At Meritain Health, we know how important it is for you to understand how your benefits work.

That's why this packet contains:

- Useful information about your benefits plan.
- Everything you need to choose the best options for you and your family.
- Instructions on how to enroll, and to begin using your new benefits.

Why do we feel this is important? Because, let's face it, living today can be larger than life. Getting through the day at top speed is a sign of our hurry-up, drive-through times. Many people put themselves at the bottom of their to-do lists, giving everything else the best of their energy.

In this way, life gets out of balance. Most of us can keep juggling it all until one day health and well-being begin to pay the price.

Take a deep breath, step back and see the big picture. Help yourself. Put that life on pause for a few minutes, and take the time to read this packet. You'll see that your employer provides tools, resources and benefits to help you regain your best life and make smart healthcare decisions.

We want to help you get the most from your benefits—so you can live a life that's balanced and informed.

**A balanced life means a healthier you.**

These materials were created to help you understand the benefits available to you. This is not a Summary Plan Description and is not intended to replace the benefit summary or schedule of benefits contained within the Plan. If any provision of these materials is inconsistent with the language of the Plan, the language of the Plan will govern. Meritain Health is not an insurer or guarantor of benefits under the Plan.
In this packet, you’ll learn more about the following

Preventive care
- Annual exams and check-ups
- Well-child care
- Immunizations and screenings

Healthcare benefits when you’re sick
- Inpatient and outpatient care
- Home healthcare
- Rehabilitation services
- Doctor visits and prescription drugs with reasonable copays
- Mail order and online prescription options
- A large and convenient provider network
- Dental care
- Vision care

Support when you need it
- Get the medical advice you need, when you need it with Teladoc™.
- www.meritain.com—access easy-to-use decision support tools that help you weigh your care options, and provide cost and quality information.

Other benefits to help restore and protect peace of mind
- Flexible Spending Account (FSA)—a tax-effective, money saving option for eligible healthcare and dependent care expenses.
How healthcare reform affects your plan

In March 2010, President Obama signed the Affordable Care Act, or ACA, into law. The ACA, also known as healthcare reform, includes certain consumer protections that apply to your health plan, for example, the requirement for the provision of preventive health services without any cost sharing. Be sure to review the important information about the ACA that is included throughout this kit.

Questions regarding how healthcare reform affects your plan can be directed to Meritain Health at 1.866.808.2609. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Important things to know about eligibility

Health plans are put together carefully to provide the best benefits possible for participants. Meritain Health knows how important it is for healthcare consumers like you to really understand how your plan works. In this way, you can make the changes you want in your health and in your life. The next section of this packet describes some of the most important provisions of your benefits. It’s another way we’re working with you to help you get the most from your benefits—so you can live a life that’s balanced and informed, with no surprises.

Healthy balance for your family, too

Your family members can reap the rewards of the plan, too. Healthcare benefits are available for every eligible dependent. It’s a great way to help your family members find the right balance between life’s "roller-coaster ride" and their best health. Be sure your family knows about the opportunities open to them—share this packet and other materials you receive from the plan!
Your eligible dependents

This benefit plan is open to you and your eligible dependents. An eligible dependent is:

- Your spouse (as defined in your plan documents).
- Your children, natural or adopted.
- Stepchildren.
- Children who have been placed with you for adoption.
- Children for whom you are the legal guardian.

ACA note: Dependent coverage is available for any child (regardless of marital status, residency, student status, etc.) of an employee who is deemed to be the employee’s biological, step, or adopted child (including a child placed for adoption) until such child reaches age 26.

Please refer to your summary plan description for specific requirements.

Family members covered by a different plan

If you have a family member covered by a different plan:

- You can enroll yourself and your eligible dependents in this plan.
- You can enroll yourself in this plan, but decline benefits for some or all dependent(s).
- You can decline benefits for your whole family.

When your dependents are not eligible for benefits under your plan

Tell your employer if:

- You become divorced or are legally separated from a spouse who was covered under this plan.
- A dependent child ceases to meet the terms of the plan.

To enroll the dependent for COBRA—a special limited-time plan for continuing benefits at your own expense—you must notify your employer within 60 days of that person’s change in dependent status.

When you have benefits from two group plans

If you or one of your dependents have benefits under both this plan and another plan, the two plans will coordinate your benefits. One plan will be considered the primary plan (or first payer) and the other will be the secondary plan (pays only after the first plan has paid).

Generally, Meritain Health uses a birthday rule to decide which of the two plans would be the primary plan.

The birthday rule

If both parents provide benefits for a child, then the primary plan is the one from the parent whose birthday comes first in the year.

So, if one parent’s birthday is January 12 and the other parent’s is April 1, the primary payer will be the plan from the parent whose birthday comes first—January 12. In the unusual case that both parents have the same birthday, the plan of the parent who has provided benefits longest for the child will be primary.

If you say “no” to this plan now

You can refuse the benefits of this plan, but be sure you’ve looked at the pluses and minuses of that decision.

If you lose other group benefits that you or your dependents might have, and it’s not your fault (for example, the covered person is laid off or let go from a job) you’ll be able to sign up for this plan. Likewise, if you have an event such as your own marriage, divorce, or the birth or adoption of a child, you will have another brief period to sign up for this plan. These are considered qualifying events.

Special enrollment situations

In these situations, you may be able to add, delete or change your benefit choices.

- Involuntary loss of other benefits
- Marriage
- Birth
- Adoption
- Placement of a child in your home for adoption

If you’re adding a dependent to your benefits through a special enrollment situation, let your employer know within 60 days of the marriage, birth, adoption, etc.; however, this can vary by group.
Understanding your medical benefits

Chances are, you try every day to restore a healthy balance to your life, but time gets away from you, or other details come first. Meritain Health is here to help you focus, to support you every step of the way. Read about your benefits in the next sections, and learn all you can about using your plan to make healthy changes. Think of the benefits and programs as an important resource in the protection of your body, mind and spirit!

In this section
- Preventive care
- Online tools with Meritain Connect
- Using your benefits
- Teladoc
- Medical management and precertification
- Dental care
- Vision care
- Prescription benefits
- BridgeHealth

Preventive care for you and your family—protecting your healthy balance

Question: Which is better: Taking an hour or two out of your busy day to have your annual checkup—or missing hidden symptoms and paying the price in sick days, copays and missed events?

Answer: Nothing makes more sense in these busy times than preventing illness before it happens. That’s why your plan offers excellent benefits for preventive services.

Preventive care at-a-glance

Yukon and Borealis Plans

Preventive services and routine care (includes office visit and any other related item or service)
- Routine care (age 19 and over)
- Well-child and baby care (up to age 19)
- Routine immunizations
- Routine pelvic exam & lab work (age 16+)
- Routine prostate exam & lab work (age 40+)
- Routine mammogram (age 40+)
- Routine colorectal screening (age 50+)

100%; Deductible waived

100% of the first $500* per calendar year (deductible waived), then 80% after deductible
100% of the first $500* per calendar year (deductible waived), then 80% after deductible
100% of the first $500* per calendar year (deductible waived), then 80% after deductible
100%; Deductible waived, 1 exam per calendar year
100%; Deductible waived, 1 exam per calendar year
100%; Deductible waived, 1 exam per calendar year

*This $500 is a combined maximum between all providers for all routine care services listed above. One exam per year. Meritain Health
Medical benefits at-a-glance – Yukon Plan

### Participating providers

- **Calendar year deductible**
  - Per individual: $500
  - Per family: $1,000

- **Total calendar year medical and Rx out-of-pocket maximum (includes ded., copays and coinsurance)**
  - Per individual: $4,000
  - Per family: $11,500

### Non-participating providers – Alaska (subject to Usual and Customary Charges)

- **Calendar year deductible**
  - Per individual: $500
  - Per family: $1,000

- **Total calendar year medical and Rx out-of-pocket maximum (includes ded., copays and coinsurance)**
  - Per individual: Unlimited
  - Per family: Unlimited

### Non-participating providers – Outside Alaska (subject to Usual and Customary Charges)

- **Calendar year deductible**
  - Per individual: $500
  - Per family: $1,000

- **Total calendar year medical and Rx out-of-pocket maximum (includes ded., copays and coinsurance)**
  - Per individual: Unlimited
  - Per family: Unlimited

Borealis Plan

### Participating providers

- **Calendar year deductible**
  - Per individual: $2,000
  - Per family: $4,000

- **Total calendar year medical and Rx out-of-pocket maximum (includes ded., copays and coinsurance)**
  - Per individual: $6,500
  - Per family: $14,000

### Non-participating providers – Alaska (subject to Usual and Customary Charges)

- **Calendar year deductible**
  - Per individual: $2,000
  - Per family: $4,000

- **Total calendar year medical and Rx out-of-pocket maximum (includes ded., copays and coinsurance)**
  - Per individual: Unlimited
  - Per family: Unlimited

### Non-participating providers – Outside Alaska (subject to Usual and Customary Charges)

- **Calendar year deductible**
  - Per individual: $2,000
  - Per family: $4,000

- **Total calendar year medical and Rx out-of-pocket maximum (includes ded., copays and coinsurance)**
  - Per individual: Unlimited
  - Per family: Unlimited

Healthcare for you and your family

When sickness or injury throw you off balance

Knowing that you’re in good hands when you’re sick is one of the most comforting feelings there is. You can be assured that your health plan has everything you’ll need to get the right care when something goes wrong.

**Remember this:** Meritain Health is only a phone call away. If you have questions about your provider network, benefits, deductibles or claims, just give us a call.

### Balancing healthcare costs—what you pay and what the plan pays

The **Summary of Benefits** in the appendix of this packet shows how much you pay for care, and how much the plan pays. It’s a listing of what is and isn’t included in your benefits plan. For more detailed information, see your summary plan description.

After you pay your annual deductible and any up-front copays, the plan begins to pay a percentage of your provider’s charges, for example 80 percent. The remaining percentage, for example 20 percent, is your responsibility—your out-of-pocket costs. You’re protected from financial hardship by a maximum out-of-pocket amount each year—the most you’ll have to pay before the plan covers costs at 100 percent.

#### About your deductible

The deductible does not apply to everything your plan covers. Be sure to spend some time reviewing the Summary of Benefits in the appendix of this packet for more details.
24-hour access to online tools with Meritain Connect

Your Meritain Health member website at www.meritain.com is designed to provide a secure, user and family-friendly, one-stop-shop for you to access the account and claims information you can use to manage your health and wellness.

We’re committed to providing you with all the basics you expect, along with added features to support a healthy lifestyle, assist you with medical decisions, and give insight into the maximization of your healthcare dollars.

Your online tools and resources

With Meritain Connect you can:
- Look up health and wellness topics.
- Keep track of your FSA.
- Find the status of a claim.
- Find in-network doctors, clinics and hospitals.
- Look up prescription and over-the-counter drug information.
- Order ID Cards.

Your secure member site

First, visit www.meritain.com. Return users, just sign in using your username and password. Then take advantage of the smart, safe resources your health plan offers, right at your fingertips.

New users can create an account by following the easy instructions. You’ll need your health plan ID Card the first time. Remember, each member of your family can have an account, too.

If you need help registering for Meritain Connect, you can contact Meritain Health Customer Service at 1.866.808.2609.

Privacy regulations

Members over 18 years of age have partially protected information according to HIPAA Privacy Regulations. To access their information, they will need to register for their own Meritain Connect account. Financial information can be viewed for all dependents, regardless of age.

Members over 18 having difficulty creating an account with their SSN, please contact Meritain Health Customer Service at: 1.866.808.2609.

ACA note

Beginning the first day of the new plan year following October 1, 2010, a lifetime or annual dollar limitation will no longer be imposed for:
- Emergency services and hospitalizations
- Prescription drugs
- Maternity, newborn and pediatric care (including oral/vision care)
- Preventive and wellness services and chronic disease management
- Laboratory services
- Rehabilitative services
Using your medical benefits

Save when you see network providers
Your plan offers a provider network of doctors and other healthcare professionals who have agreed to accept lower amounts than their standard charges, just for members of this plan. These lower amounts are negotiated and predetermined. That means when you see a network provider, your share of costs is based on a lower charge—so your costs are lower, too. Network providers are conveniently located in both urban and rural areas. Lower costs and convenient doctors and clinics are important ways that Meritain Health can support your efforts to stay well and have a healthy lifestyle—or to get care as simply as possible when you’re sick.

Remember: If you go outside the network, you may still have benefits, but your share of costs will be higher, and the amount you pay will not be based on a lower rate.

Helpful tip
You can realize savings while on the road to meeting your annual deductible when you visit doctors and facilities within your provider network.

No referrals
You don’t have to choose a primary care doctor to direct all of your care or to provide referrals to specialists, but Meritain Health recommends that you build a relationship with a “home base” doctor—one who has all of your records and health history. For best benefits, see specialists that are in the network (called in-network or participating providers). Remember, if you see providers outside the network, you’ll share more of the cost.

When it’s an emergency
If you can’t see a network provider in an emergency, don’t worry! Your plan will cover out-of-network emergency charges at the in-network level. For more information, refer to your summary plan description.

Helpful tip
It’s important to know what is covered under your health plan. This can help you to plan for the cost of your healthcare expenditures. For more information, refer to your summary plan description.

Re-claiming your time
With some health plans, paperwork can put you over the edge. Time-consuming and complicated, claim forms rob you of precious time and the balance you seek. That’s why Meritain Health network providers file your claims for you. Pay your copay (if applicable), and you’re on your way!
Support for your health journey

Your employer wants you to get the best, most appropriate care, when and where you need it. That’s why your plan includes the extra expertise of Medical Rehabilitation Consultants (MRC). The medical management nurses are like personal health consultants who can help you make decisions about certain types of care you and your doctor may be considering. Registered nurses review treatment plans, then help to assure that you get the right treatment in the right setting, when you need it.

Before you get care, call Medical Rehabilitation Consultants

To keep your benefits at the highest level, be sure to call Medical Rehabilitation Consultants before any of these situations:

- **Hospital Admissions.** Notify Medical Rehabilitation Consultants at least ten business days, or as soon as possible, before Hospitalization to obtain certification of Medical Necessity for the admission, including the number of days of Hospital Confinement.
- **Emergency Admissions.** When you are admitted to any Hospital on an Emergency basis, notify Medical Rehabilitation Consultants within two days after admission (or as soon as possible after admission) to obtain certification, including the number of days of Hospital Confinement. In any event, notify Medical Rehabilitation Consultants before discharge.
- **Additional Hospital Days.** If your doctor believes that it is necessary for you to stay in the Hospital longer than the number of days that were originally certified, notify Medical Rehabilitation Consultants again to obtain certification for additional days.
- **Durable Medical Equipment.** Charges for the purchase of Durable Medical Equipment (DME) over $1,000 or rental costs valued at more than $3,000.

