

Alaska Radiology Associates

Adult Dental Optima Plan

1040097

HOW TO CONTACT US

Please call or write our customer service staff for help with the following:

- Questions about the benefits of this plan
- Questions about your claims
- Questions or complaints about care or services you receive
- Change of address or other personal information

CUSTOMER SERVICE

Mailing Address:

Premera Blue Cross Blue Shield of Alaska

For Claims Only

PO Box 91059
Seattle, WA 98111-9159

Physical Address:

Premera Blue Cross Blue Shield of Alaska
3800 Centerpoint Dr, Suite 940
Anchorage, AK 99503-5825

Telephone Numbers:

Local and toll-free number: 800-508-4722

Local and toll-free TTY number: 800-842-5357

Online information about this dental care plan is at your fingertips whenever you need it

You'll find answers to most of your questions about this plan in this benefit booklet. You also can explore our website at www.premera.com anytime you want to:

- Learn more about how to use this plan
- Locate a dental care provider near you
- Get details about the types of expenses you're responsible for and this plan's benefit maximums
- Check the status of your claims
- Visit our health-information resource to gain knowledge about diseases, illnesses, medications, treatments, nutrition, fitness and many other health topics

You also can call our customer service staff at the numbers listed above. We're happy to answer your questions and appreciate any comments you want to share. In addition, you can get benefit, eligibility and claim information through our Interactive Voice Response system when you call customer service.

Group Name: Alaska Radiology Associates

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Group Number: 1040097

Plan: Alaska Adult Dental Optima

Certificate Form Number: AKSGDIMAO FSD OPT (01-2024)

INTRODUCTION

This benefit booklet is for members of Premera Blue Cross Blue Shield of Alaska, an Independent Licensee of the Blue Cross Blue Shield Association. This booklet describes the benefits of this plan and replaces any other benefit booklet you may have received.

The benefits, limitations, exclusions and other coverage provisions described on the following pages are subject to the terms and conditions of the contract we've issued to the Group. The "Group" is the firm, corporation, partnership or association of employers that contracts with us. This booklet is a part of the complete contract, which is on file in the Group's office and at the headquarters of Premera Blue Cross Blue Shield of Alaska.

HOW TO USE THIS BOOKLET

We realize that using a dental care plan can seem complicated, so we've prepared this booklet to help you understand how to get the most out of your benefits. Please familiarize yourself with the Table of Contents, which lists sections that answer many frequently asked questions.

Every section in this booklet contains important information, but the following sections may be particularly useful to you.

- **HOW TO CONTACT US** – our website address, phone numbers, mailing addresses and other contact information conveniently located inside the front cover.
- **WHAT DO I NEED TO KNOW BEFORE I GET CARE?** – important information that helps you understand about the benefits of this plan
- **WHAT ARE MY BENEFITS?** – what is covered under this plan
- **EXCLUSIONS AND LIMITATIONS** – services that are either limited or not covered under this plan
- **WHO IS ELIGIBLE FOR COVERAGE?** – eligibility requirements for this plan
- **HOW DO I FILE A CLAIM?** – step-by-step instructions for claims submissions
- **COMPLAINTS AND APPEALS** – addresses and processes to follow if you want to share ideas, ask questions, file a complaint or submit an appeal
- **DEFINITIONS** – many terms that have specific meanings under this plan. Example: The terms "you" and "your" refer to members under this plan. The terms "we," "us" and "our" refer to Premera Blue Cross Blue Shield of Alaska in the state of Alaska.

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WHAT DO I NEED TO KNOW BEFORE I GET CARE?

Note: This plan requires all enrollees to be 19 years of age or older to be covered under this plan. See *Who Is Eligible For Coverage?* section for eligibility requirements specific to subscriber and dependents.

The services under this plan are classified as Class I - Diagnostic and Preventive, Class II - Basic, and Class III – Major services. The list of covered services that relate to each type are outlined in the following pages under **Description of Covered Services**. These services are covered once all of the following requirements are met. It's important to understand all of these requirements so you can make the most of your dental benefits.

Benefits are available for the services described in this section that are furnished for a covered dental condition including treatment of an enrolled dependent child's congenital anomaly. Such services must meet all of the following requirements:

- They must be medically or dentally necessary. See definition of **Medically Necessary** or **Dentally Necessary**.
- They must not be excluded from coverage under this plan
- They must be furnished by a licensed dentist (DMD or DDS), except that they may also be furnished by a dental hygienist or other individual, performing within the scope of their license as allowed by law. These services must be rendered under the supervision and guidance of a dentist. The above providers are called "dental care providers" in this booklet.
- They must not be excluded from coverage under this benefit

At times we may need to review diagnostic materials such as dental x-rays to determine your available benefits. These materials will be requested directly from your dental care provider. If we're unable to obtain necessary materials, we'll provide benefits only for those dental services we can verify as covered.

Coverage under this dental plan is based on allowable charges for medically or dentally necessary covered services. The percentage of an allowable charge you're responsible for is called coinsurance. See the **Definitions** section in this booklet for a detailed explanation of "allowable charge."

ALTERNATIVE TREATMENT

To determine benefits available under this plan, we consider alternative treatment with different fees that are consistent with accepted standards of dental practice. Frequently, several alternate treatments exist to treat a dental condition. For example, a tooth can be restored with a crown or a filling, and missing teeth can be replaced either with a fixed bridge or a partial denture.

In all cases, we will make payment based on the allowance for the least expensive alternative treatment that is covered under this plan and that meets accepted standards of dental practice. If you and your dental care provider choose the more expensive treatment when a less expensive alternative treatment is available, you are responsible for the additional cost above what the plan allows for the less costly alternative treatment.

DENTAL ESTIMATE OF BENEFITS

A dental estimate of benefits verifies, for the dental care provider and you, your eligibility and benefits. Because we consider alternative treatment at the time we review the dental estimate, our review may result in a lower cost of treatment and additional services under this benefit. It may also clarify, before services are rendered, treatment that isn't covered in whole or in part. This can protect you from unexpected out-of-pocket expenses.

A dental estimate of benefits isn't required in order for you to receive your dental benefits. However, we suggest that your dental care provider submit a dental estimate to us for any proposed services in which you are concerned about your out-of-pocket expenses.

Our dental estimate of benefits shouldn't be considered a guarantee of payment. Payment of any service will be based on your eligibility and benefits available at the time services are rendered.

CALENDAR YEAR DENTAL DEDUCTIBLE

Covered Class I - Diagnostic and Preventive services aren't subject to a calendar year dental deductible. However, a calendar year dental deductible does apply to covered Class II-Basic and Class III - Major services. The dental deductible is the amount you must pay per calendar year before benefits are payable under this plan. The amount credited toward the dental deductible won't exceed the allowable charge for the covered service.

For each member, your individual dental deductible amount is \$50.

This plan has an annual dollar maximum described below. We don't count allowable charges that apply to your

individual dental deductible toward that annual dollar maximum. However, the plan also has limits on how often some procedures can be covered in a specific period of time. If you receive services or supplies covered by a benefit that has such a limit, we count the procedures that apply to your individual dental deductible toward each limit.

