative treatment available, coverage will be provided for the least costly among medically appropriate alternatives

If payment or benefits were denied in whole or in part, and you disagree with that decision, you have the right to ask Blue Cross to review that adverse benefit determination through a formal, internal appeals process.

Your Questions, Complaints and Appeals

DIRECTPATH IS YOUR ADVOCATE

When you have problems, questions or need more information about the plan or how a claim processed, you can always call Premera Blue Cross directly as described below. The University of Alaska also has an advocacy service that you can call for assistance. DirectPath is your advocate for any health care plan issue or question. Call Direct-Path at 866-253-2273 for confidential help, Monday through Friday 4:00 a.m. to 5:00 p.m. Alaska time, or Saturdays from 5:00 a.m. to 10:00 a.m. Alaska time. More information is in the DirectPath section of this Handbook.

WHEN YOU HAVE QUESTIONS

Call your provider of care when you have questions about the health care services you receive. If you have questions about a benefit or coverage decision, the quality or availability of a health care service or Premera's service, you may contact Blue Cross Customer Service at the following numbers:

- **University of Alaska dedicated number:** 1-800-364-2982
- **Alaska Number:** 1-800-345-6784
- **Hearing-impaired TTY:** 1-800-842-5357 (Only calls from the hearing-impaired will be accepted on this line.)

Premera customer service can quickly and informally correct errors, clarify benefits, or take steps to improve service. Please give Blue Cross the Group and employee numbers shown on your identification card when you call or write. Blue Cross needs this information to identify the type of coverage you have. If you are asking about a specific claim that Blue Cross has processed, please also include or have available the EOB you received from them for that claim.

If you need an interpreter to help with your question, please tell Blue Cross when you call, and they will provide one for the call.

WHEN YOU HAVE A COMPLAINT

When you have a complaint about a benefit or coverage decision, customer service, or the quality or availability of a health care service, you can call Premera Blue Cross at the numbers above, or write a letter to the address below. There may be times when Customer Service will ask you to submit your complaint for review through the formal appeals process outlined below.

Blue Cross will review your complaint and notify you of the outcome and the reasons for the decision as soon as possible, but no later than 30 days from the date your complaint was received.

WHEN YOU DISAGREE WITH A PAYMENT OR BENEFIT DECISION

If payment or benefits were denied in whole or in part, and you disagree with that decision, you have the right to ask the plan to review that adverse benefit determination through a formal, internal appeals process. This plan's appeals process will comply with any new requirements as necessary under state and federal laws and regulations.

What Is An Adverse Benefit Determination?

An adverse benefit determination means a decision to deny, reduce, terminate, or a failure to make payment. This includes:

- A decision regarding a member's eligibility in this plan
- A limitation on otherwise covered benefits
- A clinical review decision
- A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective
- When there is more than one alternative treatment available, coverage will be provided for the least costly among medically appropriate alternatives

WHEN YOU HAVE AN APPEAL

Your plan includes two levels of internal appeals.

Your **Level I** internal appeal will be reviewed by individuals who were not involved in the initial adverse benefit determination. If the adverse benefit determination involved medical judgment, the review will be provided by a health care provider who holds the same professional license as the treating provider. They will review all of the information relevant to your appeal and will provide a written determination. If you are not satisfied with the decision, you may request a Level II appeal.

Your **Level II** internal appeal will be reviewed by a panel of individuals who were not involved in any previous decisions. If your appeal involves medical judgment, the review will be provided by a health care provider who holds the same professional license as the treating provider. You may participate in the Level II panel meeting in person or by phone to present evidence and testimony. Please contact Premera Blue Cross for additional information about this process. Once the Level II review is complete, you will receive a written determination. If you are not satisfied with the final internal appeal decision, you may be eligible to request an external review, as described below.

APPEALS PROCESS

This plan, the University of Alaska and Premera Blue Cross Blue Shield of Alaska will comply with any requirements as necessary under the Affordable Care Act and its governing regulations. The full appeal process is available at www.premera.com, or by calling Premera Customer Service at (800) 364-2982.

You or your authorized representative, someone you have named to act on your behalf, may file an appeal. To appoint an authorized representative, you must sign an authorization form (available by calling customer service, or online at www.premera.com) and mail or fax the signed form to the address or fax number below. This release provides Blue Cross with the authorization for this person to appeal on your behalf, and allows the release of information, if any, to them.

You or your authorized representative may file an appeal by writing to the address listed below. Your appeal request must be received as follows:

- For a **Level I** internal appeal, within 180 calendar days of the date you were notified of the adverse benefit determination. If you are hospitalized or traveling, or have other reasonable cause why you can't submit the appeal within the timeframe, it will be extended to 180 days from the end of the event (hospitalization, travel or other circumstance).
- For a **Level II** internal appeal, within 60 calendar days of the date you were notified of the Level I determination. If you are hospitalized or traveling, or for other reasonable cause beyond your control, this time line may be extended up to 180 calendar days to allow you to obtain additional medical documentation, physician consultations or opinions.

Mail all appeals to:

Premera Blue Cross Blue Shield of Alaska

Attn: Member Appeals Department, MS 123

PO Box 91102

Seattle, WA 98111-9202

Or, you may fax your request to Appeals Department at (425) 918-5592.

If you need help filing an appeal, or would like a copy of the appeals process, call Premera customer service at (800) 364-2982. A written notice acknowledging receipt of your appeal will be sent to you.

If your provider believes that your situation is clinically urgent under law, your appeal will be conducted on an expedited basis. A clinically urgent situation means one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. You may request an expedited internal appeal by calling customer service. If your situation is clinically urgent, you may also request an expedited external review at the same time you request an expedited internal appeal.

You may supply additional information to support your appeal at the time you file an appeal, or at a later date by mailing or faxing to the address and fax number shown above. Please provide this information as soon as possible.

You can request copies of information relevant to the adverse benefit determination. This information will be provided as well as any new or additional information that was considered, relied upon, or generated in connection to our appeal as soon as possible and free of charge. You will have the opportunity to review this information and respond before a decision is made.

What Happens Next?

The adverse benefit determination will be reviewed and you will receive a written decision as stated below:

- Expedited appeals: as soon as possible, but no later than 72 hours after Blue Cross receives your request. You will be notified of the decision by phone, fax or e-mail, and will be followed by a written decision.
- Adverse benefit determination made prior to you receiving services: 15 days of the date Blue Cross receives your request.
- All other appeals: within 30 days of receipt of your request.

If the adverse benefit determination is upheld, you will be provided information about your right to a Level II internal appeal or your right to external review at the end of the internal appeals process.

Appeals Regarding Ongoing Care

If you appeal a decision to change, reduce or end coverage of ongoing care for a previously approved course of treatment because the service or level of service is no longer medically necessary or appropriate, the plan's denial of benefits during the internal appeal period will be suspended. The plan's provision of benefits for services received during the internal appeal period does not, and should not be construed to, reverse the plan's denial. If the decision is upheld, you must repay all amounts the plan paid for such services. You will be responsible for any difference between the allowable charge and the provider's billed charge.

EXTERNAL REVIEW

If you are not satisfied with the final internal adverse benefit determination based on medical necessity, experimental or investigative, health care setting, level of care or effectiveness of a covered benefit, you may have the right to have the decision reviewed by an Independent Review Organization (IRO).

An IRO is an independent organization of medical reviewers who are qualified to review medical and other relevant information. There is no cost to you for an external review.

You will be provided with an external review request form at the end of the internal appeal process notifying you of your rights to an external review. Your written request for an external review must be received no later than four months after the date you received the final internal adverse benefit determination. Your request must include a signed waiver granting the IRO access to medical records and other materials that are relevant to your request.

You can request an expedited external review when your provider believes that your situation is clinically urgent under the law. Please call customer service at (800) 364-2982 to request an expedited external review.

Blue Cross will notify the IRO of your request for an external review. The IRO will let you, your authorized representative and/or your attending physician know where additional information may be submitted directly to the IRO and when the information must be provided.

Once the external review is completed, the IRO will notify you and Blue Cross in writing of their decision within 45 days. If you have requested an expedited external review, the IRO will notify you and Blue Cross of their decision immediately by phone, e-mail or fax after they make their decision, and will follow up with a written decision by mail.

The plan is bound by the decision made by the IRO. If the IRO overturned the final internal adverse benefit determination, their decision will be implemented. If the IRO upheld the final internal adverse benefit determination, there is no further review available under this plan's internal appeals or external review process. However, you may have other remedies available under state or federal law, such as filing a lawsuit.

If you have questions understanding a denial of a claim or your appeal rights, you may contact Premera Customer Service for assistance.

COORDINATION OF BENEFITS

INTRODUCTION

You may also be covered under one or more other health care plans, such as one sponsored by your spouse's employer. Your health care plan includes a "coordination of benefits" feature to handle such situations. Blue Cross will coordinate the benefits of the University's plan with those of your other plans to make certain that, in each plan year, the total payments from all plans are not more than the total allowable expenses. All of the benefits of this plan are subject to coordination of benefits.

If you do have other coverage besides this plan, Blue Cross recommends that you send your claims to the employee's primary plan first. In that way, the proper coordinated benefits may be most quickly determined and paid.

If you are covered as an employee and also as a dependent of a covered employee, you will receive benefits both as an employee and as a dependent. Benefits you receive are subject to this Coordination of Benefits provision.

TERMS YOU SHOULD KNOW

To understand coordination of benefits, it is important to know the meanings of the following terms:

- **Allowable Medical Expense**—the usual, customary and reasonable charge for any medically necessary health care service or supply when the service or supply provided by a licensed medical professional is covered at least in part under any of the plans involved. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense.
- **Allowable Dental Expense**—the usual, customary and reasonable charge for any dentally necessary service or supply provided by a licensed dental professional when the service or supply is covered at least in part under this plan. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense.
- **Claim Determination Period**—a plan year (July 1 through June 30)
- **Medical Plan**—all of the following, even if they don't have their own coordination provisions:
 - Group, individual or blanket disability insurance policies
 - Group agreements with health care service contractors and health maintenance organizations that are issued by insurers, health care service contractors, and health maintenance organizations
 - Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
 - Government programs that provide benefits for their own civilian employees or their dependents
 - Group coverage required or provided by any law including Medicare; this does not include workers' compensation
 - Group student coverage that is sponsored by a school or other educational institution, and includes medical benefits for illness or disease
- **Dental Plan**—all of the following
 - Group, individual or blanket disability insurance policies
 - Group agreements with health care service contractors and health maintenance organizations that are issued by insurers, health care service contractors, and health maintenance organizations
 - Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans

- Government programs that provide benefits for their own civilian employees or their dependents

Each contract or other arrangement for coverage described above is a separate plan. Also, if an arrangement has two or more parts and the coordination of benefits provision applies only to one of the two, each of the two parts is a separate plan.

ORDER OF CLAIM FILING

An important part of coordinating benefits is determining the order in which the plans provide benefits. One plan is responsible for providing benefits first. This is called the “primary” plan. The primary plan provides its full benefits as if there were no other plans involved. The other plans then become “secondary.” This means they reduce their payment amounts so that the total benefits from all plans are not more than the allowable expenses. Coordination of benefits always considers amounts that **would** be payable under the other plan, whether or not a claim has actually been filed.

Here is the order in which the plans should provide benefits:

First: A plan that does not provide for coordination of benefits.

Next: A plan that covers you as other than a dependent, i.e. as an employee.

Next: A plan that covers you as a dependent. For dependent children, the following rules apply:

- When the parents **are not** separated or divorced—The plan of the parent whose birthday falls earlier in the year will be primary, if that is in accord with the coordination of benefits provisions of both plans. Otherwise, the rule set forth in the plan which does not have this provision shall determine the order of benefits.
- When the parents **are** separated or divorced—If a court decree makes one parent responsible for paying the child’s health care costs, that parent’s plan will be primary. Otherwise, the plan of the parent with custody will be primary, followed by the plan of the spouse of the parent with custody, followed by the plan of the parent who does not have custody.

If the rules above do not apply, the plan that has covered you for the longest time will be primary, except benefits of a plan that covers you as a laid-off or retired employee, or as the dependent of such an employee, shall be determined after the benefits of any plan that covers you as other than a laid-off or retired employee, or as the dependent of such an employee. This applies, however, only when other plans involved have this provision regarding laid-off or retired employees.

EFFECT OF MEDICARE

If you are also covered under Medicare, federal law may require this program to be primary over Medicare. When this program is not primary, Blue Cross will coordinate benefits with Medicare as stated in Coordination of Benefits.

RIGHT OF RECOVERY/FACILITY OF PAYMENT

Premiera Blue Cross Blue Shield of Alaska has the right to recover, on behalf of the Group, any payments made by the plan that are greater than those required by the coordination of benefits provisions from one or more of the following: the persons the plan paid or for whom it has paid, providers of service, insurance companies, service plans, or other organizations. If a payment that should have been made under this program was made by another program, Premiera Blue Cross Blue Shield of Alaska also has the right to direct the plan’s payment directly to another program of any amount that should have been paid by the plan. The payment will be considered a benefit under this program and will meet the plan’s obligations to the extent of that payment.

This plan has the right to appoint a third party to act on its behalf in recovery efforts.

THIRD PARTY RECOVERY (SUBROGATION)

If you become ill or are injured by the actions of a third party, your medical care should be paid by that third party. For example, if you are hurt in a car crash, the other driver or his or her insurance company may be required under law to pay for your medical care.

This plan does not pay for claims for which a third party is responsible. However, the plan may agree to advance benefits for your injury with the understanding that it will be repaid from any recovery received from the third party. By accepting plan benefits for the injury, you agree to comply with the terms and conditions of this section.

In addition, the plan maintains a right of subrogation, meaning the right of the plan to be substituted in place of the member who received benefits with respect to any lawful claim, demand, or right of action against any third party that may be liable for the injury, illness or medical condition that resulted in payment of plan benefits. The third party may not be the actual person who caused the injury and may include an insurer to which premiums have been paid.

The plan administrator has discretion to interpret and to apply the terms of this section. It has delegated such discretion to Premera Blue Cross Blue Shield of Alaska and its affiliates to the extent needed in order to administer this section.

Definitions The following definitions shall apply in this section:

- **Recovery:** All payments from another source that are related in any way to your injury for which plan benefits have also been paid. This includes any judgment, award, or settlement. It does not matter how the recovery is termed, allocated, or apportioned or whether any amount is specifically included or excluded as a medical expense. Recoveries may also include recovery for pain and suffering, non-economic damages, or general damages. This also includes any amounts put into a trust or constructive trust set up by or for you or your family, beneficiaries or estate as a result of your injury.
- **Reimbursement Amount:** The amount of benefits paid by the plan for your injury and that you must pay back to the plan out of any recovery per the terms of this section.
- **Responsible Third Party:** A third party that is or may be responsible under the law (“liable”) to pay you back for your injury.
- **Third Party:** A person; corporation; association; government; insurance coverage, including uninsured/underinsured motorist (UM/UIIM), personal umbrella coverage, personal injury protection (PIP) insurance, medical payments coverage from any source, or workers’ compensation coverage. The third party may not be the actual party who caused the injury, and may include an insurer.

Please Note: For this section, a third party does not include other health care plans that cover you.

- **You:** In this section, “you” includes any lawyer, guardian, or other representative that is acting on your behalf or on the behalf of your estate in pursuing a repayment from responsible third parties.

EXCLUSIONS

- **Benefits From Other Sources** – Benefits are not available under this plan when coverage is available through:
 - Any type of excess coverage
 - Any type of liability insurance, such as home owner’s coverage or commercial liability coverage
 - Any type of no-fault coverage, such as Personal injury protection (PIP), Medical Payment coverage or Medical Premises coverage
 - Boat coverage
 - Motor vehicle medical or motor vehicle no-fault
 - School or athletic coverage

- **Work-Related Conditions:** Any illness, condition or injury arising out of or in the course of employment, for which the member is entitled to receive benefits, whether or not a proper and timely claim for such benefits has been made under:
 - Occupational coverage required of or voluntarily obtained by the employer
 - State or federal workers compensation acts
 - Any legislative act providing compensation for work-related illness or injury

These exclusions apply when the available or existing contract or insurance is either issued to a member or makes benefits available to a member, whether or not the member makes a claim under such coverage. Further, the member is responsible for any cost-sharing required by motor vehicle coverage, unless applicable state law requires otherwise. If other insurance is available for medical bills, the member must choose to put the benefit to use towards those medical bills before coverage under this plan is available. Once benefits under such contract or insurance have been used and exhausted or considered to no longer be injury-related under the no-fault provisions of the contract, this plan's benefits will be provided.

REIMBURSEMENT AND SUBROGATION RIGHTS

If the plan advances payment of benefits to you for an injury, the plan has the right to be repaid in full for those benefits.

- The plan has the right to be repaid first and in full, without regard to lawyers' fees or legal expenses, make-whole doctrine, the common fund doctrine, your negligence or fault, or any other common law doctrine or state statute that the plan is not required to comply with that would restrict the plan's right to reimbursement in full. The reimbursement to the plan shall be made directly from the responsible third party or from you, your lawyer or your estate.
 - The plan shall also be entitled to reimbursement by asking for refunds from providers for the claims that it had already paid.
- The plan's right to reimbursement first and in full shall apply even if:
 - The recovery is not enough to make you whole for your injury.
 - The funds have been commingled with other assets. The plan may recover from any available funds without the need to trace the source of the funds.
 - The member has died as a result of the injury and a representative is asserting a wrongful death or survivor claim against the third party.
 - The member is a minor, disabled person, or is not able to understand or make decisions.
 - The member did not make a claim for medical expenses as part of any claim or demand
- Any party who distributes your recovery funds without regard to the plan's rights will be personally liable to the plan for those funds.
- In any case where the plan has the right to be repaid, the plan also has the right of subrogation. This means that the Plan Administrator can choose to take over your right to receive payments from any responsible third party. For example, the plan can file its own lawsuit against a responsible third party. If this happens, you must cooperate with the plan as it pursues its claim.

The plan shall also have the right to join or intervene in your suit or claim against a responsible third party.
- You cannot assign any rights or causes of action that you might have against a third party tortfeasor, person, or entity, which would grant you the right to any recovery without the express, prior written consent of the plan.

YOUR RESPONSIBILITIES

- If any of the requirements below are not met, the plan shall:
 - Deny or delay claims related to your injury
 - Recoup directly from you all benefits the plan has provided for your injury
 - Deduct the benefits owed from any future claims

- You must notify Premera Blue Cross Blue Shield of Alaska of the existence of the injury immediately and no later than 30 days of any claim for the injury.
- You must notify the third parties of the plan's rights under this provision.
- You must cooperate fully with the plan in the recovery of the benefits advanced by the plan and the plan's exercise of its reimbursement and subrogation rights. You must take no action that would prejudice the plan's rights. You must also keep the plan advised of any changes in the status of your claim or lawsuit.
- If you hire a lawyer, you must tell Premera Blue Cross right away and provide the contact information.
Neither the plan nor Premera Blue Cross Blue Shield of Alaska shall be liable for any costs or lawyer's fees you must pay in pursuing your suit or claim. You shall defend, indemnify and hold the plan and Premera Blue Cross Blue Shield of Alaska harmless from any claims from your lawyer for lawyer's fees or costs.
- You must complete and return to the plan an **Incident Questionnaire** and any other documents required by the plan. Claims for your injury shall not be paid until Premera Blue Cross Blue Shield of Alaska receives a completed copy of the Incident Questionnaire when one was sent.
- You must tell Premera Blue Cross Blue Shield of Alaska if you have received a recovery. If you have, the plan will not pay any more claims for the injury unless you and the plan agree otherwise.
- You must notify the plan at least 14 days prior to any settlement or any trial or other material hearing concerning the suit or claim.

