


**Benefit Summary
ASO Choice Plus**

Effective: January 1, 2026 Fairbanks Local Schools Core Medical Plan 7EM-M

UnitedHealthcare and EPC want to help you take control and make the most of your health care benefits. That's why we provide convenient services to get your health care questions answered quickly and accurately:

- **myuhc.com®** - Take advantage of easy, time-saving online tools. You can check your eligibility, benefits, claims, claim payments, search for a doctor and hospital and much, much more.
- **Customer Care telephone support** – Need more help? Call a customer care professional using the toll-free number on the back of your ID card. Get answers to your benefit questions or receive help looking for a doctor or hospital.

The Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine your coverage. If this Benefit Summary conflicts in any way with the Summary Plan Description (SPD), the SPD shall prevail. It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

PLAN HIGHLIGHTS

Types of Coverage	Network Benefits	Non-Network Benefits
Annual Deductible		
Individual Deductible	\$475 per year	\$950 per year
Family Deductible	\$950 per year	\$1,900 per year
• Member Copayments do not accumulate towards the Deductible • All individual deductible amounts will count towards meeting the family deductible, but an individual will not have to pay more than the individual deductible amount.		
Out-of-Pocket Maximum		
Individual Out-of-Pocket Maximum	\$3,000 per year	\$6,000 per year
Family Out-of-Pocket Maximum	\$6,000 per year	\$12,000 per year
• Member Copayments and coinsurance do accumulate towards the Out-of-Pocket Maximum. • Out-of-Pocket Maximum includes the deductible • All individual out of pocket amounts will count towards meeting the family out of pocket, but an individual will not have to pay more than the individual out of pocket amount.		
Benefit Plan Coinsurance – The Amount the Plan Pays		
	80% after Deductible has been met for most services	60% after Deductible has been met for most services
Lifetime Maximum Benefit		
The maximum amount the Plan will pay during the entire period of time you are enrolled under the Plan	Unlimited	Unlimited
Prescription Drug Benefits		
• Prescription drug benefits are shown under separate cover.		
Information of Pre-service Notification		
*Prior Authorization <i>is required for certain services.</i>		
Information on Benefit Limits		
• The Annual Deductible, Out-of-Pocket Maximum and Benefit limits are calculated on a calendar year basis. • All Benefits are reimbursed based on Eligible Expenses. For a definition of Eligible Expenses, please refer to your Summary Plan Description. • When Benefit limits apply, the limit refers to any combination of Network and Non-Network Benefits unless specifically stated in the Benefit category.		

BENEFITS

Types of Coverage	Network Benefits	Non-Network Benefits
Ambulance Services – Emergency and Non-Emergency		
	* 80% after Deductible is met.	* 80% after Network Deductible has been met
Dental Services – Accident Only		
	* 80% after Deductible is met.	* 80% after Network Deductible has been met

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Durable Medical Equipment (DME)		
Benefits are limited as follows: Benefits are limited to a single purchase of a type of Durable Medical Equipment (including repair and replacement) every three years. Hearing Aid Benefits limited to \$2500 every 3 years. Limited to a single purchase (including repair/replacement) per hearing impaired ear every three years. Hearing Testing is unlimited.	**80% after Deductible is met.	**60% after Deductible has been met