Medical management nurses

Medical management nurses focus on:

- The recommended treatment for your health condition.
- The proposed location of your treatment.
- The proposed length of stay at that location.
- The cost-effectiveness of your treatment and setting.

Note: You and your doctor always have the right to appeal a decision made by the medical management team if you disagree with their decision. A panel of doctors will review the appeal.

On-demand medical advice from qualified physicians

With Teladoc, you can contact board-certified, licensed doctors by phone or video, 24 hours a day!

Sometimes you need to speak with a doctor when it’s not possible to attend an office visit. That’s why the Teladoc program is available to you and your family, and can be used in a variety of ways:

- During weekends, holidays or after business hours, when general practitioners don’t typically schedule appointments.
- When you can’t attend a medical appointment, such as when traveling or at work.
- If you need a prescription medication or refill for a common condition.

Get the medical advice you need, when you need it

Contact a Teladoc physician at 1.800.362.2667, or by logging in at [www.meritain.com](http://www.meritain.com) for advice on commonly treated conditions such as:

- Headaches/migraines.
- Stomach ache/diarrhea.
- Respiratory infections.
- Urinary tract infections.
- Prescription refills*.
- Many other conditions.
Improve your overall health with dental benefits

It’s amazing how important your oral health can be to your body’s total balance and wholeness. Did you know that good dental care not only helps to prevent periodontal disease, but can also add as many as six years onto your life? That’s just one of the reasons why this plan includes dental care benefits for you and your enrolled dependents. Regular check-ups can keep your smiles bright and beautiful.

Dental plan deductibles and plan maximum

- **Deductible**
  - Per individual: None
  - Annual maximum: $1,500

Covered dental services

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Plan Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive and diagnostic</td>
<td>100%</td>
</tr>
<tr>
<td>Basic restorative</td>
<td>80%</td>
</tr>
<tr>
<td>Major restorative</td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontic treatment</td>
<td>50%</td>
</tr>
<tr>
<td>Plan payment</td>
<td></td>
</tr>
<tr>
<td>Calendar year maximum</td>
<td>$750</td>
</tr>
<tr>
<td>Lifetime maximum</td>
<td>$1,500</td>
</tr>
</tbody>
</table>

Vision care—part of any balanced healthcare picture

To lead your busy life, you need to protect your vision, so your benefit plan includes eye care. Visit any vision care provider. Some providers may require you pay for your care at the time you receive it. If they do, you can download a claim form from [www.meritain.com](http://www.meritain.com) and send the completed claim to Meritain Health at the address shown on your ID Card.

You’ll be reimbursed for the covered services shown below:

**Vision benefits:**

- **Exams**
  - One complete eye exam per person per Calendar Year
  - 100%

- **Lenses**
  - (per pair)
  - 80%

- **Contact lenses**
  - (in lieu of eyeglass lenses)
  - 80%

  Two eyeglass lenses or a 12-month supply of contact lenses per person per Calendar Year

  The Plan will pay for either one pair of eyeglasses or contact lenses (not both) during a Calendar Year

- **Frames**
  - One pair of frames per person, per two consecutive Calendar Years
  - 80% up to $120
Your prescription for a healthier budget

Your prescription drug benefit—available when you need prescriptions filled—is administered by Scrip World, powered by Express Scripts. They provide unbeatable resources for our plan participants. The Express Scripts pharmacy network includes more than 96 percent of all independent and chain pharmacies nationwide.

Controlling your prescription copay

To get the most from your benefits plan, it pays to be a wise consumer. In many cases, you can control how much your share of costs will be when you fill a prescription. How? Generic drugs cost less to manufacture and they’re just as effective as the name brands. You’ll save money when you request them because generics have a lower copay than name brand drugs.

Note: To see whether a prescription drug is generic or name brand, check the list in the appendix of this packet.

The preferred drug list

Also called a formulary, a preferred drug listing is created by pharmacy experts and lists FDA-approved, safe, effective and economical drugs.

How the preferred drug list works:
- Drugs are added to the list on a quarterly basis.
- Brand-name drugs can be removed at the end of the calendar year.
- Every January, the list is updated and available.
- When a generic drug becomes available, you’ll pay the lowest copay if you choose the generic.

Why generics make sense

Because companies that develop new drugs have long-term patent protection for their products, other drug companies are prevented by law from manufacturing those drugs—even if they can produce them less expensively.

When patents expire, other companies can make equivalent drugs, usually at a much lower price. Generic equivalents go through rigorous FDA testing regularly to assure that they are just as effective as the brand-name drugs.

Consider all of the compelling reasons to protect your pocketbook with the lower-price generic drugs:
- Generics can cost up to 75 percent less than their brand-name equivalents.
- FDA testing is exactly the same for generic and brand-name drugs.
- Generics contain the same active ingredients as the original, brand-name drug, in the same amounts and dosages.
- Generic drugs sometimes look different from the original brand-name drug in color or shape, but only because they may have different inactive ingredients that won’t change how the drug works.
- Nearly half of all brand-name drugs have generic equivalents—but you may have to ask for them.
- Generics have the lowest copay under this plan, so you save on every prescription.

Easy on your time—three ways to get your prescription drugs

Your plan is designed with your time in mind. Use any of these three prescription options.

At your local pharmacy

When you need a prescription for 34 days or less, have it filled at a participating pharmacy. Just show the pharmacist your Meritain Health ID Card and pay your copay at the time of your purchase. If the pharmacy you choose is not in-network and your plan allows reimbursement for out-of-network pharmacies, you’ll pay the entire cost at the time of purchase, then submit a claim for reimbursement. You’ll receive the same amount that a participating pharmacy would receive, minus your copay.

By mail order

If you have a chronic condition and you take medication for it for long periods of time, you may fill a larger quantity prescription all at once. Ask your doctor to write two prescriptions—one for 34 days, and one for 90 days. Fill the 34-day prescription at a network pharmacy. Then complete a mail order form and send it, along with the original 90-day prescription signed by your doctor and your copay, to the address on the form.

Online

You can also fill 90-day prescriptions online at www.meritain.com. Again, ask your doctor for two prescriptions. Before you request your prescription online, fill the 34-day order at a network drug store, and send (or ask your doctor to send) the 90-day prescription to the address shown on the website. Simply use a credit card to pay your copay.
Prescriptions and Meritain Connect

By logging in to www.meritain.com, you can:
- Order new prescriptions.
- Check the status of your online order.
- Find a nearby network pharmacy.
- Check on the price of a drug.
- Research drugs, supplements and vitamins.
- Learn more about your coverage.

Not every drug is covered

The plan does not include benefits for over-the-counter medications or drugs used for cosmetic purposes. There may be other exclusions. Scrip World customer service can help you if you have questions, or refer to your more complete summary plan description.

Certain drugs must be approved

If your prescription is for a very expensive drug, or one that can be easily abused, prior authorization may be required. Trained professionals review these prescriptions for your protection. You may need a new written prescription from your doctor for each refill. For more information, see your summary plan description or contact Scrip World customer service at 1.877.468.6592.

Contact Scrip World

You can contact Scrip World customer service by calling 1.877.468.6592.

The BridgeHealth Surgery Benefit

The plan provides you and your eligible dependents with an option to receive certain surgical procedures through the BridgeHealth Surgery Benefit when a treating physician recommends certain covered expenses and you or your eligible dependent elects to receive treatment at certain medical providers participating in the BridgeHealth Network ("BridgeHealth Providers"). The BridgeHealth Surgery Benefit is only available to you and your eligible dependents if coverage under this plan is primary. If you and/or your eligible dependents have other health coverage that causes this plan to pay secondary, you and/or your dependents may not be eligible for benefits under the BridgeHealth Surgery Benefit.

BridgeHealth Surgery Benefit

Your plan has been enhanced to include the BridgeHealth Surgery Benefit, giving you access to:
- Centers of Excellence for major planned surgeries and procedures.
- Coverage for travel costs for you and a companion.
- Provisions to eliminate your out-of-pocket costs.
- A dedicated Care Coordinator who provides concierge service and support.

The BridgeHealth Surgery Benefit includes coverage for the following procedures:
- Cardiac procedures
- Spine surgeries
- Vascular surgeries
- Specific cancer treatments
- Orthopedic surgeries
- Other planned surgeries

If you or family members have the need for a procedure, you will want to explore what the BridgeHealth Surgery Benefit can do for you.

Prescription drug benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>Retail – 90-day supply</th>
<th>Mail order – 90-day supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic</td>
<td>$10 copay, then 100%</td>
<td>$10 copay, then 100%</td>
</tr>
<tr>
<td>Preferred</td>
<td>20% copay, then 100%</td>
<td>20% copay, then 100%</td>
</tr>
<tr>
<td>Non-preferred</td>
<td>50% copay, then 100%</td>
<td>50% copay, then 100%</td>
</tr>
<tr>
<td>Preventive (as classified by HHS)</td>
<td>$0 copay (plan pays 100%)</td>
<td>$0 copay (plan pays 100%)</td>
</tr>
<tr>
<td>Specialty (30-day supply)</td>
<td>$100 copay, then 100%</td>
<td>$100 copay, then 100%</td>
</tr>
</tbody>
</table>
Responsible, hardworking people have a lot on their minds. That’s why your employer has included benefits that can protect your family if you’re not able to provide your regular financial support. They’re good for your peace of mind—and peace of mind is good for your health and well-being.

In this section

- Your Flexible Spending Account
Your Flexible Spending Account (FSA)

Making the most of your money
What if you could make your earnings stretch further? A Flexible Spending Account (FSA) can help you do just that. Yukon Koyukuk School District offers you an opportunity to participate in two FSA programs: A Healthcare FSA and a Dependent Care FSA. An FSA is a tax-effective, money-saving option that will help you pay for qualified healthcare expenses that aren’t covered by your medical plan, and for dependent care services necessary to enable you to work.

Here’s how an FSA works:
- **Eligible medical expenses.** Use pre-tax dollars to pay for eligible medical care expenses not reimbursed by a medical plan. All IRS code 213(d) expenses are eligible, including your deductible, coinsurance and copays, and expenses above usual and customary limits, as well as out-of-pocket expenses on prescription drugs, dental, vision, hearing and orthodontic care. Certain over-the-counter items may qualify, too.
- **Dependent care costs.** Pre-tax dollars can be set aside for day care type expenses for eligible children or adults. Expenses are eligible if they’re for the care of a person under age 13, or an older dependent who is unable to care for themselves. They must regularly spend at least eight hours a day in your home.

Maximize your savings potential
You will gain the most savings from your FSA if you plan carefully. When you enroll in an FSA, you designate in advance the amount of money you wish to have deducted from your salary and deposited into your FSA over the length of a year. To do this, you must estimate in advance the annual costs you want your FSA to cover.

If you underestimate, you will deplete your FSA before the end of the year, losing some of your tax-savings potential. If you overestimate and there is money left in your FSA at the end of the year, you may have to forfeit some of this money. Your employer allows you to carry over up to $500.

Important note! While it probably is not possible to precisely anticipate your eligible FSA costs, Meritain Health provides two calculation worksheets to help you: FSA Worksheet and Eligible Expenses Guide and Dependent Care FSA Determination. These worksheets are located in this kit, and include examples of eligible and ineligible expenses that can be applied towards your Healthcare and Dependent Care FSAs.

The bottom line
An FSA saves you money. Pre-tax deductions mean that your payroll taxes (federal, state and Social Security) are decreased and your take-home pay is increased. Your gross earnings are adjusted to account for the amounts withheld, and your tax percentage is applied to a lower amount of income. You maximize your spendable income. And that’s a goal we all share.

Frequently asked questions about FSAs

If I have a question about my FSA, whom should I call?
You can contact your dedicated service team for help with claims questions, or for more information about your benefits. The phone number for customer service is 1.800.566.9305.

What is the maximum amount of money I can contribute each year?
The IRS allows a contribution of up to $2600 towards the healthcare portion of your FSA. For dependent care, the IRS allows a contribution of up to $5,000 per calendar year, or $2,500 if you are married and filing separate tax returns.

What if I want to change my election mid-year?
IRS regulations do not allow you to stop, start or change your contributions at any time during the plan year UNLESS you experience a qualified change in status, such as a change in marital status, number of dependents or employment status. Keep in mind that the election change must be consistent with the event.

How do I file a claim?
Fill out a claim form and attach your healthcare and/or dependent care receipts. Claim forms are available inside this packet. If you need additional forms, contact your benefits department, or access forms online at www.meritain.com. If you have an automatic rollover feature, this will take care of claims submission for you.
How often can I submit reimbursement requests?

Claims can be submitted at any time; however, your employer has chosen to issue checks weekly. Claims need to be received by Meritain Health at least five business days prior to this date.

What if I have more expenses during the plan year than I have contributed at that time?

The annual amount you have elected for healthcare costs is available to you at the beginning of the plan year. The amount available for reimbursement for dependent care is limited to the balance in your account.

What if I still have money in my FSA at year’s end?

Your employer allows you to carry over up to $500; however, a portion of your unused funds may be lost at the end of the plan year. Please review the FSA Reminders page within this kit, for the FSA claim filing deadline.

What if I terminate employment?

Reimbursement can only be requested on healthcare expenses incurred before the date of your termination, unless you qualify and elect continuation of coverage under COBRA. You will have 90 days following the date of termination to submit your FSA claims.

What is the auto-rollover feature?

If you have health, dental or vision coverage through Meritain Health, you can elect automatic rollover. All out-of-pocket expenses incurred under your Meritain Health plan, while an active employee of Yukon Koyukuk School District, can automatically be reimbursed through your Meritain Health FSA plan up to the annual amount elected on the auto-rollover form (see the appendix). Note: If you have secondary insurance through a spouse, DO NOT elect the auto-rollover option.

This optional benefit must be re-elected for each new FSA plan year.

FSA reminders

<table>
<thead>
<tr>
<th>Group number</th>
<th>AK316</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan year</td>
<td>1/1/2017–12/31/2017</td>
</tr>
<tr>
<td>FSA Reimbursement checks</td>
<td>Claims are processed weekly.</td>
</tr>
<tr>
<td>Healthcare FSA maximum</td>
<td>$2,600</td>
</tr>
<tr>
<td>Dependent Care FSA maximum</td>
<td>$5,000 per household or $2,500 per spouse if filing separate tax returns.</td>
</tr>
</tbody>
</table>

Claim forms

A completed claim form must accompany every claim. Claim forms can be obtained from your employer or downloaded at [www.meritain.com](http://www.meritain.com).

Claim submission

Mail FSA claim forms and attachments to:

Meritain Health
P.O. Box 27847
Minneapolis, MN 55427-0847

Or fax to: 1.763.852.5004

End of the year run-out

Healthcare and dependent care FSA claims can be submitted up until 3/31/18.