REIMBURSEMENT AND SUBROGATION PROCEDURES

If you receive a recovery, you or your lawyer shall hold the Recovery funds separately from other assets until the plan's reimbursement rights have been satisfied. The plan shall hold a claim, equitable lien, and constructive trust over any and all recovery funds. Once the plan's reimbursement rights have been determined, you shall make immediate payment to the plan out of the recovery proceeds.

If you or your lawyer do not promptly set the recovery funds apart and reimburse the plan in full from those funds, the plan has the right to take action to recover the reimbursement amount. Such action shall include, but shall not be limited to one or both of the following:

- Initiating an action against you and/or your lawyer to compel compliance with this section.
- Withholding plan benefits payable to you or your family until you and your lawyer complies or under the reimbursement amount has been fully paid to the plan.

AGREEMENT TO ARBITRATE

Any disputes between you and the Group and/or Premera Blue Cross on the Group's behalf that arise in carrying out this provision will be resolved by arbitration. You and Blue Cross and the University of Alaska will be bound by the decisions of the arbitration proceedings.

Disputes will be resolved by a single arbitrator in accordance with the current rules of the American Arbitration Association. Either party may demand arbitration by serving notice of this demand on the other party. Each party will bear its own costs and share equally in the fees of the arbitrator. Arbitration proceedings pursuant to this provision shall take place in a mutually agreed upon location.

This agreement to arbitrate will begin on the date the plan goes into effect. It will continue until any dispute about Premera Blue Cross' efforts to recover payment have been resolved.

TERMINATION OF BENEFITS

TERMINATION OF COVERAGE

Except as specified under “Extended Benefits,” coverage will end without notice on the last day of the month in which one of these events occurs:

- For the employee and dependents, when the employee terminates from a benefits-eligible position, or the employee dies or is no longer eligible as an employee; termination means cessation of employment for any reason, including resignation, retirement, and non-retention
- For a spouse, when his or her marriage to the employee is annulled, or he or she becomes legally separated or divorced from the employee
- For a child, when he or she is no longer eligible as a dependent

Please Note: The employee must notify the University within 30 days of the date of the enrollee’s loss of eligibility when an enrolled family member is no longer eligible to be enrolled as a dependent under this program. Failure to notify the University within 30 days may result in loss of eligibility for continuation of coverage. The University will give Blue Cross notice of an enrollee’s cancellation.

PLAN TERMINATION

No rights are vested under this plan. The Group is not required to keep the plan in force for any length of time. If the plan were to be terminated, you would only have a right to benefits for covered care you receive before the plan’s end date. Termination of the Group Contract for this program completely ends all enrollees’ coverage and all University of Alaska and Premera Blue Cross Blue Shield of Alaska’s obligations, except as provided under “Extended Benefits.”

COVERAGE CONTINUATION (COBRA)

Under the following conditions, you and/or your dependents may continue to participate in the health plans after you, or they, would normally become ineligible for coverage. You may continue coverage for yourself and your dependents for up to 18 months after one of the following qualifying events:

- You retire
- You are terminated (for reasons other than gross misconduct)
- Your employment status is changed to a position that does not include benefits
- Reduction of hours below the threshold for benefit eligibility, including leave without pay

COBRA coverage can be extended if you lost coverage due to one of the events above, and are determined to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act at any time during the first 60 days of COBRA coverage. In such cases, all family members who elected COBRA may continue coverage for up to a total of 29 consecutive months from the first date of COBRA eligibility.

Your spouse and/or dependent children may continue coverage for up to 36 months after one of the following qualifying events:

- Your death (the University of Alaska will pay their first twelve months of coverage and will count this time concurrent with COBRA)
- You are divorced or legally separated
- Your dependent children cease to qualify for coverage because of age

Under the COBRA regulations, you (the employee) or a family member has the responsibility to notify the University of Alaska upon a divorce, legal separation, or a child's loss of dependent status. To notify the University of Alaska of a qualifying event for spouse or dependent child, you must submit a dependent enrollment/drop form to your regional human resources office. You or a family member must provide this notice no later than 60 days after the date of divorce, legal separation or a child losing dependent status.

If you or a family member fails to provide this notice to the University of Alaska during this 60-day notice period, any family member who loses coverage *will not be offered the option to elect COBRA continuation coverage*. Furthermore, if you or a family member fails to notify the University of Alaska, and any claim are mistakenly paid for expenses incurred after the date of the divorce, legal separation or a child losing dependent status, then you and your qualifying family members will be required to reimburse the Plan for any claims so paid.

Individuals will no longer be eligible for this continued coverage if one of the following occurs:

- You or your dependents fail to pay the required premium for a participating individual on a timely basis
- You or your dependents become covered under another group health plan with no pre-existing condition clause after the date you elect COBRA coverage
- You or your dependents become entitled to Medicare benefits after the date you elect COBRA coverage
- An eligible spouse remarries and becomes covered by a group health plan
- You or your dependents are no longer subject to the pre-existing condition clause of another group health plan
- The University ceases to provide a group health plan

The continuation coverage provides the same benefits as the University's Health Care Plan. No medical examination is required for continuation; however, the election must be made within 60 days of either the date coverage was to end due to the qualifying event or the date you are notified of your continuation rights, whichever is later.

Should you wish to continue plan coverage, you and/or your dependents are required to pay the cost of the insurance premiums. Contact your regional human resources office for continuation coverage information and current rates.

LEAVE OF ABSENCE

Coverage for an employee and enrolled dependents may be continued for up to 18 months when the University of Alaska grants the employee a leave of absence and the required premiums continue to be paid.

The leave of absence period counts toward the maximum COBRA continuation period, except as prohibited by state and federal family leave laws. Contact your regional human resources office for information on leaves of absence.

MEDICARE SUPPLEMENT COVERAGE

If you are eligible for and enrolled in Parts A and B of Medicare, you may be eligible for guarantee-issued coverage under certain Medicare supplement plans. You must apply within 63 days of losing coverage under this plan. For more information, contact Premera Blue Cross Blue Shield of Alaska customer service at (800) 364-2982.

ALTERNATIVES TO COBRA

You may have other options available to you when you lose coverage under this plan. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace, Medicaid, or other group health 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, and you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs.

You can learn more about many of these options at www.healthcare.gov.

EXTENDED BENEFITS

Under the following circumstances, certain benefits of this program may be extended after your coverage ends.

EXTENDED INPATIENT BENEFITS

The inpatient benefits of this program will continue to be available after coverage ends if:

- your coverage had been in effect for more than 31 days;
- your coverage did not end because of fraud or an intentional misrepresentation of material fact under the terms of the coverage by you or the Group;
- you were admitted to a medical facility prior to the date coverage ended; and
- you remained continuously confined in a medical facility because of the same medical condition for which you were admitted.

Such continued inpatient coverage will end when the first of the following occurs:

- You are covered under a health plan or contract that provides benefits for your confinement or could provide benefits for your confinement if coverage under this program did not exist.
- You are discharged from that facility or from any other facility to which you were transferred.
- Inpatient care is no longer medically necessary.

CONTINUED ELIGIBILITY FOR A DISABLED ENROLLEE

If on the date an employee's coverage terminates, he or she is disabled by injury or illness (including pregnancy) and is unable to work at his or her own occupation as determined by an approved application for LTD benefits, the university will cover the first 12 months of COBRA coverage, provided the disabled employee completes and returns any application for continuation coverage within the required timeframe. COBRA applications are provided by the university's third-party administrator for COBRA continuation coverage.

However, these benefits will be available only if expenses are for covered services and supplies that have been rendered and/or received prior to the end of the 12-month period.

Such benefits will be paid for charges incurred until the earliest of the following:

- one year from the date the enrollee's coverage terminates for comprehensive medical benefits
- the date on which the enrollee becomes covered under another group program
- the date the enrollee is no longer disabled

This continued eligibility runs concurrent with the first 12 months of your COBRA eligibility.

SURVIVING DEPENDENTS

In the event of your death, the university will cover the first 12 months of COBRA coverage for your surviving enrolled dependents, provided the application for continuation coverage is completed and returned within the required timeframe. COBRA applications are provided by the university's third-party administrator for COBRA continuation coverage.

However, these benefits will be available only if expenses are for covered services and supplies that have been rendered and/or received prior to the end of the 12-month period.

Such benefits will be paid for charges incurred until the earlier of the following:

- The 12-month period ends
- A dependent becomes covered under another group medical program
- Dependent coverage ceases under this program
- For the spouse, when he or she remarries
- For a child, when he or she is no longer eligible as a dependent

This continued eligibility runs concurrent with the first 12 months of their 36-month COBRA eligibility. If coverage is being continued for your dependents, your child born after your death will also be covered.

CONTINUATION UNDER USERRA

The Uniformed Services Employment and Reemployment Rights Act (USERRA) protects the job rights (including enrollment rights on employer-provided health care coverage) of individuals who voluntarily or involuntarily leave employment positions to undertake military service.

If you leave your job to perform military service, you have the right to elect to continue existing employer-based health plan coverage for you and you dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are re-employed, generally without any waiting periods or exclusions, except for service-connected illnesses or injuries.

Contact your regional human resources office for information on USERRA rights and requirements.

You may also contact the U.S. Department of Labor at (866) 4-USA-DOL (866-487-2365) or visit its Web site at www.dol.gov/vets. An online guide to USERRA can be viewed at www.dol.gov/elaws/userra.htm.

GENERAL LIMITATIONS AND EXCLUSIONS

This section of your handbook outlines circumstances in which benefits of this program are limited or in which no benefits are provided. Benefits can also be affected by Blue Cross' Care Management provisions and your eligibility. In addition, some benefits have their own specific limitations.

WHAT YOUR PROGRAM DOES NOT COVER

In addition to the specific limitations stated elsewhere in this program, benefits will not be provided for the following:

- Services and supplies directly related to any condition, service, or supply that is not covered under this program
- Services and supplies received or ordered when this program is not in effect, or when you are not covered under this program, except as stated under specific benefits and under "Extended Benefits"
- Services and supplies provided to someone other than the ill or injured member, other than outpatient health education services covered under the Health Education part of the Health Management benefit or donor costs under the Transplant benefit
- Services and supplies for which no charge is made, for which none would have been made if this program were not in effect, or for which you do not legally have to pay, unless benefits must be provided by law in the case of federally qualified health center services
- Services and supplies that are outside the scope of the provider's license, registration, or certification, or that are furnished by a provider that is not licensed, registered, or certified by the jurisdiction in which the services or supplies were received
- Services and supplies that you furnish to yourself or that are furnished to you by a provider who is an immediate relative, defined as spouse, natural or adoptive parent, child, sibling, stepparent, stepchild, stepsibling, father-in-law, mother-in-law, daughter-in-law, son-in-law, brother-in-law, sister-in-law, grandparent, grandchild, spouse of grandparent or spouse of grandchild
- Services and supplies that are not medically necessary, in the judgment of Blue Cross, even if they are court-ordered; this also includes places of service, such as inpatient hospital care
- Services and supplies that are for your convenience or that of your family; services of a personal nature, such as meals for guests, long-distance telephone charges, radio or television charges, or barber or beautician charges
- Any direct complications, consequences, or aftereffects, whether immediate or delayed, that arise from any condition, service, or supply that is not covered under this program, except as specifically stated in this program
- Amounts that exceed the allowable charge or maximum benefit for a covered service
- Separate charges for records, correspondence or reports, except those requested for utilization review
- Custodial care, except as specified in the Hospice Benefit
- Over-the-counter drugs (except as specifically stated), solutions, supplies, food and nutritional supplements; over-the-counter contraceptive drugs, supplies and devices; herbal, naturopathic or homeopathic medicines or devices; hair analysis; and vitamins that don't require a prescription, except as required by law
- Any service or supply that Blue Cross determines is experimental or investigational on the date it is furnished; the determination is based on the criteria stated in the definition of "Experimental/Investigational"

If Blue Cross determines that a service is experimental or investigational, and therefore not covered, you may appeal the decision. Please refer to "Your Questions, Complaints and Appeals" for an explanation of the appeals process.

Note: this exclusion does not apply to certain experimental or investigational services provided as part of oncology clinical trials. Benefit determination is based on the criteria specified in the definition of "Oncology Clinical Trials" in the Glossary of Terms section.

- Care rendered by any medical facility that is owned or operated by a government agency to the extent required by state and federal law; however, this exclusion does not apply to covered services to treat a medical emergency, or to covered services for which available benefits must be provided by law or regulation.
- Institutional care, housing, incarceration or programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions. Examples are prisons, nursing homes, juvenile detention facilities, group homes, foster homes and adult family homes. Benefits are provided for medically necessary medical or behavioral health treatment received in these locations.
- Counseling, education, or training services, except as stated under the Health Management, Nutritional Counseling and the Mental Health Care Benefit, services related to contraceptive management and the support services stated in the Substance Abuse Treatment Benefit or for services that meet the standards for preventive medical services in the Preventive Medical Care (Wellness) Benefit. This includes vocational assistance and outreach; and social, sexual, lifestyle and fitness counseling
- Community wellness classes and programs that promote positive health and lifestyle choices. Examples of these classes and programs are adult, child and infant CPR, safety, baby-sitting skills, back pain prevention, stress management, bicycle safety and parenting skills.
- Biofeedback that is deemed experimental or investigational treatment for the condition (see Glossary of Terms). Examples of what is not covered are EEG biofeedback and neurofeedback.
- Therapy designed to provide a changed or controlled environment
- Light therapy for Vitiligo
- Low-level laser therapy
- Services, drugs, or supplies for cosmetic purposes, including any direct or indirect complications and aftereffects. Examples of what is not covered are:
 - Reshaping normal structures of the body in order to improve or change your appearance and self-esteem and not primarily to restore an impaired function of the body

Except that benefits will be provided for the following:

- All stages of the repair of a defect that is the result of an accidental injury if the surgery is performed in the plan year of the accident or in the next plan year
- All stages of the repair of a dependent child's congenital anomaly
- Reconstructive breast surgery in connection with a mastectomy as provided under the Mastectomy and Breast Reconstruction Services benefit
- All stages of the repair of a malformation that is a direct result of a disease, or surgery performed to treat a disease or injury
- Genital or breast surgery that meets medical necessity criteria, or is for the treatment of gender dysphoria diagnosis
- Correction of functional disorders (not including removal of excess skin and/or fat related to weight loss surgery or the use of obesity drugs), upon Blue Cross' review and approval
- Hair prosthesis, such as wigs or air weaves, transplants, and implants, except as stated in the Prosthetic Devices benefit; drugs, supplies, equipment or procedures to replace hair, slow hair loss, or stimulate hair growth
- Impression casting for prosthetics or appliances and prescriptions therefor, except as specified for foot support supplies, devices and shoes as covered under the "Home Medical and Respiratory Equipment/Medical Supplies" benefit. However, this exclusion doesn't apply to services and supplies that meet the requirements for preventive medical services as described in the Preventive Medical Care (Wellness) Benefit.
- Diagnosis and treatment of sexual dysfunction, regardless of origin or cause; surgical, medical or psychological treatment of frigidity or impotence, including drugs or medications (except as specified in Pharmacy Program), or penile or other implants
- Any assisted reproduction techniques, regardless of reason or origin of condition, including but not limited to artificial insemination, in-vitro fertilization, and gamete intra-fallopian transplant (GIFT)
- Reversal of surgical sterilization

- Donor breast milk
- Military and war-related conditions, including:
 - Acts of war, declared or undeclared, including acts of armed invasion
 - Service in the armed forces of any country, including the Air Force, Army, Coast Guard, Marines, National Guard, Navy, or civilian forces or units auxiliary thereto
- Illness or injury resulting from a member's commission of the following:
 - a felony
 - an act of terrorism, riot or insurrection
- Treatment of caffeine dependency, except for services covered under the Health Management Benefit
- Treatment of nicotine dependency, except for services covered under the Health Management Benefit, and as specified in the Pharmacy Drug Benefit
- Any illness or injury arising out of or in the course of employment or self-employment; for which the enrollee is entitled to receive benefits, whether or not a proper and timely claim for such benefits has been made under:
 - Occupational coverage required of, or voluntarily obtained by, the employer
 - State or federal workers' compensation acts, or
 - any legislative act providing compensation for work-related illness or injury
- Services or supplies to the extent that benefits are payable under the terms of any contract or insurance offering one of these coverages:
 - Motor vehicle medical, motor vehicle no-fault, or personal injury protection (PIP) coverage
 - Commercial premises or homeowner's medical premises coverage, or other similar type of contract or insurance
- Services and supplies that are not directly related to an illness, accidental injury, or distinct physical symptoms, except as specified under the Routine Newborn Care Benefit, the Wellness Provisions Benefit, Physicians' Services Benefit, Diagnostic Services Benefit, or the Mammography Benefit
- Serious Adverse Events and Never Events: members and this plan are not responsible for payment of services by network providers for serious adverse events, never events and resulting follow-up care. Serious adverse events and never events are medical errors that are specific to a nationally-published list. They are identified by specific diagnoses codes, procedure codes, and specific present-on-admission indicator codes. Network providers may not bill members for these services and members are held harmless.
 - Serious Adverse Event means a hospital injury caused by medical management (rather than an underlying disease) that prolonged the hospitalization, and/or produces a disability at the time of discharge.
 - Never Events are events that never should occur, such as a surgery on the wrong patient, a surgery on the wrong body part, or wrong surgery.

Not all medical errors are defined as serious adverse events or never events. You can obtain a list of serious adverse events by contacting Premera customer service at (800) 364-2982, or on the Centers for Medicare and Medicaid Services (CMS) Web page at www.cms.hhs.gov.

- Well-baby care, except for the services provided under the Routine Newborn Care Benefit, the Newborn Hearing Exams and Testing Benefit and the Preventive (Wellness) Benefit
- Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), and pleoptics; also not covered are treatment to change the refractive character of the cornea; examples are radial keratotomy, keratomileusis, or refractive keratoplasty, including any results of such treatment; routine vision services and supplies, including services of an optician, are not covered except as specified in the Vision Benefit
- Routine hearing care, including hearing examinations, diagnostic screenings, and tests; services and supplies for or related to hearing aids or other devices to improve hearing sharpness except as specified in the Audio Care Benefit and the Newborn Hearing Exams and Testing Benefit
- Over-the-counter drugs, food supplements, and supplies, except as specified under the Pharmacy Drug Benefit
- Vitamins, except for pre-natal and fluoridated vitamins

- Dental services, except as specified under the Dental Care Benefit, and except those performed in conjunction with treatment that is the direct result of an accidental injury to natural teeth, gums, or jaw, but only when all of the following requirements are met:
 - the services are within the scope of the provider’s license;
 - the injury is not caused by biting or chewing, even if due to a foreign object in food;
 - the services are performed in the plan year of the accident causing the injury or in the next plan year;
 - for services provided to a natural tooth, the tooth must be the member’s natural, living tooth that was free from decay and otherwise functionally sound at the time of the injury. “Functionally sound” means that the affected teeth:
 - do not have extensive restoration, veneers, crowns or splints; and
 - do not have periodontal disease or other condition that, in the judgment of Blue Cross, would cause the tooth to be in a weakened state prior to the injury.
 - the services are, in the judgment of Blue Cross, essential and appropriate to the repair of the accidental injury (treatment plan review will be performed by a dentist licensed to practice dentistry in the State of Alaska); and
 - the maximum benefits under the Dental Benefit for the accidental injury have been provided.
- Orthodontia, including casts, models, X-rays, photographs, examinations, appliances, braces, and retainers, except in the case of accidental injury as described above, and as stated under the Orthodontia Benefit of the 750 Plan option
- Hospital care for dental procedures, unless adequate treatment cannot be provided without the use of hospital facilities, **and** you have a medical condition besides the one requiring treatment that makes hospital care medically necessary
- Treatment of psychiatric conditions and eating disorders, such as anorexia nervosa, bulimia, or any similar conditions, except as specified under the Mental Health Care Benefit
- Treatment of alcohol or drug use or abuse that does not meet the definition of Substance Abuse as stated in the Glossary of Terms.
- Human growth hormone therapy.