FAMILY DENTAL DEDUCTIBLE

We also keep track of the expenses applied to the individual dental deductible that are incurred by all enrolled family members combined. When the total equals \$150, we will consider the individual dental deductible of every enrolled family member to be met for the year. The \$150 is called the "family dental deductible." Only the amounts used to satisfy each enrolled family member's individual dental deductible will count toward the family dental deductible.

COINSURANCE

As used in this plan, "coinsurance" is a defined percentage of allowable charges for covered services and supplies you receive. The percentage you're responsible for, not including any applicable calendar year deductible, is called "coinsurance."

DENTAL BENEFIT MAXIMUM

The maximum amount of dental benefits available to any one member in a calendar year is \$2,000.

IN-NETWORK PROVIDERS

For the most current information on in-network dental care providers, please refer to our website or contact customer service. You'll find this information on the inside front cover of this booklet.

This plan is designed to cover all dental care providers at the same benefit level. When you receive services from in-network providers, your claims will be submitted directly to us, and available benefits will be paid directly to the dental care provider. In-Network providers agree to accept our "allowable charge" (see the **Definitions** section in this booklet) as payment in full. You're responsible only for any applicable calendar year deductible, coinsurance, amounts that are in excess of stated benefit maximums, and charges for non-covered services.

Important Note: You're entitled to receive a provider directory automatically, without charge.

We will notify you at least 30 days prior to your provider's termination date. When a termination for cause provides us less than 30 days' notice, we will make a good faith effort to assure that a written notice is provided to you immediately.

OUT-OF-NETWORK PROVIDERS

When there isn't an in-network provider located within 50 miles from your home or decide not to use an in-network provider, you may choose any dental care provider. Your dental services will be paid at the same benefit level as in-network providers. However, if you receive services from out-of-network dental care providers, you're responsible for amounts above the allowable charge in addition to any applicable calendar year deductible, coinsurance, amounts that are in excess of stated benefit maximums, and charges for non-covered services. Amounts that are in excess of the allowable charge don't accrue toward your calendar year deductible if one applies.

You may be required to submit the dental claim yourself if your dental care provider doesn't do this for you. See the **How Do I File A Claim?** section in this booklet for instructions on submitting claims for reimbursement.

WHAT ARE MY DENTAL BENEFITS?

BENEFIT PERCENTAGES

Coinsurance

You pay the following coinsurance per calendar year, up to the dental benefit maximum and after satisfying any applicable calendar year deductible. Dental services fall into three categories:

- Class I - Diagnostic and Preventive Services....0%
- Class II - Basic Services.....20%
- Class III - Major Services.....50%

DESCRIPTION OF COVERED SERVICES

Class I - Diagnostic And Preventive Services

- Routine, comprehensive and periodic oral evaluations are limited to two per calendar year. Professional consultations, periodontal evaluations and other office visits apply to this limit.
- Problem focused (including emergency) oral evaluations and re-evaluations are limited to once per calendar year. See the **Definitions** section for the definition of a **Dental Emergency**.
- Prophylaxis (cleaning of teeth) is limited to two per calendar year
- Dental x-rays include:
 - Bitewing limited to one set (up to four images) per calendar year
 - Either a panoramic x-ray or comparable cone beam or a complete full mouth series of x-rays, once every 36 consecutive months
 - Periapical x-rays
 - Occlusal x-rays
 - Oral pathology laboratory services, not including the removal of tissue sample, are covered when directly related to teeth and gums

Class II - Basic Services

- Fillings, consisting of amalgam and composite resins on any given tooth surface are limited to once in any 24 consecutive months
- Periodontal maintenance, as a follow-up to active periodontal treatment is limited to 4 treatments per calendar year
- Pulp vitality tests
- Protective restorations (sedative fillings)
- Endodontic services of teeth with diseased or damaged nerves include:
 - Direct pulp cap
 - Pulpotomy
 - Endodontic therapy (root canal) on permanent teeth is limited to once per tooth in any 24 consecutive months.
 - Retreatment of a root canal when services are done at least 12 months after the original procedure when performed by a different dental office
 - Open and drain (open and broach) (open and medicate) procedures may be limited to a combined allowance based on our review of the services rendered
 - Apexification, periradicular surgery, apicoectomy, and retrograde filling
- Non-surgical periodontal services of the gums and supporting structures include:
 - Periodontal scaling and root planing is limited to once per quadrant in any 24 consecutive months.
 - Full mouth debridement is limited to once every 36 consecutive months.
 - Localized delivery of antimicrobial agents are subject to review
- Periodontal Surgery is covered in the same quadrant once every 36 consecutive months.
- Periodontal soft tissue grafts are covered in the same quadrant once every 36 consecutive months.

- Simple extractions
- Surgical extractions of erupted or impacted teeth and removal of residual tooth roots
- Emergency palliative treatment. We require a written description and/or office records of services provided.
- Anesthesia in conjunction with covered services in a dental care provider's office includes:
 - General anesthesia, deep sedation or intravenous (conscious) sedation when necessary due to age, condition or degree of difficulty
 - Regional or trigeminal block anesthesia
 - Nitrous Oxide
- Therapeutic drug injections administered in a dental office
- Application of desensitizing medicament or resin
- Limited occlusal adjustments are limited to once every 12 consecutive months as dentally necessary

Class III - Major Services

- Oral surgery related to the tooth and gum includes:
 - Oral excision of soft tissue or bone
 - Oral excision of intra-osseous lesions
 - Oral Surgical Incision
 - Alveoplasty or vestibuloplasty
- Inlays, onlays, crowns and labial veneers for a tooth that is decayed, fractured or where there is significant loss of clinical crown and no other dentally appropriate restoration will restore the tooth are limited to once every five calendar years from the original seat date.
- Crown build-ups or post and cores for covered crowns are limited to once every 5 calendar years
- Labial veneers are limited to anterior teeth and subject to review for dental necessity. Labial veneers are often considered cosmetic and not covered by this dental plan. For this reason, a dental estimate of your benefits is strongly recommended.
- Initial placement of a fixed bridge or denture. Replacement is limited to:
 - Once every 5 calendar years from the original seat date and only if it is unserviceable and cannot be made serviceable.
 - The replacement or addition of teeth is required to replace 1 or more additional teeth extracted after initial placement.
- Repair or recement of inlays, crowns, onlays, bridgework and dentures are covered when services are done 6 or more months after initial placement
- Reline, rebase and adjustments of dentures are covered when services are done 6 or more months after denture installation.
- Occlusal guard (nightguard) is limited to once every 36 consecutive months.
- Occlusal guard repair, reline and adjustments are limited to once every 12 consecutive months when services are done 6 or more months after initial placement of occlusal guard.
- Implants and implant-related services
- Replacement implant/abutment supported crowns, dentures, and bridges are limited to once every 5 calendar years from the original seat date:

Dental Care Services For Accidental Injuries

When services are related to an accidental injury, benefits are provided for the reparation or repair of the natural tooth structure when such repair is performed within 12 months of the accidental injury.