Terminated employee filing deadline

You will have 90 days following the date of termination to submit healthcare FSA claims incurred while employed at Yukon Koyukuk School District. You will have 90 days following the date of termination to submit dependent care FSA claims.
Election changes

The IRS does not allow changes in your annual election unless you have a qualified change in status. You need to notify your employer within 31 days of any qualified status change.

Viewing claims with Meritain Health

For online claim status inquiry, log on to www.meritain.com by following the steps below.

- Click on the link for First Time Users.
- Enter your member ID, date of birth and group number.
- Your password will then be emailed to you.

For additional plan information

For additional plan information, refer to your Summary Plan Description (SPD), contact your employee benefits department, or contact our FSA team at 1.800.566.9305.

The right balance—look over the counter

Guidelines for Over-The-Counter (OTC) medications and supplies for FSAs

The Internal Revenue Service (IRS) allows FSA reimbursement for certain OTC items. To confirm whether or not an item is allowable before it's purchased, you may contact Meritain Health toll-free at 1.800.566.9305 or visit www.irs.gov.

Important note: OTC items that contain a medication or drug are not eligible for reimbursement through your FSA without a doctor’s prescription. In other words, you must first obtain a prescription for any OTC medications or drugs in order to obtain reimbursement from your FSA, regardless of when the plan year ends. OTCs that do not contain medications or drugs will not require a prescription.

In order for the OTC medicine and/or drug to qualify as a prescription, there must be a written or electronic order that meets the legal requirements of a prescription in the state in which the medical expense is incurred. Also, that the prescription must be issued by an individual who is legally authorized to issue a prescription in that state.

How do I know which OTCs will require a prescription?

OTCs that will require a doctor’s prescription include, but are not limited to the following:

- Acid controllers
- Allergy and sinus
- Antibiotic products
- Anti-diarrheals
- Anti-gas
- Anti-itch and insect bite
- Antiparasitic treatments
- Aspirin, ibuprofen, pain relief
- Baby rash ointments/creams
- Bandages that contain antibiotic ointment
- Cold sore remedies
- Cough, cold and flu
- Digestive aids
- Hemorrhoidal preps
- Laxatives
- Motion sickness
- Respiratory treatments
- Sleep aids and sedatives
- Stomach remedies

Here are some helpful tips

- If you have a prescription for an OTC medicine or drug, you must pay out of pocket at the point of sale and then submit a manual claim requesting reimbursement.
- You can continue to use your FSA funds to purchase OTC items that do not contain a medicine or drug (for example: bandages without antibiotic ointments, splints, cold/hot packs, rubbing alcohol, thermometers, etc.).
- Insulin may continue to be reimbursed with or without a prescription.
- You may only carry over up to $500 of FSA dollars, so remember to consider these OTC regulations when estimating the dollar amount you put in your FSA for the next plan year.
Direct deposit for FSA reimbursements

How the program works
When you submit a claim for reimbursement for an eligible medical or dependent care expense, the Meritain Health claims office will process it and, instead of sending you a check in the mail, Meritain Health will deposit the funds into your checking account. Later, you will receive an Explanation of Payment (EOP), giving you the full details of the reimbursement.

A $10 minimum reimbursement applies to all FSA claims, whether they are dispensed by check or direct deposit.

How to sign up for this program
As soon as possible, complete and return the setup form included in this mailing to your human resources department. Along with the setup form, you will need to provide a copy of a voided check listing your account and bank routing (transit) numbers. There is no set up fee, and this is a one-time set up process. You will only need to repeat this process if your bank account information changes.

Tired of waiting to receive your FSA Explanation of Payment (EOP) in the mail?
Members with direct deposit® can view FSA EOPs online. When your FSA claim is processed, you will receive an email notification that your FSA EOP is available to view when you log on to www.meritain.com.

You have the option to provide your email address to Meritain Health if you wish to begin receiving FSA EOP notices by email. If you already have your email address loaded into the Meritain Health system, you will begin receiving FSA EOP notices automatically.

Want to receive your EOP via email?
Simply provide your email address to Meritain Health, and you’re on your way!
- When you elect direct deposit, simply note your email address on the direct deposit form.
- You can also contact Meritain Health and provide your email address that way. Call customer service at 1.800.566.9305.

If you have any questions regarding the direct deposit program, please contact our FSA department at 1.800.566.9305.

FSA reimbursement made easy

The IRS requires proof that you received medical services before claims can be reimbursed by your Flexible Spending Account (FSA). Follow the guidelines below to receive prompt payment.

Guidelines for FSA reimbursement

Medical expenses if you have automatic rollover
If your medical plan includes an automatic rollover option and you have accepted it, claims are filed for you. After your medical claim is processed, any amount of patient responsibility that's eligible for FSA reimbursement will automatically roll over to your FSA and be reimbursed.

Prescription drug copays may not automatically roll over to your FSA with all medical plans. In that case, submit an FSA claim form along with a prescription drug copay receipt showing the name of the drug, amount paid, the date of purchase and name of patient.

Expenses if you don’t have automatic rollover, and other medical expenses
Submit a completed and signed FSA claim form with the following attachments:

- A copy of your Explanation of Benefits (EOB)
  - All claims must be submitted to your insurance company or healthcare plan before you request FSA reimbursement.
  - Estimates for services that haven’t been received can’t be accepted.

- Or a receipt for copays
  - Your office visit copay receipt must show the amount paid and the date of service.
  - Your prescription drug copay receipt must show the name of the drug, amount paid, the date of purchase and the name of the patient.
  - Credit card receipts, cancelled checks or cash register receipts can’t be accepted for copays.
For OTC items

- Itemized cash register receipts are acceptable for OTC items/supplies that do not contain a medicine or drug.
- If the OTC item contains a medicine or drug, you will need to submit a cash register receipt as well as a doctor’s prescription.
- A customer receipt issued by a pharmacy that identifies the name of the purchaser (or the name of the person to whom the prescription applies), the date and amount of the purchase, and an Rx number.

Or when you don't have coverage

- An itemized statement from your healthcare provider if you don’t have insurance coverage (e.g., for dental or vision services).

If you have any questions, please contact our FSA department at 1.800.566.9305.

An important note about OTCs

In order to obtain FSA reimbursement for OTCs that contain a medicine or drug, you must first obtain a prescription from your doctor.

Make sure the OTC prescription includes the following:

- Patient name
- Name of the OTC item
- Date prescribed (the prescription will be valid for one year from this date)

An important note about orthodontic care

With your first FSA claim, submit a copy of the following:

- The orthodontic contract or signed financial agreement
- Banding date
- A signed FSA claim form
- Proof of down payment

For future claims, you will only need to submit a signed FSA claim form along with proof of payment.
Are you ready for a health plan that can help restore balance to your life? It’s simple to enroll—just follow the four steps below. If you have any questions during the enrollment process, check with your benefits administrator. Once you’ve completed Step 4 and you’ve served any waiting period, you’re on your way to a fresh new approach to living your best health.

In this section
- Gathering information
- Double checking your information
- Making your decision
- Completing enrollment
- A more balanced you

Step 1—gather your information
For a complete, efficient enrollment, you may need some of the following information:
- Spouse’s and children’s birth dates.
- Spouse’s and children’s Social Security Numbers (SSN).
- Date of marriage.
- If your spouse or children are covered under another health plan, the name of the plan or insurance carrier and the effective date of benefits.
- If your benefits will include life insurance, your beneficiaries’ names and SSNs.

Step 2—double-check every form
The decisions you make as you enroll in your health plan will affect your future healthcare and finances. We want to help you choose wisely. If you have not yet read the earlier sections of this packet, take time to do it now. Don’t enroll without understanding your options.
Consider:
- Your personal health and the health of your family members.
- Healthcare expenses you can predict for you and your family.
- Other health benefits you or your family members may have.
- Your budget for benefits and expected healthcare services.

Step 3—make your decision
It’s time to make changes in the way you think about your health and your healthcare. It’s time to step up, take charge and make the best use of your plan, your money and your time. Are you ready to commit to better health, a better life—and the balance you want? Meritain Health is ready and committed to helping you.

Enrollment tips
Before you enroll, remember:
- Copays and deductibles are out-of-pocket costs you will pay for doctor visits and other medical services.
- If you or any dependent(s) are covered by another health plan, you have several options.
- If you decline benefits now, you won’t be able to enroll later unless a special enrollment situation occurs, or during an open enrollment period.

Step 4—Complete your enrollment, and you’re on your way!
All eligible employees must complete the enrollment form, whether you’re choosing this plan or declining benefits. Your enrollment form is included in the back of this packet.
Complete, sign and return your enrollment form to your employer within 60 days of your eligibility date whether you’re enrolling or declining benefits.

- Write clearly
  If your form is unreadable, your enrollment may be delayed, or incorrect.
- Don’t forget the back side
  Missing or incomplete information will delay your enrollment.
- Sign and date your enrollment form
  Remember to sign and date the form, even if you’re declining benefits.
The final step toward better balance and better living

After you’ve completed enrollment, your employer has approved it, and after any waiting period has passed, your benefits will be effective.

Your Meritain Health ID Card will be on its way to you soon. The card shows Meritain Health as your health plan administrator. Keep it in your wallet and carry it with you.

Sample ID Card

- Your healthcare plan includes a network of providers you can visit for healthcare services. When you visit providers in this network, you will receive the best service rate. Call the provider information number for participating providers.
- Your name, identification number, medical group number and your group name, are used to identify you and your covered dependents’ benefits.
- Your pharmacy coverage information is listed on the front of your card, and includes the Scrip World customer service number.
- Please ensure that you precertify with medical management, if required.
- All claims should be submitted to Meritain Health at the address listed on the back of your card.
- You or your provider can call Meritain Health to verify eligibility of benefits or check on your claims status.
- You can call for information on a doctor or specialist who is close to you and serves your specific needs.

Need to fill a prescription before you receive your ID Card?

Not to worry—if you need to see your doctor but you don’t have your ID Card yet, just tell the clinic staff that you’re a member of this plan. The clinic will contact Meritain Health Customer Service to verify your benefits.

If you need a prescription before you get your new Meritain Health ID Card, just pay for your prescription and send Express Scripts a completed prescription drug claim form (see the appendix for a copy). Send your receipt and the completed claim form to the address shown on the form and you’ll be reimbursed up to plan limits, minus any copay.

You or your pharmacist may contact Scrip World Customer Service at 1.877.468.6592 with any questions.

Lost ID Card?

Contact Meritain Health at 1.866.808.2609, or visit www.meritain.com to order new cards.
In this section

- Glossary of terms
- Important contact information
- Summary of benefits
- Enrollment forms
- Claim forms
- Preferred drug listing (formulary)

Glossary of terms

Ambulatory surgery
Surgery performed at an ambulatory surgical facility (a licensed public or private facility), which does not provide services or accommodations for a patient to stay overnight.

Copay
An amount of money that a participant is required to pay each time he or she visits a healthcare provider or fills a prescription.

Deductible
The annual out-of-pocket amount that a plan participant is responsible for paying before the health plan covers his or her medical costs according to the terms of the plan. Until a person meets the annual deductible, he or she pays the full cost of healthcare services received, unless the service is not subject to the annual deductible as stated in the benefit schedule.

Meritain Connect
Your online health information portal and your personal connection to your plan. Here you can order prescriptions, find healthcare providers, research health topics and get answers to your questions about healthcare. The personal information used to access www.meritain.com is confidential. You may need the information on your ID Card to log in for the first time.

Provider network
Organization that negotiates special, lower rates for healthcare services provided by physicians and other care providers who are within the network. Providers who belong to a network are called participating or in-network providers.

Usual and customary charge
Your plan reimburses charges from non-participating or out-of-network providers that are equal to, or less than, usual and customary charges. Usual and customary charges are the amounts most frequently charged for the same service:

- In the same geographic area; and
- By other providers in the same or similar medical area.

The fees charged by non-participating providers may exceed the usual and customary charges recognized by your plan. In such cases, Meritain Health will process an amount equal to the usual and customary charge for the healthcare service you received, and you will be reimbursed for a portion of that amount according to your plan’s out-of-network benefits.
Your plan includes the BridgeHealth Surgery Benefit

The BridgeHealth Surgery Benefit, gives you access to:

- Centers of Excellence for major planned surgeries and procedures.
- Coverage for travel costs for you and a companion.
- Provisions to eliminate your out-of-pocket costs.
- A dedicated Care Coordinator who provides service and support.

The program includes coverage for:

- Cardiac procedures
- Spine surgeries
- Vascular surgeries
- Specific cancer treatments
- Orthopedic surgeries
- Other planned surgeries

Dedicated Care Coordination

Your BridgeHealth Care Coordinator will work with you to:

- Review all options available under the BridgeHealth Surgery Benefit.
- Transfer your medical records to a BridgeHealth provider for initial review.
- Provide detailed information about BridgeHealth providers, including education and experience.
- Satisfy all health plan requirements regarding medical necessity review and precertification.
- Schedule travel and lodging for you and a companion, including meal and incidental allowances.

Customer testimonials

Carole, Fairbanks resident

“Traveling ‘outside’ for medical care in an unfamiliar city, with an unknown doctor, and no family or friends close by can be a very scary situation. BridgeHealth makes it easy and expertly calms your fears...You don’t have to think of anything. BridgeHealth does it all for you. They are wonderful to work with! I could not have asked for anything better. There were no problems (none!) from start to finish.”

Sindy, Fairbanks resident

“I needed to have my lower back fused. My health coordinator did her research and sent me information on three facilities and the surgeons at each one. I was able to study each surgeon, their schooling, background, experience, along with the national ratings on each hospital. I was able to choose the facility with the surgeon I felt would be the best for me. I never once had to pick up the phone and plan or book anything. It’s been almost one year since the surgery and I must say I’m doing great, and what’s even better, I don’t have one medical bill from the surgery.”

How can I take advantage of the BridgeHealth Surgery Benefit?

Simply call BridgeHealth at 1.800.680.1366 to speak with a Care Coordinator and explore what the BridgeHealth Surgery Benefit can do for you. You’ll need to provide your member ID (which can be found on your member ID Card), your date of birth, and any information you’ve received related to your procedure—including any relevant medical records, such as reports and x-rays.

You can also visit BridgeHealth online at www.BridgeHealthMedical.com.
Reach a doctor 24/7
The Teladoc™ solution

Teladoc is the on-demand healthcare solution that gives you the medical care you need, when you need it. You can talk to a doctor anytime, anywhere about non-emergent medical conditions.

Benefits of Teladoc

- Saves time and money
- Quicker recovery from illness
- Convenient prescriptions
- Choice of consultation method
- Great health means peace of mind

With Teladoc, you can talk to a doctor 24/7/365 by phone, online video or mobile app. Use Teladoc for medical advice and care when:

- Your primary care doctor is not open.
- You are at home, traveling or do not want to take time off work to see a doctor.
- You need a prescription or refills*.