GENERAL PROVISIONS

ENROLLEE COOPERATION

All enrollees are duty-bound to cooperate in a timely and appropriate manner with the University and Premera Blue Cross Blue Shield of Alaska in the administration of benefits or in the event of a lawsuit.

NOTICE OF OTHER COVERAGE

As a condition of receiving benefits under the University's health care program, you must notify Blue Cross of the following:

- Any legal action or claim against another party for a condition or injury for which Blue Cross paid benefits; and the name and address of that party's insurance carrier
- The name and address of any insurance carrier that provides personal injury protection (PIP), underinsured motorist, uninsured motorist, or any other insurance under which you are or may be entitled to recover compensation
- The name of any other group insurance plan(s) under which you are covered

EVIDENCE OF MEDICAL NECESSITY

Premera Blue Cross Blue Shield of Alaska has the right to require proof of medical necessity from you or your provider when you are receiving benefits under this program. No benefits will be available under this program if the proof is not provided or not acceptable to the plan.

HEALTH CARE PROVIDERS - INDEPENDENT CONTRACTORS

All health care providers who provide services and supplies to a member do so as independent contractors. None of the provisions of this plan or the contract between Premera and the Group are intended to create, nor shall they be deemed or construed to create, any employment or agency relationship between Premera and the Group and the provider of service other than that of independent contractors.

NOTICE OF INFORMATION USE AND DISCLOSURE

Premera Blue Cross Blue Shield of Alaska may collect, use, or disclose certain information about you. This protected personal information (PPI) may include health information, or personal data such as your address, telephone number or Social Security Number. Blue Cross may receive this information from, or release it to, health care providers, insurance companies, or other sources. This information is collected, used or disclosed for conducting routine business operations such as:

- underwriting and determining your eligibility for benefits and paying claims (Blue Cross does not use genetic information for underwriting or enrollment purposes);
- coordinating benefits with other health care plans;
- conducting care management, case management or quality reviews; and

- fulfilling other legal obligations that are specified under the plan and the administrative services contract with the University of Alaska.

This information may also be collected, used, or disclosed as required or permitted by law.

To safeguard your privacy, Blue Cross takes care to ensure that your information remains confidential by having a company confidentiality policy and by requiring all employees to sign it. If a disclosure of PPI is not related to a routine business function, Blue Cross removes anything that could be used to easily identify you or they obtain your prior written authorization. You have the right to request inspection and/or amendment of records retained by Blue Cross that contain your PPI. Please contact Blue Cross Customer Service and ask that a request form be mailed to you.

RIGHT TO AND PAYMENT OF BENEFITS

All rights to the benefits of this program are available only to members.

However, Blue Cross, on behalf of the plan, will honor subscribers' requests to assign benefit payments to the provider who furnished the care when such requests do not conflict with Blue Cross' obligations under their provider agreements. Blue Cross will also honor such assignments on behalf of the plan when they are made by a third party to whom the right to make such assignments has been clearly designated in a valid qualified domestic relations order. To find out how to make assignments, please call Customer Service at the numbers shown in "Your Questions, Complaints and Appeals" section of this Handbook. Blue Cross will not honor any other attempted assignment, garnishment, attachment or transfer of any right of this program.

At Blue Cross' option and in accordance with this provision, Blue Cross has the right to direct the plan's benefits to the subscriber, provider, other carrier, member, or other party legally entitled to such payment under federal or state medical child support laws, or jointly to any of these. Such payment will discharge the plan's obligation to the extent of the amount paid so that the plan will not be liable to anyone aggrieved by their choice of payee.

RIGHT OF RECOVERY

On behalf of the plan, Premera Blue Cross has the right to recover amounts the plan has overpaid in error. Such amounts may be recovered from the employee/subscriber or any other payee, including a provider. Or, such amounts may be deducted from future benefits of the subscriber or any of his or her dependents (even if the original payment was not made on that member's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a provider that does not have a contract with Blue Cross.

The plan will give written notice to the subscriber, or any other payee, including a provider, at least 30 calendar days before the plan seeks recovery of an overpayment. The notice will include how to identify the specific claim and the specific reason for the recovery. You have the right to challenge the recovery of overpayment. The plan may also exercise the right to delegate all or part of the responsibility for recoveries to another third party.

VENUE

All suits or legal proceedings, including arbitration proceedings, brought against the University of Alaska and/or Blue Cross Blue Shield of Alaska by you or anyone claiming any right under this program must be filed:

- within 3 years of the date Blue Cross denied, in writing, the rights or benefits claimed under this program; and
- in a mutually agreed upon location.

WORKERS' COMPENSATION INSURANCE

This contract does not replace, affect, or supplement any state or federal requirement for the University of Alaska to provide workers' compensation insurance, employer's liability insurance or other similar insurance.

INTENTIONALLY FALSE OR MISLEADING STATEMENTS

If this program's benefits are paid in error due to any intentionally false or misleading statements, the plan will be entitled to recover these amounts on behalf of the University of Alaska. See "Right Of Recovery" above.

Please Note: your coverage cannot be voided (in other words, canceled back to it's effective date as if it had never existed at all) based on a misrepresentation you made unless you have performed an act or practice that constitutes fraud; or made an intentional misrepresentation of material fact that affects your (or your dependent's) acceptability for coverage.

LIMITATIONS OF LIABILITY

The plan, the University of Alaska and Blue Cross are not liable for any of the following:

- Situations such as epidemics, disasters, or other causes or conditions beyond their control, that prevent enrollees from obtaining the benefits of this contract
- The quality of services or supplies received by enrollees, or the regulation of the amounts charged by any provider, because all those who provide care do so as independent contractors
- Harm that comes to an enrollee while in a provider's care
- Amounts in excess of the actual cost of services and supplies
- Amounts in excess of this program's maximums; this includes recovery under any claim of breach
- General damages including, without limitation, alleged pain, suffering, or mental anguish

FLEXIBLE SPENDING ACCOUNTS

INTRODUCTION

The high costs of healthcare and dependent care aren't going away. How can you get the care you need and keep more money in your pocket? Sign up for a Flexible Spending Account (FSA)! These IRS-approved accounts allow you to set aside a portion of your taxable income prior to paying taxes. Then, as you incur eligible expenses, you request tax-free withdrawals from your account to reimburse yourself. There are two kinds of FSAs: a Medical FSA and a Dependent Care FSA. These flexible spending accounts are administered by ASIFlex. Visit www.asiflex.com for more information and to sign up for direct deposit and text/e-mail notifications.

BENEFITS

Beginning on your effective date in the Plan, you may choose to reduce your salary to pay for the following tax-free benefits:

- **Medical FSA**— Allows you to pay for your medical, dental and vision out-of-pocket expenses before taxes. Employees can contribute a maximum of \$2,650 per Plan Year (in FY19).
- **Dependent Care FSA**— Allows you to pay for employment-related daycare expenses before taxes. You may contribute a maximum of \$5,000 per Plan Year (\$2,500, if married, filing separately). You may not contribute more than \$5,000 in a tax year (calendar year), so deductions may be adjusted to avoid exceeding this limit.

PLAN YEAR

The Plan Year for both the Medical FSA and the Dependent Care FSA runs from July 1 through June 30. You have until September 30 following the end of the plan year to submit your claims, but the date of service for the claims must be within the plan year.

ELIGIBILITY

If you are a regular or term-funded employee and eligible to participate in the University's health care plan, you are eligible to participate in the FSA Plan. Current employees have the opportunity to elect a flexible spending account either during open enrollment or within 30 days after a qualifying change in status event as described in the plan. Extended temporary employees are not eligible for the FSA.

ENROLLMENT AND EFFECTIVE DATES

To participate in the plan, you must complete and sign the Flexible Spending Account election form. If you are a new employee, this form should be completed and signed **prior** to receiving your first paycheck, but no later than 30 days after you become eligible. You will need to complete a new enrollment form for this plan each year as the plans do not continue past June 30.

If you will be an eligible employee on July 1, your effective date will be July 1. If you become an eligible employee after July 1, your effective date will be the date you become eligible to participate. If you elect an FSA because of an qualifying change in status event, your effective date will be the date of the event in the case of birth, adoption or

placement for adoption. **All other event changes will be made prospectively.** Your payroll reductions will start on the first payday on or after your effective date.

You **must** complete and sign a new election form during the open enrollment period for each new Plan Year. If you do not complete the appropriate form as indicated above, you will not be eligible to participate in the plan until the following July 1, unless you have a qualifying change in status event.

QUALIFYING CHANGE IN STATUS EVENT

Once you have enrolled in the Plan, you cannot revoke, discontinue, or change your election for the duration of the Plan Year unless you have a qualified change in status event. If you have a qualifying change in status event, you are allowed to change your election providing the change is appropriate and consistent with the event.

Some examples of qualifying change in status events are as follows:

- Change in legal marital status (marriage, divorce, death of a spouse, legal separation or annulment)
- Change in number of dependents (birth, adoption or placement for adoption of a child, death of a spouse or child, child changing residence between divorced parents)
- Change in employment status of employee, spouse or dependent that affects eligibility (termination or commencement of employment, full-time to part-time or vice versa, strike or lockout, commencement of or return from an unpaid leave of absence, change in hours worked, change in work site)
- Dependent eligibility change (dependent satisfies or ceases to satisfy eligibility requirements)
- Some qualifying events are specific only to the Dependent Care FSA, which include:
 - Change in provider
 - Cost change
 - Child reaches age 13

Contact your regional human resources office immediately if you experience a qualifying change in status event and would like to participate or change your election. You must notify your regional human resources office within 30 days of the event. The effective date of the change will depend on the type of event. Changes made due to birth, adoption or placement of adoption are effective the date of the event. **Changes made due to other life events such as marriage or divorce are effective prospectively from the date you submit your election form.** To be considered, your request for a change must be submitted within 30 days of the event.

If you elect to reduce the contribution to your Medical FSA due to a major life event, your annual contribution amount will be recalculated and reduced based on your new election regardless of the amount of reimbursements made to you. If you elect to increase the contribution to your Medical FSA due to a major life event, your annual contribution amount will be recalculated and increased based on your new election regardless of the amount of reimbursements made to you.

TERMINATION OF BENEFITS

You will remain a participant in the FSA Plan until the earliest of the following dates:

- The end of the month following the date you are no longer an eligible employee (through termination or transfer to an ineligible position)
- The end of the month following the date you stop participating in the Plan because of a qualifying change in status event
- The date the Plan Year ends (June 30)
- The date the Plan ends

USE IT OR LOSE IT RULE

The IRS has established strict guidelines for flexible spending accounts. One of the guidelines is known as the “use it or lose it” rule. This means that if you elect to contribute money to a Flexible Spending Account, and then do not incur enough expenses during the Plan Year to meet the amount you elected, you forfeit the unused money. If you leave the University during the Plan Year, you may continue to submit claims and be reimbursed during the remainder of the Plan Year; however, the dates of service you are submitting **must** have been prior to your termination. By law, any forfeited amount will revert back to the University to cover administrative costs associated with the FSA Plan. Also see “COBRA Rights,” below.

MEDICAL FLEXIBLE SPENDING ACCOUNT

If you know you will have out-of-pocket health care expenses during the Plan Year, you may elect to participate in a Medical FSA to pay for those expenses with tax-free dollars. After you determine the amount you want to contribute, the University will deduct a set dollar amount each pay period, on a pre-tax basis, until you have reached your annual goal amount. The money will be placed in your Medical FSA, with the total annual goal amount available to you at any time during your period of coverage. It’s like a cash advance because you don’t have to wait for the cash to accumulate in your account before you can use it.

As your health care claims are processed by Blue Cross, your qualifying out-of-pocket expenses will be eligible for reimbursement from your Medical FSA. If you have expenses that are not submitted to Blue Cross because they are not eligible under your health plan, or you have secondary health care insurance, you may submit a copy of the provider’s itemized billing statement or a copy of the Explanation of Benefits (EOB) from Blue Cross (and any other insurance you may have) as supporting documentation for reimbursement. Please see “How To Submit a Claim for Reimbursement” for detailed instructions.

DEBIT CARD

ASIFlex offers an optional debit card to make it easier to pay for qualifying expenses. **While the debit card isn’t a paperless process (you’ll still need to submit substantiation for many expenses)**, it does give you easy access to your account at the pharmacy, doctor’s or dentist’s office as well as at many drugstores for qualifying purchases. The debit card application is online at www.asiflex.com/debitcards. The first cards are free; replacement or additional cards have a fee. Be sure to download the ASIFlex Wallet Card to carry with you, and review the other material online so you understand how to use the card.

ELIGIBLE EXPENSES

Health care expenses that are eligible for reimbursement, per IRS regulations, are expenses incurred by you, or your spouse or dependent(s), for medically necessary services as defined in Section 213 of the IRS Code. Your dependents do not have to be enrolled in the health care plan to be eligible for this plan, but they do need to be dependents as defined by IRS Code. *Taxable financially interdependent partners are not eligible for this plan.* Expenses are treated as having been incurred when the medical care was given, not the date you were billed or charged, or the date you paid for the services. In addition, the expense must not be eligible for reimbursement from any other health plan. You can view an extensive listing of eligible/ineligible expenses at asiflex.com, and also view IRS publication 502.

Some examples of eligible expenses are:

- Your out-of-pocket expenses, such as deductibles, coinsurance and copays
- Hearing exams, aids and batteries

- Dental expenses, including exams, x-rays, fillings, root canals, crowns, bridges, dentures and adhesives, implants, occlusal guards, orthodontics
- Vision expenses including exams, prescription eyeglasses, prescription sunglasses, contact lenses and cleaning solutions, over-the-counter reading glasses, corrective eye surgery (Lasik, cataract, etc.)
- Medical expenses such as physician charges, x-rays, testing, prescription drugs, chiropractic treatments, acupuncture, etc.
- Mileage expenses you incur while traveling to obtain health care (medical, dental, vision, hearing)
- Over-the-counter **health care items** such as bandages, birth control, pregnancy/ovulation kits, wrist braces, diagnostic tests and monitors (blood pressure, etc.), first aid kits, insulin and diabetic supplies, pill holders and splitters, sunscreen, thermometers, vaporizers, wheelchairs, walkers, canes, crutches, etc. Go to asiflex.com and click on the FSA Store icon for more information.
- Over-the-counter **medicines or drugs** with a prescription from your attending physician (pain relievers, allergy medicines, cold/cough/flu medicines, etc.)

Some examples of expenses that are **not** eligible for reimbursement from your Medical FSA include:

- Services for purely cosmetic purposes or for general health and well-being
- Vitamin or mineral supplements not covered by Blue Cross or other insurance plans
- Services with dates of service occurring prior to your effective date or after the close of the Plan Year
- Weight loss programs for general health purposes, even if prescribed by your doctor
- Insurance premiums (including premiums for continuing coverage under COBRA)
- Health club memberships or exercise equipment for general health purposes, even if prescribed by your doctor
- Claims submitted without a fully completed FSA Claim Form, along with a copy of an explanation of benefits from your insurance company, or a provider's itemized billing statement showing the provider name and address, patient name, dates of service, description of service and charge

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

If you know you will have employment-related dependent daycare expenses for an eligible dependent during the Plan Year, you may elect to use the Dependent Care FSA to pay for them with tax-free dollars. This may be done only if the expenses are incurred to allow you (and your spouse, if applicable) to work. The maximum amount you may contribute to the plan in a plan year is \$5,000 (\$2,500 if married and filing separately); or if you or your spouse earns less than \$5,000 a year, your maximum contribution is equal to the lower of the two incomes. If your spouse is a full-time student or incapable of self-care, your maximum contribution amount is \$3,000 a year for one dependent and \$6,000 a year for two or more dependents.

An eligible dependent falls under one of these two categories:

- You or your spouse's child (depending on the tax status of that dependent) who is under 13 years of age
- Your spouse (or other individual claimed as a dependent for federal tax purposes) who is physically or mentally incapable of self-care and who regularly spends at least eight hours a day in your home

Dependent care can be rendered either inside or outside the home. If care outside the home is provided by a dependent care center that cares for seven or more children, it must comply with all applicable state or local laws and regulations. Also, the provider must not be your child age 18 or younger, or someone who you claim as a dependent for federal income tax purposes.

After you determine the amount of dependent care expenses you will incur during the Plan Year, the University will deduct a portion each pay period, on a pre-tax basis, until you have reached your annual goal amount. The money will be placed in your Dependent Care FSA, to be reimbursed to you as you incur dependent care expenses. Please see "How To Submit a Claim for Reimbursement" for detailed instructions.

Depending on your income level, you may also use the Federal Income Tax Credit for dependent care expenses. It is important to remember that you may use either of these up to the maximum allowable, but you may not take a tax deduction for those expenses reimbursed under this plan, or vice versa. See IRS Publication 503 and consult your tax advisor for more details.

Unlike the Medical FSA, any reimbursement will not exceed the balance available in your account when your claim is received. Dependent care services must have been incurred to receive reimbursement, regardless when you pay for the service.

HOW TO SUBMIT A CLAIM FOR REIMBURSEMENT

ASIFlex gives you several convenient reimbursement options. Many health FSA claims can be done on the spot with your debit card; you'll just need to submit follow-up documentation for some claims. Other options are filing claims online or using the mobile app. Remember that after June 30, the deadline to submit claims is September 30 for dates of service incurred during your coverage period or by June 30.

ONLINE CLAIMS

You can pay many of your eligible health care and dependent care expenses directly from your FSA with no need to fill out paper forms. It's quick, easy, secure and available online at any time.

Using your Mobile Device: With the ASIFlex mobile app, you can file and manage your reimbursement claims on the spot, with a click of your smartphone camera or tablet, from anywhere.

- Download the ASIFlex app from www.asiflex.com, the App Store or Google Play.
- Log into FSA your account from your smartphone or tablet.
- Choose the type of claim from the simple menu and enter some basic information about the claim.
- Use your smartphone or tablet camera to capture the documentation OR attach your picture from the gallery and submit.
- With the mobile app, you can check your balances and submit claims anytime.

Reimburse Yourself: You can also file a claim online through your account detail to request reimbursement for your eligible expenses.

- Go to www.asiflex.com, sign in to your account and click "File a Claim" under Participant Services.
- Just follow the prompts to fill in the information, and submit
- If you don't already have them saved on your computer, scan your EOB or itemized billing statement*.
- Upload the supporting documentation and submit the claim.

* Remember, your itemized billing statement must include the provider name/address, patient name, dates of service or purchase, a description of the service provided, and the dollar amount charged.

Most claims are processed within one to three business days after they are received, and payments are sent shortly thereafter. Be sure to sign up for direct deposit and email/text alerts through your online account detail!

If you prefer to submit a paper claim by fax or mail, find the FSA claim form on asiflex.com or the university's benefits web site at www.alaska.edu/benefits/forms and follow the instructions. Send the completed claim form, along with copies of your itemized billing statement from the provider or the insurance plan EOB and, for dependent care, the receipts from your dependent/child care provider showing the name, address and tax ID number (or Social Security number) of the provider, and beginning and end dates of service. In lieu of a separate receipt, your day care provider may sign the "Day Care Provider or Care Facility Certification" section of the claim form. Be sure to sign

your claim form before faxing or mailing it to ASIFlex.

Please retain originals of all claims and documentation for IRS purposes. It is your responsibility to provide the claims information if you are audited by the IRS. If faxing your claim, be sure to save a copy of your fax confirmation page.