These services are only covered when they're:

- Necessary as a result of an accidental injury;
- Performed within the scope of the provider's license;
- Not required due to damage from biting or chewing; and

- Rendered on natural teeth that were free from decay and otherwise functionally sound at the time of the injury. “Functionally sound” means that the affected teeth don’t have:
 - Extensive restoration, veneers, crowns or splints
 - Periodontal disease or other condition that would cause the tooth to be in a weakened state prior to the injury

Note: An accidental injury doesn’t include damage caused by biting or chewing, even if due to a foreign object in food.

If the necessary, services can’t be completed within 12 months of an injury, coverage may be extended if your dental care meets our extension criteria. We must receive extension requests within 12 months of the injury date. To request an extension, please have your provider contact customer service. In order for us to review an extension request, we will ask the provider to send additional information that would show the necessity for the extension; such as, the severity of the accident or other circumstances.

If you have a medical plan with Premera Blue Cross Blue Shield of Alaska, benefits for dental care services related to an accidental injury are covered under the Dental Services benefits of the medical plan.

In addition to "Exclusions and Limitations" this benefit doesn't cover any of the following:

- Oral evaluation for a patient under three years of age and counseling with a primary caregiver
- Pre-diagnostic screening and assessments
- Vertical bitewings
- Extra-oral images, posterior-anterior, lateral skull and facial bone surveys, and tomographic surveys
- Photographic images
- Cone beam CT capture and interpretation except when used as a comparable panoramic x-ray
- MRI and ultrasounds
- Genetic and caries susceptibility tests
- Study models and diagnostic casts
- Non-ionizing diagnostic procedures
- Caries risk assessment and documentation
- Fluoride
- Sealants, preventive resin restorations, and interim caries arresting medicament application
- Nutritional or tobacco counseling and oral hygiene instruction
- Counseling for the control and prevention of adverse oral behavioral and systemic health effects associated with high-risk substance abuse
- Space maintainers including re-cement or removal
- Gold foil
- Resin infiltration of lesions
- Temporary, interim or provisional services for crowns, bridges or dentures
- Prefabricated stainless steel, porcelain, ceramic, resin or other esthetic coated stainless-steel crowns
- Indirect pulp caps
- Endodontic therapy on primary teeth
- Surgical procedure for isolation of tooth with rubber dam
- Canal preparation for post or dowels
- Pulpal regeneration
- Endodontic bone grafts and biologic materials in conjunction with periradicular surgery
- Intraorifice barrier
- Periodontal materials to aid in soft and osseous tissue regeneration
- Periodontal splinting
- Gingival irrigation
- Tissue Conditioning
- Precision or semi-precision attachments and replacement of precision or semi-precision attachments

- Maxillofacial prosthetics
- Cleaning and inspection of appliances
- Implant maintenance, including cleansing of prostheses and abutments
- Pediatric partial dentures
- Oral surgery related to the lip, tongue, and cheeks
- Drugs or medicaments dispensed in the office for home use
- Athletic mouth guards and stress breakers
- Testing and treatment for mercury sensitivity or that are allergy related
- Duplicate appliances
- Sleep apnea appliance fabrication placement, adjustment, or repair
- Occlusion analysis
- Complete occlusal adjustment or equilibration
- Crowns and copings in conjunction with an overdenture
- Hospital or an ambulatory surgical center call
- Case management, presentation, or extensive treatment planning
- Cosmetic services such as enamel microabrasion, odontoplasty, and bleaching of teeth

EXCLUSIONS AND LIMITATIONS

In addition to services listed as not covered under *Description of Covered Services*, this section lists the services that are either limited or not covered by this plan.

Amounts Over The Allowed Amount

Costs over the allowable charge as defined by this plan, for a non-emergency services from a Non-Participating provider.

Benefits from other sources

Services that are covered by other types of insurance or coverage, such as:

- Motor vehicle medical or motor vehicle no-fault coverage
- Any type of no-fault coverage, such as Personal injury protection (PIP), Medical Payment coverage or Medical Premises coverage
- Any type of liability insurance, such as homeowners coverage or commercial liability coverage
- Any type of excess coverage
- Boat coverage
- School or athletic coverage

Benefits that have been exhausted

Services in excess of benefit limitations or maximums of this plan.

Broken or missed appointments

Charges for records or reports

Charges from providers for supplying records or reports that aren't requested by Premera for utilization review.

Complications of a non-covered service

Includes follow-up services or effects of those services.

Cosmetic Services

- Drugs, services, or supplies for cosmetic services that are not medically necessary. This includes services performed to reshape normal structures of the body in order to improve or alter your appearance and not primarily to restore an impaired function of the body.
- Treatment of congenital malformations, unless the patient is an eligible dependent child

Counseling, Education or Training

Counseling, education, or training in the absence of illness or injury, including but not limited to:

- Job help and outreach.
- Social or fitness counseling.
- Acting as a tutor, helping a member with schoolwork, acting as an educational or other aide for a member while the member is at school, or providing services that are part of a school's individual education program or should otherwise be provided by school staff.
- Private school or boarding school tuition.
- Community wellness or safety programs.

Court-Ordered Services

Services that you must get to avoid being tried, sentenced or losing the right to drive when they are not medically necessary.

Dental Services Received From A:

- Dental or medical department maintained for employees by or on behalf of an employer; or
- Mutual benefit association, labor union, trustee or similar person or group

Experimental or Investigational Services

Experimental or investigational services or supplies, including any complications or effects of such services. This does not apply to certain services that are part of an approved clinical trial.

Extra Or Replacement Items

- Extra dentures or other appliances, including replacements due to loss or theft
- Replacement of amalgam or resin-based composite fillings due to mercury or other allergic reactions

Facility Charges

Hospital and ambulatory surgical center care for dental procedures.

Family Members Or Volunteers

Services or supplies that you provide to yourself. It also doesn't cover a provider who is:

- Your spouse, mother, father, child, brother or sister
- Your mother, father, child, brother or sister by marriage
- Your stepmother, stepfather, stepchild, stepbrother or stepsister
- Your grandmother, grandfather, grandchild or the spouse of one of these people
- A volunteer

Fluoride Treatment

Topical application of fluoride is not covered.

Government Facilities

Services provided by a state or federal facility that are not emergency services or required by law or regulation.

Home-Use Products

Services and supplies that are normally intended for home use, such as take home fluoride, toothbrushes, floss and toothpaste.

Home Visits

Dental visits or procedures received in a member's home.

Illegal Acts, Illegal Services, and Terrorism

Illness or injury you get while committing a felony, an act of terrorism, or an act of riot or revolt as well as any service that is illegal under state or federal law.

Increase Of Vertical Dimension

Any service to increase or alter the vertical dimension.

Military Service and War

Illness or injury that is caused by or arises from:

- Acts of war, such as armed invasion, no matter if war has been declared or not
- Service in the armed forces of any country, including any related civilian forces or units

Multiple Providers

Services provided by more than one dental care provider for the same dental procedure.

Non-Standard Techniques

Other than standard techniques used in the making of restorations or prosthetic appliances, such as personalized restorations.

Non-Treatment Facilities, Institutions or Programs

- Institutional care
- Housing
- Incarceration
- Programs from facilities that are not licensed to provide treatment for covered conditions. Examples are prisons, nursing homes and juvenile detention facilities.