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
Emergency Health Services - Outpatient		
	100% after you pay a \$100 Copayment per visit. If you are admitted as an inpatient to a Network Hospital directly from the Emergency room, you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.	* 100% after you pay a \$100 Copayment per visit
Home Health Care		
Benefits are limited as follows: 60 visits per year	80% after Deductible is met.	* 60% after Deductible has been met
Hospice Care		
	80% after Deductible is met.	* 60% after Deductible has been met
Hospital – Inpatient Stay		
	80% after Deductible is met.	* 60% after Deductible has been met
Lab, X-Ray and Diagnostics – Outpatient		
For Preventive Lab, X-Ray and Diagnostics, refer to the Preventive Care Services category.	100%, Deductible does not apply	60% after Deductible has been met Prior Authorization is required sleep studies
Lab, X-Ray and Major Diagnostics – CT, PET, MRI and Nuclear Medicine – Outpatient		
	80% after Deductible is met.	60% after Deductible has been met Prior Authorization is required
Mental Health and Substance Abuse Services – Inpatient and Intermediate		
	*80% after Deductible is met.	* 60% after Deductible has been met
Mental Health and Substance Abuse Services – Outpatient		
	* 100% after you pay a \$25 Copayment per visit	* 60% after Deductible has been met
Ostomy		
	80% after Deductible is met.	60% after Deductible has been met
Physician Fees for Surgical and Medical Services		
	80% after Deductible is met.	60% after Deductible has been met
Physician's Office Services – Sickness and Injury		
Primary Physician Office Visit	100% after you pay a \$25 Copayment per visit	60% after Deductible has been met
Specialist Physician Office Visit	100% after you pay a \$35 Copayment per visit	60% after Deductible has been met
In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies when these services are done: Pharmaceutical Products. Allergy injections are covered at 100% if no physicians charge is assessed, if performed in conjunction with an office visit, an office copay will be applied.		
Pregnancy – Maternity Services		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each covered Health Service category in this Benefit Summary	
	For services provided in the Physician's Office, a Copayment will only apply to the initial office visit.	Prior Authorization is required if Inpatient Stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.
Preventive Care Services		
Covered Health Services include but are not limited to:		
Primary Physician Office Visit	100%	Non-Network Benefits are not available
Specialist Physician Office Visit	100%	
Lab, X-Ray or other preventive tests	100%	
Prosthetic Devices		
	80%	60% after Deductible has been met Prior Authorization is required for Prosthetic Device in excess of \$1000
Reconstructive Procedures		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those	

BENEFITS		
Types of Coverage	Network Benefits	Non-Network Benefits
	stated under each Covered Health Service category in this Benefit Summary	
		Prior Authorization is required for certain services.
Rehabilitation Services – Outpatient Therapy and Chiropractic Treatment		
Benefits are limited as follows: Network and Non-Network benefits are limited to a combined total of 90 visits per calendar year for any combination of the following: Chiropractic treatment Physical therapy Occupational therapy Speech therapy Post-Cochlear implant aural therapy Vision therapy Pulmonary rehabilitation -unlimited visits Cardiac rehabilitation – unlimited visits	The first three visits for any combination of physical therapy and Manipulative Treatment for new low back pain are not subject to any co-payment, co-insurance or deductible and subject to the annual visit limit. For all other visits, please see the payment information listed below. 80% after deductible has been satisfied. Benefits for Habilitative Services are provided under and as part of Rehabilitation Services – Outpatient Therapy and Manipulative Treatment and are subject to the limits as stated below in this benefit summary	* 60% after Deductible has been met
Scopic Procedures – Outpatient Diagnostic and Therapeutic		
Diagnostic scopic procedures include, but are not limited to: Colonoscopy; Sigmoidoscopy; Endoscopy For Preventive Scopic Procedures, refer to the Preventive Care Services category.	80% after Deductible is met.	60% after Deductible has been met
Skilled Nursing Facility / Inpatient Rehabilitation Facility Services		
Benefits are limited as follows: 60 days maximum benefit per calendar year	80% after Deductible is met.	* 60% after Deductible has been met
Surgery – Outpatient		
	80% after Deductible is met. 100% after \$25 copay if performed in Primary Care Physician's office 100% after \$35 copay if performed in a Specialist's office	60% after Deductible has been met
Therapeutic Services		
	80% after Deductible is met.	*60% after Deductible has been met
Transplantation Services		
	*80 after Deductible is met%	* 60% after Deductible has been met
	For Network Benefits, services must be received at a Designated Facility.	
Urgent Care Center Services		
	100% after you pay a \$35 Copayment per visit	60% after Deductible has been met
In addition to the visit Copayment, the applicable Copayment and any Deductible/Coinsurance applies when these services are done: Pharmaceutical Product		
Vision Examinations		
Benefits are limited as follows: 1 exam every year	100% after you pay a \$25 Copayment per visit	Non-Network Benefits are not available
Non-Surgical Treatment of Temporomandibular Joint Dysfunction Treatment		
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Benefit Summary