QUESTIONS REGARDING YOUR PLAN?

Online: www.asiflex.com or www.asiflex.com/debitcards

Email: asi@asiflex.com

Phone: (800) 659-3035 Monday through Friday, 4 a.m. to 4 p.m. Alaska time; Saturdays 6 a.m. to 10 a.m. Alaska time.

COBRA RIGHTS

To the extent required by the Consolidated Budget Reconciliation Act of 1985 (COBRA, codified under Code Section 4980B), the Participant, Spouse, and Dependents, whose coverage terminated under the Plan because of a COBRA qualifying event, shall be given the opportunity to continue their coverage under the Medical FSA Plan on an after-tax basis for the limited time period (end of current plan year) prescribed by COBRA, subject to all conditions and limitations under COBRA.

If you have questions about the Plan, you should contact ASIFlex at the number or e-mail shown above, or your regional human resources office.

HEALTH SAVINGS ACCOUNT (HSA)

If you are enrolled in the Consumer-Directed Health Plan (CDHP), you might be able to establish and contribute to a Health Savings Account (HSA). The HSA is another type of healthcare reimbursement account, but it differs from the FSA in several ways.

A Health Savings Account (HSA) is a health care account that you can use to pay for qualified medical expenses with pre-tax dollars. You can set up and contribute to an HSA if you are enrolled in a qualified high deductible health plan like the University of Alaska's Consumer-Directed Health Plan (CDHP). You cannot be covered by any other health plan such as Medicare, Tricare, retiree health coverage or a spouse's health plan that is not a qualified high deductible health plan. Unused HSA dollars roll over year to year and have the potential to grow into an account you can use for qualifying medical expenses in retirement. The HSA funds can grow with interest, all tax-free.

There are restrictions and limitations on HSA contributions and withdrawals and you must comply with IRS guidelines. While the University of Alaska provides convenient pre-tax payroll deductions for the HSA, all aspects of managing and maintaining the account remain the responsibility of the employee. More information is available on the benefits web site at www.alaska.edu/benefits, and see Publication 969 at www.irs.gov.

The value of the HSA comes from the ability to make higher pre-tax contributions than to a Flexible Spending Account and the fact that the unused dollars roll over from year to year accruing interest and a growing balance for future use. You own the HSA, so you take it with you when you leave the university. The university will support contributions by pre-tax payroll deduction or you can contribute directly to the account with after-tax dollars and report it on your tax return. The 2018 annual maximum contributions to the HSA is \$3,450 for an individual, and \$6,900 for family coverage, vs. \$2,650 to the FSA regardless of family size. Additionally, if you are 55 or older, you are able to contribute an additional \$1,000 into the HSA annually.

You cannot have an HSA and a health care FSA at the same time, but you can have the dependent care FSA with an HSA. The CDHP with the HSA is best for people who:

- Do not have coverage under any other health plan that is not an HSA-qualified health plan. For example, if you are covered as a dependent through a spouse's health plan and that plan is not an HSA-qualified health plan, you would be ineligible to open or contribute to an HSA.
- Are not enrolled in any Medicare program, including Medicare coverage for persons with disabilities under the age of 65, or Medicaid.
- Are not enrolled in Tricare (benefits offered to military personnel).
- Have not received Veteran's Administration medical benefits within the last three months.
- Are not covered as a dependent under an FSA through your spouse's employer (unless that Health FSA coverage is limited to dental, vision, and/or preventive care expenses).
- File U.S. taxes.

BANK OF AMERICA HSA FOR LIFE

The University has partnered with Bank of America to offer the Health Savings Account. After you enroll in the HSA, you will receive a welcome kit from Bank of America with a debit card to pay for eligible health care expenses with your HSA. Bank of America's Customer Care Center is available from Monday through Friday, 4:00 a.m. to 7:00 p.m. Alaska time at (866) 791-0250.

Login to Bank of America's web site at www.myhealth.bankofamerica.com to check your HSA balance, review claim transactions, access a variety of on-line tools and calculators, view educational videos, and order replacement or additional debit cards.

EMPLOYEE ASSISTANCE PROGRAM

The University offers an Employee Assistance Program (EAP) to all its regular full- or part-time faculty and staff and their dependents, as well as COBRA participants. The University offers this program because from time to time, anyone can be burdened by the pressures of life. Such burdens can affect your health, family life, abilities, and work performance.

Maintaining a healthy balance between your work and personal life is important to you. At work and home, our lives are busier than ever, and at times, we all can use a little extra help in coping with personal challenges. Your EAP provides you and your family with short-term, person-to-person counseling services to help you handle concerns before they become major issues.

To provide you with a full-service benefit that you and your family can easily access as you need it, the University of Alaska has partnered with Deer Oaks, a leading provider of EAP services to public sector organizations.

Professional counselors are available 24 hours a day, 7 days a week to help you with issues such as

- Job or work stress
- Family / Parenting issues
- Alcohol, drugs and other substance abuse
- Burnout
- Marital or relationship problems
- Anxiety or depression
- Anger management
- Legal issues, including will preparation
- Financial, budgeting and debt concerns
- Coping with change
- Self-esteem
- Grief or bereavement

Crisis counseling is always available to provide you with assistance you need when you need it. Deer Oaks also offers free, easy-to-use personal help with child and elder care services.

All EAP network providers are fully qualified and licensed in their area of service. The program's providers are licensed psychologists, social workers, marriage and family counselors, and lawyers. The identity of the people who elect to use this program, as well as any information revealed to EAP staff, is held in the strictest professional confidence allowed by law.

HOW TO USE THE PROGRAM

You or your eligible family members may contact Deer Oaks directly any time, 24 hours a day, 7 days a week, at (888) 993-7650 for any reason and talk to a trained counselor. These counseling professionals can assist you and guide you to in-person care with an expert in your area. The EAP is *strictly confidential*, as mandated by law.

You can also access your EAP services via the Web at www.deeroakseap.com and enter the university username and password: UofA. Information about health, work-life balance, life events (such as marriage, having or adopting children, sending children to college, divorce, death of a loved one) and a variety of other topics is just a click away.

Download the mobile app iConnectYou at the App Store or Google Play, and register using the code 124773.

For most types of problems, you and your eligible dependents are entitled to receive up to ten counseling sessions per incident (initially three sessions, then additional sessions based on need). All EAP sessions are prepaid by the University of Alaska. If you want counseling beyond the benefits of the EAP, your EAP counselor can help you select the most cost-effective and appropriate treatment resources.

Download the EAP Fact Sheet from the benefits web site at www.alaska.edu/benefits/employee-assistance-progr/.

DISABILITY BENEFITS

INTRODUCTION

The University's disability plan will help to replace lost income from serious disabilities that last longer than 90 days. The Long Term Disability income plan premium is paid by the University on your behalf. The University's Long Term Disability plan benefits are provided by ReliaStar Life Insurance Company.

In addition to this plan, you may be entitled to disability benefits from the following sources:

- other group insurance contracts
- Workers' Compensation
- benefits provided by any state or federal government
- any retirement plan benefit toward which the University contributes or makes payroll deductions (such as PERS or TRS)
- leave share program(s)

Because disability insurance is designed to supplement other disability benefits, the amount payable under the Long Term Disability plan will be reduced when coordinated with payments from other sources. For full details on the provisions and offsets of the long-term disability plan, please read the Long Term Disability Certificate of Coverage.

ELIGIBILITY

If you are an active regular or term-funded employee working at least 20 hours a week, you are eligible for Long Term Disability coverage. Your eligibility begins on the first day of the month following the date you are hired. Disabilities resulting from pregnancy are covered on the same basis as an illness or injury.

DEFINITION OF DISABILITY

During the first 24 months, disability means that you are unable to perform with reasonable continuity the essential functions of your own occupation.

After you receive Long Term Disability benefits for 24 months, you are considered disabled if you are unable to perform the essential functions of any gainful occupation for which you are qualified by education, experience, or training.

BENEFITS

Long Term Disability benefits start after you have been disabled for the longer of these qualifying periods:

- 90 days
- the duration of your accumulated sick leave plus any leave benefits from any applicable leave share program(s)
If you are able to return to work in some capacity, you may still be eligible for benefits.

Periods of disability as a result of the same cause or causes are considered a single period of disability, provided they are separated by a recovery period of six months or less.

If you have more than one period of disability and the periods are from different causes, they are considered separate periods of disability. Each period of disability is subject to a new qualifying period and to the maximum duration of the benefit.

MONTHLY BENEFIT AMOUNT

The income you receive from the Long Term Disability plan depends upon your monthly earnings at the time you are disabled. The maximum monthly benefit is the lesser of the following:

- 60% of your monthly earnings
- or \$3,000

The maximum disability benefit is reduced by benefits you may receive from other sources (see Benefit Offsets).

The minimum monthly benefit is \$100, regardless of how much you receive from other sources. If you are disabled for less than a full month, your benefits will be prorated for that month.

MONTHLY EARNINGS

If you are compensated on a 12-month basis, monthly earnings means your current rate of wages or salary, computed on a monthly basis. This does not include overtime pay, out-of-class earnings, overload pay, additional assignment pay, bonuses, shift differential, premium pay, or other special compensation. The following rules apply to the computation of your annual rate of earnings:

- If you are paid on an annual contract basis, your annual rate of earnings is your annual salary for your primary assignment.
- If you are paid on an hourly basis, your annual rate of earnings is your hourly rate times the number of hours you are regularly scheduled to work each year. If you do not have regular hours, your annual rate of earnings will be based on the number of months you worked, not counting any hours over 173 in any one calendar month.
- If you are paid on any other basis, your annual rate of earnings will be the pay you received for the period you are regularly scheduled to work each year.

Months in which you would not otherwise receive a salary are not used in computing monthly earnings. Monthly earnings are based on your salary or wages the last day you are at work before you were disabled.

BENEFIT OFFSETS (INCOME FROM OTHER SOURCES)

If you are also eligible to receive disability benefits from any of the following sources, the amount you receive may be subtracted from your monthly Long Term Disability benefit:

- Benefits for loss of time provided by the following:
 - Any other group-sponsored disability insurance contract
 - Worker's compensation, non-job-related disability benefit laws, or similar legislation
- Benefits payable under the U.S. Social Security Act (as a primary benefit), or any other benefits provided by U.S. or Canadian law, or by any state or federal regulation
- Retirement benefits that are provided by the Public Employees' Retirement System, the Teachers' Retirement System or the University of Alaska Optional Retirement Plan

- Periodic benefits for loss of time in connection with accidental bodily injury or illness

For a complete description of all benefit offsets, please see the Long Term Disability benefit booklet, online at www.alaska.edu/benefits/long-term-disability.

REHABILITATION/RETURN TO WORK INCENTIVE

The Long Term Disability plan includes a rehabilitation/return to work incentive for up to 12 consecutive months. Your monthly benefit will continue as long as the sum of your current monthly earnings and net disability benefit do not exceed 100% of your pre-disability earnings. If the sum of your monthly benefit and earnings exceeds 100% of your pre-disability earnings, the monthly benefit will be reduced by the amount of the excess. However, your monthly benefit will not be less than the minimum monthly benefit.

You may be eligible for a workplace modification benefit. If the university and ReliaStar agree to workplace modifications to reasonably accommodate your return to work and the performance of your essential job functions, benefits up to the monthly maximum benefit may be payable to reimburse the university for such workplace modifications.

LENGTH OF BENEFIT PAYMENTS

The longest period for which disability benefits are payable for one period of continuous disability is determined as follows:

<u>Your Age When Disability Begins</u>	<u>Your Maximum Benefit Period</u>
63 years of age or younger	To normal retirement age or 48 months, if greater
Age 63	To normal retirement age or 42 months, if greater
Age 64	36 months
Age 65	30 months
Age 66	27 months
Age 67	24 months
Age 68	21 months
Age 69 or older	18 months

Normal Retirement Age means the Social Security Normal Retirement Age, determined by your date of birth. For more details, see the long-term disability benefit booklet at www.alaska.edu/benefits/long-term-disability.

LIMITATION OF BENEFITS

Benefits will not be paid for any period when you are not under the care of a physician.

If a disability is caused by a mental disorder, alcoholism, drug addiction, or substance abuse, payment of benefits is limited to 24 months during your entire lifetime.

However, if you are a resident patient in a hospital at the end of the 24 months, or you become a resident patient in a hospital within 6 months of discharge from a previous confinement for which LTD benefits were payable, this limitation will not apply while you remain continuously confined.

Payment of benefits is limited to 12 months while you are continuously residing outside of the United States and Canada.

LONG TERM DISABILITY EXCLUSIONS

Your Long Term Disability insurance does not cover any disability caused or contributed to by self-inflicted injury, war or an act of war, your committing or attempting to commit an assault or felony, or your active participation in a violent disorder or riot. For a full list of exclusions, please consult the long-term disability booklet, available online at www.alaska.edu/benefits.

LONG TERM DISABILITY CLAIMS

Notify your regional human resources office immediately of your disability and obtain a claim form. Completed forms are to be returned to that office for transmittal to the insurance carrier. You must file written proof of your disability within 90 days after the beginning of the disability. The insurance carrier has the right to have you examined by the doctor(s) of their choice.

TERMINATION OF INSURANCE

Your insurance ends when your employment with the University ends, your position no longer meets the eligibility requirements, or the University discontinues offering a Long Term Disability program. If you renew your employment contract with the University for the following year and then cease active, full-time work during the summer months, your coverage continues during the summer months.

CONVERSION PRIVILEGE

If this protection ceases because your employment with the University terminates, you may arrange with the insurance carrier to provide Long Term Disability coverage under an individual policy. This coverage may be converted without medical examination if you apply within 30 days from the date your group coverage ceases. The individual Long Term Disability benefits are not the same as the University's Group Long Term Disability Plan.

To request conversion coverage, contact your regional human resources office for forms. You may not convert to an individual plan if you retire or are disabled at the time employment terminates.

LIFE INSURANCE BENEFITS

INTRODUCTION

Financial protection for your survivors in the event of your death is important for your family's welfare. The University of Alaska provides the opportunity for income protection through the following benefit plans:

- Basic life insurance
- Supplemental life insurance
- Accidental death and dismemberment insurance

BENEFICIARIES

The benefits will be paid to the beneficiary or beneficiaries you name on the university's beneficiary form. You may change your beneficiary at any time by completing a new beneficiary form and returning it to your regional human resources office. The beneficiary form is available on the benefits web site at www.alaska.edu/benefits.

If you should die without naming a beneficiary, or if you are not survived by a named beneficiary, life insurance benefits will be paid in equal shares to the first surviving class of the following, in this order:

- Your spouse
- Your children
- Your parents
- Your siblings (brothers and sisters)
- Your estate

OTHER DEATH BENEFITS

Benefits paid to your beneficiary and/or benefits to which they may be entitled at the time of your death may include the following:

Life Insurance

- PERS/TRS Retirement Benefits
- University of Alaska Pension Plan Benefits
- Sick Leave Payoff
- Annual Leave Payoff
- Special Continuation of Health Care Benefits
- Distributions from TDA Accounts
- Optional Retirement Plan Accounts

The University of Alaska's life insurance and accidental death and dismemberment benefits are provided by Securian Life Insurance.

BASIC LIFE INSURANCE

INTRODUCTION

The University provides a basic \$50,000 Life Insurance benefit at no cost to employees.

Employees may purchase additional life insurance through payroll deductions (see supplemental life insurance sections).

ELIGIBILITY

All regular full-time, and regular part-time employees are eligible for insurance coverage. Eligibility begins on the date of hire.

BENEFITS

The amount that will be paid from this benefit to your beneficiary(ies) in the event of your death is a total of \$50,000. Benefits will be paid by check and sent directly to your beneficiary or beneficiaries in the percentages you indicated on the beneficiary form.

CLAIMS

Life insurance claims should be filed through your regional human resources office. Claims should be returned to that office for final completion and transmittal to the insurance carrier.

TERMINATION

Your Basic Group Life Insurance ceases on the date that you terminate eligible employment with the University. Portability or Conversion to an individual policy is available; see the Portability or Conversion Privilege information at the end of this section.

DISABILITY WAIVER OF PREMIUM

If an employee becomes totally disabled while insured and before reaching age 60, basic life insurance coverage will remain in effect without further premium payment as long as the disability continues or until age 65, whichever is sooner.

Proof of your inability to work because of total disability must be furnished annually. If disabled prior to age 60, insurance will continue as long as you are disabled, but not past age 65. The amount of continued protection is subject to any plan changes and to reductions shown in the insurance schedule. Within one year of the start of your disability, you must submit proof that you are currently disabled and have been continuously disabled for at least six months.

Application for the waiver of premium will be made on your behalf when you are approved for Long-Term Disability benefits. Securian will contact you for any additional information they may require to approve your waiver.

PORTABILITY OR CONVERSION PRIVILEGE

You may arrange with Securian to continue your basic life insurance protection, without medical examination, **if you apply for it within 31 days** after the date your group insurance ceases.

Because the Group Life Insurance will be payable for death occurring during the 31 days after the date your insurance ceases, the elected individual policy will not become effective until after the 31-day period has expired. With conversion, the individual life insurance benefits will be converted to a Whole Life policy. Portability allows you to continue under a group term policy. Premiums may be higher than those paid by active employees.

For information and forms, log on to www.lifebenefits.com/continue to review your options on continuing your coverage through portability or conversion. Use the policy number 70229, and the access key is uofak.

For more information on Portability or Conversion, contact Securian at (866) 365-2374. Remember, forms must be received at Securian within 31 days of employment termination or loss of eligibility.

TRAVEL ACCIDENT BENEFITS

There is a travel accident policy for accidental death and dismemberment in effect while you are traveling on University business. The principal sum is \$250,000 and is subject to the policy terms, conditions and exclusions. Commuting to and from work is not covered. This benefit is provided by UA Risk Management and is not part of your Group Basic Life Insurance and is not in lieu of and does not affect any requirements for coverage by any Workers' Compensation Act or similar law.

SUPPLEMENTAL LIFE INSURANCE

INTRODUCTION

This plan provides for income benefits to the survivors of a deceased employee. Coverage amounts under this plan are in multiples of \$25,000 to a maximum of \$400,000. Within 30 days of hire, a new employee may purchase up to \$200,000 of coverage without providing evidence of insurability (EOI). Coverage elections above this amount require EOI. If you do not enroll in Supplemental Life within 30 days, you may not enroll until the next open enrollment period, or after a qualifying major life event.

ELIGIBILITY

Only University of Alaska employees are eligible for enrollment in the plan; dependents are not covered. If you are a regular full-time or regular part-time employee, you are eligible for this optional plan.

ENROLLMENT

You may enroll within 30 days of the date of your employment in an eligible position. During open enrollment or within 30 days after a qualifying major life event, an employee may elect to increase his or her supplemental life coverage in \$25,000 increments, not to exceed \$200,000 without evidence of insurability. The maximum amount of supplemental life insurance that a university employee can purchase under this plan is \$400,000. You will need to submit evidence of insurability if you are electing over \$200,000 of coverage.

Submit the UA Choice Supplemental Life and AD&D Election form to your regional human resources office. If electing more than \$200,000 of coverage, you must complete the Evidence of Insurability form, and send it directly to Securian at the address on the form, or fax it to (651) 665-7092. You will be enrolled at \$200,000 until the higher benefit level is approved by Securian. Initial enrollment in the supplemental life insurance benefit also requires a completed beneficiary form. All forms are available on the benefits web site at www.alaska.edu/hr/forms.

Employees with current coverage levels over \$200,000 who are electing a higher level of coverage at open enrollment or because of a qualifying life event will maintain their current level until the increase is approved. If the increase is not approved, they will retain their current level of coverage.