Not Covered Under This Plan

- Services that are not listed in this booklet as covered or that are directly related to any condition, service or supply that isn't covered under this plan
- Services received or ordered when this plan isn't in effect, or when you aren't covered under this plan (including services and supplies started before your effective date or after the date coverage ends), except for Major services and root canals that:
 - Were started after your effective date and before the date your coverage ended under this plan; and
 - Were completed within 90 days after the date your coverage ended under this plan

Orthodontia Services

Orthodontia, including casts, models, x-rays, photographs, examinations, appliances, braces, and retainers. However, this exclusion doesn't apply to extractions incidental to orthodontic services.

Orthognathic Surgery

Orthognathic surgery is not covered other than for treatment of the following:

- Temporomandibular joint disorder due to illness or injury which meet the criteria of our medical policy
- Sleep apnea, or
- Congenital anomaly

Personal comfort or convenience items

This plan does not cover:

- Personal services or items like meals for guests while hospitalized, long-distance phone, radio or TV, personal grooming and babysitting.
- Normal living needs, such as food, clothes, housekeeping and transport. This doesn't apply to chores done by a home health aide as prescribed in your treatment plan.
- Dietary assistance, including "Meals on Wheels"

Prescription Drugs

Any prescription drugs or medicines. This includes vitamins, food supplements, and patient management drugs, such as premedication and sedation.

Provider's Licensing or Certification

Services that are outside the scope of the provider's license or certification or any unlicensed or uncertified

providers.

Serious Adverse Events and Never Events

Serious adverse events are hospital injury(ies) caused by medical management that prolonged the hospitalization, and/or produces a disability at the time of discharge.

Near Events are events that should never occur, such as a surgery on the wrong patient, surgery on the wrong body part or a wrong surgery.

Members and this plan are not responsible for payment of services provided by in-network providers for serious adverse events, never events and resulting follow-up care. Serious adverse events and never events are medical errors that are specific to a nationally published list. They are identified by specific diagnoses codes, procedure codes and specific present-on-admission indicator codes. In-network providers may not bill members for these services and members are held harmless.

Not all medical errors are defined as serious adverse events or never events. You can obtain a list of serious adverse events by contacting us or on the Center for Medicare and Medicaid Services (CMS) website.

Services or Supplies Not Dentally Necessary

Services that are not dentally necessary

Services or Supplies Not Medically Necessary

Services or supplies that are not medically necessary even if they're court-ordered. This also includes places of service, such as inpatient hospital care.

Services Provided to Members Who Do Not Meet Age Requirements

This plan has specific age requirements to be eligible for dental services; members must be 19 years or older and dependent children must be between age 19 and 26. Any dental services provided to members who do not meet age requirements are excluded under this plan.

Temporomandibular Joint (TMJ) Disorders

Treatment of TMJ disorders. TMJ disorders are problems with the lower jaw joint that have one or more of the features below:

- Pain in the muscles near the TMJ
- Internal derangements of the parts of the TMJ
- Arthritic problems with the TMJ
- The TMJ has a limited range of motion or its range of motion is not normal

Testing And Treatment Services

Testing and treatment for mercury sensitivity or that are allergy-related.

Work-Related Illness or Injury

Any illness or injury for which you can get benefits under:

- Separate coverage for injuries on the job, even if you did not have to buy it
- Worker's compensation laws
- Any other law that will repay you for an illness or injury you get from your job.

WHAT IF I HAVE OTHER COVERAGE?

COORDINATING BENEFITS

You may be covered under one or more other group or individual plans, such as one sponsored by your spouse's employer. This plan includes a "coordination of benefits" feature to handle such situations.

All of the benefits of this plan are subject to coordination of benefits. However, please note that benefits provided under this plan for allowable dental expenses will be coordinated separately from allowable medical expenses.

If you have other coverage besides this plan, we recommend that you submit your claim to the primary carrier first, then submit the claim to the secondary carrier with the primary carrier processing information. In that way, the proper coordinated benefits may be most quickly determined and paid.

If you are a member of the U.S. Military (active or retired) or you have dependents enrolled in the TRICARE program, this plan is the primary plan and TRICARE would be secondary, when required by federal law.

Definitions Applicable To Coordination Of Benefits

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

- **Allowable Medical Expense** means the usual, customary and reasonable charge for any medically necessary health care service or supply provided by a licensed medical professional when the service or supply is covered at least in part under this plan. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense.
- **Allowable Dental Expense** means the usual, customary and reasonable charge for any dentally necessary service or supply provided by a licensed dental professional when the service or supply is covered at least in part under this plan. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense. For the purpose of this plan, only those dental services to treat an accidental injury to natural teeth will be considered an allowable dental expense.
- **Medical Plan** means all of the following health care coverages, even if they don't have their own coordination provisions:
 - Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization group or individual agreements issued by insurers, health care service contractors, and health maintenance organizations
 - Labor-management trustee plans, labor organization plans, employer organization plans or employee benefit organization plans
 - Government programs that provide benefits for their own civilian employees or their dependents
 - Group coverage required or provided by any law, including Medicare. This doesn't include workers' compensation.
 - Group student coverage that's sponsored by a school or other educational institution and includes medical benefits for illness or disease
- **Dental Plan** means all of the following dental care coverages, even if they don't have their own coordination provisions:
 - Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization group or individual agreements issued by insurers, health care service contractors, and health maintenance organizations
 - Labor-management trustee plans, labor organization plans, employer organization plans or employee benefit organization plans
 - Government programs that provide benefits for their own civilian employees or their dependents

Each contract or other arrangement for coverage described above is a separate plan. It's also important to note that for the purpose of this plan, we'll coordinate benefits for allowable medical expenses separately from allowable dental expenses, as separate plans.

Effect On Benefits

An important part of coordinating benefits is determining the order in which the plans provide benefits. One plan is responsible for providing benefits first. This is called the "primary" plan. The primary plan provides its full benefits as if there were no other plans involved. The other plans then become "secondary." When this plan is secondary, it will reduce its benefits for each claim so that the benefits from all medical plans aren't more than the allowable medical expense for that claim and the benefits from all dental plans aren't more than the allowable dental expense for that claim. Coordination of benefits applies only on a per-claim basis, and is not cumulative.

We will coordinate benefits when you have other health care coverage that is primary over this plan. Coordination of benefits applies whether or not a claim is filed with the primary coverage.

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

First: A plan that doesn't provide for coordination of benefits.

Next: A plan that covers you as **other than** a dependent.

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

- When the parents **aren't** separated or divorced: The plan of the parent whose birthday falls earlier in the year will be primary, if that's in accord with the coordination of benefits provisions of both plans. Otherwise, the rule set forth in the plan that doesn't have this provision shall determine the order of benefits.
- When the parents **are** separated or divorced: If a court decree makes one parent responsible for paying the child's health care costs, that parent's plan will be primary. Otherwise, the plan of the parent with custody will be primary, followed by the plan of the spouse of the parent with custody, followed by the plan of the parent who doesn't have custody. If the rules above don't apply, the plan that has covered you for the longest time will be primary, except that benefits of a plan that covers you as a laid-off or retired employee, or as the dependent of such an employee, shall be determined after the benefits of any plan that covers you as other than a laid-off or retired employee, or as the dependent of such an employee. However, this applies only when other plans involved have this provision regarding laid-off or retired employees.