MEDICAL EXCLUSIONS
It is recommended that you review your SPD for an exact description of the services and supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.
Alternative Treatments
Acupressure; aromatherapy; hypnotism; massage therapy; rolfing (holistic tissue massage); art, music, dance, horseback therapy; and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Chiropractic Treatment and osteopathic care for which Benefits are provided as described in the SPD.
Dental
Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia). This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan as described in the SPD. Dental care that is required to

treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication. Endodontics, periodontal surgery and restorative treatment are excluded. Diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include: extraction (including wisdom teeth), restoration, and replacement of teeth; medical or surgical treatment of dental conditions; and services to improve dental clinical outcomes. This exclusion does not apply to accidental-related dental services for which Benefits are provided as described under Dental Services – Accidental Only in the SPD. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services – Accident Only in the SPD. Dental braces (orthodontics). Congenital Anomaly such as cleft lip or cleft palate.
Devices, Appliances and Prosthetics Devices used specifically as safety items or to affect performance in sports-related activities. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, cranial banding and some types of braces, including over-the-counter orthotic braces. The following items are excluded, even if prescribed by a Physician: blood pressure cuff/monitor; enuresis alarm; home coagulation testing equipment; non-wearable external defibrillator; trusses; ultrasonic nebulizers; and ventricular assist devices. Devices and computers to assist in communication and speech except for speech aid prosthetics and tracheo-esophageal voice prosthetics. Oral appliances for snoring. Repair and replacement prosthetic devices when damaged due to misuse, malicious damage or gross neglect. Prosthetic devices. This exclusion does not apply to breast prosthesis, mastectomy bras and lymphedema stockings for which Benefits are provided as described under Reconstructive Procedures in the SPD.
Drugs The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See the SPD for coverage details and exclusions. Prescription drugs for outpatient use that are filled by a prescription order or refill. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. Over-the-counter drugs and treatments. Growth hormone therapy.
Experimental or Investigational or Unproven Services Experimental or Investigational or Unproven Services, unless the Plan has agreed to cover them as defined in the SPD. This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in the SPD.
Foot Care Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in the SPD or when needed for severe systemic disease. Cutting or removal of corns and calluses. Nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot. Examples include: cleaning and soaking the feet; applying skin creams in order to maintain skin tone. This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. Treatment of flat feet. Shoes (standard or custom), lifts and wedges; shoe orthotics; shoe inserts and arch supports
Medical Supplies and Equipment Prescribed or non-prescribed medical supplies and disposable supplies. Examples include: elastic stockings, ace bandages, diabetic strips, and syringes; urinary catheters. This exclusion does not apply to: • Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in the SPD. • Diabetic supplies for which Benefits are provided as described under Diabetes Services in the SPD. • Ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in the SPD. Tubings, nasal cannulas, connectors and masks, [except when used with Durable Medical Equipment as described under Durable Medical Equipment as described in the SPD. The repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect and deodorants, filters, lubricants, tape, appliance clears, adhesive, adhesive remover or other items that are not specifically identified in the SPD
Mental Health / Substance Abuse Inpatient, intermediate or outpatient care services that were not pre-authorized by the Mental Health/Substance Abuse (MH/SA) Administrator; Services performed in connection with conditions not classified in the current edition of the <i>American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders</i>. Mental Health Services and Substance Abuse Services that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention. Mental Health Services as treatment for insomnia and other sleep disorders, neurological disorders and other disorders with a known physical basis. Treatment for conduct and impulse control disorders, personality disorders, paraphilias (sexual behavior that is considered deviant or abnormal) and other Mental Illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Mental Health/Substance Abuse Administrator. Services utilizing methadone, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclozine, or their equivalents as maintenance treatment for drug addiction. Treatment provided in connection with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Mental Health/Substance Abuse Administrator. Residential treatment services. Routine use of psychological testing without specific authorization; pastoral counseling. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Mental Health/Substance Abuse Administrator, typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective, or are not consistent with: • Prevailing national standards of clinical practice for the treatment of such conditions. • Prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome. • The Mental Health/Substance Abuse Administrator's level of care guidelines as modified from time to time. The Mental Health/Substance Abuse Administrator may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