You may cancel this coverage at any time by completing a UA Choice Supplemental Life and AD&D Election form or upon written notice to your regional human resources office.

AGE REDUCTIONS IN SUPPLEMENTAL LIFE INSURANCE

In accordance with the Age Discrimination in Employment Act (ADEA), any supplemental life insurance coverage offered shall adhere to the following reductions for coverage of employees aged 65 or older. An employee's in-force supplemental life insurance benefit amount will be reduced once he or she attains age 65 by 35%, at age 70 by 50%, and at age 75 by 65%. This reduction applies to currently elected coverage and takes effect based on the employee's age on July 1.

The amount of reduced insurance coverage due to an employee's age on July 1 will be rounded up to the next higher multiple of \$25,000 if not already a multiple of \$25,000. The premium rate charged to the employee will be based

on the new reduced benefit amount and not the original elected benefit amount rate.

COSTS

This plan is age-banded so that each employee pays only what it costs to insure him or her for that time. The rate that will be charged an employee is based upon their age as of July 1 of each year.

Payments for the coverage are made through bi-weekly payroll deductions on an after-tax basis. For the most current rates, please see www.alaska.edu/benefits/life-insurance/.

PAYMENT OF BENEFITS

The amount that will be paid to your beneficiary in the event of your death is the most recent effective level of supplemental insurance. If you die while covered by the plan, benefits will be paid by check to the beneficiary you name and sent directly to that beneficiary.

To request payment of benefits, the beneficiary should contact your regional human resources office for a claim form and information about other required documents. Claims should be returned to that office for final completion and processing.

TERMINATION

Your Supplemental Life Insurance ceases on the date that you terminate eligible employment with the University. Portability or Conversion to an individual policy is available; see the Portability or Conversion Privilege information below.

DISABILITY WAIVER OF PREMIUM

If an employee becomes totally disabled while insured and before reaching age 60, coverage will remain in effect without further premium payment as long as the disability continues or until age 65, whichever is sooner.

Proof of your inability to work because of total disability must be furnished annually. If disabled prior to age 60, insurance will continue as long as you are disabled, but not past age 65. The amount of continued protection is subject to any plan changes and to reductions shown in the insurance schedule. Waiver of premium begins when you complete the waiting period. Waiting period means the 180 consecutive day period beginning on the date you become totally disabled. Premium payment must continue until the later of the date you complete your waiting period, or the date we approve your claim for waiver of premium.

Application for the waiver of premium will be made on your behalf when you are approved for Long-Term Disability benefits. Securian will contact you for any additional information they may require to approve your waiver.

PORTABILITY OR CONVERSION PRIVILEGE

As with the basic life insurance, you may arrange with Securian to continue your supplemental life insurance protection under an individual policy, without medical examination, **if you apply for it within 31 days** after the date your group insurance ceases.

See the information on portability or conversion in the basic life insurance section.

ACCIDENTAL DEATH AND DISMEMBERMENT

INTRODUCTION

This supplemental plan provides financial benefits for loss of life, limbs, or eyes as a result of bodily injury due to a covered accident.

ELIGIBILITY

All regular full-time and regular part-time employees and their dependents are eligible for this plan. Employees become eligible for enrollment in the plan on their date of hire into an eligible position. Employee dependents become eligible for coverage if and when the employee enrolls for family coverage in the plan.

ENROLLMENT

To enroll, complete the optional benefit selection form and return it to your regional human resources office. Your coverage will begin the first day of the pay period following your payroll deduction for this coverage. You may enroll within 30 days of the date you are hired, during open enrollment, or following a major life event.

COSTS

Current rates may be found on the supplemental benefits election form, or at www.alaska.edu/benefits.

BENEFITS

The full benefit amount for you, the employee, is \$100,000.

If, while you are covered under this plan, you should die within one year of the accident, the full benefit will be paid to the beneficiary you have designated.

If you should have any of the following losses within one year of the accident, benefits will be paid as follows:

- Loss of both eyes, feet, or hands or any combination thereof: full benefit amount
- Loss of one eye, foot, or hand: one-half of benefit amount
- Loss of thumb and index finger of same hand: one-fourth of benefit amount

If you enroll for family coverage, the benefit amount for dependents is based on the composition of the family at the time of the loss. The actual amount that will be paid is a percentage of the amount that you would be paid if you sustained the same loss:

- If you have a spouse but no dependent children, your spouse will be covered for 50% of the full benefit.
- If you have dependent children but no spouse, each child will be covered for 15% of the full benefit.
- If you have both a spouse and dependent children, your spouse will be covered for 40% and each child for 10% of the full benefit.

BENEFICIARIES

Employee Accidental Death benefits will be paid to the beneficiary they have selected. If you wish to change your beneficiary, complete a new beneficiary form and return it to your regional human resources office. Dependent AD&D benefits will be paid to the employee.

AD&D EXCLUSIONS

In no event will benefits be paid for accidental death or dismemberment where an insured's accident, injury, loss, death or dismemberment is caused directly or indirectly by, results in whole or in part from or during, or there is contribution from, any of the following:

- self-inflicted injury, self-destruction, or autoeroticism, whether sane or insane; or
- suicide or attempted suicide, whether sane or insane; or
- an insured's participation in, or attempt to commit, a crime, assault, felony, or any illegal activity, regardless of any legal proceedings thereto; or
- bodily or mental infirmity, illness or disease; or
- the use of alcohol; or
- the use of prescription drugs, non-prescription drugs, illegal drugs, medications, poisons, gases, fumes or other substances taken, absorbed, inhaled, ingested or injected; or
- motor vehicle collision or accident where you are the operator of the motor vehicle and your blood alcohol level meets or exceeds the level at which intoxication is defined in the state where the collision or accident occurred, regardless of any legal proceedings thereto; or
- infection, other than infection occurring simultaneously with, and as a direct and independent result of, the accidental injury; or
- medical or surgical treatment or diagnostic procedures or any resulting complications, including complications from medical misadventure; or
- travel or flight in or on any vehicle used for aerial navigation including getting in, out, on, or off such vehicle, if the insured is:
 - riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
 - riding as a passenger in a non-chartered aircraft which is owned, leased, operated, or controlled by the eligible employee's employer; or
 - a student taking a flying lesson, unless riding as a passenger; or
 - hang gliding; or
 - parachuting, except when the insured has to make a parachute jump for self-preservation; or
- War or any act of war, whether declared or undeclared war.

CLAIMS

To request payment of benefits, you or your representative should contact your regional human resources office for claim forms and information about other required documents. Claims should be returned to that office for processing.

RETIREMENT PLANS AND OPTIONS

INTRODUCTION

There are several retirement programs available to University of Alaska employees. They are the:

- State of Alaska Public Employees' Retirement System (PERS)
- State of Alaska Teachers' Retirement System (TRS)
- University of Alaska Optional Retirement Plan (ORP)
- University of Alaska Pension Plan
- Tax-Deferred Annuity Program (TDA)
- Social Security

Each of the above plans has limitations as to which employees are eligible to participate. The plans are described in summary on the following pages. For more detailed information, please consult the specific plan's handbook or plan document.

SOCIAL SECURITY

The University of Alaska withdrew from the federal Social Security system on January 1, 1982, after university employees voted to discontinue participation in the program. Consequently, university employees do not earn quarters toward a Social Security benefit during their employment with the university.

Pension income based on earnings from a job not covered by Social Security can reduce future Social Security benefits when you retire or become disabled. Under the Social Security law, there are two ways your Social Security benefit amount may be affected.

- Under the *Windfall Elimination Provision*, your Social Security retirement or disability benefit is figured using a modified formula when you are also entitled to a pension from a job where you did not pay Social Security tax. This provision reduces, but does not totally eliminate, your Social Security benefit.
- The *Government Pension Offset Provision* offsets any Social Security spouse or widow(er) benefit to which you become entitled by two-thirds of the amount of your pension. Even if your pension is high enough to totally offset your spouse or widow(er) benefit, you are still eligible for Medicare at age 65.

Social Security publications and additional information, including information about exceptions to each provision, are available at www.socialsecurity.gov. You may also call toll free (800) 772-1213, or for the deaf or hard of hearing, call the TTY number (800) 325-0778, or contact your local Social Security office.

Effective April 1, 1986, federal law requires that all employees hired after March 31, 1986, participate in the Medicare portion of the Social Security program. The Medicare portion of the Social Security contribution is 1.45% of gross wages in a calendar year.

Effective July 1, 1991, all temporary staff employees and adjunct faculty are required by federal law to participate fully in both Medicare and Social Security, except as noted below. The contribution for both portions is 7.65% of subject gross wages. If you have any questions regarding your participation in either plan, contact your regional human resources office.

Temporary employees (staff and adjunct faculty) who are retirees of the PERS, TRS or ORP, or who meet the age, service and vesting requirements for benefits from the plans, are *exempt* from Social Security but are required to contribute to Medicare. For more information on this requirement, please see IRS Publication 963.

STATE RETIREMENT PLANS

Through the University's affiliation with the State of Alaska, regular employees are eligible to participate in either the Teachers' Retirement System (TRS) or the Public Employees' Retirement System (PERS). Please see the State of Alaska Division of Retirement and Benefits for complete information, including the PERS and TRS Handbooks, at doa.alaska.gov/dr/b/.

ELIGIBILITY

TRS

If you are an active regular employee occupying a regular position that requires academic standing and/or teaching (faculty and academic officers and senior administrators), you are eligible to participate in TRS on the effective date of hire or the first day of employment unless an election is made within 30 days to participate in the Optional Retirement Plan.

PERS

All regular full-time and part-time exempt or non-exempt staff members are eligible for PERS on the first day of employment. Non-academic officers and senior administrators may choose between PERS and ORP within 30 days of hire into an eligible position.

CONTRIBUTION RATE

Costs of the plan are shared by the employee and the University. The amount of the contribution depends on whether you are a participant of TRS or PERS, and your date of hire.

TRS

Employees participating in the TRS defined contribution plan hired on or after July 1, 2006 contribute 8% of salary through a bi-weekly pre-tax payroll deduction. The defined contribution plan is referred to as TRS Tier III.

Employees in TRS hired before July 1, 2006 contribute 8.65% of their salary through a bi-weekly payroll deduction to the TRS defined benefit plan known as TRS Tier I or Tier II.

For all TRS tiers, the University contributes an additional percentage of salary as determined annually by the TRS program.

PERS

Employees participating in the PERS defined contribution plan hired on or after July 1, 2006 contribute 8% of salary through a bi-weekly pre-tax payroll deduction. The defined contribution plan is referred to as PERS Tier IV.

Employees in PERS hired before July 1, 2006 contribute 6.75% of their salary (7.5% for Peace Officers and Firefighters) through a bi-weekly pre-tax payroll deduction to the PERS defined benefit program under PERS Tiers I, II or III.

For all PERS tiers, the University contributes an additional percentage of salary as determined annually by the PERS retirement program.

VESTING

Both TRS and PERS contain vesting features that give you the right to your account balance or retirement benefits after a specified period of time. Defined benefit plan members accrue membership service that, when 100% vested, gives you the right to future retirement benefits regardless of continued employment with the University. Defined contribution plan members vest over a period of five years, with 25% vesting at two years of service, 50% at three years, 75% at four years and 100% at five years. Please refer to your PERS or TRS handbook for more detailed information on vesting.

BENEFITS

DEFINED CONTRIBUTION PLAN MEMBERS

With a defined contribution plan, you and the university make bi-weekly contributions to accounts set up for you by the State of Alaska Division of Retirement and Benefits. Contributions and investment earnings (and losses) accumulate in your account and the benefit payable at retirement depends on the value of your account.

DEFINED BENEFIT PLAN MEMBERS

The amount of your monthly retirement income is determined by your length of service at the University, as well as any additional credited service, and your average monthly compensation (usually your three highest years' salary; PERS years must be consecutive, highest five consecutive years for PERS employees first hired between July 1, 1996 and June 30, 2006). Benefits may also be paid in the event of a permanent disability or in the event of your death. Please refer to your PERS or TRS handbook for more detailed information.

TERMINATION

In the event of your termination of employment with the University, your employee contributions to either TRS or PERS may be refunded to you; employer contributions to the defined benefit plan are non-refundable. If you have question regarding vesting and/or benefits available upon your termination, please contact your regional human resources office.

ADDITIONAL INFORMATION

This summary highlights only key features of the TRS and PERS plans. For more specific information, please refer to the TRS or PERS handbook. Where any inconsistency exists between this description and the official documents, the rules and regulations of PERS and TRS will take precedence. All of the provisions of the plans are explained in more detail in the PERS and TRS handbooks. The handbooks are available from the State of Alaska Division of Retirement and Benefits, P.O. Box 110203, Juneau, AK 99811-0203, or 550 West 7th Avenue, Suite 540, Anchorage, AK 99501-3555.

You can also access the handbooks, forms and more information online at doa.alaska.gov/drb/.

UNIVERSITY OF ALASKA OPTIONAL RETIREMENT PLAN

Eligible University of Alaska employees must make an irrevocable election to participate in either the Optional Retirement Plan (ORP) or the appropriate state retirement system (TRS or PERS) within 30 days from notification of eligibility. Your choice to participate or not to participate is irrevocable for the duration of your current employment or future employment with the University of Alaska or as long as you remain in a participating position. Please see the University of Alaska Retirement Plan Decision Guide for more detailed information about this program and a description of the tiers.

ELIGIBILITY

Eligible employees are all regular and term-funded faculty, and officers and senior administrators of the University of Alaska. Members of the Fairbanks Firefighters' Association Employees first hired into an eligible position on or after July 1, 2006 participate in Tier 3 of the ORP. Employees first hired before July 1, 2005 participate in Tier 1, with Tier 2 being for those employees first hired between July 1, 2005 and June 30, 2006.

CONTRIBUTIONS

Contributions made by you and by the University on your behalf will be invested in an account in your name and with the fund sponsor(s) you select from the list below. The amount of the contribution depends on which Tier of the plan you are participating in, based on your initial date of hire into an eligible position.

VESTING

The Optional Retirement Plan Tier 3 provides for full vesting of the employer contribution account after three calendar years of employment. The Tier 3 employee contribution account is always 100% vested with the employee. Employees participating in the ORP Tier 1 or Tier 2 are immediately 100% vested in both the employer and employee accounts.

YOUR INVESTMENT DECISION

You must choose an investment company for your employee and employer contributions (can be the same fund sponsor, or a different one for each type of contribution) from these four investment fund sponsors:

Company	Phone Number	Company	Phone Number
Fidelity Investments	(800) 343-0860	TIAA	(800) 842-2776
Lincoln National	(800) 348-1212	VALIC	(800) 448-2542
Toll Free in Alaska	(800) 478-6393	in Anchorage	279-8302
in Fairbanks	452-6393	in Fairbanks	458-0101

The plan allows you to change your investment elections within or between fund sponsors at any time. You can use the same fund sponsor for both the employer and employee contributions, or you can use a separate fund sponsor for each.

FORMS OF PAYMENT

After an official termination of all employment and a 45-day waiting period, you may choose one of the following options for your ORP account:

- Transfer your account to another qualified plan
- Roll your account to an IRA
- Receive payment of your account balance through an annuity contract purchased from the fund sponsor
- Receive a lump-sum distribution, subject to any applicable early withdrawal penalties and taxes

Please Note: Loans or hardship distributions are not permitted under this plan. All distributions require employer authorization.

If there is any conflict between information in the Retirement Plan document and this Handbook, the Retirement Plan document will prevail.

YOUR CHOICES OF INVESTMENT OPTIONS

The ORP consists of two accounts: one for contributions made by you (the mandatory 403(b) account), and one for contributions made by the University on your behalf (the 401(a) employer-funded account). Only one of the options listed below can be selected for each account at any one time, yet changes could be made each pay period. You can use the same fund sponsor for both accounts, or different fund sponsors. You may also transfer account balances between the fund sponsors as allowed by your fund sponsor. Please be aware that some of the accounts that fund sponsors offer do have restrictions, redemption fees, penalties for early withdrawal and charges for making transfers.

FIDELITY INVESTMENTS

Fidelity Investments applies more than 70 years of investment experience, innovation and professionalism to help meet the needs of its clients. Once known primarily as a mutual fund company, Fidelity has adapted and evolved over the years to meet the changing needs of its customers. Investing with Fidelity Investments will offer you a broad range of over 195 investment options. You can choose from relatively conservative money market funds to aggressive international equity funds. Fidelity also offers a fixed annuity which is underwritten by Metropolitan Life. At www.fidelity.com/atwork you will find an extensive array of retirement planning tools, calculators, videos and other retirement planning resources.

LINCOLN NATIONAL

Lincoln Financial Group is the marketing name for Lincoln National Corporation (NYSE:LNC) and its affiliates. Lincoln National Corp., a fortune 250 company has over \$200 billion in assets under management and over a 100-year-old heritage of helping people find solutions to their financial challenges. Our dedicated Lincoln Financial Representatives in Alaska have been proudly serving the University and their employees for over 25 years: Providing the guidance and solutions that help empower participants to take charge of their financial lives with confidence and optimism. Today, more than 17 million customers trust Lincoln's retirement, insurance and wealth protection expertise to help address their lifestyle, savings and income goals.

TIAA

TIAA is a Fortune 100 financial services organization dedicated to helping participants achieve financial well-being. TIAA was founded nearly a century ago as the vision of one of history's great philanthropists, Andrew Carnegie, to make a difference in the lives of teachers. Since then, TIAA has helped millions at academic, medical, research and cultural organizations—the people whose work makes the world a better place—retire with financial security.

Today, TIAA is a global asset manager with award-winning performance and \$861 billion in assets under management. TIAA's investment model and long-term approach aim to benefit the 5 million people and more than 16,000 institutions they serve. With powerful performance that drives better outcomes for participants, TIAA is committed to growing, innovating, continually improving and building on their proud history of diversity and inclusion.

VALIC

VALIC's group retirement plan offers a flexible mix of investments, financial planning services and individualized support, providing the education, resources, and technology necessary to keep your retirement plans on track. With more than half a century of experience, we help Americans plan for and enjoy a secure retirement. Serving nearly 25,000 group plans and over a million participants, VALIC is a leading plan provider to higher education institutions and the not-for-profit industry. VALIC is committed to an unchanging standard of one-on-one service that we have delivered since our founding. Our full-time, experienced and trusted financial advisors are committed to serving your needs and are located in Anchorage and Fairbanks with service to other parts of the state as well. Our goal is to help University of Alaska employees live retirement on their terms. VALIC has a unique style of helping employees get—and stay—on track for retirement.

DEFAULT INVESTMENT

The University will direct contributions for both ORP accounts to the Fidelity Investments default account until you have selected an investment option. The default investment is one of the Fidelity Freedom Funds, a mix of equity and income investments based on your projected retirement date.

CHOOSING A FUND SPONSOR

The variety of investment opportunities provides considerable flexibility in designing a retirement investment program that fits your personal financial situation. You might consider a few things when making your decision:

- Your family circumstances
- The balance of risk and return you are comfortable with
- Your anticipated income needs at retirement
- Your financial objectives
- Your ability to save outside the university's retirement program
- The number of years to retirement

If you have questions about the University's plan, contact your regional human resources office.

DISTRIBUTIONS

Vested ORP account balances can be distributed after an official termination of all employment from the University; however, distributions are subject to a 45-day waiting period. Termination of employment means that for an extended period of time you have not received any wages or salary from the University (transferring into a position or status that is not benefit eligible is not a termination). The exception to this rule is employees who have reached normal retirement age (60) and have transferred to a non-participating position (temporary staff or adjunct).

To roll over your account to an Individual Retirement Account or another qualified plan, begin an annuity payment or request a lump-sum distribution, contact your fund sponsor for the appropriate forms. All distributions require employer authorization.