If none of the rules above determine the order of benefits, the plan that's covered the employee or subscriber for the longest time will be primary.

Right Of Recovery/Facility Of Payment

The plan has the right to recover any payments that are greater than those required by the coordination of benefits provisions from one or more of the following:

- The persons the plan paid or for whom the plan has paid
- Providers of service
- Insurance companies
- Service plans or other organizations

If a payment that should have been made under this plan was made by another plan, the plan also has the right to pay directly to another plan any amount that the plan should have paid. Such payment will be considered a benefit under this plan and will meet the plan's obligations to the extent of that payment. This plan has the right to appoint a third party to act on its behalf in recovery efforts.

SUBROGATION AND REIMBURSEMENT

If we make claims payment on your behalf for injury or illness for which another party is liable, or for which uninsured/underinsured motorist (UIM) or personal injury protection (PIP) insurance exists, we are entitled to be repaid for those payments out of any recovery from that liable party. The liable party is also known as the "third party" because it's a party other than you or us. This party includes a UIM carrier because it stands in the shoes of a third party tortfeasor and because we exclude coverage for such benefits.

Definitions The following terms have specific meanings in this contract:

- **Subrogation** means we may collect directly from third parties to the extent we have paid on your behalf for illnesses or injury caused by the third party.
- **Reimbursement** means that you are obligated under the contract to repay any monies advanced by us from amounts received on your claim.
- **Restitution** means all equitable rights of recovery that we have to the monies advanced under your plan. Because we have paid for your illness or injuries, we are entitled to recover those expenses.

To the fullest extent permitted by law, we're entitled to the proceeds of any settlement or judgment that results in a recovery from a third party, up to the amount of benefits paid by us for the condition. Our right to recover exists regardless of whether it is based on subrogation, reimbursement or restitution. We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not "made whole" for all of your damages in the recoveries that you receive. Our right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine. Such recoveries will not be sought more than 365 days after we receive notice of the settlement or judgment. Exceptions will be allowed when required by law or regulation. In recovering benefits provided, we may at our election hire our own attorney or be represented by your attorney. We will not pay for any legal costs incurred by you or on your behalf, and you will not be required to pay any portion of the costs incurred by us or on our behalf.

Before accepting any settlement on your claim against a third party, you must notify us in writing of any terms or conditions offered in a settlement, and you must notify the third party of our interest in the settlement established by this provision. You also must cooperate with us in recovering amounts paid by us on your behalf. If you retain an attorney or other agent to represent you in the matter, you must require your attorney or agent to reimburse us directly from the settlement or recovery. If you fail to cooperate fully with us in the recovery of benefits we have

paid as described above, you are responsible for reimbursing us for such benefits.

To the extent that you recover from any available third party source, you agree to hold any recovered fund in trust or in a segregated account until our subrogation and reimbursement rights are fully determined.

Agreement To Arbitrate Any disputes that arise as part of this provision may be resolved by arbitration. Both you and we will be bound by the decision of the arbitration proceedings.

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

This agreement to arbitrate will begin on the effective date of the contract, and will continue until any dispute regarding this plan's subrogation or reimbursement is resolved.

Uninsured and Underinsured Motorist/Personal Injury Protection Coverage

We have the right to be reimbursed for benefits provided, but only to the extent that benefits are also paid for such services and supplies under the terms of a motor vehicle uninsured motorist and/or underinsured motorist (UIM) policy, personal injury protection (PIP) or similar type of insurance or contract.

WHO IS ELIGIBLE FOR COVERAGE?

NOTE: Enrollment on this plan is limited to eligible employees and dependents who are 19 years of age or older. Specific age requirements are described below.

EMPLOYEE ELIGIBILITY

Under this small employer dental benefit plan, to be an "eligible employee," an employee must be one of the following:

- Be an employee who works on a full-time basis, with a normal work week of the minimum hours stated on the Group's application, and includes a sole proprietor, a partner of a partnership or an independent contractor, provided the sole proprietor, partner, or contractor is included as an employee under a dental benefit plan of a small employer, but doesn't include an employee who works on a part-time, temporary, or substitute basis.
- Satisfy any eligibility waiting period, if one is required by the Group
- Be 19 years of age or older

DEPENDENT ELIGIBILITY

Note: All dependents must be 19 years of age or older to be enrolled on this plan.

An "eligible dependent" is defined as one of the following:

- The lawful spouse of the subscriber and 19 years of age or older, unless legally separated. However, if the spouse is an employee, owner, partner, or corporate officer of the Group who meets the requirements in **Employee Eligibility** earlier in this section, the spouse can only enroll as a subscriber.
- The domestic partner of the subscriber as specifically included as eligible by the Group and 19 years of age or older. In determining benefits for domestic partners and their children under this plan, the term "establishment of the domestic partnership" shall be used in place of "marriage," and the term "termination of the domestic partnership" shall be used in place of "legal separation" and "divorce."
- An eligible child is over age 19 but under 26 years of age except as provided for in the **Eligibility For a Disabled Child** provision. However, if the child is an employee, owner, partner, or corporate officer of the Group who meets the requirements in **Employee Eligibility** earlier in this section, the child can only enroll as a subscriber. An eligible child is one of the following:
 - A natural offspring of either or both the subscriber or spouse
 - A legally adopted child of either or both the subscriber or spouse
 - A child placed with the subscriber for the purpose of legal adoption in accordance with state law. "Placed" for adoption means assumption and retention by the subscriber of a legal obligation for total or partial support of a child in anticipation of adoption of such child
 - A minor or foster child for whom the subscriber or spouse has a legal guardianship. There must be a court order signed by the judge, which grants guardianship of the child to the subscriber or spouse as of a specific date. When the court order terminates or expires, the child is no longer an eligible child.

WHEN DOES COVERAGE BEGIN?

ENROLLMENT

Enrollment is timely when we receive the completed enrollment application and required subscription charges within 60 days of the date the employee becomes an "eligible employee" as defined earlier in this section. When enrollment is timely, coverage for the employee and enrolled dependents will become effective on the first of the month that falls on or after the **latest** of the applicable dates below:

- The employee's date of hire
- The date the employee enters a class of employees to which the Group offers coverage under this plan
- The next day following the date the eligibility waiting period ends, when one is required by the Group
- Another date as designated in the Group Master Application or Group Contract

If we don't receive the enrollment application within 60 days of the date you became eligible, none of the dates above will apply. See **Open Enrollment** and **Special Enrollment** below.

Dependents Acquired Through Marriage After The Subscriber's Effective Date

When we receive the completed enrollment application and any required subscription charges within 60 days after the marriage or domestic partnership, coverage will become effective on the first of the month following the date of marriage. When the enrollment application isn't received by us within 60 days of marriage, refer to **Open Enrollment** later in this section.

Note: new dependents must be at least 19 years of age to be eligible for this plan; refer to *When Coverage Begins* section for further detail.

Adoptive Children

Adoptive dependent children who are adopted or placed for adoption on or after the subscriber's effective date will be covered from their date of adoption or placement for adoption. However, if payment of additional subscription charges is required to provide coverage for an adoptive dependent child, and the subscriber desires coverage of the adoptive child to extend beyond the 31-day period following the dependent child's date of adoption or placement for adoption, we must receive a completed enrollment application and the required additional subscription charges within the 60-day period following the date of adoption or placement for adoption.