MEDICAL EXCLUSIONS Continued
Nutrition Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy. Nutritional counseling for either individuals or groups except as defined under Nutritional Counseling in the SPD. Food of any kind. Foods that are not covered include: enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU) – infant formula available over the counter is always excluded; foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes; oral vitamins and minerals; meals you can order from a menu, for an additional charge, during an Inpatient Stay, and other dietary and electrolyte supplements; and health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.
Personal Care, Comfort or Convenience Television; telephone; beauty/barber service; guest service. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include: air conditioners, air purifiers and filters, dehumidifiers and humidifiers; batteries and battery chargers; breast pumps; car seats; chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners; electric scooters; exercise equipment and treadmills; home modifications to accommodate a health need such as ramps, swimming pools, elevators, handrails and stair glides; hot tubs; Jacuzzis, saunas and whirlpools; ergonomically correct chairs, non-Hospital beds, comfort beds, mattresses; medical alert systems; motorized beds; music devices; personal computers, pillows; power-operated vehicles; radios; saunas; strollers; safety equipment; vehicle modifications such as van lifts; and video players.
Physical Appearance Cosmetic Procedures. See the definition in the SPD. Examples include: pharmacological regimens, nutritional procedures or treatments; Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); Skin abrasion procedures performed as a treatment for acne; treatment of hair loss; varicose vein treatment of the lower extremities, when it is considered cosmetic; Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple; Treatment for skin wrinkles or any treatment to improve the appearance of the skin; Treatment for spider veins; Hair removal or replacement by any means. Replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Treatment of benign gynecomastia (abnormal breast enlargement in males). Breast reduction except as coverage is required by the Women's Health and Cancer Right's Act of 1998 for which Benefits are described under Reconstructive Procedures in the SPD. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded, even if for morbid obesity. Wigs regardless of the reason for the hair loss, except for temporary loss of hair resulting from treatment of a malignancy.
Procedures and Treatments Procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy, and brachioplasty. Medical and surgical treatment of excessive sweating (hyperhidrosis). Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or autism spectrum disorders. Speech therapy to treat stuttering, stammering or other articulation disorders. Psychosurgery. Sex transformation operations. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. Biofeedback. Chiropractic treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies. Chiropractic treatment (the therapeutic application of chiropractic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function). Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury, dislocation, tumors or cancer. Diagnosis or treatment of the jawbones, including Orthognathic surgery, and jaw alignment, except as a treatment of obstructive sleep apnea. Non-surgical treatment of obesity even if for morbid obesity. Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under Obesity Surgery in the SPD. Treatment of tobacco dependency. Chelation therapy, except to treat heavy metal poisoning.