If there is any conflict between information in the Retirement Program plan document and this Handbook, the Retirement Program plan document will prevail.

UNIVERSITY OF ALASKA PENSION PLAN

On January 1, 1982, in conjunction with the University's withdrawal from the federal Social Security system, a supplemental retirement plan was adopted for University employees called the University of Alaska Pension Plan. It does not attempt to duplicate benefits available under Social Security. The Pension Plan is a University-sponsored 401(a) plan. The University contributes to this program on behalf of eligible regular full-time and part-time faculty and staff. Employees are not eligible to make supplemental contributions into this plan.

ELIGIBILITY

Regular full-time and part-time faculty and staff are eligible for the Pension Plan. Employees first hired between July 1, 2006 and June 30, 2015 must have elected the Optional Retirement Plan to participate in the Pension Plan, even if rehired after June 30, 2015. Employees first hired on or after July 1, 2015 are eligible for the Pension Plan regardless of their other retirement plan enrollment.

CONTRIBUTION RATE

The University contributes an amount equal to 7.65% of an employee's wages, up to an annual wage base of \$42,000, to the employee's Pension Plan account.

VESTING AND DISTRIBUTIONS

Employees first hired and participating in the plan before July 1, 2006 are 100% vested from the date of hire. Participants first hired on or after July 1, 2006 are subject to a vesting period of three calendar years from date of hire in an eligible position.

Vested account balances are available for distribution after termination of all employment from the University (subject to a 45-day waiting period). The exception to this rule is employees who have reached normal retirement age (60) and have transferred to a non-participating position. Please note that hardship distributions or loans against this account are not allowed.

INVESTMENT OPTIONS

The University's Pension Plan provides employees investment flexibility and broad investment opportunities. You should receive a statement on a quarterly basis from the company you select to manage your pension plan account. It is critical that you thoroughly review your quarterly statement and notify the company and/or the University of any errors.

The plan offers employees four investment company (or Fund Sponsor) options. See the Optional Retirement Plan section for a description of each fund sponsor.

Company	Phone Number	Company	Phone Number
Fidelity Investments	(800) 343-0860	TIAA	(800) 842-2776
Lincoln National	(800) 348-1212	VALIC	(800) 448-2542
Toll Free in Alaska	(800) 478-6393	in Anchorage	279-8302
in Fairbanks	452-6393	in Fairbanks	458-0101

TAX-DEFERRED ANNUITY (TDA) PLANS

Tax-deferred annuity plans (TDAs) are designed to offer you the opportunity to make tax-deferred contributions to supplement your retirement income. These plans are available only to employees of nonprofit and governmental organizations, such as the University of Alaska.

All University of Alaska employees have the opportunity to invest in a variety of tax-deferred annuity or 403(b) plans. Each of these plans has specific advantages for retirement security. When combined with the University's other retirement programs, they enhance your ability to provide a solid financial foundation for your retirement years.

Tax-deferred annuities are available with a variety of companies through the University of Alaska. Contact your regional human resources office for an updated list, or visit the benefits web site at www.alaska.edu/benefits.

DISCLAIMER OF RESPONSIBILITY

As a benefit to its employees, the University of Alaska allows participation in various TDA plans. A number of the tax-deferred annuities (Internal Revenue Code Section 403(b) plans) are available through various providers who are registered with the University. Registration merely indicates that the annuity or fund provider has agreed to provide tax-deferred annuities to university employees and has demonstrated that a number of employees have an interest in participating in their plan. Registration does not mean that the provider has met any specific standard of quality or reliability.

Important: The participant is solely responsible for personal income tax consequences associated with the participation in tax-deferred annuity arrangements. IRS requirements related to 403(b) plans can be extremely complex. While recent tax law changes have made contributing to a TDA easier for many employees, the participant is urged to seek appropriate income tax advice prior to contributing to a TDA plan.

ELIGIBILITY

All employees of the University of Alaska are eligible to participate in the tax-deferred annuity plans. Participation is voluntary.

ENROLLMENT

To enroll in this program, you need to complete an enrollment form or application with the appropriate company as well as a Salary Reduction Agreement form (available from your regional human resources office or on the web at www.alaska.edu/benefits). Through this agreement, you authorize the University of Alaska to reduce your salary by a designated amount and direct this portion of your salary to your chosen 403(b) provider.

CONTRIBUTIONS

You decide the amount of your bi-weekly payroll reduction and how the funds will be invested. The amount you may invest is limited by the Internal Revenue Code, and is updated annually. Employees are responsible for determining if their contributions are within the provisions of the law. For details, refer to IRS Publication 571.

In effect, your total yearly contributions to the TDA account reduce your gross annual salary by that amount. You

pay federal income tax only on your reduced annual salary. Contributions and earnings will be taxed upon their withdrawal.

If the University determines that you have exceeded the maximum allowable contribution limits, the University will take corrective action.

PAYMENT OF BENEFITS

Tax-deferred annuities can be used for a variety of purposes. They are primarily used for retirement because of the immediate tax reductions to your income. Some TDA programs allow you to borrow against the value of your account; check with your TDA provider to see if loans are a provision of their 403(b) program.

Hardship distributions are available for an immediate and heavy financial need, such as severe medical debt previously incurred, risk of foreclosure or eviction, educational expenses, expenses to repair damage to your home and others. After a hardship distribution has been approved, you must stop all deferrals to your 403(b) account for a period of six months. See the IRS Publication 571 for more information regarding hardship distributions.

Many different payout options are offered at retirement, including single life and survivor annuities; funds can be distributed as a lifetime annuity, an annuity over a fixed period of years, a partial or total lump-sum payment withdrawn at one time, or other options. Contact your TDA provider for the options offered under their program.

If your death should occur before TDA retirement benefits begin, a variety of options are generally available to beneficiaries for the payment of death benefits.

PLANWITHEASE.COM

The University of Alaska uses a third party administrator to manage most transactions under the voluntary 403(b) program. Planwithease.com offers administrative services for the plan, such as approvals for distributions, loans, qualified domestic relations orders (QDROs) and hardship withdrawals.

Log in at www.planwithease.com with your initial user ID of your social security number (no dashes) and your temporary password is your birthdate in MMY format with no punctuation. You will be prompted to set up your own user ID and password for future use.

If you have questions or problems accessing the site, contact their customer service team at 1-855-464-6928 or by e-mail at customerservice@planwithease.com.

OTHER BENEFITS

INTRODUCTION

This section summarizes University policies such as leaves and educational benefits that directly affect regular non-union employees. You are encouraged to contact your regional human resources office for any further policy information you may need.

EDUCATIONAL BENEFITS

All regular benefit-eligible full-time and part-time employees may take up to eight credit hours of University course credits per semester, with no tuition fee, to a maximum of 16 credit hours per calendar year. You may take up to three credit hours during working hours, without being required to make up the time, if the course will enhance job-related skills or knowledge; approval must be granted by your supervisor and the appropriate forms completed.

In addition, you may have course charges waived for up to four non-credit courses from a UA-approved list per semester, with prior approval from your supervisor. These non-credit courses are designed to enhance job-related skills and work performance.

Course charges may be waived for a maximum of 16 credit hours and eight non-credit courses per academic year, beginning with the fall semester and ending with the summer term. Course fees other than tuition, such as lab, supply or technology fees, student activity or health center fees, and books, etc., are not covered by the tuition waiver and are the student's responsibility.

Your spouse and dependent children through age 23 may have an unlimited number University course credits tuition waived (self-support courses excluded). As with employees, other non-tuition course fees are the student's responsibility.

To remain eligible for the tuition waiver benefit, recipients need to maintain good academic standing and are subject to academic probation for failing grades.

If the courses taken by either an employee, spouse, or dependent are considered graduate level courses, the value of these classes will be added to the employee's gross income and taxed as if it were regular earnings. However, if the employee is taking graduate-level courses that are a requirement of their position, those courses may not be subject to taxation.

HOLIDAYS

The University observes twelve holidays each year. These include

- New Year's Day, and the day before or after New Year's Day
- Martin Luther King, Jr. Day in Celebration of Alaska Civil Rights (the third Monday in January)
- a day during spring recess
- Memorial Day
- Independence Day (July 4), and the day before or after July 4
- Labor Day
- Thanksgiving Day and the following Friday, and

- Christmas Day, and the day before or after Christmas Day

Personal Holiday: After satisfying the six-month probation period, each benefit-eligible non-represented employee may select a Personal Holiday, which must be approved by the immediate supervisor. Personal Holiday cannot be used during the pay period in which July 1 falls.

A list of holidays and the dates on which they are observed is issued by the President's Office and posted on the benefits web site at www.alaska.edu/benefits. Generally, holidays falling on a Saturday are observed on the preceding Friday, while those falling on a Sunday are celebrated on the following Monday.

ANNUAL LEAVE

University employees (non-faculty) earn annual leave on a bi-weekly basis. The amount earned depends on the number of years employed. Regular full-time and regular part-time employees who work at least 20 hours a week are entitled to earn annual leave. Regular part-time employees are eligible to earn an amount of leave based on the percentage of full-time hours they work per week. Your immediate supervisor must approve all annual leave taken. Annual leave must be taken while an employee is on contract. Represented faculty do not accrue annual leave, but receive Faculty Time Off (FTO) per their collective bargaining agreement.

Accrual Rates: Annual leave for full-time employees is accrued as follows:

- 5.54 hours per pay period during the first 5 years of employment
- 6.46 hours per pay period during years 6 through 10
- 7.38 hours per pay period after 10 years of employment

Unused annual leave may be accrued to a maximum of 240 hours. Any unused leave in excess of this amount will be forfeited at the end of the pay period in which June 30 falls.

Cashing In Annual Leave: Non-represented, benefit-eligible employees may cash in up to 40 hours of accrued annual leave once per fiscal year by completing the Annual Leave Cash-In Request Form and submitting it to payroll. Leave may not be cashed in during the pay period that includes June 30, and an accrued balance of 40 hours must remain after the cashed-in hours are paid. See the benefits web site for program updates, more information and the necessary form to cash in leave, at www.alaska.edu/benefits/leaves.

If you transfer from a position that provides annual leave to one that does not, or if you terminate from the University, you will be paid for the balance of your accrued annual leave time up to 240 hours. If you die while employed, your beneficiary will be paid for your accrued leave time.

Annual leave is not accrued during leave without pay, nor can an employee accrue leave when running out annual leave for termination purposes. Annual leave taken as terminal leave, cashed-out while employed or paid-off at termination does not generate retirement plan contributions nor count towards calculating annual salary or service credit for PERS or TRS retirement verification.

SICK LEAVE

The University grants paid sick leave to all faculty members, regular full-time, regular part-time, and extended temporary employees who work 20 or more hours per week on a regular basis. Full-time employees accrue 4.62 hours per pay period (if they are in pay status for the entire pay period), while part-time employees earn an amount based on the percentage of full time hours they work per pay period. You may use sick leave for those hours you are regularly scheduled to work. If your sick leave balance is exhausted, eligible sick leave hours will be deducted from your annual leave. If all leave is exhausted, you may be eligible for the Leave Share Program or leave without pay.

Sick leave may be taken for a variety of reasons:

- Illness or medical condition
- An appointment with a doctor or dentist
- Emergency care for members of your immediate family
- Childbirth (by you or your spouse) or newborn adopted child
- Adoption of a minor if required by the adoption process
- A death in the family; funeral attendance (maximum of five days); additional time may be granted by the supervisor/department head upon approval of a written request from the employee

When you must be absent, you must notify your immediate supervisor within the first hour of the normally scheduled work day (exceptions may be made in emergency situations). An absence due to an illness may require a physician's note or other verification as to your illness (unless waived by your supervisor).

For more information, or for extended use of sick leave, please see the section on Family Medical Leave (FML).

LEAVE OF ABSENCE WITHOUT PAY

If an employee must be gone from work for an extended period of time, the University may grant a leave of absence without pay. Up to a year of approved leave time may be granted. If necessary, the leave may be renewed for an additional year.

During the leave, annual or sick leave does not accrue. However, participation in health, life, and long-term disability programs may be continued if the employee pays the premium. The effect on PERS or TRS retirement service credit varies. Please contact your regional human resources office for more information on benefit continuation while on a leave of absence without pay.

The University may grant leaves of absence for a variety of reasons, and available benefits may vary with each set of circumstances. Your regional human resources office can explain how an extended leave of absence would affect your own position and University benefits. In general, application must be made to continue benefits.

OTHER LEAVES

Leaves of absence are granted for a variety of reasons, including medical, family, and military, as well as jury duty.

MEDICAL LEAVE

Medical leave may be granted in case of serious illness, accident, surgery, or other medical condition as certified by a physician. During a medical leave of absence, you will be required to use all paid leave that you have accrued before beginning leave without pay. This paid leave includes sick leave benefits and annual leave. After 90 days of medical disability, you may become eligible to receive long-term disability benefits.

FAMILY MEDICAL LEAVE (FML)

The University's benefit programs have two distinct types of sick leave absences: absences for minor illness, injuries, and professional appointments; *or* absences for health conditions that qualify under the University's Family and Medical Leave provisions. Family and Medical Leave (FML) will be granted in accordance with applicable state and federal law when an employee takes leave for one of the following reasons:

- the employee is unable to work because of a serious health condition
- the employee's or spouse's health is affected by pregnancy
- childbirth
- to care for a child (within the first 12 months following birth or placement through adoption or foster care)
- to care for a spouse or certain immediate family members with a serious health condition
- a qualifying exigency when a covered service member is called to active duty

Upon approval of the employee's request or need for FML, the employee will be granted FML for one or more of the following:

- up to 18 weeks (720 hours) in a "rolling" 24-month period for a serious health condition under state law, or
- up to 18 weeks (720 hours) in a "rolling" 12-month period for pregnancy or childbirth under state law, and
- up to 12 weeks (520 hours) in a "rolling" 12-month period for any qualifying reason under federal law,

The 12- and 24-month periods are calculated backward from the date of any FMLA leave usage. All FML taken, either paid or unpaid depending on the employee's available leave balances, will be counted towards the length of leave available under the University's FML Regulation (R04.06.160). Whenever possible, state and federal FML entitlements are counted concurrently. FML will not continue beyond the expiration of an employee's appointment.

In addition to the above reasons for leave, under the federal FMLA, eligible employees may also take up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness.

An employee must give 30 days' notice for scheduled or anticipated leave, such as scheduled surgery, childbirth or adoption. If 30 days' notice is not possible, the employee must give notice as soon as it is practicable to do so.

To be eligible for state FML, an employee must have been employed with the University of Alaska for at least 35 hours a week for at least six consecutive months, *or* for at least 17 1/2 hours a week for twelve consecutive months immediately preceding the leave. To be eligible for federal FML, an employee must have been employed with the University of Alaska for at least twelve months and have worked at least 1,250 hours during the 12-month period immediately preceding the commencement of the leave.

The employee will be asked to provide certification of the serious health condition from their health care provider. The employer may place an employee on FML when there is cause to believe a serious health condition exists.

If you anticipate the need for leave under FML, please contact your regional human resources office for more information and the necessary forms.

LEAVE SHARE PROGRAM

A leave share program has been established to allow employees to voluntarily transfer hours from their unused sick leave balance to the sick leave balance of an employee with a catastrophic medical crisis. To be eligible for leave share, an employee must be on approved FML for a serious health condition (their own or a family member), and have exhausted all paid leave and had 80 hours of leave without pay within a 28 day period while on FML. 40 hours of donated leave will be credited to the recipient when leave share is approved and donated hours are available. The leave share program is limited to a maximum of 520 hours in a 12-month period, and is prorated for part-time employees. Extended temporary employees are not eligible for leave share.

Procedures for request and use of the leave share program are available through your regional human resources office.

PARENTAL LEAVE

Parental leave is available to employees and will be granted in the order of sick leave with pay, accrued annual leave and sick leave without pay. All parental leave will be granted in accordance with the University's FML Regulations. Parental leave is not eligible for the leave share program. The use of intermittent FML for parental leave is subject to supervisory approval.

JURY DUTY

In order that University employees may fulfill their civic responsibility as jurors or subpoenaed witnesses, regular employees are granted leave of absence with pay for these purposes.

It is the responsibility of the employee to keep her/his supervisor or department head informed of the anticipated time to be spent away from the job for this purpose.

Any pay received by regular employees from a court system must be promptly submitted by the employee to the University to offset part of the cost of such absences. Temporary and extended temporary employees receive leave without pay and may retain the moneys from the court.

MILITARY LEAVE

A regular employee who is a member of a reserve component of the United States Armed Forces is entitled to a leave of absence with pay for all days during which the employee is required to serve in order to keep current their status with the National Guard or Reserve Forces. Such leaves of absence with pay may not exceed 16 and one-half working days in one calendar year. Other than for training periods discussed above, regular employees of the University are entitled to a military leave of absence without pay to serve in the Armed Forces of the United States and shall be entitled to statutory re-employment benefits provided for by federal law.

GLOSSARY OF TERMS

Accidental Injury—Physical harm caused by a sudden and unforeseen event at a specific time and place. It is independent of illness, except for infection of a cut or wound.

Affordable Care Act—The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Allowable Charge—Premera Blue Cross Blue Shield of Alaska reserves the right to determine the amount allowed for any given service or supply. The meaning of this term depends on the provider:

Providers in Alaska and Washington Who Have Agreements with Premera Blue Cross—The allowable charge is the fee that the provider has agreed to accept as full payment for medically necessary covered services and supplies. This fee is determined by agreements that Blue Cross has with the providers. Providers that have contracts with Blue Cross will seek payment from Blue Cross when they furnish covered services to you. You will be responsible only for any applicable deductibles, coinsurance, copayments, charges in excess of the stated benefit maximums, and charges for services and supplies not covered under this program.

Your liability for any applicable deductibles, coinsurance, copayments, and amounts applied toward benefit maximums will be calculated on the basis of the allowable charge.

Providers Outside Alaska and Washington Who Have Agreements with other Blue Cross Blue Shield Licensees—For covered services and supplies received outside Alaska and Washington, allowable charges are determined as stated in “The BlueCard Program” section of this handbook.

Providers Who Do Not Have Agreements with Premera Blue Cross or another Blue Cross Blue Shield Licensee—For services and supplies received within Alaska and Washington, the allowable charge is the least of the three amounts shown below. The allowable charge for providers outside Alaska or Washington that don’t have a contract with Premera or the local Blue Cross and/or Blue Shield Licensee is also the least of the three amounts shown below.

- An amount that is no less than the lowest amount paid for the same or similar service from a comparable provider that has a contracting agreement with Premera Blue Cross Blue Shield of Alaska;
- 200% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), if available, in Alaska and 125% of the Medicare allowed amount in Washington State or through the Blue Card program; or
- The provider’s billed charges. Ambulance providers that do not have agreements with Premera or another Blue Cross Blue Shield licensee are always paid based on billed charges.

If applicable law requires a different charge than the least of the three amounts shown above, this plan will comply with that law.

Remember, when you seek services from providers that do not have agreements with Blue Cross, your liability is for any amount above the allowable charge, and for any applicable deductibles, copayments, coinsurance, amounts in excess of stated benefit maximums, and charges for noncovered services and supplies. These amounts will be reflected on the Explanation of Benefits that Blue Cross sends to you.

Allowable Charge for Dialysis Due to End Stage Renal Disease

Providers Who Have Agreements with Premera Blue Cross or another Blue Cross Blue Shield Licensee—The allowable charge is the amount explained above in this definition.

Providers Who Do Not Have Agreements with Premera Blue Cross or another Blue Cross Blue Shield Licensee—The amount paid for dialysis during Medicare’s waiting period will be no less than 125% of Medicare approved amount (200% in Alaska) and no more than 90% of billed charges. The amount paid for dialysis after Medicare’s waiting period is the Medicare-approved amount, even with a member who is eligible for Medicare but does not enroll in Medicare.