If we don't receive the completed enrollment application and the required additional subscription charges within the 60-day period, initial coverage will be limited to the 31-day period referenced above. The child may then be enrolled at a later date, subject to the **Open Enrollment** provisions described later in this section.

Children Acquired Through Legal Guardianship

When we receive the completed enrollment application, any required subscription charges, and a copy of the guardianship papers within 60 days of the date legal guardianship began with the subscriber, coverage for an otherwise eligible child will begin on the date legal guardianship began. When the enrollment application isn't received by us within 60 days of the date legal guardianship began, refer to **Open Enrollment** below.

Children Covered Under Medical Child Support Orders

When we receive the completed enrollment application within 60 days of the date of the medical child support order, coverage for an otherwise eligible child that is required under the order will become effective on the date of the order. Otherwise, coverage will become effective on the date we receive the enrollment application for coverage. The enrollment application may be submitted by the subscriber, the child's custodial parent or a state agency. When subscription charges being paid don't already include coverage for dependent children, such charges will begin from the child's effective date. Please contact your Group for detailed procedures.

Court-Ordered Dependent Coverage

When we receive the completed enrollment application within 60 days of the date of the court order, coverage for a lawful spouse and/or dependent children will become effective on the date of the order. Otherwise, coverage will become effective on the first of the month following the date we receive the enrollment application for coverage. When subscription charges being paid don't already include coverage for a spouse and/or dependent children, such charges will begin from the dependent's effective date.

SPECIAL ENROLLMENT

Involuntary Loss Of Other Coverage

If the employee and/or dependent didn't enroll in this plan or another plan sponsored by the Group when the employee and/or dependent were first eligible because the employee and/or dependent weren't required to do so, the employee and/or dependent may later enroll in this plan outside of the annual open enrollment period if each of the following requirements is met:

- The employee and/or dependent were covered under group dental coverage or a dental insurance plan at the time coverage under this plan was previously offered; and
- The employee and/or dependent coverage under the other group dental coverage or dental insurance plan ended as a result of one of the following:
 - Loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or the reduction in the number of hours of employment);
 - Termination of employer contributions toward such coverage; or
 - The employee and/or dependent were covered as required by the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) at the time coverage under this plan was previously offered and COBRA coverage has been exhausted.

An eligible employee who qualifies as stated above may also enroll all eligible dependents. When only an eligible dependent qualifies for special enrollment, but the eligible employee is not enrolled in any of the Group's plans or is enrolled in a different plan sponsored by the Group, the employee is also allowed to enroll in this plan in order for the dependent to enroll.

When we receive the eligible employee and/or dependent's completed enrollment application and any required subscription charges within 60 days of the date such other coverage ended, coverage under this plan will become effective on the first of the month following receipt of the employee and/or dependent's enrollment application.

When we don't receive the employee and/or dependent's completed enrollment application within 60 days of the date prior coverage ended, refer to **Open Enrollment** below.

Subscriber And Dependent Special Enrollment

An eligible employee and otherwise eligible dependents that previously elected not to enroll in any of the employer's group dental plans when such coverage was previously offered, may enroll in this plan at the same time a newly acquired dependent is enrolled under **Enrollment** in the case of marriage, birth, adoption, or placement for adoption. The eligible employee may also choose to enroll with some or all eligible dependents.

When we receive the completed enrollment application and any required subscription charges within 60 days of the date of marriage, birth, adoption, or placement for adoption. Coverage under this plan will become effective on the first of the month following the date the other coverage was lost.

Adult Disabled Children

If a subscriber or eligible employee has a child under age 26 who meets the requirements in **Dependent Eligibility** and who lost health coverage sponsored by the Group or was not eligible for such coverage, that child can now enroll in this plan. Dependent children who enrolled in COBRA coverage can now also enroll.

A one-time 30-day special enrollment period will be held for this purpose. When the employee is eligible for but not enrolled in any of the Group's plans or is enrolled in a different plan sponsored by the Group, the employee can also enroll in this plan during the 30-day special enrollment period in order to cover the dependent.

OPEN ENROLLMENT

If you're not enrolled when you first become eligible, or as allowed under **Special Enrollment** above, you cannot be enrolled until the Group's next **Open Enrollment** period. An open enrollment period occurs once a year unless otherwise agreed upon between the Group and us. During this period, eligible employees and their dependents can enroll for coverage under this plan.

If the Group offers multiple dental care plans and you're enrolled under one of the Group's other dental care plans, enrollment for coverage under this plan can only be made during the Group's open enrollment period.

CHANGES IN COVERAGE

Its terms, benefits, and limitations may be changed by us at any time. Changes to this plan will apply as of the

date the change becomes effective to all members and to eligible employees and dependents that become covered under this plan after the date the change becomes effective.

PLAN TRANSFERS

Subscribers (with their enrolled dependents) may be allowed to transfer to this plan from another plan with us offered by the Group. Transfers also occur if the Group replaces another dental plan (with us) with this plan. Also, we may replace the Group's current contract for this plan with an updated one from time to time. All transfers to this plan must occur during "open enrollment" or on another date agreed upon by us and the Group.

When we update the contract for this plan, or you transfer from the Group's other plan with us, and there is no lapse in your coverage, the following provisions that apply to this plan will be reduced to the extent they were satisfied and/or credited under the prior plan:

- Calendar year deductible
- Benefit maximums
- Lifetime maximums

In the event an employee enrolls for coverage under a different dental plan also offered by the Group, enrollment for coverage under this plan can only be made during the Group's next open enrollment period.

This provision doesn't apply to transfers from plans not offered by us.

WHEN WILL MY COVERAGE END?

EVENTS THAT END COVERAGE

Coverage will end without notice on the last day of the month in which one of these events occurs:

- For the subscriber and dependents when any of the following occur:
 - The Group Contract is terminated
 - The next monthly subscription charge isn't paid when due or within the grace period
 - The subscriber dies or is otherwise no longer eligible as a subscriber
 - In the case of a collectively bargained plan, the employer fails to meet the terms of an applicable collective bargaining agreement or to employ employees covered by a collective bargaining agreement
- For a spouse when their marriage to the subscriber is annulled, or when they become legally separated or divorced from the subscriber
- For a child when they no longer meet the requirements for dependent coverage shown in the ***Who Is Eligible For Coverage?*** section
- For a grandchild of the subscriber or spouse when their parent is no longer enrolled in the plan or no longer meets the requirements for dependent coverage shown in the ***Who Is Eligible For Coverage?*** section
- For fraud or intentional misrepresentation of material fact under the terms of the coverage by the subscriber or the subscriber's dependents

The subscriber must promptly notify the Group when an enrolled family member is no longer eligible to be enrolled as a dependent under this plan. The Group must give us written notice of a member's termination within 30 days of the date the Group is notified of such event.

CONTRACT TERMINATION

Termination of the Group Contract for this plan completely ends all members' coverage and all our obligations.

The Group Contract will automatically be terminated if subscription charges or contributions aren't paid when due; coverage will end on the last day for which payment was made. This plan may also terminate as indicated below.