*Please note, there is no guarantee you will be prescribed medication.

Highly qualified, experienced doctors

When you use Teladoc, your medical questions will be answered by a highly qualified doctor. Teladoc doctors are:

- Experienced—with an average of over 10–15 years in practice.
- Progressive—using the latest technology to provide excellent care.
- U.S. board certified and state licensed.
- Specially trained in telemedicine.

Common conditions treated:

- Allergies
- Bronchitis
- Cold/flu
- Headaches/migraines
- Eye/ear infections
- Rash/skin infections
- Sinus infections
- Stomachache/diarrhea
- Urinary tract infections
- Many other conditions

Our members love Teladoc

“We had a good experience with the doctor. She called and talked to me, and gave great service. I had no problem picking up my prescription. This is a really good service.”


© 2015 Teladoc, Inc. All rights reserved. Teladoc and the Teladoc logo are registered trademarks of Teladoc, Inc. and may not be used without written permission. Teladoc does not replace the primary care physician. Teladoc does not guarantee that a prescription will be written. Teladoc operates subject to state regulation and may not be available in certain states. Teladoc does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. Teladoc physicians reserve the right to deny care for potential misuse of services. Teladoc phone consultations are available 24 hours, 7 days a week while video consultations are available during the hours of 7am to 9pm, 7 days a week.
## Important plan contacts

<table>
<thead>
<tr>
<th>What do you need help with?</th>
<th>Who to contact</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>My medical/dental/vision benefits</td>
<td>Meritain Health Customer Service</td>
<td>1.866.808.2609</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.meritain.com">www.meritain.com</a></td>
</tr>
<tr>
<td>The Aetna Choice® POS II provider network</td>
<td>Aetna provider line</td>
<td>1.800.343.3140</td>
</tr>
<tr>
<td></td>
<td>TAPPN</td>
<td><a href="http://WWW.TAPPN.COM">WWW.TAPPN.COM</a></td>
</tr>
<tr>
<td>My Flexible Spending Account (FSA)</td>
<td>Meritain Health FSA Department</td>
<td>1.800.566.9305</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.meritain.com">www.meritain.com</a></td>
</tr>
<tr>
<td>My prescription drug benefits</td>
<td>Scrip World Customer Service</td>
<td>1.877.468.6592</td>
</tr>
<tr>
<td>Precertification</td>
<td>Medical Rehabilitation Consultants</td>
<td>1.800.827.5058</td>
</tr>
<tr>
<td>Medical advice</td>
<td>Teladoc</td>
<td>1.800.362.2667</td>
</tr>
<tr>
<td>Planned surgeries</td>
<td>BridgeHealth</td>
<td>1.800.680.1366</td>
</tr>
<tr>
<td>• Enrollment or benefit elections</td>
<td>Yukon Koyukuk human resources representative</td>
<td>1.907.374.9410</td>
</tr>
<tr>
<td>• Enrolling in COBRA benefits</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Summary of Benefits

### MEDICAL SCHEDULE OF BENEFITS – YUKON PLAN

<table>
<thead>
<tr>
<th></th>
<th>PARTICIPATING PROVIDERS</th>
<th>NON-PARTICIPATING PROVIDERS - Alaska (Subject to Usual and Customary Charges)</th>
<th>NON-PARTICIPATING PROVIDERS – Outside Alaska (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LIFETIME MAXIMUM BENEFIT</strong></td>
<td>Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CALENDAR YEAR MAXIMUM BENEFIT</strong></td>
<td>Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CALENDAR YEAR DEDUCTIBLE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td>Family</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td><strong>CALENDAR YEAR MEDICAL OUT-OF-POCKET MAXIMUM (includes Coinsurance and Medical copays)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$1,000</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Family</td>
<td>$3,000</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td><strong>TOTAL CALENDAR YEAR MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM (includes Deductible, Copays and Coinsurance – combined with Prescription Drug Card)</strong></td>
<td>Participating Providers and other Non-Hospital Related Charges</td>
<td>Non-Participating Provider Facility Charges</td>
<td>Non-Participating Provider Charges</td>
</tr>
<tr>
<td>Single</td>
<td>$4,000</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Family</td>
<td>$11,500</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

### MEDICAL BENEFITS

<table>
<thead>
<tr>
<th>Service</th>
<th>PARTICIPATING PROVIDERS</th>
<th>NON-PARTICIPATING PROVIDERS - Alaska (Subject to Usual and Customary Charges)</th>
<th>NON-PARTICIPATING PROVIDERS – Outside Alaska (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ground</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Air (other than through Guardian Flight)</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Air (provided by Guardian Flight)*</td>
<td>80% after Deductible of allowable rate listed below:</td>
<td>80% after Deductible of allowable rate listed below:</td>
<td>80% after Deductible of allowable rate listed below:</td>
</tr>
<tr>
<td>One way transport (fixed wing or rotary)</td>
<td>225% of the Medicare/CMS rate**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed wing air mileage per statute mile</td>
<td>600% of the Medicare/CMS Rural rate**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rotary wing air mileage, per statute mile</td>
<td>350% of the Medicare/CMS Rural rate**</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*NOTE: If the provider is Guardian Flight, allowable charges will be payable at the Medicare/CMS Rural Rate instead of the Usual and Customary level and no discount will be given.

**NOTE: Amounts paid by the Covered Person in excess of the Medicare/CMS Rural rate do not accrue toward the Plan Year Out-of-Pocket Maximum Expense.

<table>
<thead>
<tr>
<th>Service</th>
<th>PARTICIPATING PROVIDERS</th>
<th>NON-PARTICIPATING PROVIDERS - Alaska (Subject to Usual and Customary Charges)</th>
<th>NON-PARTICIPATING PROVIDERS – Outside Alaska (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic Care/Spinal Manipulation</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
</tbody>
</table>

**NOTE: After 20 visits, treatment will be reviewed for Medical Necessity.

<table>
<thead>
<tr>
<th>Service</th>
<th>PARTICIPATING PROVIDERS</th>
<th>NON-PARTICIPATING PROVIDERS - Alaska (Subject to Usual and Customary Charges)</th>
<th>NON-PARTICIPATING PROVIDERS – Outside Alaska (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Education</td>
<td>100%; Deductible waived</td>
<td>100%; Deductible waived</td>
<td>60% after Deductible</td>
</tr>
</tbody>
</table>
## Summary of Benefits

<table>
<thead>
<tr>
<th>Emergency Services/Emergency Room Services</th>
<th>PARTICIPATING PROVIDERS</th>
<th>NON-PARTICIPATING PROVIDERS - Alaska (Subject to Usual and Customary Charges)</th>
<th>NON-PARTICIPATING PROVIDERS – Outside Alaska (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$250 Copay, then Deductible, then 80%</td>
<td>Paid at the Participating Provider level of benefits</td>
<td>Paid at the Participating Provider level of benefits</td>
<td></td>
</tr>
</tbody>
</table>

NOTE: The Emergency Room Copay will be waived if the person is directly admitted as an Inpatient, or treatment is for accidental Injury and is received within 2 days after the Accident.

### Hearing Benefit

<table>
<thead>
<tr>
<th>Service</th>
<th>PARTICIPATING PROVIDERS</th>
<th>NON-PARTICIPATING PROVIDERS - Alaska (Subject to Usual and Customary Charges)</th>
<th>NON-PARTICIPATING PROVIDERS – Outside Alaska (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Routine Hearing Exams</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>Constant 80%; Deductible waived</td>
<td>Constant 80%; Deductible waived</td>
<td>Constant 80%; Deductible waived</td>
</tr>
</tbody>
</table>

### Home Health Care

<table>
<thead>
<tr>
<th>Service</th>
<th>PARTICIPATING PROVIDERS</th>
<th>NON-PARTICIPATING PROVIDERS - Alaska (Subject to Usual and Customary Charges)</th>
<th>NON-PARTICIPATING PROVIDERS – Outside Alaska (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
</tbody>
</table>

### Hospice Care

<table>
<thead>
<tr>
<th>Service</th>
<th>PARTICIPATING PROVIDERS</th>
<th>NON-PARTICIPATING PROVIDERS - Alaska (Subject to Usual and Customary Charges)</th>
<th>NON-PARTICIPATING PROVIDERS – Outside Alaska (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Facility (Inpatient and Outpatient)</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>All other locations</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Maximum Benefit per Confinement</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Respite Care Maximum Benefit</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
</tbody>
</table>

### Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)

<table>
<thead>
<tr>
<th>Service</th>
<th>PARTICIPATING PROVIDERS</th>
<th>NON-PARTICIPATING PROVIDERS - Alaska (Subject to Usual and Customary Charges)</th>
<th>NON-PARTICIPATING PROVIDERS – Outside Alaska (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Room and Board Allowance</td>
<td>Semi-Private Room Rate*</td>
<td>Semi-Private Room Rate*</td>
<td>Semi-Private Room Rate*</td>
</tr>
<tr>
<td>Intensive Care Unit</td>
<td>ICU/CCU Room Rate</td>
<td>ICU/CCU Room Rate</td>
<td>ICU/CCU Room Rate</td>
</tr>
<tr>
<td>Miscellaneous Services &amp; Supplies</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td>60% after Deductible</td>
</tr>
</tbody>
</table>

* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.

### Maternity (Professional Fees)*

<table>
<thead>
<tr>
<th>Service</th>
<th>PARTICIPATING PROVIDERS</th>
<th>NON-PARTICIPATING PROVIDERS - Alaska (Subject to Usual and Customary Charges)</th>
<th>NON-PARTICIPATING PROVIDERS – Outside Alaska (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Prenatal and Breastfeeding Support (other than lactation consultations)</td>
<td>100%; Deductible waived</td>
<td>100%; Deductible waived</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Lactation Consultations</td>
<td>100%; Deductible waived</td>
<td>100%; Deductible waived</td>
<td>100%; Deductible waived</td>
</tr>
<tr>
<td>All Other Prenatal, Delivery and Postnatal Care</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
</tbody>
</table>

* See Preventive Services under Eligible Medical Expenses for limitations.

### Neurodevelopmental Therapy – for Covered Persons under age 7 (Physical, Occupational & Speech Therapy)

<table>
<thead>
<tr>
<th>Service</th>
<th>PARTICIPATING PROVIDERS</th>
<th>NON-PARTICIPATING PROVIDERS - Alaska (Subject to Usual and Customary Charges)</th>
<th>NON-PARTICIPATING PROVIDERS – Outside Alaska (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Facility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>15 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>All other locations</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
</tbody>
</table>
## Summary of Benefits

<table>
<thead>
<tr>
<th>Physician’s Services</th>
<th>PARTICIPATING PROVIDERS</th>
<th>NON-PARTICIPATING PROVIDERS - Alaska (Subject to Usual and Customary Charges)</th>
<th>NON-PARTICIPATING PROVIDERS – Outside Alaska (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient/Outpatient Services</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Office Visits</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Physician Office Surgery</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Teladoc</td>
<td>100%; Deductible waived</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Preventive Services and Routine Care

Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)

Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)

<table>
<thead>
<tr>
<th>Routine Care (age 19 and over)</th>
<th>100% of the first $500* per Calendar Year (Deductible waived), then 80% after Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>1 exam</td>
</tr>
<tr>
<td>Well Child Care (ages 2-19)</td>
<td>100% of the first $500* per Calendar Year (Deductible waived), then 80% after Deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>1 exam</td>
</tr>
<tr>
<td>Well Baby Care (up to age 2 - as recommended)</td>
<td>100% of the first $500* per Calendar Year (Deductible waived), then 80% after Deductible</td>
</tr>
<tr>
<td>Routine Immunizations (as recommended)</td>
<td>100% of the first $500* per Calendar Year (Deductible waived), then 80% after Deductible</td>
</tr>
<tr>
<td>Routine Hearing Exams</td>
<td>100% of the first $500* per Calendar Year (Deductible waived), then 80% after Deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>1 exam</td>
</tr>
</tbody>
</table>

*This $500 is a combined maximum between all Providers for all routine care services listed above.

<table>
<thead>
<tr>
<th>Routine Pelvic Exam &amp; Associated Lab Work (age 16 and over)</th>
<th>100%; Deductible waived</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>1 exam</td>
</tr>
<tr>
<td>Routine Prostate Exam &amp; Associate Lab Work (age 40 and over)</td>
<td>100%; Deductible waived</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>1 exam</td>
</tr>
<tr>
<td>Routine Mammogram (age 40 and over)</td>
<td>100%; Deductible waived</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>1 exam</td>
</tr>
<tr>
<td>Routine Colorectal Screening (age 50 and over)</td>
<td>100%; Deductible waived</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>1 exam</td>
</tr>
<tr>
<td>FOBT (home kit or referred lab)</td>
<td>100%; Deductible waived</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>1 exam</td>
</tr>
</tbody>
</table>
### Summary of Benefits

<table>
<thead>
<tr>
<th></th>
<th>PARTICIPATING PROVIDERS</th>
<th>NON-PARTICIPATING PROVIDERS - Alaska (Subject to Usual and Customary Charges)</th>
<th>NON-PARTICIPATING PROVIDERS – Outside Alaska (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Flexible Sigmoidoscopy</strong></td>
<td></td>
<td>100%; Deductible waived</td>
<td></td>
</tr>
<tr>
<td><strong>Maximum Benefit</strong></td>
<td></td>
<td>1 sigmoidoscopy every 5 years</td>
<td></td>
</tr>
<tr>
<td><strong>Colonoscopy</strong></td>
<td></td>
<td>100%; Deductible waived</td>
<td></td>
</tr>
<tr>
<td><strong>Maximum Benefit</strong></td>
<td></td>
<td>1 colonoscopy every 5 years</td>
<td></td>
</tr>
<tr>
<td>* Age requirement is waived for high risk criteria &amp; Physician referral per AK Statute.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Rehabilitation Therapy and Chronic Pain Care
(e.g., physical, speech, occupational)

<table>
<thead>
<tr>
<th></th>
<th>PARTICIPATING PROVIDERS</th>
<th>NON-PARTICIPATING PROVIDERS - Alaska (Subject to Usual and Customary Charges)</th>
<th>NON-PARTICIPATING PROVIDERS – Outside Alaska (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Facility</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td><strong>Calendar Year Maximum Benefit</strong></td>
<td>15 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>All other location</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td><strong>Calendar Year Maximum Benefit</strong></td>
<td>20 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td><strong>Calendar Year Maximum Benefit</strong></td>
<td>60 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Procedures</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Certain Surgical Procedures are covered at 100% (Deductible waived) when they are received through the BridgeHealth Surgery Benefit Option. Not all Surgical Procedures are eligible for coverage under this option. Please refer to the BridgeHealth Surgery Benefit Option for a more detailed description of this benefit.</td>
<td></td>
</tr>
<tr>
<td><strong>Transplants</strong></td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>(Aetna IOE Program)*</td>
<td></td>
<td>*Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit. Travel and lodging will be paid at 100% with no Deductible.</td>
<td></td>
</tr>
<tr>
<td><strong>All Other Eligible Medical Expenses</strong></td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
</tbody>
</table>
### Prescription Drug Schedule of Benefits - Yukon Plan

#### Benefit Description

**NOTE:** The Covered Person will be reimbursed the amount that would have been paid to a Participating Provider less the applicable Copay if Prescription Drugs are obtained from a Non-Participating Provider.