After Medicare’s waiting period, the deductible and coinsurance, if any, for dialysis are waived for network and non-network providers.

- Network providers are paid according to their provider contracts.
- The amount the plan pays for non-network providers for dialysis after Medicare’s waiting period is 200% of the fee schedule determined by Medicare, if available, in Alaska and 125% of the fee schedule determined by Medicare for Washington State or through the Blue Card program; even if you do not enroll in Medicare. If the dialysis services are provided by a non-network provider and you do not enroll in Medicare, then you will owe the difference between the non-network provider’s billed charges and the plan’s payment for covered services. See the “Dialysis” benefit for more details.

Allowable Charge for Emergency Services—Consistent with the requirements of the Affordable Care Act, the allowable charge will be the greatest of the following amounts:

- The median amount that heritage network providers have agreed to accept for the same services
- The amount Medicare would allow for the same services
- The amount calculated by the same method the plan uses to determine payment to out-of-network providers

In addition to your deductible, copayments and coinsurance, you will be responsible for charges received from out-of-network providers that are above the allowed amount. When you receive services from providers that do not have agreements with Premera Blue Cross or the local Blue Cross and/or Blue Shield Licensee, your liability is for any amount above the allowed charge, and for your normal share of the allowable charge. If you have questions about this information, please call Premera customer service at (800) 364-2982.

Ambulatory Surgical Center—A facility that is certified or licensed as required by the state in which it operates and meets all of the following requirements:

- It has an organized staff of physicians.
- It has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures.
- It does not provide inpatient services or accommodations.

Complication of Pregnancy—A condition falling into one of the three categories listed below that requires covered, medically necessary services in addition to those services usually provided for antepartum care, normal or cesarean delivery, and postpartum care, in order to treat the condition:

- Diseases of the mother that are not caused by pregnancy but co-exist with and are adversely affected by pregnancy
- Maternal conditions caused by the pregnancy that make its treatment more difficult. These conditions are limited to the following:
 - Ectopic pregnancy
 - Hydatidiform mole/molar pregnancy
 - Incompetent cervix requiring treatment
 - Complications of administration of anesthesia or sedation during labor or delivery
 - Obstetrical trauma uterine rupture before onset or during labor
 - Antepartum or postpartum hemorrhage requiring medical/surgical treatment

- Placental conditions that require surgical intervention
 - Preterm labor and monitoring
 - Toxemia
 - Gestational diabetes
 - Hyperemesis gravidarum
 - Spontaneous miscarriage or missed abortion
- Fetal conditions requiring in utero surgical intervention

Congenital Anomaly—A marked difference, from the normal structure of a body part, that is physically evident at birth.

Coordination of Benefits—A group health program procedure designed to eliminate duplicate payments for the same service as a result of a claim being submitted to two different programs.

Convalescent Nursing Home—An institution that provides room, board, and skilled nursing care 24 hours a day or under the supervision of a registered professional nurse.

Cost Containment—Plan modifications that are aimed at holding down the cost of the health care program or reducing its rate of increase.

Cost Sharing—A plan modification whereby employees pay a portion of the cost of their health care program.

Custodial Care—Any portion of a service, procedure, or supply that, in the judgment of Blue Cross, is provided primarily for the following reasons:

- Ongoing maintenance of the enrollee’s health, and not for therapeutic value in the treatment of an illness or injury.
- To assist the enrollee in meeting the activities of daily living. Examples are help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication not requiring constant attention of trained medical personnel.

Dental Care Provider—A dentist or other dental care professional named in this plan that is licensed or certified as required by the state in which the services were received to provide a dental service or supply, and who does so within the lawful scope of that license or certification.

Dentally Necessary—Those covered services and supplies that a dentist, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of dental practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease
- Not primarily for the convenience of the patient, dentist or other dental care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease

For those purposes, “generally accepted standards of dental practice” means standards that are based on authoritative dental or scientific literature.

Decisions regarding dental necessity are based on the criteria stated above. If you disagree with a decision that has been made, you have the right to additional review. See the “When You Have An Appeal” section of this Handbook.

Detoxification—Detoxification is active medical management of medical conditions due to substance intoxication or substance withdrawal, which requires repeated physical examination appropriate to the substance, and use of medication. Observation alone is not active management.

Disability—Disability occurs when you are prevented from engaging in your customary occupation because of injury or disease, and are performing no work of any kind for pay or profit, or when any insured dependent is prevented, because of injury or disease, from engaging in substantially all of the normal activities of a person of like age and in good health.

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

Emergency Care—A medical screening examination to evaluate a medical emergency that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department. Further medical examination and treatment to stabilize the member to the extent the services are within the capabilities of the hospital staff and facilities, or, if necessary, to make an appropriate transfer to another medical facility. “Stabilize” means to provide such medical treatment of the medical emergency as may be necessary to assure, within reasonable probability that no material deterioration of the condition is likely to result from or occur during the transfer of the member from a medical facility.

Enrollee—A person who is covered under this program as an employee or dependent, as described in the “Eligibility” section of this handbook; also called “you” and “your” in this booklet (also see: Member).

Enrollment Date—For the employee and eligible dependents enrolling when first eligible, the enrollment date is the employee’s date of hire or the date they enter an eligible class, whichever is later. For a dependent who enrolls on a date other than when first eligible for coverage, the enrollment date is the effective date of coverage.

Expense Incurred—An expense is incurred on the date that the service is received or the supply is ordered.

Experimental/Investigational—Any service, including a treatment, procedure, equipment, drug, drug usage, medical device, or supply which, as determined by Premera Blue Cross Blue Shield of Alaska, meets one or more of the following criteria:

- A drug or device which cannot be lawfully marketed without the approval of the United States Food and Drug Administration, and has not been granted such approval on the date it is furnished.
- The service is subject to oversight by an Institutional Review Board.
- Reliable evidence does not demonstrate efficacy of the service, nor does it define a specific role for the service in clinical evaluation, management or treatment.
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy.
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

Reliable evidence includes, but is not limited to, reports and articles published in authoritative medical and scientific literature, and assessments and coverage recommendations published by the Blue Cross Blue Shield Association Technical Evaluation Center (TEC).

Explanation of Benefits (EOB)—A summary description of benefits received and paid under the health program.

Group—The entity that sponsors the self-funded health plan, in this case the University of Alaska.

Home Medical and Respiratory Equipment/Medical Supplies—Mechanical equipment that can stand repeated use and is used in connection with the direct treatment of an illness or accidental injury. It is of no use in the absence of illness or accidental injury.

Hospital—A facility legally operating as a hospital in the state in which it operates and that meets the following requirements:

- It has facilities for the inpatient diagnosis, treatment, and acute care of injured and ill persons by or under the supervision of a staff of physicians.
- It continuously provides 24-hour nursing services by or under the supervision of registered nurses.

In no event will a “hospital” be an institution that is run mainly as one of the following:

- A rest, nursing, or convalescent home; residential treatment center; or health resort
- To provide hospice care for terminally ill patients
- For care of the elderly
- For treatment of substance abuse or tuberculosis

Illness—A sickness, disease, medical condition, complication of pregnancy, or pregnancy.

Inpatient—Confined in a medical facility as an overnight bed patient.

Medical Emergency—A sudden onset of a medical condition or accidental injury manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention would reasonably be expected by a prudent person who possesses an average knowledge of health and medicine to result in one of the following:

- Place the enrollee’s life in serious jeopardy
- Serious impairment to bodily functions
- Serious and permanent dysfunction of any bodily organ or part

Medical Facility (also called **Facility**)—A hospital, skilled nursing facility, state-approved substance abuse treatment facility, or hospice.

Medically Necessary—Those covered services and supplies that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and
- Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Member—A person who is covered under this program as an employee or dependent, as described in the “Eligibility” section of this handbook; also called “you” and “your” in this booklet (also see: Enrollee).

Non-Occupational Injury/Disease—A non-occupational injury is an accidental bodily injury that does not arise out of (or in the course of) any work for pay or profit, nor in any way results from an injury that does.

A non-occupational disease is a disease that does not arise out of (or in the course of) any work for pay or profit, nor in any way results from a disease which does. However, if proof is furnished that the individual is covered under a

workers' compensation law or similar law, but is not covered for that particular disease under such a law, that disease will be considered non-occupational regardless of cause.

Oncology Clinical Trials— Treatment that is part of a scientific study of therapy or intervention in the treatment of cancer being conducted at the phase 2 or phase 3 level in a national clinical trial sponsored by the National Cancer Institute or institution of similar stature, or trials conducted by established research institutions funded or sanctioned by private or public sources of similar stature. All approvable trials must have Institutional Review Board (IRB) approval by a qualified IRB.

The clinical trial must also be to treat cancer that is either life-threatening or severely and chronically disabling, has a poor chance of a positive outcome using current treatment, and the treatment subject to the clinical trial has shown promise of being effective.

An “oncology clinical trial” does not include expenses for:

- costs for treatment that are not primarily for the care of the patient (such as lab services performed solely to collect data for the trial);
- any drug or device provided as part of a phase 1 oncology clinical trial;
- services, supplies or pharmaceuticals that would not be charged to the member, were there no coverage;
- services provided in a clinical trial that are fully funded by another source.

The member for whom benefits are requested must be enrolled in the trial at the time of treatment for which coverage is being requested. You, your provider, or the medical facility should ask Blue Cross for a benefit advisory to determine coverage **before** you enroll in the clinical trial.

Orthodontia—The branch of dentistry that specializes in the correction of tooth arrangement problems, including poor relationships between the upper and lower teeth (malocclusion).

Orthotics—A support or brace applied to an existing portion of the body for weak or ineffective joints or muscles, to aid, restore, or improve function.

Outpatient—Treatment received in a setting other than as an inpatient in a medical facility.

Participating Pharmacy (Participating Retail/Participating Mail Order Pharmacy)—A licensed pharmacy which contracts with Premera or the Pharmacy Benefits Administrator (Express Scripts), to provide prescription drugs as specified under the Pharmacy Program section.

Period of Convalescent Nursing Home Confinement—If you are re-admitted into a convalescent nursing home and less than 90 days has passed between confinements, it is considered one stay.

Periods of Hospital Confinement—If you are re-admitted into a hospital and there has not been at least 90 days between confinements, it is considered one stay.

Physician—A state-licensed Doctor of Medicine and Surgery (M.D.), Doctor of Osteopathy and Surgery (D.O.) or a Podiatrist (D.P.M.). Professional services provided by one of the following types of providers will also be considered to be physicians' services for the purposes of this program but only when the provider is licensed to practice where the care is provided, is providing a service within the scope of that license, is providing a service or supply for which benefits are specified in this program, and when benefits would be payable if the services were provided by a “Physician” as defined above:

- Advanced Registered Nurse Practitioner (A.R.N.P.)
- Certified Direct-Entry Midwife
- Chiropractor (D.C.)

- Christian Science Practitioner authorized by the Mother Church, the First Church of Christ, Scientist, in Boston, Massachusetts
- Dentist (D.D.S. or D.M.D.)
- Licensed Clinical Social Worker (L.C.S.W.)
- Licensed Marital and Family Therapist (L.M.F.T)
- Licensed Marriage and Family Counselor (L.M.F.C.)
- Licensed Massage Therapist (L.M.T.)
- Naturopath (N.D.)
- Nurse Midwife
- Occupational Therapist (O.T.)
- Optometrist (O.D.)
- Physical Therapist (P.T.)
- Physician Assistant supervised by a collaborating M.D. or D.O.
- Psychological Associate
- Psychologist

Physician Assistant—A professional who is trained to perform certain medical procedures and is employed under the supervision of a physician.

Plan (also called “This Plan”)—The self-funded health plan described in this Handbook.

Plan Year—The period of 12 consecutive months that starts each July 1 at 12:01 a.m. and ends on the next June 30 at midnight.

Premera Blue Cross Blue Shield of Alaska—Premera Blue Cross Blue Shield of Alaska in the State of Alaska, and Premera Blue Cross in Washington State.

Prescription Drug—Any medical substance, including biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication or for the treatment of people with HIV or AIDS, the label of which—under the Federal Food, Drug, and Cosmetic Act, as amended—is required to bear the legend: “Caution: Federal law prohibits dispensing without a prescription.”

Benefits available under this program will be provided for “off-label” use, including administration, of prescription drugs for treatment of a covered condition when use of the drug is recognized as effective for treatment of such condition by one of the following standard reference compendia:

- The American Hospital Formulary Service-Drug Information;
- The American Medical Association Drug Evaluation;
- The United States Pharmacopoeia-Drug Information; or
- Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services or the Insurance Commissioner.

If not recognized by one of the standard reference compendia cited above, then recognized by the majority of relevant, peer-reviewed medical literature (original manuscripts of scientific studies published in medical or scientific journals after critical review for scientific accuracy, validity, and reliability by independent unbiased experts), or the Federal Secretary of Health and Human Services.

“Off-label” use means the prescribed use of a drug which is other than that stated in its FDA-approved labeling.

Benefits are not available for any drug when the U.S. Food and Drug Administration (FDA) has determined its use

to be contraindicated, or for experimental or investigational drugs not otherwise approved for any indication by the FDA.

Program, This—The benefits, terms, and limitations set forth in the contract between Premera Blue Cross Blue Shield of Alaska and the University of Alaska.

Provider—A physician or other health care professional or facility named in this program that is licensed, registered, or certified to provide a medical service or supply as required by the state in which the services were received, and who does so within the lawful scope of that license, registration, or certification.

Psychiatric Condition—A condition listed in the current edition of “Diagnostic and Statistical Manual of Mental Disorders.”

Required Contributions—The rates for the benefits offered in this program.

Reasonable and Customary Charge—See Allowable Charge.

Service Area—The area in which Premera Blue Cross directly operates provider networks. This is made up of the state of Alaska and the state of Washington (except for Clark County).

Skilled Care—Care which is ordered by a physician and, in the judgment of Blue Cross, requires the medical knowledge and technical training of a licensed registered nurse.

Skilled Nursing Facility—A medical facility providing services that require the direction of a physician and nursing supervised by a registered nurse, and that is approved by Medicare or would qualify for Medicare approval if so requested.

Subscriber—An enrolled employee of the University of Alaska. Coverage under this plan is established in the subscriber’s name.

Substance Abuse—A condition characterized by a physiological and/or psychological dependence on alcohol or a state-regulated, controlled substance. It is further characterized by a frequent or intense pattern of pathological use, to the point that the user:

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

Substance abuse includes alcohol and drug psychoses, and alcohol and drug dependence syndromes.

Temporomandibular Joint (TMJ) Disorders—TMJ disorders shall include those disorders which have one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.

University—University of Alaska

APPENDIX

NOTICE OF PRIVACY PRACTICES FOR UNIVERSITY OF ALASKA HEALTH CARE PLAN PARTICIPANTS, THEIR COVERED SPOUSES AND DEPENDENTS

Effective Date: July 1, 2016

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

As used in this notice, the term “Plan” refers to the University of Alaska Health Care Plan, the term “University” refers to the University of Alaska, the term “Participant” refers to an individual who is or was a Participant in the Plan and thereby entitled to health benefits under the Plan and the term “Potential Participant” refers to an individual who may at sometime become a Participant but who is not yet a Participant. If you have any questions about this notice, please contact the Contact Person of the Plan. The Plan’s Contact Person can be reached as follows:

Keli Hite McGee, Chief Human Resources Officer
Statewide Office of Human Resources
University of Alaska
PO Box 755140
Fairbanks, AK 99775-5140
Phone (907) 450-8200
Fax: (907) 450-8201

Or

Erika Van Flein, Director of Benefits
Statewide Office of Human Resources
University of Alaska
PO Box 755140
Fairbanks, AK 99775-5140
Phone (907) 450-8226
Fax: (907) 450-8201

WHY WE ARE PROVIDING THIS NOTICE

The University of Alaska sponsors the Plan for the benefit of certain of its employees, certain of their family members and their designated domestic partners. As a necessary part of the operation and administration of the Plan, the University’s employees and entities such as claims administrators, COBRA vendors and case management companies (and their employees, agents and representatives) (the “Business Associates”) may have access to individually identifiable health information of Participants and Potential Participants which is protected under applicable federal law (such information is sometimes referred to as “PHI”). Federal law (i.e., the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)) requires that access to PHI be limited and that individuals and entities having access to PHI be restricted in their use and disclosure of PHI. The purpose of this notice is to provide you with information regarding your PHI privacy rights and certain special protections for genetic information.

WHO WILL FOLLOW THIS NOTICE

The privacy practices described in this notice will be followed by the Plan and its fiduciaries (i.e., the University of Alaska’s human resources staff), and the Plan’s Business Associates.

GENERAL RULES REGARDING HEALTH INFORMATION

Information about you and your health is personal. The Plan is committed to protecting health information about you which is obtained in connection with the operation and administration of the Plan. This notice will tell you about the ways in which the Plan may use and disclose health information about you to someone other than yourself (or your legal representative). It also describes your rights regarding and certain obligations the Plan has regarding the use and disclosure of health information.

The Plan is required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of the Plan's legal duties and privacy practices with respect to health information about you; and
- follow the terms of the Plan's privacy practices notice that is currently in effect.

HOW THE PLAN MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that the Plan uses and may disclose PHI. For each category of uses or disclosures this notice will explain what it means and, in some cases, try to give some examples. Not every use or disclosure in a category will be listed. In addition, many of the uses and disclosures may be performed on the Plan's behalf by Business Associates, the University and its employees or agents. However, all of the ways the Plan is permitted to use and disclose PHI will fall within one of the categories and in most cases the amount of health information used or disclosed will be limited to the minimum necessary amount (determined under a standard defined in HIPAA).

- **For Treatment.** The Plan may receive, use and disclose health information about you to provide you with or help you to obtain health treatment (i.e., providing, coordinating or managing your health care) or services. For example, the Plan may request and receive from a doctor who is treating you information about the health condition for which you are seeking treatment in order to determine if the treatment you are seeking (for instance, cosmetic surgery) is not covered by the Plan. As another example, the Plan may request a doctor who is recommending that you obtain treatment from a specialist for health information regarding your condition to determine if the specialist referral is for ordinary and necessary medical treatment that is covered by the Plan.
- **For Payment.** The Plan may receive, use and disclose health information about you so that the bills for health treatment and services you have received may be paid by the Plan. For example, the Plan may need to have information about a surgery which you have received provided to the Plan to determine if the charges for such surgery exceed the reasonable and customary charges for such surgery to determine what portion of such charges should be paid by the Plan. The Plan might also need to receive information about a health condition which you have in order to preauthorize a given health procedure for that condition where such approval is required in advance of your obtaining that procedure in order to qualify for any payment by the Plan for the procedure or for payment by the Plan at a more favorable reimbursement rate for the procedure. Similarly, the Plan may receive, use and disclose health information to fiduciaries of the Plan in order to provide them with information necessary to process an appeal that you file with respect to a claim for Plan benefits which has been modified or denied. Other payment activities of the Plan with respect to which the Plan may use and disclose health information about you include claims management, risk adjustment, reinsurance, collection and other "behind the scenes" Plan functions.
- **For Health Care Operations.** The Plan may receive, use and disclose health information about you for purposes of the Plan's operations such as underwriting (except as prohibited with respect to the use and disclosure of genetic information), premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, for legal or auditing functions or for general management and administrative activities. For instance, the Plan may request from any insurer currently funding or providing medical benefits under the Plan information relating to your and other Plan Participants' health procedures and treatments over a prior period in order to provide other insurers with information to make knowledgeable offers

to insure benefits under the Plan for future periods. Also, the Plan might use information about your Plan claims to review the effectiveness of wellness programs or cost containment measures.