The Group may terminate the Group Contract:

- Effective on any subscription charge due date with 30 days' advance written notice to us.
- By rejecting in writing the contract changes we make after the initial term. The written rejection must reach us at least 15 days before the changes are to start. The Group Contract will end on the last date for which subscription charges were paid.

We may terminate the Group Contract, **upon 45 days advance written notice to the Group if:**

- The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage
- The Group has failed to comply with a material plan provision relating to minimum participation or employer contribution requirements
- In the case of a network plan, the Group no longer has any members who reside or work in Alaska or Washington
- We discontinue offering a particular type of dental care plan in the group market providing:
 - We furnish written notice of the decision to discontinue coverage to all affected groups, members, and to the insurance regulatory official in each state in which an affected member is known to reside. Such notice must be given at least 180 days before we decide to discontinue the dental care plan;
 - We furnish written notice of the decision to discontinue coverage to the director and to the insurance regulatory official in each state in which we're licensed at least 45 days before notice is given to the affected groups and members as described above
 - We offer each group who is provided the particular type of dental plan the option to purchase another dental care plan currently being offered by us to groups in the same market in that state
 - We act uniformly without regard to the claims experience of those groups, or to any health status factor of a member or a prospective member who may become eligible for coverage
 - We discontinue offering and renewing all dental plans in the group market providing:

- We furnish written notice of the decision to discontinue coverage to all affected groups, members, and to the insurance regulatory official in each state in which an affected member is known to reside. Such notice must be given at least 180 days before we decide to discontinue the dental care plans;
- We furnish written notice of the decision to discontinue coverage to the director and to the insurance regulatory official in each state in which we're licensed at least 45 days before the notice is given to the affected groups and members as described above
- We don't issue a dental plan in the group market in the applicable states for 5 years from the date the last group dental plan was discontinued

HOW DO I CONTINUE COVERAGE?

CONTINUED ELIGIBILITY FOR A DISABLED CHILD

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

- The child became disabled before reaching the limiting age
- The child is incapable of self-sustaining employment by reason of developmental or physical disability
- The child mainly depends on the subscriber for support and maintenance
- The subscriber continues to be covered under this plan
- The child's subscription charges, if any, continue to be paid
- Within 31 days of the child reaching the limiting age, the subscriber gives us a Request for Certification of Disabled Dependent form. We must approve the request for certification for coverage to continue.
- The subscriber provides us with proof of the child's disability and dependent status when we request it. After the child has been covered under this provision for two years, we don't ask for proof more often than once a year.

Note: This provision does not apply to dependent grandchildren.

CONTINUATION UNDER USERRA

The Uniformed Services Employment And Reemployment Rights Act (USERRA) protects the job rights (including enrollment rights on employer-provided health care coverage) of individuals who voluntarily or involuntarily leave employment positions to undertake military service. If you leave your job to perform military service, you have the right to elect to continue existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are re-employed, generally without any waiting periods or exclusions (e.g. pre-existing condition exclusions) except for service-connected illnesses or injuries.

Contact your employer for information on USERRA rights and requirements. You may also contact the US Department of Labor at 866-4-USA-DOL or visit its website at www.dol.gov/vets. An online guide to USERRA can be viewed at www.dol.gov/elaws/userra.htm.

LEAVE OF ABSENCE

Coverage for a subscriber and enrolled dependents may be continued for up to 90 days when the employer grants the subscriber a leave of absence and subscription charges continue to be paid.

The 90-day leave of absence period counts toward the maximum COBRA continuation period, except as prohibited by the Family and Medical Leave Act of 1993.

COBRA

When group coverage is lost because of a "qualifying event" shown below, federal laws and regulations known as "COBRA" require the Group to offer qualified members an election to continue their group coverage for a limited time. Under COBRA, a qualified member must apply for COBRA coverage within a certain time period and may also have to pay the subscription charges for it.

At the Group's request, we'll provide qualified members with COBRA coverage under this plan when COBRA's enrollment and payment requirements are met. But, coverage is provided only to the extent that COBRA requires and is subject to the other terms and limitations of this plan. Members' rights to this coverage may be affected by the Group's failure to abide by the terms of its contract with us. The Group, **not us**, is responsible for all notifications and other duties assigned by COBRA to the "plan administrator" within COBRA's time limits.

The following summary of COBRA coverage is taken from COBRA. Members' rights to this coverage and obligations under COBRA automatically change with further amendments of COBRA by Congress or interpretations of COBRA by the courts and federal regulatory agencies.

Qualifying Events and Length of Coverage

Please contact the Group immediately when one of the qualifying events highlighted below occurs. The continuation periods listed extend from the date of the qualifying event.

Note: Covered domestic partners and their children have the same rights to COBRA coverage as covered

spouses and their children.

- The Group must offer the subscriber and covered dependents an election to continue coverage for up to 18 consecutive months if their coverage is lost because of one of two qualifying events:
 - **The subscriber's work hours are reduced.**
 - **The subscriber's employment terminates, except for discharge due to actions defined by the Group as gross misconduct.**

However, if one of the events listed above follows the covered employee's entitlement to Medicare by less than 18 months, the Group must offer the covered spouse and children an election to continue coverage for up to 36 months starting from the date of the Medicare entitlement. This happens only if the event would've caused a similar dependent who wasn't on COBRA coverage to lose coverage under this plan.

- COBRA coverage can be extended if a member who lost coverage due to a reduction in hours or termination of employment is determined to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act at any time during the first 60 days of COBRA coverage. In such cases, all family members who elected COBRA may continue coverage for up to a total of 29 consecutive months from the date of the reduction in hours or termination.
- The Group must offer the covered spouse or children an election to continue coverage for up to 36 consecutive months if their coverage is lost because of 1 of 4 qualifying events:
 - **The subscriber dies.**
 - **The subscriber and spouse legally separate or divorce.**
 - **The subscriber becomes entitled to Medicare.**
 - **A child loses eligibility for dependent coverage.**

In addition, the occurrence of one of these events during the 18-month period described above can extend that period for a continuing dependent. However, extended COBRA coverage is available only when the event would have caused a similar dependent who was not on COBRA coverage to lose coverage under this plan. For example, if a subscriber not on COBRA coverage would be able to remain covered after enrolling in Medicare, then a subscriber's enrolling on Medicare while on COBRA coverage would not be a second qualifying event for dependents.

Conditions of COBRA Coverage

For COBRA coverage to become effective, all of the requirements below must be met:

You Must Give Notice Of Some Qualifying Events

The plan will offer COBRA coverage only after the Group receives timely notice that a qualifying event has occurred.

The subscriber or affected dependent must notify the Group in the event of a divorce, legal separation, child's loss of eligibility as a dependent, or any second qualifying event which occurs within the 18-month period as described in **Qualifying Events And Lengths Of Coverage**. The subscriber or affected dependent must also notify the Group if the Social Security Administration determines that the subscriber or dependent was disabled on any of the first 60 days of COBRA coverage. You also have the right to appoint someone to give the Group this notice for you.

If the required notice isn't given or is late, the qualified member loses the right to COBRA coverage.

Except as described below for disability notices, the subscriber or affected dependent has 60 days in which to give notice to the Group. The notice period starts on the date shown below.