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calendar Year Prescription Drug Out-of-Pocket Maximum</strong> (includes prescription drug Copays)</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$2,500</td>
</tr>
<tr>
<td>Family</td>
<td>$7,500</td>
</tr>
<tr>
<td><strong>Total Calendar Year Medical and Prescription Drug Out-of-Pocket Maximum</strong> (includes Deductible, Copays and Coinsurance – combined medical)</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$4,000</td>
</tr>
<tr>
<td>Family</td>
<td>$11,500</td>
</tr>
</tbody>
</table>

#### Retail Pharmacy: 90-day supply

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Description</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drug</td>
<td>$10 Copay, then 100%</td>
<td></td>
</tr>
<tr>
<td>Preferred Drug</td>
<td>20% Copay, then 100%</td>
<td></td>
</tr>
<tr>
<td>Non-Preferred Drug</td>
<td>50% Copay, then 100%</td>
<td></td>
</tr>
<tr>
<td>Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)</td>
<td>$0 Copay (Plan pays 100%)</td>
<td></td>
</tr>
<tr>
<td>Specialty Drug (limited to 30-day supply)</td>
<td>$100 Copay, then 100%</td>
<td></td>
</tr>
</tbody>
</table>

#### Mail Pharmacy: 90-day supply

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Description</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drug</td>
<td>$10 Copay, then 100%</td>
<td></td>
</tr>
<tr>
<td>Preferred Drug</td>
<td>20% Copay, then 100%</td>
<td></td>
</tr>
<tr>
<td>Non-Preferred Drug</td>
<td>50% Copay, then 100%</td>
<td></td>
</tr>
<tr>
<td>Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)</td>
<td>$0 Copay (Plan pays 100%)</td>
<td></td>
</tr>
<tr>
<td>Specialty Drug (limited to 30-day supply)</td>
<td>$100 Copay, then 100%</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** Coverage for preventive contraceptives and contraceptive devices is only available for women of child bearing age and limited to contraceptives that are considered Generic Drugs unless no equivalent Generic Drug is available and the Preferred or Non-Preferred Drug is otherwise covered under the Prescription Drug Card Program.

**Specialty Pharmacy Program**

The CuraScript Pharmacy is available to service specialty medication prescription needs. Specialty medications tend to be more complex to administer and monitor than traditional medications. These medications treat chronic conditions such as rheumatoid arthritis, multiple sclerosis, cancer, hepatitis, psoriasis, hemophilia and HIV/AIDS. CuraScript is highly regarded for its series of CARELogic programs, which are based on solid clinical management and patient adherence to prescribed therapies. The program also includes topics such as self-injection techniques and therapy-education during the new-patient enrollment process.

When you have filled a specialty medication for the first time at a retail pharmacy, you will receive information in the mail from Scrip World informing you that you will need to contact CuraScript for your next refill. When you call the toll-free number, an Admission Coordinator will set-up the delivery of your next refill, and assign you to a dedicated Patient Care Coordinator. The Patient Care Coordinator will coordinate ongoing medication delivery, perform ongoing adherence and compliance monitoring, and provide medication refill reminders.

**Preventive Drug** means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website: https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a paper copy, please contact the Plan Administrator.
# MEDICAL SCHEDULE OF BENEFITS – BOREALIS PLAN

<table>
<thead>
<tr>
<th></th>
<th>PARTICIPATING PROVIDERS</th>
<th>NON-PARTICIPATING PROVIDERS - Alaska (Subject to Usual and Customary Charges)</th>
<th>NON-PARTICIPATING PROVIDERS – Outside Alaska (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LIFETIME MAXIMUM BENEFIT</strong></td>
<td>Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CALENDAR YEAR MAXIMUM BENEFIT</strong></td>
<td>Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CALENDAR YEAR DEDUCTIBLE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$2,000</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Family</td>
<td>$4,000</td>
<td>$4,000</td>
<td>$4,000</td>
</tr>
<tr>
<td><strong>CALENDAR YEAR MEDICAL OUT-OF-POCKET MAXIMUM</strong> (includes Coinsurance and Medical copays)</td>
<td>Participating Providers and other Non-Hospital Related Charges</td>
<td>Non-Participating Provider Facility Charges</td>
<td>Non-Participating Provider Charges</td>
</tr>
<tr>
<td>Single</td>
<td>$2,000</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Family</td>
<td>$5,000</td>
<td>$6,500</td>
<td>$14,000</td>
</tr>
<tr>
<td><strong>TOTAL CALENDAR YEAR MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM</strong> (includes Deductible, Copays and Coinsurance – combined with Prescription Drug Card)</td>
<td>Participating Providers and other Non-Hospital Related Charges</td>
<td>Non-Participating Provider Facility Charges</td>
<td>Non-Participating Provider Charges</td>
</tr>
<tr>
<td>Single</td>
<td>$6,500</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Family</td>
<td>$14,000</td>
<td>$14,000</td>
<td>$14,000</td>
</tr>
</tbody>
</table>

## MEDICAL BENEFITS

<table>
<thead>
<tr>
<th>Service</th>
<th>Participating Providers</th>
<th>Non-Participating Providers - Alaska</th>
<th>Non-Participating Providers – Outside Alaska</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Ground</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Air (other than through Guardian Flight)</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Air (provided by Guardian Flight)*</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>One way transport (fixed wing or rotary)</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
</tr>
<tr>
<td>Fixed wing air mileage per statute mile</td>
<td>225% of the Medicare/CMS rate**</td>
<td>225% of the Medicare/CMS rate**</td>
<td>225% of the Medicare/CMS rate**</td>
</tr>
<tr>
<td>Rotary wing air mileage, per statute mile</td>
<td>600% of the Medicare/CMS Rural rate**</td>
<td>600% of the Medicare/CMS Rural rate**</td>
<td>600% of the Medicare/CMS Rural rate**</td>
</tr>
<tr>
<td>*NOTE: If the provider is Guardian Flight, allowable charges will be payable at the Medicare/CMS Rural Rate instead of the Usual and Customary level and no discount will be given. **NOTE: Amounts paid by the Covered Person in excess of the Medicare/CMS Rural rate do not accrue toward the Plan Year Out-of-Pocket Maximum Expense.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chiropractic Care/Spinal Manipulation</th>
<th>80% after Deductible</th>
<th>80% after Deductible</th>
<th>60% after Deductible</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Diabetes Education</th>
<th>100%; Deductible waived</th>
<th>100%; Deductible waived</th>
<th>60% after Deductible</th>
</tr>
</thead>
</table>

NOTE: After 20 visits, treatment will be reviewed for Medical Necessity.
## Summary of Benefits

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Participating Providers</th>
<th>Non-Participating Providers - Alaska (Subject to Usual and Customary Charges)</th>
<th>Non-Participating Providers – Outside Alaska (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Services/Emergency Room Services</td>
<td>$250 Copay, then</td>
<td>Paid at the Participating Provider level of benefits</td>
<td>Paid at the Participating Provider level of benefits</td>
</tr>
<tr>
<td></td>
<td>Deductible, then 80%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NOTE: The Emergency Room Copay will be waived if</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>the person is directly admitted as an Inpatient,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>or treatment is for accidental injury and is</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>received within 2 days after the Accident.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Hearing Benefit
- **Non-Routine Hearing Exams**: 80% after Deductible
- **Hearing Aids**: Constant 80%; Deductible waived
- **Home Health Care**: 80% after Deductible

### Hospice Care
- **Hospital Facility (Inpatient and Outpatient)**: 80% after Deductible
- **Maximum Benefit per Confinement**: 10 days
- **Lifetime Maximum Benefit**: 6 months
- **Respite Care Maximum Benefit**: 120 hours in each 3-month period of Hospice

### Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)
- **Inpatient**: 80% after Deductible
- **Room and Board Allowance**: Semi-Private Room Rate*
- **Intensive Care Unit**: ICU/CCU Room Rate
- **Miscellaneous Services & Supplies**: 80% after Deductible
- **Outpatient**: 80% after Deductible

* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.

### Maternity (Professional Fees)*
- **Preventive Prenatal and Breastfeeding Support (other than lactation consultations)**: 100%; Deductible waived
- **Lactation Consultations**: 100%; Deductible waived
- **All Other Prenatal, Delivery and Postnatal Care**: 80% after Deductible

* See Preventive Services under Eligible Medical Expenses for limitations.

### Neurodevelopmental Therapy – for Covered Persons under age 7 (Physical, Occupational & Speech Therapy)
- **Hospital Facility**
  - **Inpatient**: 80% after Deductible
  - **Calendar Year Maximum Benefit**: 15 days
- **Outpatient**: 80% after Deductible
- **All other locations**: 80% after Deductible
## Summary of Benefits

<table>
<thead>
<tr>
<th>Physician’s Services</th>
<th>PARTICIPATING PROVIDERS</th>
<th>NON-PARTICIPATING PROVIDERS - Alaska (Subject to Usual and Customary Charges)</th>
<th>NON-PARTICIPATING PROVIDERS – Outside Alaska (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient/Outpatient Services</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Office Visits</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Physician Office Surgery</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Teladoc</td>
<td>100%; Deductible waived</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Preventive Services and Routine Care

Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)

Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)

| Routine Care (age 19 and over) | 100% of the first $500* per Calendar Year (Deductible waived), then 80% after Deductible |
| Calendar Year Maximum Benefit | 1 exam |
| Well Child Care (ages 2-19) | 100% of the first $500* per Calendar Year (Deductible waived), then 80% after Deductible |
| Calendar Year Maximum Benefit | 1 exam |
| Well Baby Care (up to age 2 - as recommended) | 100% of the first $500* per Calendar Year (Deductible waived), then 80% after Deductible |
| Routine Immunizations (as recommended) | 100% of the first $500* per Calendar Year (Deductible waived), then 80% after Deductible |
| Routine Hearing Exams | 100% of the first $500* per Calendar Year (Deductible waived), then 80% after Deductible |
| Calendar Year Maximum Benefit | 1 exam |

*This $500 is a combined maximum between all Providers for all routine care services listed above.

| Routine Pelvic Exam & Associated Lab Work (age 16 and over) | 100%; Deductible waived |
| Calendar Year Maximum Benefit | 1 exam |
| Routine Prostate Exam & Associate Lab Work (age 40 and over) | 100%; Deductible waived |
| Calendar Year Maximum Benefit | 1 exam |
| Routine Mammogram (age 40 and over) | 100%; Deductible waived |
| Calendar Year Maximum Benefit | 1 exam |
| Routine Colorectal Screening (age 50 and over) | 100%; Deductible waived |
| Calendar Year Maximum Benefit | 1 exam |
| FOBT (home kit or referred lab) | 100%; Deductible waived |
| Calendar Year Maximum Benefit | 1 exam |
## Summary of Benefits

<table>
<thead>
<tr>
<th></th>
<th>PARTICIPATING PROVIDERS</th>
<th>NON-PARTICIPATING PROVIDERS - Alaska (Subject to Usual and Customary Charges)</th>
<th>NON-PARTICIPATING PROVIDERS – Outside Alaska (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexible Sigmoidoscopy</td>
<td>100%; Deductible waived</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum Benefit</td>
<td>1 sigmoidoscopy every 5 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colonoscopy* (not covered if less that 5 years of Flexible Sigmoidoscopy)</td>
<td>100%; Deductible waived</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum Benefit</td>
<td>1 colonoscopy every 5 years</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Age requirement is waived for high risk criteria & Physician referral per AK Statute.

**Rehabilitation Therapy and Chronic Pain Care (e.g., physical, speech, occupational)**

<table>
<thead>
<tr>
<th></th>
<th>PARTICIPATING PROVIDERS</th>
<th>NON-PARTICIPATING PROVIDERS - Alaska (Subject to Usual and Customary Charges)</th>
<th>NON-PARTICIPATING PROVIDERS – Outside Alaska (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Facility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>15 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>All other location</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>20 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>60 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Procedures</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>*Certain Surgical Procedures are covered at 100% (Deductible waived) when they are received through the BridgeHealth Surgery Benefit Option. Not all Surgical Procedures are eligible for coverage under this option. Please refer to the BridgeHealth Surgery Benefit Option for a more detailed description of this benefit.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Transplants**

<table>
<thead>
<tr>
<th></th>
<th>PARTICIPATING PROVIDERS</th>
<th>NON-PARTICIPATING PROVIDERS - Alaska (Subject to Usual and Customary Charges)</th>
<th>NON-PARTICIPATING PROVIDERS – Outside Alaska (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80% after Deductible (Aetna IOE Program)*</td>
<td>60% after Deductible (All Other Network Hospitals)</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Please refer to the Aetna Institute of Excellence (IOE) Program section of this Plan for a more detailed description of this benefit. Travel and lodging will be paid at 100% with no Deductible.

**All Other Eligible Medical Expenses**

<table>
<thead>
<tr>
<th></th>
<th>PARTICIPATING PROVIDERS</th>
<th>NON-PARTICIPATING PROVIDERS - Alaska (Subject to Usual and Customary Charges)</th>
<th>NON-PARTICIPATING PROVIDERS – Outside Alaska (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
</tbody>
</table>
## Summary of Benefits

### PRESCRIPTION DRUG SCHEDULE OF BENEFITS - BOREALIS PLAN

<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NOTE:</strong> The Covered Person will be reimbursed the amount that would have been paid to a Participating Provider less the applicable Copay if Prescription Drugs are obtained from a Non-Participating Provider.</td>
<td></td>
</tr>
</tbody>
</table>

| **CALENDAR YEAR PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM** (includes prescription drug Copays) |          |
| Single | $2,500 |
| Family | $5,000 |

| **TOTAL CALENDAR YEAR MEDICAL AND PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM** (includes Deductible, Copays and Coinsurance – combined medical) |          |
| Single | $6,500 |
| Family | $14,000 |

### Retail Pharmacy: 90-day supply

- **Generic Drug**: $10 Copay, then 100%
- **Preferred Drug**: 20% Copay, then 100%
- **Non-Preferred Drug**: 50% Copay, then 100%
- **Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)**: $0 Copay (Plan pays 100%)
- **Specialty Drug (limited to 30-day supply)**: $100 Copay, then 100%

### Mail Pharmacy: 90-day supply

- **Generic Drug**: $10 Copay, then 100%
- **Preferred Drug**: 20% Copay, then 100%
- **Non-Preferred Drug**: 50% Copay, then 100%
- **Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)**: $0 Copay (Plan pays 100%)
- **Specialty Drug (limited to 30-day supply)**: $100 Copay, then 100%

### NOTE: Coverage for preventive contraceptives and contraceptive devices is only available for women of child bearing age and limited to contraceptives that are considered Generic Drugs unless no equivalent Generic Drug is available and the Preferred or Non-Preferred Drug is otherwise covered under the Prescription Drug Card Program.