Providers
Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. Services performed by a provider with your same legal residence. Services ordered or delivered by a Christian Science practitioner. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider has not been actively involved in your medical care prior to ordering the service, or is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography. Foreign language and sign language interpreters.
Reproduction
Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. The following infertility treatment-related services: cryo-preservation and other forms of preservation of reproductive materials, long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue, donor services. Surrogate parenting, donor eggs, donor sperm and host uterus. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue. The reversal of voluntary sterilization. Health services and associated expenses for elective surgical, non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage). Services provided by a doula (labor aide); and parenting, prenatal or birthing classes. Artificial reproduction treatments done for genetic or eugenic.
Services Provided under Another Plan
Health services for which other coverage is available under another plan, except for Eligible Expenses payable as described in the SPD. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation, no-fault automobile coverage or similar legislation is optional for you because you could elect it, or could have it elected for you. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you. Health services while on active military duty.
Transplants
Health services for organ and tissue transplants, except as identified under Transplantation Services in the SPD. Mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).
Travel
Travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging in the SPD. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion.
Types of Care
Multi-disciplinary pain management programs provided on an inpatient basis. Custodial care; domiciliary care. Private duty nursing. Respite care; rest cures; services of personal care attendants. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).
Vision and Hearing
Purchase cost and associated fitting charge for eye glasses and contact lenses. Implantable lenses used only to correct a refractive error (such as Intacs corneal implants). Eye exercise therapy. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.
All Other Exclusions
Health services and supplies that do not meet the definition of a Covered Health Service – see the definition of Covered Health Services in the Glossary in the SPD. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when: required solely for purposes of career, education, school, sports or camp, travel, employment, insurance, marriage or adoption; or as a result of incarceration; related to judicial or administrative proceedings or orders; conducted for purposes of medical research; required to obtain or maintain a license of any type. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. Health services received after the date your coverage under the Plan ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Plan ended. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan. Charges that exceed Eligible Expenses or any specified limitation in the SPD. Health services when a provider waives the Copay, Annual Deductible or Coinsurance amounts. Autopsies and other coroner services and transportation services for a corpse. Charges for: missed appointments; room or facility reservations; completion of claim forms; or record processing. Charges prohibited by federal anti-kickback or self-referral status. Diagnostic tests that are: delivered in other than a Physician's office or health care facility; and self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests. Vision therapy when rendered in connection with behavioral health disorders, including but not limited to: learning and reading disabilities; attention deficit/hyperactivity disorder; TBI; or dyslexia

Here's an overview of your CVS Caremark Benefits

Fairbanks Core PPO – 1/1/2026

Visit [caremark.com](https://www.caremark.com) to access plan materials, price medications and locate pharmacies. If you have further questions about your prescription plan or costs, please call 1-888-202-1654. For TDD assistance, please call 1-800-863-5488.

	Short-Term Medicines CVS Caremark Retail Pharmacy Network (Up to a 30-day supply)	Long-Term Medicines CVS Caremark Mail Service Pharmacy or CVS Pharmacy Locations (Up to a 90-day supply)
Generic Medicines Always ask your doctor if there's a generic option available. It could save you money.	\$10 for a generic medicine	\$20 for a generic medicine
Preferred Brand-Name Medicines If a generic is not available or appropriate, ask your doctor to prescribe from your plan's preferred drug list.	20% \$25 min / \$40 max for a preferred brand-name medicine	20% \$60 min / \$100 max for a preferred brand-name medicine
Non-Preferred Brand-Name Medicines Drugs that aren't on your plan's preferred list will cost more.	30% \$40 min / \$60 max for a non-preferred brand-name medicine	30% \$100 min / \$150 max for a non-preferred brand-name medicine
Refill Limit	None	None
Maximum Out-of-Pocket	\$3,000 per individual / \$6,000 per family	
Specialty Medicines	\$30% coinsurance OR \$0 copay with PrudentRx Specialty medications are required to be filled through CVS Specialty Mail Order Pharmacy or at a retail CVS/pharmacy. Please contact Customer Care toll-free at 1-888-202-1654 for questions or to get started today.	
Prior Authorization	Certain medications may require prior authorization. Please contact Customer Care toll-free at 1-888-202-1654 or visit www.caremark.com for verification of prior authorization requirements.	

Copayment, copay or coinsurance means the amount a plan member is required to pay for a prescription in accordance with a Plan which may be a deductible, a percentage of the prescription price, a fixed amount or other charge, with the balance, if any, paid by a Plan. Your feedback is important as it helps us improve our service. Please contact us with any questions or concerns at 1-888-202-1654. If you access your pharmacy benefits information through the Caremark Web site, you can find Plan Members Rights and Responsibilities at www.caremark.com.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle private health information