- **Plan Sponsor Information Request.** The Plan may disclose to the University at its request summary health information (i.e., information that summarizes the claims history, claims expenses or type of claims experienced by Participants under the Plan) for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or modifying, amending or terminating the Plan. For example, the University may request summary health information about Plan Participants' claims over a given period to determine ways in which the Plan design may be changed in the future to reduce the costs of providing the Plan. The University can only be provided other health information regarding Plan Participants for use by persons identified in the Plan documents, such as the employees in the University's Benefits Department, and for the purpose or purposes described in the Plan document, such as specific plan administration activities, and only if the Plan documents restrict use and disclosure of such information by the University and establish adequate separation between the Plan and the University with respect to the use and disclosure of PHI. In addition, the Plan must provide that it will disclose PHI to the University only upon receipt of a certification from the University that the Plan documents have been amended to incorporate these restrictive provisions and that the Company agrees to comply with such restrictions. A summary of such restrictive provisions may also be obtained at any time, without charge, from the Plan's Contact Person.
- **Disclosure to You.** The Plan may disclose your medical information to you.
- **Individuals Involved in Your Care or Payment for Your Care.** Unless you advise the Plan otherwise by completing a Disclosure Objection Form and returning a copy of such completed form to the Plan's Contact Person, the Plan will be entitled to disclose protected health information that is relevant to your health care treatment under the Plan or payment for such treatment as follows: if you are married, to your spouse; if you have a financially interdependent partner (FIP) which you have designated as such under the University's financially interdependent partner benefit policy, to your FIP; and if you are covered by the Plan as a child (regardless of whether you have obtained the age of legal majority), to either of your parents (which may include a stepparent). The Plan will have the right to make such disclosures for as long as you are covered by the Plan (including coverage following reenrollment should you for any reason discontinue your Plan coverage and thereafter reenroll in the Plan) or have claims pending with the Plan following the termination of your coverage. However, you may file a Disclosure Objection Form at any time if you want the Plan to cease making family member or FIP disclosures as described above. Your Disclosure Objection Form should be returned to the Plan's Contact Person at the address noted on the first page of this notice.
- **Disclosures to Business Associates.** The Plan may disclose your medical information to a Business Associate and the Business Associate will be required to appropriately safeguard your medical information and use or disclose it only for permitted purposes.
- **To Notify of a Data Breach.** In the unlikely event that there is an unauthorized acquisition, access, use, or disclosure of your medical information that compromises the security or privacy of this information, the Plan is generally required to provide you written notice concerning this data breach no later than 60 days from the date the breach was discovered. For this purpose, security or privacy is generally considered compromised when the unauthorized acquisition, access, use, or disclosure of the medical information poses a significant risk of financial, reputational or other harm to you.
- **Marketing.** The Plan may use or disclose your medical information for purposes of marketing products or services if the particular marketing activity either occurs face-to-face with you or involves giving you an inexpensive item that promotes the Plan.
- **Limited Data Set.** The Plan may use or disclose your medical information for purposes of health care operations, research, or public health activities if the information is stripped of direct identifiers and the recipient agrees to keep the information confidential.
- **Pursuant to Your Authorization.** Other uses and disclosures of health information not covered by this notice or the laws that apply to the Plan will be made only with your written permission. If you provide the Plan permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, the Plan will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that the Plan is unable to take back any disclosures already made with your permission, and that the Plan is required to retain its records regarding your protected health information which the Plan has obtained.

- **As Required By Law.** The Plan may disclose PHI about a Participant when required to do so by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety.** The Plan may use and disclose PHI about a Participant when necessary to prevent a serious health and safety threat.
- **Specialized Governmental Functions.** The Plan may disclose PHI about a Participant as required by military command authorities (including appropriate foreign military authority in the case of foreign military personnel). The Plan may also release PHI about a Participant in connection with: national security and intelligence activities and protective services for governmental officials.
- **Workers' Compensation.** The Plan may disclose PHI about a Participant for workers' compensation or similar programs.
- **Lawsuits and Disputes.** Subject to a number of protective requirements and restrictions, the Plan may disclose PHI about a Participant in response to (i) a court or administrative order and (ii) a subpoena, discovery request, or other lawful process by someone else involved in the dispute.
- **Law Enforcement.** The Plan may disclose PHI about a Participant if asked to do so by a law enforcement official for law enforcement purposes or in response to certain court orders or in the course of judicial or administrative proceedings.
- **Inmates.** If a Participant is an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may disclose PHI about the Participant to the correctional institution or law enforcement officials to: provide the Participant with health care; protect the Participant's health and safety or the health and safety of others; or protect the safety and security of the correctional institution.
- **Public Health Activities.** The Plan may disclose PHI about a Participant to persons who may be at risk of contacting or spreading a disease or condition, to public health authorities to prevent or control disease or to report child abuse or neglect and to the Federal Food and Drug Administration with respect to adverse events or product defects.
- **Victims of Abuse, Neglect or Domestic Violence.** The Plan may disclose PHI about a Participant to governmental authorities authorized by law to receive reports of abuse, neglect or domestic violence as required by law or if the Participant agrees or the Plan believes the disclosure is necessary to prevent serious harm.
- **Decedents.** The Plan may disclose PHI about a Participant to a coroner or medical examiner to identify a deceased or determine the cause of death and to funeral directors to carry out their duties.
- **Organ, Eye or Tissue Donations.** The Plan may disclose PHI about a Participant to organ procurement organizations or other entities to facilitate organ, eye or tissue donations and transplantations.
- **Research Purposes.** The Plan may disclose PHI about a Participant subject to special rules and restrictions under HIPAA to facilitate medical research.
- **Health Oversight Activities.** The Plan may disclose PHI about a Participant for activities authorized by law for oversight of the health care system, government benefit programs and compliance with regulatory programs or civil rights laws.
- **Department of Health and Human Services.** The Plan may disclose PHI about a Participant to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rules.
- **Incidental Uses and Disclosures.** Uses and disclosures that occur incidentally with a use or disclosure described above in this notice may occur, as long as the Plan has implemented and followed reasonable safeguards to limit such uses and disclosures.

Special Protections For Genetic Information. In accordance with the Genetic Information Nondiscrimination Act of 2008, the Plan is not permitted to use or disclose your genetic information for underwriting purposes, which generally includes (1) determining your eligibility for benefits under the Plan, (2) computing the premium amounts for Plan coverage, (3) applying any pre-existing condition exclusion under the Plan, and (4) other activities related to the creation, renewal, or replacement of health benefits. In general, and subject to certain exceptions, your genetic information includes genetic tests of you and your family members (up to the fourth degree of kinship), family medical histories, and genetic counseling and education.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information the Plan has about you:

- **Right to Inspect and Copy.** You have the right to inspect and obtain a copy of all health information that the Plan has about you. Usually, this includes health and billing records, but according to the HIPAA privacy rules does not include psychotherapy notes. To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to the Plan's Contact Person. If you request a copy of the information, the Plan may charge a fee for the costs of copying, mailing or other supplies associated with your request. The Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may file a complaint with the Plan's Contact Person or the Secretary of Health and Human Services.

If the Plan maintains an electronic health record containing your medical information, you have the right to request that a copy of this medical information be sent in an electronic format to you or to a clearly designated third party. An "electronic health record" is an electronic record of health-related information that is created, gathered, managed, and consulted by authorized health care clinicians and staff. The Plan may charge a reasonable fee for sending the electronic copy of your medical information.

- **Right to Amend.** If you feel that health information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Plan's Contact Person. In addition, you must provide a reason that supports your request. The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask the Plan to amend information that: was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment; is not part of the health information kept by or for the Plan; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures made by the Plan of health information about you for reasons other than treatment, payment or health care operations or pursuant to your authorization. To request this list or accounting of disclosures, you must submit your request in writing to the Plan's Contact Person. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12 month period will be free. For additional lists, the Plan may charge you for the costs of providing the list. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the health information the Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. If the Plan agrees, it will comply with your request unless the information is needed to provide you emergency treatment or required by law until you or the Plan cancels the limitation. To request restrictions, you must make your request in writing to the Plan's Contact Person. In your request, you must tell the Plan (1) what information you want to limit; (2) whether you want to limit its use, disclosure or both; and (3) to whom you want the limits to apply.

The Plan is generally not required to agree to your request for restrictions. However, except as otherwise required by law, a covered entity (such as the Plan or a health care provider) must agree to certain requested restrictions if the disclosure is to a health plan for purposes of carrying out payment or health care operations (and not for purposes of carrying out treatment) and relates solely to a health care item or service for which the health care provider has been paid out of pocket in full. For example, this means that a doctor or other health care provider generally must agree to your request to not send medical information to the Plan in certain circumstances if the medical information concerns an item or service for which you have paid the provider out of pocket in full.

- **Right to Request Confidential Communications.** You have the right to request that the Plan communicate with

you about health matters in a certain way or at a certain location. For example, you can ask that the Plan only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Plan's Contact Person. The Plan will not ask you the reason for your request. The Plan will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Copy of This Notice.** You may ask us to give you a copy of this notice at any time. If you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain an electronic copy of this notice at the following website: www.alaska.edu/benefits/.

CHANGES TO THIS NOTICE

The Plan reserves the right to change this notice. The Plan reserves the right to make the revised or changed notice effective for health information the Plan already has about you as well as any information it receives in the future. The Plan will post a copy of the current notice in the University's Benefits Office and at the Benefits Web site set forth in the above paragraph. The effective date of the notice will be written on the notice's first page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Plan's Contact Person or with the Secretary of the Department of Health and Human Services. A complaint filed with the Plan's Contact Person must be submitted in writing and must comply with the Plan's privacy rights complaint procedures. A copy of such procedures can be obtained from the Plan's Contact Person without charge upon written request.

You will not be penalized for filing a complaint.

You may contact Department of Health and Human Services by telephone at 1-800-368-1019, by electronic mail at ocrprivacy@hhs.gov, or by regular mail addressed to:

Director, Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

HEALTH PROVIDERS AND YOUR HEALTH INFORMATION

Health providers (such as doctors, medical clinics, hospitals, etc.) may also use and disclose health information about you. You also have rights regarding the health information which they obtain and have about you. You should consult the notices of privacy practices which you receive from health care providers for information regarding how and under what circumstances they may use and release your health information and what rights you have with respect to their practices regarding your health information.

MISCELLANEOUS

The Plan may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you, subject to limits imposed by law.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 was signed into law on October 21, 1998. The Act requires that all group health plans providing medical and surgical benefits with respect to a mastectomy must provide coverage for all of the following:

- Reconstruction of the breast on which a mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Protheseses
- Treatment of physical complications of all stages of mastectomy, including lymphedema

This coverage will be provided in consultation with the attending physician and the patient. These reconstructive benefits are subject to the same annual deductible and coinsurance provisions as other plan medical and surgical benefits (see Mastectomy and Breast Reconstruction Services under Covered Services and Supplies).

HIPAA SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

- Loss of eligibility includes but is not limited to:
- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Reaching the plan's lifetime benefit maximum on all benefits, if the person is covered under a separate plan or a single plan with multiple options and the other option has a higher lifetime maximum, or the benefits paid under the first option were not integrated with the second option;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or Alaska's Denali KidCare, or other state's Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or Denali KidCare (or other CHIP), you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or Denali KidCare (or other CHIP). Similarly, if you or your dependent(s) become eligible for Denali KidCare or another state's premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or Denali KidCare (or other CHIP) determine that you or the dependent(s) qualify.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact your regional human resources office.

NOTICE OF NONDISCRIMINATION

Board of Regents Policy and University Regulation 01.02.025

The University of Alaska does not discriminate on the basis of race, religion, color, national origin, citizenship, age, sex, physical or mental disability, status as a protected veteran, marital status, changes in marital status, pregnancy, childbirth or related medical conditions, parenthood, sexual orientation, gender identity, political affiliation or belief, genetic information, or other legally protected status.

When implementing this commitment, the University is guided by Title VI and VII of the Civil Rights Act of 1964 and Civil Rights Act of 1991; Title IX of the Education Amendments of 1972; Executive Order 11246, and Executive Order 11375, as amended; Equal Pay Act of 1963; Age Discrimination in Employment Act of 1967 and Age Discrimination Act of 1975; Vietnam Era Veterans Readjustment Assistance Act of 1974; Americans with Disabilities Act (ADA) of 1990; the Americans with Disabilities Act Amendments Act of 2008; Genetic Information Nondiscrimination Act of 2008; Pregnancy Discrimination Act; Immigration Reform & Control Act; Vocational Rehabilitation Act of 1973 and other federal laws or Alaska Statutes which guarantee equal opportunity to individuals and protected classes within our society.

The University's commitment to nondiscrimination, including against sex discrimination, applies to students, employees, and applicants for admission and employment.

This policy therefore affects employment policies and actions, as well as the delivery of educational services at all levels and facilities of the University. Further, the University's objective of ensuring equal opportunity will be met by taking affirmative action: i.e., making intensified, goal-oriented efforts to substantially increase the participation of groups where their representation is less than proportionate to their availability; providing reasonable accommodations to employees and students with disabilities; and ensuring that employment opportunities are widely disseminated to agencies and organizations that serve underrepresented protected classes.

The following person has been designated to handle inquiries regarding the nondiscrimination policies:

University of Alaska Anchorage
Director, Office of Equity and Compliance
3890 University Lake Dr, Ste 108
Anchorage, AK 99508
Phone: 907-786-4680
E-mail: uaa_titleix@uaa.alaska.edu
Website: <https://www.uaa.alaska.edu/about/equity-and-compliance/>

University of Alaska Fairbanks
Director of Diversity and Equal Opportunity
739 Columbia Circle
PO Box 756910
Fairbanks, AK 99775-6910
Phone: 907-474-7300
E-mail: uaf-deo@alaska.edu
Website: <http://www.uaf.edu/oeo/>

University of Alaska Southeast
Director of Human Resources
11066 Auke Lake Way
Juneau, Alaska 99801
Phone: 907-796-6473
E-mail: gcheney@alaska.edu
Website: <http://uas.alaska.edu/hr>

For sex discrimination claims or other inquiries concerning the application of Title IX of the Education Amendments of 1972 and its implementing regulations, individuals may contact the University's Title IX Coordinator or the Assistant Secretary in the U.S. Department of Education Office of Civil Rights:

UAA Title IX Coordinator
3890 University Lake Drive, Suite 108, Anchorage, AK 99508
Phone: 907-786-4680
E-Mail: uaa_titleix@uaa.alaska.edu
Website: www.uaa.alaska.edu/about/equity-and-compliance/

UAF Title IX Coordinator
739 Columbia Cr., Fairbanks, AK 99775
Phone: 907-474-7300
E-Mail: uaf-tix@alaska.edu
<http://www.uaf.edu/titleix/>

UAS Title IX Coordinator
11066 Auke Lake Way, Juneau, AK 99801
Phone: 907-796-6036
E-Mail: uas_jytitle9@alaska.edu
<http://www.uas.alaska.edu/policies/titleix.html>

Office for Civil Rights, Seattle Office
U.S. Department of Education
915 Second Ave., Room 3310
Seattle, WA 98174-1099
Phone: 206-607-1600
TDD: 800-877-8339
E-mail: OCR.Seattle@ed.gov
Website: <http://www2.ed.gov/about/offices/list/ocr/docs/howto.html>

For employment or educational discrimination, students, parents, employees and applicants for employment may file a complaint with the U.S. Department of Education within 180 calendar days of the alleged discriminatory act.

Office for Civil Rights, Seattle Office

U.S. Department of Education

915 Second Ave., Room 3310

Seattle, WA 98174-1099

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TDD: 800-877-8339

E-mail: OCR.Seattle@ed.gov

Website: <http://www2.ed.gov/about/offices/list/ocr/docs/howto.html>

For employment discrimination, employees and applicants for employment may file a complaint with the Equal Employment Opportunity Commission at the below addresses within 180 calendar days of the alleged discriminatory act.

Equal Employment Opportunity Commission

Federal Office Building

909 First Avenue

Suite 400

Seattle, WA 98104-1061

Phone: 800-669-4000

Fax: 206-220-6911

TTY: 800-669-6820

Website: <http://www.eeoc.gov/employees/charge.cfm>

For educational discrimination, individuals may file a complaint with the U. S. Department of Justice

U.S. Department of Justice Civil Rights Division

950 Pennsylvania Avenue, N.W.

Educational Opportunities Section, PHB

Washington, D.C. 20530

Phone: 202-514-4092 or 1-877-292-3804 (toll-free)

Fax: 202-514-8337

E-mail: education@usdoj.gov

Website: <http://www.justice.gov/crt/how-file-complaint#three>

For employment or educational discrimination, individuals may file a complaint with the State of Alaska:

Alaska State Human Rights Commission

800 A Street, Suite 204

Anchorage, AK 99501-3669

Anchorage Area: 907-274-4692

Anchorage Area TTY/TDD: 907-276-3177

Toll-Free Complaint Hot Line (in-state only): 800-478-4692

TTY/TDD Toll-Free Complaint Hot Line (in-state only): 800-478-3177

Website: www.humanrights.alaska.gov

For discrimination related to a Department of Labor funded grant, individuals may file a complaint with the U. S. Department of Labor within 180 calendar days of the alleged discriminatory act.

U.S. Department of Labor
ATTENTION: Office of External Enforcement
Director, Civil Rights Center
200 Constitution Avenue, NW
Room N-4123
Washington, DC 20210
Fax: 202-693-6505, ATTENTION: Office of External Enforcement (limit of 15 pages)
E-mail: CRCEXternalComplaints@dol.gov
Website: <http://www.dol.gov/oasam/programs/crc/index.htm>

For discrimination related to a National Science Foundation funded grant, individuals may file a complaint with the National Science Foundation within 180 calendar days of the alleged discriminatory act.

National Science Foundation
Complaints Adjudication & Compliance Manager
Office of Diversity & Inclusion (ODI)
4201 Wilson Blvd., Rm. 255
Arlington, VA 22230
Phone: 703-292-8020
E-mail: tsisley@nsf.gov
Website: <http://www.nsf.gov/od/odi/>

IMPORTANT NUMBERS TO KNOW...

Blue Cross Blue Shield of Alaska (medical, dental, pharmacy).....	(800) 364-2982
24-Hour NurseLine	(800) 841-8343
Teladoc (Virtual Care).....	(855) 332-4059
Travel for Elective Procedures.....	(800) 364-2994
DirectPath (advocacy and price transparency)	(866) 253-2273
COBRA (BenefitHelp Solutions).....	(800) 556-3137
Employee Assistance Program (Deer Oaks EAP)	(888) 993-7650
Securian (Life and AD&D Insurance) Claims Questions	(888) 658-0193
Evidence of Insurability Questions.....	(800) 872-2214
ASIFlex (Medical/Child Care Flexible Spending Accounts).....	(800) 659-3035
ASIFlex Claims submission via fax (toll free)	(877) 879-9038
Reliastar/Voya (Long Term Disability).....	(888) 305-0602

Pension/ORP Fund Sponsors

Fidelity	(800) 343-0860
Lincoln National	(800) 348-1212
toll free in Alaska.....	(800) 478-6393
in Anchorage	561-3187
in Fairbanks.....	452-6393
TIAA	(800) 842-2776
AIG VALIC.....	(800) 448-2542
in Anchorage	279-8302
in Fairbanks.....	458-0101

Division of Retirement and Benefits (PERS and TRS)

Toll Free	(800) 821-2251
in Anchorage	269-0333
in Juneau	465-4460

University Human Resource Offices

Anchorage	786-4608
Fairbanks.....	474-7700
Juneau	796-6473
Statewide.....	450-8200

The University of Alaska is an AA/EEO employer and does not discriminate on the basis of sex, race, national origin, or religious preference.