### Specialty Pharmacy Program

The CuraScript Pharmacy is available to service specialty medication prescription needs. Specialty medications tend to be more complex to administer and monitor than traditional medications. These medications treat chronic conditions such as rheumatoid arthritis, multiple sclerosis, cancer, hepatitis, psoriasis, hemophilia and HIV/AIDS. CuraScript is highly regarded for its series of CARELogic programs, which are based on solid clinical management and patient adherence to prescribed therapies. The program also includes topics such as self-injection techniques and therapy-education during the new-patient enrollment process.

When you have filled a specialty medication for the first time at a retail pharmacy, you will receive information in the mail from Scrip World informing you that you will need to contact CuraScript for your next refill. When you call the toll-free number, an Admission Coordinator will set-up the delivery of your next refill, and assign you to a dedicated Patient Care Coordinator. The Patient Care Coordinator will coordinate ongoing medication delivery, perform ongoing adherence and compliance monitoring, and provide medication refill reminders.

**Preventive Drug** means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website: https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a paper copy, please contact the Plan Administrator.
## Estimating your healthcare expenses

The planning worksheet below can help you estimate your eligible healthcare expenses that may not be covered under your company’s group insurance plan. Remember, all eligible healthcare expenses for you, your spouse and your eligible dependents are reimbursable from your Healthcare FSA.

### Medical expenses

<table>
<thead>
<tr>
<th>Medical expenses</th>
<th>Estimated plan year expenses</th>
<th>Vision Expenses</th>
<th>Estimated plan year expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copays</td>
<td>$</td>
<td>Contact lens supplies</td>
<td>$</td>
</tr>
<tr>
<td>Deductibles</td>
<td>$</td>
<td>Copays</td>
<td>$</td>
</tr>
<tr>
<td>Lab fees</td>
<td>$</td>
<td>Deductibles</td>
<td>$</td>
</tr>
<tr>
<td>Physical exams</td>
<td>$</td>
<td>Eye examinations</td>
<td>$</td>
</tr>
<tr>
<td>Physician fees</td>
<td>$</td>
<td>Prescription contact lenses</td>
<td>$</td>
</tr>
<tr>
<td>Prescription drug</td>
<td>$</td>
<td>Prescription eyeglasses or sunglasses</td>
<td>$</td>
</tr>
<tr>
<td>Other medical expenses</td>
<td>$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Dental Expenses

<table>
<thead>
<tr>
<th>Dental Expenses</th>
<th>Estimated plan year expenses</th>
<th>Vision Expenses</th>
<th>Estimated plan year expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copays</td>
<td>$</td>
<td>Other Expenses</td>
<td></td>
</tr>
<tr>
<td>Deductibles</td>
<td>$</td>
<td>Acupuncture or chiropractic</td>
<td>$</td>
</tr>
<tr>
<td>Dentures</td>
<td>$</td>
<td>Hearing aids</td>
<td>$</td>
</tr>
<tr>
<td>Examinations</td>
<td>$</td>
<td>Immunization fees</td>
<td>$</td>
</tr>
<tr>
<td>Orthodontia</td>
<td>$</td>
<td>Psychiatrist, psychologist, counseling*</td>
<td>$</td>
</tr>
<tr>
<td>Restorative work (crowns, caps, bridges)</td>
<td>$</td>
<td>Other eligible expenses</td>
<td>$</td>
</tr>
<tr>
<td>Teeth cleaning</td>
<td>$</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other dental expenses</td>
<td>$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total column 1** $ + **Total column 2** $ = **Total estimated expense** $

*Allowed for treatment of physical or mental disorder (e.g., depression, alcohol or drug treatment). A diagnosis is necessary for reimbursement.

### Examples of costs your Healthcare FSA may cover

- Copays, deductibles, and out-of-pocket costs
- Acupuncture as a treatment
- Certain alcoholism and drug addiction treatment costs
- Artificial teeth or dentures
- Braille books for visually impaired
- Certain residential improvements to accommodate the disabled
- Eye examinations, contact lenses (including cleaning and maintenance supplies) and eyeglasses
- Guide dogs for sight or hearing impaired persons
- Car controls for disabled drivers
- Hypnosis to treat illness
- Lead-based paint removal
- Learning disability tuition/therapy
- Psychological or psychiatric care
- Nursing home expenses
- Certain medical transportation

Important note! Reimbursement for certain services listed above is subject to specific requirements. Call the IRS toll free at 1.800.829.3676, or visit [www.irs.gov](http://www.irs.gov), to obtain a copy.
Dependent care tax credit vs. dependent care flexible spending account

If you have qualifying dependent care expenses, you may be able to choose one or both of two ways to reduce your taxes. You may be able to obtain a tax credit (a direct reduction in the amount of taxes you otherwise would owe) or you may be able to reduce your taxable income. This worksheet will help you decide which is better for you.

If you qualify for the tax credit, you are allowed to deduct from the taxes you owe a percentage of the lesser of

1. your actual qualifying dependent care expense or
2. $3,000 if you have one dependent or $6,000 if you have two or more dependents. The percentage is based on your adjusted gross income for the year. The chart to the right will help you determine your percentage.

In lieu of the Dependent Care Tax Credit, each year you may elect to have an amount deducted from your paycheck before taxes and put into your Dependent Care FSA. This amount must be used during the year for qualifying dependent care expenses. In other words, you will not have to pay taxes on the amount you contribute to the Dependent Care FSA that is used to pay your qualifying dependent care expenses. If, however, either you or your spouse has Earned Income (as defined in the plan) of less than $5,000, your income exclusion will be limited to the amount of that Earned Income.

Use the following worksheet to determine whether you should use the Dependent Care Tax Credit or the Dependent Care Flexible Spending Account. Remember to compare your actual dependent care expenses to $3,000 (for one dependent) or $6,000 (for two or more dependents). Take the lesser amount from this comparison and multiply it by your adjusted gross income percentage from the chart. This will be your tax credit.

Worksheet

<table>
<thead>
<tr>
<th></th>
<th>Using the tax credit</th>
<th>Using the dependent care FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjusted yearly</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>gross income</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(subtract dependent care account)</td>
<td>$</td>
<td>- $</td>
</tr>
<tr>
<td>Taxable yearly income</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Taxes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Federal* (%)</td>
<td>+ $</td>
<td>+ $</td>
</tr>
<tr>
<td>State* (%)</td>
<td>+ $</td>
<td>+ $</td>
</tr>
<tr>
<td>Social Security (generally 7.65%)</td>
<td>+ $</td>
<td>+ $</td>
</tr>
<tr>
<td>Total (subtract tax credit)</td>
<td>= $</td>
<td>= $</td>
</tr>
<tr>
<td></td>
<td>- $</td>
<td>$ Total taxes</td>
</tr>
</tbody>
</table>

*The actual tax rate will vary depending upon your annual income. Estimate your own tax liability or check with your tax consultant.

Eligible expenses
- Fees paid to a childcare center or to a day care camp that, if providing care for more than six children, complies with all state and local regulations
- Fees paid to a babysitter inside or outside the home
- Fees paid to a relative who provides dependent care services, other than your spouse, to your child (on the last day of the calendar year) or to a dependent you claim for federal income tax purposes
- Legally mandated taxes paid on behalf of the provider

Ineligible expenses
- Transportation to and from the place where dependent care services are provided
- Food, clothing and education
- Expenses for which federal child care tax credits are taken, or are claimed under your Healthcare FSA
- Overnight camps
- Tuition

COMPANY NAME: Yukon Koyukuk School District   GROUP #: AK316

 THIS FORM IS TO BE COMPLETED FOR NEW ENROLLMENTS AND COVERAGE CHANGES
PLEASE PRINT CLEARLY AND COMPLETE THE ENTIRE FORM
(ALL INFORMATION MUST BE COMPLETED OR ENROLLMENT WILL BE DELAYED)

EMPLOYEE INFORMATION – ALL INFORMATION IS REQUIRED

LAST NAME    FIRST NAME    MI
SOCIAL SECURITY NO.    DATE OF BIRTH (MM/DD/YY)    GENDER    MARITAL STATUS
□ M □ F    □ Single □ Married □ Divorced □ Widowed
MAILING ADDRESS
CITY    STATE    ZIP
HOME PHONE NUMBER    WORK PHONE NUMBER

ARE YOU THE EMPLOYEE COVERED UNDER ANY OTHER INSURANCE? □ YES □ NO (i.e. Medicare, Tricare, spouse’s plan)

IF YES, NAME OF INSURANCE:    EFFECTIVE DATE:

TYPE OF POLICY (Retiree, COBRA, Spouse):    POLICY HOLDER (Self, Spouse):

IF ENROLLED IN MEDICARE: EFFECTIVE DATE:    PART A    PART B    HICN

ENTITLEMENT TO MEDICARE DUE TO: □ AGE □ DISABILITY □ END STAGE RENAL DISEASE (ESRD)

EMPLOYER USE ONLY

DATE OF HIRE    EFFECTIVE DATE
DIVISION #    DEPT. # / CLOCK #
ANNUAL SALARY: $
□ HOURLY □ SALARY
□ NEW ENROLLMENT
□ Active □ Retiree
□ Full Time □ Part Time
□ COBRA
□ ENROLLMENT CHANGE
□ Marriage □ Birth □ Adoption
□ Reinstatement □ Loss of Coverage
□ Other:

Employer Representative Signature:    Date:

BENEFIT SELECTION

COVERAGE TYPE    PLAN OPTION    COVERAGE LEVEL
□ MEDICAL/RX/DENTAL/VISION    □ YUKON PLAN    □ SINGLE
□ BOREALIS PLAN    □ EMPLOYEE + SPOUSE    □ EMPLOYEE + CHILD
□ FAMILY    □ DECLINE

DEPENDENT INFORMATION (ALL INFORMATION MUST BE COMPLETED OR ENROLLMENT WILL BE DELAYED)

Special Enrollment due to coverage under Medicaid or under a State Children’s Health Insurance Program (CHIP). If an employee or eligible dependent did not enroll in the plan when initially eligible, he or she will be permitted to later enroll in the plan under one of the following circumstances:

a. The employee or eligible dependent loses their eligibility status to participate in Medicaid or CHIP; or
b. The employee or eligible dependent qualifies for premium assistance under Medicaid or CHIP at the state level in which the individual resides. The employee or eligible dependent must request enrollment in the plan within 60 days after coverage under Medicaid or CHIP terminates or within 60 days of being notified of eligibility for premium assistance from the state in which the individual resides.

DEPENDENT FULL NAME (REQUIRED)
(LAST, FIRST, MIDDLE)
SOCIAL SECURITY NO. (REQUIRED)
RELATIONSHIP (REQUIRED)
DATE OF BIRTH (MM/DD/YY)
GENDER (M/F)

CHECK COVERAGE
□ MEDICAL/RX/DENTAL/VISION
□ YES
□ NO

DISABLED DEPENDENT*
□ MEDICAL/RX/DENTAL/VISION
□ YES
□ NO

*IF YOUR CHILD IS MENTALLY OR PHYSICALLY DISABLED, PLEASE PROVIDE APPROPRIATE DOCUMENTATION

169.7292015
COMPANY NAME: Yukon Koyukuk School District

COORDINATION OF BENEFITS – SPOUSE INFORMATION (IF APPLICABLE) COMPLETE ALL QUESTIONS

IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO   IF YES, ☐ FULL TIME ☐ PART TIME ☐ SPouse EMPLOYER NAME: ☐ SPouse DATE OF BIRTH:

INDICATE THE COVERAGE, CARRIER NAME AND EFFECTIVE DATE THAT YOUR SPOUSE IS ENROLLED IN WITH HIS/HER EMPLOYER

<table>
<thead>
<tr>
<th>TYPE OF OTHER COVERAGE</th>
<th>CARRIER NAME</th>
<th>CARRIER ADDRESS</th>
<th>EFFECTIVE DATE (MM/DD/YY)</th>
<th>TYPE OF POLICY (I.E. EMPLOYER, RETIREE, COBRA)</th>
<th>LIST ALL FAMILY MEMBERS ENROLLED IN THIS PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ MEDICAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ PRESCRIPTION</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ DENTAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ VISION</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

COORDINATION OF BENEFITS – DEPENDENT CHILD(REN) INFORMATION (IF APPLICABLE) COMPLETE ALL QUESTIONS

ARE ANY OF YOUR DEPENDENT CHILD(REN) COVERED BY ANOTHER PARENT/GUARDIAN OR PLAN NOT LISTED ABOVE? ☐ YES ☐ NO

EMPLOYER PROVIDING COVERAGE:

IF YES, COMPLETE THE QUESTIONS BELOW

<table>
<thead>
<tr>
<th>TYPE OF OTHER COVERAGE</th>
<th>CARRIER NAME</th>
<th>CARRIER ADDRESS</th>
<th>EFFECTIVE DATE (MM/DD/YY)</th>
<th>TYPE OF POLICY (I.E. EMPLOYER, RETIREE, COBRA)</th>
<th>COURT ORDER REQUIRING COVERAGE (I.E. DIVORCE DECREE, QMCSO)*</th>
<th>LIST ALL FAMILY MEMBERS ENROLLED IN THIS PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ MEDICAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ PRESCRIPTION</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ DENTAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ VISION</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*COPY OF THE COURT ORDER MUST BE SUBMITTED. FAILURE TO DO SO WILL RESULT IN CLAIMS BEING DENIED.

COORDINATION OF BENEFITS – GOVERNMENTAL INSURANCE (I.E. MEDICARE, MEDICAID, TRICARE, MICHILD, ETC.)

IS YOUR SPOUSE AND/OR ARE ANY DEPENDENTS ENROLLED IN ANY GOVERNMENTAL INSURANCE? ☐ YES ☐ NO   IF YES, PLEASE COMPLETE BELOW

<table>
<thead>
<tr>
<th>LIST ALL FAMILY MEMBERS ENROLLED</th>
<th>TYPE OF COVERAGE</th>
<th>EFFECTIVE DATE OR IF MEDICARE COVERAGE, PART A EFFECTIVE DATE</th>
<th>PART B EFFECTIVE DATE (IF APPLICABLE)</th>
<th>HICN</th>
<th>IS MEDICARE COVERAGE DUE TO:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☐ AGE ☐ DISABILITY ☐ ESRD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>☐ AGE ☐ DISABILITY ☐ ESRD</td>
</tr>
</tbody>
</table>

PLAN DECLARATION

I understand that the above elections will remain in effect until the last day of the Plan Year for which they are effective and will continue in effect indefinitely beyond that Plan Year unless I make an election change permitted under the Plan. I understand that I may change my elections during the Plan Year only if (i) I experience a “status change”, as defined under the Plan, and if my change in elections is consistent with that “status change”, (ii) I exercise a Special Enrollment Period Right (as described in the Notice of Special Enrollment Periods below), or (iii) I qualify (under applicable law, as determined by the Plan Administrator) to make another election change because of certain changes in cost or coverage of a benefit option, or for certain other reasons. I understand that the cost of a benefit option that I have elected under the Plan may change from one Plan Year to the next and I hereby agree that my payroll deductions will automatically change accordingly unless I submit a new Election Form during the appropriate annual election period to change or terminate that coverage. I also understand, during a Plan Year, if there is a change in the cost of a benefit option that I have elected, the Employer may automatically increase the payroll deductions, if any, I am required to make per pay period to pay for that benefit option. I understand further that, except to the extent that I am permitted to make a change under the Plan, the payroll deduction elections I have made above will continue in effect notwithstanding any changes in the features or coverage offered under the benefit options I have elected above.

I understand that my employer may modify my benefit elections if appropriate to insure that the Plan complies with the terms of the Plan and the requirements (including tax-qualification requirements) of applicable law and that, subject to the requirements of applicable law or any applicable insurance contract, my employer retains the right to amend or terminate coverage under a benefit option. Also, I understand that the employer may modify my elections for health benefit options if required to do so by a Qualified Medical Child Support Order that requires me to provide health coverage for a dependent.

NOTICE OF SPECIAL ENROLLMENT PERIODS

If you are declining enrollment in the Plan’s health coverage options for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan’s health coverage features if you or your dependents lose eligibility for that coverage (or if the employer stops contributing towards your or your dependents’ other coverage). However, you must request enrollment within 60 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

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 60 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your Human Resources representative.

SIGNATURE AND AUTHORIZATION

EMPLOYEE SIGNATURE:   PRINT EMPLOYEE NAME:   DATE:
**Health Claim Form**

**Health Claim Form**

**Section 1. EMPLOYEE INFORMATION**

<table>
<thead>
<tr>
<th>Name (last, first, initial)</th>
<th>Sex</th>
<th>Employer Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Address</td>
<td>Identification Number</td>
<td>Birthdate</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
</tr>
</tbody>
</table>

**Section 2. PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>The patient is:</th>
<th>The employee</th>
<th>Employee's Spouse</th>
<th>Employee's Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Go to section 3)</td>
<td>(Complete spouse information)</td>
<td>(Complete spouse and child information)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Spouse’s Name (last, first, initial)</th>
<th>Sex</th>
<th>Child’s Name (first, last, initial)</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse’s Birthdate</td>
<td>Spouse’s Social Security Number</td>
<td>Child’s Birthdate</td>
<td>Child’s Social Security Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Spouse’s Employer</th>
<th>Spouse’s Employer’s Address</th>
</tr>
</thead>
</table>

**Section 3. OTHER COVERAGE**

<table>
<thead>
<tr>
<th>Yes (then complete)</th>
<th>No (go to section 4)</th>
<th>Name of Policy Holder:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Other Health Insurance Carrier or Plan</td>
<td>Address</td>
<td>City</td>
</tr>
<tr>
<td>Other Insurance Carrier’s or Plan’s Telephone #</td>
<td>Type of Coverage</td>
<td>Group</td>
</tr>
<tr>
<td>Group Number</td>
<td>Contract or Policy Number</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Spouse’s Employer</th>
<th>Spouse’s Employer’s Address</th>
</tr>
</thead>
</table>

**Section 4. ABOUT THIS CLAIM**

<table>
<thead>
<tr>
<th>Injury</th>
<th>Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date and time of accident:</td>
<td>Describe injury, when and how it happened or nature of illness:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Was this injury the result of an accident?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>If auto insurance was involved, please provide:</th>
<th>Policy #</th>
<th>Name of insurance company</th>
<th>Address (city, state, zip)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was this a work-related injury?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

**EMPLOYEE’S (or adult dependent’s) SIGNATURE REQUIRED**

The statements above are true and correct to the best of my knowledge. I authorize any provider of services to furnish any information requested to the Benefit Administrator. I also authorize the Benefit Administrator to release or obtain from any organization or person information that may be necessary to determine benefits payable under the Benefit Plan. A photo-static copy of this authorization shall be considered as effective and valid as the original. For any payment that exceeds the amounts payable under the Benefit Plan, I agree to reimburse the plan in a lump sum payment or by an automatic reduction in the amount of future benefits that would otherwise be payable.

**Signature:**

**ASSIGNMENT OF BENEFITS (complete this section if provider is to be paid directly)**

I authorize payment of benefits to the doctor or supplier of services listed here.

<table>
<thead>
<tr>
<th>Provider to be paid</th>
<th>Employee’s Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s tax ID number or Social Security Number</td>
<td>Date</td>
</tr>
</tbody>
</table>
**IMPORTANT:** Please have your doctor or supplier of medical services complete the reverse of this form or attach a fully itemized bill.

<table>
<thead>
<tr>
<th>A</th>
<th>Patient Name (last, first, initial)</th>
<th>Birthdate</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Is this condition the result of an injury arising from patient’s employment? □ Yes □ No</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If yes, please contact the Worker’s Compensation Carrier/Administrator for proper instruction regarding this claim.</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Pregnancy? □ Yes □ No</td>
<td>If yes, expected date of delivery</td>
</tr>
<tr>
<td>E</td>
<td>If illness, date of first treatment</td>
<td>If treating injury, date of injury</td>
</tr>
<tr>
<td>F</td>
<td>Name of referring physician</td>
<td>Referring physician’s address</td>
</tr>
<tr>
<td>G</td>
<td>Name and facility where services were rendered (if other than home or office)</td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>Was laboratory work performed outside your office? □ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>For service related to hospitalization, give dates:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Admitted □ Discharged</td>
<td></td>
</tr>
<tr>
<td>J</td>
<td>Diagnosis and current conditions (if diagnosis other than ICD-10* used, give name):</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>K</td>
<td>Dates of Service From</td>
<td>To</td>
</tr>
<tr>
<td></td>
<td>Date</td>
<td>Physician’s Name (print)</td>
</tr>
<tr>
<td></td>
<td>Physician’s Signature</td>
<td>Telephone</td>
</tr>
<tr>
<td></td>
<td>Street Address</td>
<td>City</td>
</tr>
</tbody>
</table>

**ICD-10**  International Classification of Disease  **Abbreviations:** 11-Physician’s Office  12-Patient’s Home  81-Independent Laboratory

**CPT**  Current Procedural Terminology (current edition)  12-Inpatient Hospital  22-Outpatient Hospital  23-Emergency Room

Send to:
Meritain Health
P.O. Box 27810
Minneapolis, MN 55427
Fax: 1.763.852.5057

STATUS AND BENEFIT INFORMATION:
1.866.808.2609
## ADA American Dental Association* Dental Claim Form

### HEADER INFORMATION
1. **Type of Transaction (Mark all applicable boxes)**
   - [ ] Statement of Actual Services
   - [ ] Request for Predetermination/Preauthorization
   - [ ] EPSDT / Title XIX
2. **Predetermination/Preauthorization Number**

### INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION
3. **Company/Plan Name, Address, City, State, Zip Code**
4. **Dental?**
5. **Medical?**
6. **Date of Birth (MM/DD/CCYY)**
7. **Gender**
8. **Policyholder/Subscriber ID (SSN or ID#)**
9. **Plan/Group Number**
10. **Employer Name**
11. **Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code**

### PATIENT INFORMATION
12. **Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code**
13. **Date of Birth (MM/DD/CCYY)**
14. **Gender**
15. **Policyholder/Subscriber ID (SSN or ID#)**
16. **Plan/Group Number**
17. **Employee Name**
18. **Relationship to Policyholder/Subscriber in #12 Above**
19. **Reserved For Future Use**
20. **Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code**
21. **Date of Birth (MM/DD/CCYY)**
22. **Gender**
23. **Patient ID/Account # ( Assigned by Dentist)**

### RECORD OF SERVICES PROVIDED
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### AUTHORIZATIONS
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

**X**

### BILLING DENTIST OR DENTAL ENTITY
48. **Name, Address, City, State, Zip Code**
49. **NPI**
50. **License Number**
51. **SSN or TIN**

### BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)
52. **Provider Number**
53. **Provider ID**
54. **NPI**
55. **License Number**
56. **Address, City, State, Zip Code**
57. **Provider Number**
58. **Provider ID**

### TREATING DENTIST AND TREATMENT LOCATION INFORMATION
53. **I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.**

**X**

### ANCILLARY CLAIM/TREATMENT INFORMATION
38. **Place of Treatment**
   - [ ] Use "Place of Service Codes for Professional Claims"
   - [ ] (e.g. 11=office, 22=HIP Hospital)
39. **Enclosures (Y or N)**
40. **Is Treatment for Orthodontics?**
   - [ ] No (Skip 41-42)
   - [ ] Yes (Complete 41-42)
41. **Date Appliance Placed (MM/DD/CCYY)**
42. **Months of Treatment**
   - [ ] No (Complete 43-44)
43. **Replacement of Prosthesis**
   - [ ] Yes (Complete 44)
44. **Date of Prior Placement (MM/DD/CCYY)**
45. **Treatment Resulting from**
   - [ ] Occupational illness/injury
   - [ ] Auto accident
   - [ ] Other accident
46. **Date of Accident (MM/DD/CCYY)**
47. **Auto Accident State**

### TREATING DENTIST AND TREATMENT LOCATION INFORMATION
53. **I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.**

**X**

### TREATMENT INFORMATION
54. **NPI**
55. **License Number**
56. **Address, City, State, Zip Code**
57. **Provider Number**
58. **Provider ID**
The following information highlights certain form completion instructions. Comprehensive ADA Dental Claim Form completion instructions are printed in the CDT manual. Any updates to these instructions will be posted on the ADA’s web site (ADA.org).

GENERAL INSTRUCTIONS
A. The form is designed so that the name and address (Item 3) of the third-party payer receiving the claim (insurance company/dental benefit plan) is visible in a standard #9 window envelope (window to the left). Please fold the form using the ‘tick-marks’ printed in the margin.
B. Complete all items unless noted otherwise on the form or in the CDT manual’s instructions.
C. Enter the full name of an individual or a full business name, address and zip code when a name and address field is required.
D. All dates must include the four-digit year.
E. If the number of procedures reported exceeds the number of lines available on one claim form, list the remaining procedures on a separate, fully completed claim form.

COORDINATION OF BENEFITS (COB)
When a claim is being submitted to the secondary payer, complete the entire form and attach the primary payer’s Explanation of Benefits (EOB) showing the amount paid by the primary payer. You may also note the primary carrier paid amount in the “Remarks” field (Item 35). There are additional detailed completion instructions in the CDT manual.

DIAGNOSIS CODING
The form supports reporting up to four diagnosis codes per dental procedure. This information is required when the diagnosis may affect claim adjudication when specific dental procedures may minimize the risks associated with the connection between the patient’s oral and systemic health conditions. Diagnosis codes are linked to procedures using the following fields:

   Item 29a – Diagnosis Code Pointer (“A” through “D” as applicable from Item 34a)
   Item 34 – Diagnosis Code List Qualifier (B for ICD-9-CM; AB for ICD-10-CM)
   Item 34a – Diagnosis Code(s) / A, B, C, D (up to four, with the primary adjacent to the letter “A”)

PLACE OF TREATMENT
Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard maintained by the Centers for Medicare and Medicaid Services. Frequently used codes are:

   11 = Office; 12 = Home; 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility
The full list is available online at “www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf”

PROVIDER SPECIALTY
This code is entered in Item 56a and indicates the type of dental professional who delivered the treatment. The general code listed as “Dentist” may be used instead of any of the other codes.

<table>
<thead>
<tr>
<th>Category / Description Code</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist</td>
<td>122300000X</td>
</tr>
<tr>
<td>General Practice</td>
<td>1223G0001X</td>
</tr>
<tr>
<td>Dental Specialty (see following list)</td>
<td>Various</td>
</tr>
<tr>
<td>Dental Public Health</td>
<td>1223D0001X</td>
</tr>
<tr>
<td>Endodontics</td>
<td>1223E0200X</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>1223X0400X</td>
</tr>
<tr>
<td>Pediatric Dentistry</td>
<td>1223P0211X</td>
</tr>
<tr>
<td>Periodontics</td>
<td>1223P0300X</td>
</tr>
<tr>
<td>Prosthodontics</td>
<td>1223P0700X</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Pathology</td>
<td>1223P0106X</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Radiology</td>
<td>1223D0008X</td>
</tr>
<tr>
<td>Oral &amp; Maxillofacial Surgery</td>
<td>1223S0112X</td>
</tr>
</tbody>
</table>

Provider taxonomy codes listed above are a subset of the full code set that is posted at “www.wpc-edi.com/codes/taxonomy”
# Yukon Koyukuk School District

**FSA Enrollment Form**

**EMPLOYEE INFORMATION**

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MI</th>
<th>PLAN YEAR</th>
<th>GROUP #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>1/1/2017–12/31/2017</td>
<td>AK316</td>
</tr>
</tbody>
</table>

**EMPLOYEE INFORMATION**

<table>
<thead>
<tr>
<th>MERTAIN HEALTH ID NUMBER/SSN</th>
<th>GENDER</th>
<th>DATE OF BIRTH</th>
<th>EFFECTIVE DATE</th>
<th>DIVISION #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOME ADDRESS</th>
<th>EMAIL ADDRESS</th>
<th>DATE OF HIRE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PAY CYCLE**

- [ ] WEEKLY
- [ ] MONTHLY
- [ ] BI-WEEKLY
- [ ] SEMI-MONTHLY
- [ ] OTHER: ____________

**Please check all that apply:**

- [ ] HEALTH FSA  [ ] WAIVED

I would like to contribute $_________ per pay period ($__________ annually) to my Healthcare Flexible Spending Account for the upcoming calendar year or the remainder of the current year.

**PLEASE NOTE:** The maximum annual election allowed by your employer is $2,550 per calendar year.

- [ ] DCAP  [ ] WAIVED

I would like to contribute $_________ per pay period ($__________ annually) to my Dependent Care Flexible Spending Account for the upcoming calendar year or the remainder of the current year.

**PLEASE NOTE:** The maximum annual election allowed by the IRS is $5,000 per family or $2,500 per individual (or spouse when married and filing separate tax returns)

**ELIGIBLE DEPENDENTS:**

<table>
<thead>
<tr>
<th>Dependent's Name (Last, First, MI)</th>
<th>Gender</th>
<th>Relationship</th>
<th>Birth Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>F</td>
</tr>
</tbody>
</table>

**AUTO-ROLLOVER FEATURE: CHECK ONE**

When you or your provider submits a claim to Meritain Health that is eligible for reimbursement under your Healthcare Flexible Spending Account, your FSA has the ability to automatically reimburse you for eligible out-of-pocket expenses, up to your annual maximum election amount. This feature is called auto-rollover. (Do not elect this option if you have secondary insurance coverage through a spouse.)

- [ ] Yes, I wish to elect automatic reimbursement (auto-rollover) for eligible out-of-pocket healthcare expenses.
  - I agree not to submit these expenses for reimbursement under any other insurance plan.
- [ ] No, I do not wish to elect automatic reimbursement (auto-rollover).

**EMPLOYEE SIGNATURE REQUIRED**

I understand that the above elections will remain in effect until the last day of the calendar year indicated on this Form. I understand that I may change my elections during the calendar year only if (1) I experience a “status change,” as defined under the Plan and my change in elections is consistent with that “status change,” or (2) I exercise a Special Enrollment Right as described in the Notice of Special Enrollment Periods that accompanies this Election Form. I also understand that if I do not submit a new Election Form during the next annual election period, the above elections will terminate at the end of the calendar year for which they are effective. I understand that the Employer may modify my benefit elections if appropriate to insure that the Plan complies with the requirements of the Plan and applicable law and that, subject to the requirements of applicable law, the Employer has the right to amend or terminate the Plan. I understand that if I fail to request Plan enrollment within 30 days after my (and/or my dependent’s) other coverage ends, I will not be eligible to enroll myself or my dependent(s), as applicable, during the special enrollment period.

**EMPLOYEE SIGNATURE**

[Signature]

**DATE**

[Date]
REIMBURSEMENT REQUEST FORM

Employer Name:  Yukon Koyukuk School District

Employee Name:  _____________________________________________ SS# or ID#:  ____________________________

Address:  _____________________________________________ Telephone #:  ____________________________

City:  _____________________________ State:  _________ Zip:  _________ Is this a change of address?  □ Y or □ N

Select account from which you are requesting reimbursement, and fill out all requested information completely.
For further instructions, see Guidelines for Reimbursement on the back of this form.

### Health FSA

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Name of Provider (e.g., physician, hospital, dentist, pharmacy)</th>
<th>Type of Service (e.g., copay, Rx, ortho)</th>
<th>Name of Patient</th>
<th>Amount of Expense</th>
<th>Was this service covered by any insurance plan?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>Y / N</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>Y / N</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>Y / N</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>Y / N</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
<td>Y / N</td>
</tr>
</tbody>
</table>

Total amount requested from your **Health FSA**:  $  

If more space is needed, list additional requests on a separate page. Please include all requests in the total.
A minimum request amount (as established in your plan document) may need to be met before a claim can be paid.

### Dependent Care Assistance Plan (DCAP)

<table>
<thead>
<tr>
<th>Name of Day Care Provider</th>
<th>Dates of Service</th>
<th>Dependent’s Name</th>
<th>Date of Birth</th>
<th>Amount of Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>From</td>
<td>To</td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

Total amount requested from your **DCAP**:  $  

Provider Signature:  __________________________________ Provider SSN# or Tax ID:  ____________________________

Signature not required if signed receipt or Day Care Center statement is attached. Altered receipts cannot be accepted.

I certify that I have actually incurred these eligible expenses. I understand that expense incurred means that the service has been provided that gave rise to the expense, regardless of when I am billed or charged for, or pay for the service. The expenses have not been reimbursed or are not reimbursable from any other source. I understand that any amounts reimbursed may not be claimed on my or my spouse’s income tax returns. I have received and read the printed material regarding the reimbursement accounts and understand all of the provisions.

Employee Signature:  ____________________________ Date:  ____________________________
## Guidelines for Reimbursement

NOTE: Incomplete or illegible submission may result in processing delays. Be sure to include all necessary information, and sign and date the form. Please make copies for your records, as these documents will not be returned. If you fax your claim, keep the original.

### Health Flexible Spending Account

- Attach a copy of the Explanation of Benefits (EOB) for each submission. All claims **MUST** be submitted to your insurance company prior to request for reimbursement. **Estimates for services that have not yet been incurred cannot be accepted.**

  **OR**

  Submit a paid receipt for your copays. **Credit card receipts, canceled checks, or cash register receipts cannot be accepted for copays. Itemized cash register receipts are acceptable for over-the-counter (OTC) items/supplies that do not contain a medicine or drug. If the OTC item **does** contain a medicine or drug, you will need to submit a cash register receipt as well as a doctor's prescription.**

  **OR**

  If you do not have insurance coverage, submit an itemized statement from the provider showing the provider’s name and address, patient name, date and description of service and amount charged. Additionally, prescription expenses must include the drug name or number. **Balance forward or paid on account statements cannot be accepted.**

- Orthodontic reimbursement: For the first request, submit a copy of the Service Agreement or contract itemizing the treatment period, down payment, monthly payment, banding date and amount covered by insurance, if any. For subsequent claims, submit a copy of your monthly payment coupon and/or itemized receipt each time you request reimbursement.

### Dependent Care Reimbursement Account

- Expenses submitted must have been incurred for the care of a “qualifying individual” for the purpose to be gainfully employed.

- A qualifying individual is (i) a dependent of yours under age 13, (ii) a dependent of yours (or your spouse) who is incapable of caring for himself/herself.

### Medical and Dental Expenses Generally Eligible for Reimbursement

(Source: IRS Tax Publication 502)

**You Should Claim**

- Fees for health services or supplies provided by physicians, surgeons, dentists, ophthalmologists, optometrists, chiropractors, podiatrists, psychiatrists, psychologists, or Christian Science practitioners.

- Acupuncture.

- Fees for hospital, ambulance, laboratory, surgical, obstetrical, diagnostic, dental and X-ray services.

- Costs incurred, including room and board, during treatment for alcohol or drug addiction at a hospital or treatment center.

- Special equipment, such as wheelchairs, special handicapped automotive controls, and special phone equipment for the deaf.

- Special items, such as dentures, contact lenses, eyeglasses, hearing aids, crutches, artificial limbs and guide dogs for the vision or hearing impaired.

- Transportation for needed medical therapy.

- Nursing services.

- Rehabilitation expenses.

**You Should NOT Claim**

- Any items which will be paid for by insurance or for which you are reimbursed by insurance or any other health plan.

- Bottled water.

- Health club dues.

- Any illegal operation or treatment.

- Programs to control weight (unless the program is undertaken at a physician’s direction to treat an existing illness, including obesity).

- Elective cosmetic surgery.

- Medical insurance premiums paid outside of your company by you or your spouse at his or her place of employment.

- Nursing care for a normal, healthy baby.

- Maternity clothes.

- Burial expenses.
# Direct Deposit Authorization Form

To be reimbursed directly into your bank account, please complete this form and mail it to the address on the right.

## Type of Request
- [ ] New
- [ ] Change
- [ ] Cancellation

## Employee Information

<table>
<thead>
<tr>
<th></th>
<th>Employee:</th>
<th>Work Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: (last, first, initial)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
<td>Zip Code:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Financial Information

<table>
<thead>
<tr>
<th></th>
<th>Name(s) on the account:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank or Financial Institution:</td>
<td>Routing/Transit Number:</td>
</tr>
<tr>
<td>Address:</td>
<td>Account Number:</td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Voided check (for checking account) or deposit slip (for savings account)* ~ This is required ~ Please place directly below

## Terms and Conditions

1. You must complete, sign, and date this authorization form to enroll in the direct deposit program. If you have a joint account, the form must be signed by both parties. Once your form is received by Meritain Health, there may be up to a 7-10 business day time period before the direct deposit becomes effective. Any claims paid during this time will be mailed to you as a check.

2. In order to take advantage of the direct deposit program, your financial institution must be a member of an Automated Clearing House (ACH).

3. You will receive a direct deposit statement each time an electronic transfer is made to your account. The statement will indicate what claims are paid, as well as year-to-date information on your reimbursement account. It can take up to 72 hours for a payment to post into your account after Meritain Health transmits the funds. Please verify that the deposit has been made into your account before attempting to withdraw funds.

4. It is your responsibility to notify Meritain Health of any changes to your bank account, such as a closure, or a change in the account number. Complete this form with the new information, and check the change box. There may be up to a 7-10 business day processing period before the change becomes effective. During this time, you will receive checks for any reimbursement claims paid.

5. You may cancel direct deposit at any time by completing this form and checking the cancellation box. This will take effect as soon as the form is received and processed by Meritain Health.

6. If a direct deposit is returned to Meritain Health, or for any reason cannot be made to your account, Meritain Health will investigate the cause and if needed, issue a reimbursement check. Until the problem is corrected, you will continue to receive checks for any reimbursement claims paid.

7. Direct deposit services will remain in effect from one plan year to the next unless you cancel the direct deposit services.

8. Meritain Health reserves the right to automatically cancel your direct deposit services upon termination of employment or termination of your reimbursement account.

Questions? Please call Meritain Health at 1.800.566.9305.

*If the savings deposit slip does not contain a routing number maintained by your bank, you will need to submit a bank form, or statement on bank letterhead that verifies the account and routing numbers of your savings account.

## Employee / Account Holder Certification

I certify that I have read and understand the terms and conditions on this form. By signing here, I authorize my Health Reimbursement Arrangement or Flexible Spending Account reimbursements to be sent to the financial institution and account designated above. This authorization is to remain in effect until Meritain Health has been given a reasonable amount of time to act on written notification from me to terminate the deposits and continue reimbursements with mailed checks.

<table>
<thead>
<tr>
<th>Employee Signature:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Account Holder’s Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

Note: Any joint account holder MUST sign this form in order to be reimbursed.
Intentionally left blank
Prescription Drug Claim Form  Please refer to instructions on reverse side.

STEP 1 > CARDHOLDER/PATIENT INFORMATION  (to be completed by patient)

Cardholder ID #             DIV

Cardholder’s name (Last)             (First)             (MI)

Address

City       State       ZIP

Patient information  (Please list information for the patient submitting claims; allow one claim form for each patient.)

Patient’s name (Last)            (First)             (MI)

Relationship to cardholder?  Self   Spouse   Dependent   Gender M   F

Date of birth (Month/Day/Year)

STEP 2 > CLAIM INFORMATION FROM PHARMACY RECEIPT  (to be completed by patient)

Reason for submission?  □  Forgot insurance card   □  Processing error at pharmacy   □  Out of network pharmacy

□ Other _____________________________________________________________

Is this a compound Rx?  Y   N   (If yes, please attach a compound claim form from the pharmacy.)

Does the patient reside in an assisted living facility?  Y   N

Is this for an allergy serum?  Y   N

Is this claim for a diabetic supply?  Y   N

Was this prescription filled in a foreign country?  Y   N

Was a discount card used?  Y   N

Was this prescription filled in a foreign country?  Y   N

Currency used ______________________

Foreign medication name __________________________________________________________________________________________

Foreign amount paid ______________________________________

Please include a pharmacy receipt with the following information:

Fill date, Rx number, National Drug Code (NDC), medication name (in English), strength, dosage, quantity, days supply, amount paid, prescriber name, and the prescriber NPI#.

STEP 3 > OTHER INSURANCE COVERAGE  (to be completed by patient)

Is the patient eligible for primary prescription-drug coverage from another provider?  Y   N

If yes, did the patient submit the claim to this other provider?  Y   N   (If yes, please attach the explanation of benefits from the other provider.)

Did the prior insurance pay in error?  Y   N

(Over)
STEP 4  AUTHORIZATION
(to be completed by pharmacist/physician if pharmacy receipts are not submitted)

Pharmacy name

National Provider (NPI) number

Pharmacist/physician name

Address

City            State       ZIP

Pharmacist/physician signature

Note: Payment for the above claim(s) will be made directly to the Policyholder. Any assignment of these benefits must include the signature of the Policyholder and is subject to approval of your prescription drug plan administrator.

STEP 5  SIGNATURE

PLEASE SIGN AND DATE HERE: I certify that all information provided is correct and that the prescription(s) submitted are for me or members of my family who are eligible. The patient(s) listed below has (have) received the medication, and I authorize release of all information contained on this claim to Express Scripts, Inc. and my Plan Sponsor. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Cardholder’s signature ___________________________ Date (Month/Day/Year) ☐ ☐ ☐ ☐

PLEASE READ THE FOLLOWING INSTRUCTIONS AND COMPLETE THIS FORM CAREFULLY.

• Please print clearly in each box, being careful not to touch the edges of each box.
• Please do not highlight the claim form or the prescription receipts.
• Please sign the claim form. Unsigned claim forms cannot be processed and will be returned.
• Please use a separate claim form for each patient (or family member).
• Each submission must include prescription receipts/labels OR a patient history printout from your pharmacy, signed by the dispensing pharmacist.
• If you have multiple receipts for the same patient, please attach them to this claim form.
• Please note that claims missing any of the above information may be returned or payment may be denied.
• It is preferable to submit receipts either unattached to this form or taped to a separate piece of paper. Please DO NOT use staples or glue.
• If applicable, include Power of Attorney, Executor of Estate, or Death Certificate documentation.

Questions? Call Express Scripts at the number on the back of your member ID card.

Please mail this claim to:
Express Scripts
ATTN: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

Medicare Part D members please mail to:
Express Scripts
ATTN: Med D Claims
P.O. Box 66752
St. Louis, MO 63166-6752

You may also fax your claim form to:
608.741.5475.
Please use one claim form per fax. Do not combine claims for different members in the same fax submission.

© 2011 Express Scripts, Inc. All Rights Reserved 11-2556
**2017 Express Scripts National Preferred Formulary**

The following is a list of the most commonly prescribed drugs. It represents an abbreviated version of the drug list (formulary) that is at the core of the prescription-drug benefit plan. The list is not all-inclusive and does not guarantee coverage. In addition to using this list, you are encouraged to ask your doctor to prescribe generic drugs whenever appropriate.

**PLEASE NOTE:** Brand-name drugs may move to nonformulary status if a generic version becomes available during the year. Not all the drugs listed are covered by all prescription-drug benefit programs; check your benefit materials for the specific drugs covered and the copayments for your prescription-drug benefit program. For specific questions about your coverage, please call the phone number printed on your member ID card.

This document list is effective January 1, 2017 through December 31, 2017. This list is subject to change. You can get more information and updates to this document at our website at Express-Scripts.com.