- For determinations of disability, the notice period starts on the **later** of: 1) the date of the subscriber's termination or reduction in hours; 2) the date qualified member would lose coverage as the result of one of these events; or 3) date of the disability determination. **Note: Determinations that a qualified member is disabled must be given to the Group before the 18-month continuation period ends. This means that the subscriber or qualified member might not have the full 60 days in which to give the notice.** Please include a copy of the determination with your notice to the Group.

Note: The subscriber or affected dependent must also notify the Group if a qualified member is deemed by the Social Security Administration to no longer be disabled. See **When COBRA Coverage Ends**.

- For the other events above, the 60-day notice period starts on the **later** of: 1) the date of the qualifying event, or 2) the date the qualified member would lose coverage as a result of the event.

Important Note: The Group must tell you where to direct your notice and any other procedures that you

must follow. If the Group informs you of its notice procedures after the notice period start date above for your qualifying event, the notice period will not start until the date you are informed by the Group.

The Group must notify qualified members of their rights under COBRA. If the Group has named a third party as its plan administrator, the plan administrator is responsible to notify members on behalf of the group. In such cases, the Group has 30 days in which to notify its plan administrator of a subscriber's termination of employment, reduction in hours, death, Medicare entitlement, or, if applicable, loss of retiree coverage because the Group filed for bankruptcy. The plan administrator then has 14 days after it receives notice of a qualifying event from the Group (or from a qualified member as stated above) in which to notify qualified members of their COBRA rights.

If the Group itself is the plan administrator, it has more than 14 days in which to give notice for certain qualifying events. The Group must furnish the notice required because of a subscriber's termination of employment, reduction in hours, death, Medicare entitlement, or, if applicable, loss of retiree coverage because the Group filed for bankruptcy no later than 44 days after the **later** of 1) the date of the qualifying event, or 2) the date coverage would end in the absence of COBRA. For all other qualifying events, the 14-day notice time limit applies.

You Must Enroll And Pay On Time

- You must elect COBRA coverage no more than 60 days after the **later** of 1) the date coverage was to end because of the qualifying event, or 2) the date you were notified of your right to elect COBRA coverage. You may be eligible for a second COBRA election period if you qualify under section 201 of the Federal Trade Act of 2002. Please contact the Group or your bargaining representative for more information if you believe this may apply to you.

Each qualified member will have an independent right to elect COBRA coverage. Subscribers may elect COBRA coverage on behalf of their spouses, and parents may elect COBRA coverage on behalf of their children.

If you are not notified of your right to elect COBRA coverage within the time limits above, you must elect COBRA coverage no more than 60 days after the date coverage was to end because of the qualifying event in order for COBRA coverage to become effective under this plan. If you are not notified of your right to elect COBRA coverage within the time limit and you don't elect COBRA coverage within 60 days after the date coverage ends, we won't be obligated to provide COBRA benefits under this plan. The Group will assume full financial responsibility for payment of any COBRA benefits to which you may be entitled.

- You must send your first subscription charge payment to the Group no more than 45 days after the date you elected COBRA coverage.
- Subsequent subscription charges must be paid to the Group and submitted to us with the Group's regular monthly billings.

Adding Family Members

Eligible family members may be added after the continuation period begins, but only as allowed under **Special Enrollment** or **Open Enrollment** in the **When Does Coverage Begin?** section. With one exception, family members added after COBRA begins aren't eligible for further coverage if they later have a qualifying event or if they are determined to be disabled as described under **Qualifying Events And Lengths Of Coverage** earlier in this COBRA section. The exception is that a child born to or placed for adoption with a covered employee while the covered employee is on COBRA has the same COBRA rights as family members on coverage at the time of the original qualifying event. The child will be covered for the duration of the covered employee's initial 18-month COBRA period, unless a second qualifying event occurs which extends the child's coverage. COBRA coverage is subject to all other terms and limitations of this plan.

Keep The Group Informed Of Address Changes

In order to protect your rights under COBRA, you should keep the Group informed of any address changes. It's a good idea to keep a copy, for your records, of any notices you send to the Group.

When COBRA Coverage Ends

COBRA coverage will end on the last day for which subscription charges have been paid in the monthly period in which the first of the following occurs:

- The applicable continuation period expires.
- The next monthly subscription charge isn't paid when due or within the 30-day COBRA grace period.
- When coverage is extended from 18 to 29 months due to disability (see **Qualifying Events And Lengths Of Coverage** in this section), COBRA coverage beyond 18 months ends if there's a final determination that a

qualified member is no longer disabled under the Social Security Act. However, coverage won't end on the date shown above, but on the last day for which subscription charges have been paid in the first month that begins more than 30 days after the date of the determination. The subscriber or affected dependent must provide the Group with a copy of the Social Security Administration's determination within 30 days after the **later** of: 1) the date of the determination, or 2) the date on which the subscriber or affected dependent was informed that this notice should be provided and given procedures to follow.

- You become covered under another group dental care plan after the date you elect COBRA coverage. However, if the new plan contains an exclusion or limitation for a pre-existing condition, coverage doesn't end for this reason until the exclusion or limitation no longer applies.
- You become entitled to Medicare after the date you elect COBRA coverage.
- The Group ceases to offer group health care coverage to any employee

However, even if one of the events above hasn't occurred, COBRA coverage **under this plan** will end on the date that the contract between the Group and us is terminated.

If You Have Questions

Questions about your plan or your rights under COBRA should be addressed to the plan contacts provided by the Group. For more information about your rights under ERISA, COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the US Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

HOW DO I FILE A CLAIM?

Many providers will submit their bills to us directly. However, if you need to submit a claim to us, follow these simple steps:

Step 1

Complete a Subscriber Claim Form. A separate Subscriber Claim Form is necessary for each patient and each provider. Subscriber Claim Forms are available from us.

Step 2

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

- Names of the subscriber and the member who incurred the expense
- Identification numbers for both the subscriber and the Group (these are shown on the subscriber's identification card)
- Name, address, and IRS tax identification number of the provider
- Information about other insurance coverage
- American Dental Association (ADA) Current Dental Terminology (CDT) procedure codes for each service
- Dates of service and itemized charges for each service rendered
- If the services rendered are for treatment of an accidental injury, the date, time, location, and a brief description of the accident

Step 3

If you're also covered by Medicare, and Medicare is primary, you must attach a copy of the "Explanation of Medicare Benefits."

Step 4

Check that all required information is complete. Bills received won't be considered to be claims until all necessary information is included.

Step 5

Sign the Subscriber Claim Form in the space provided.

Step 6

Mail your claims to the address listed inside the front cover of this booklet.

You should submit all claims within 90 days of the start of service or within 30 days after the service is completed. We must receive claims:

- Within 365 days of discharge for hospital or other medical facility expenses, or within 365 days of the date on which expenses were incurred for any other services or supplies
- For members who have Medicare, within 90 days of the process date shown on the Explanation of Medicare Benefits, whichever is greater

We won't provide benefits for claims we receive after the later of these two dates, nor will we provide benefits for claims which were denied by Medicare because they were received past Medicare's submission deadline.

CLAIMS PROCEDURE

Claims for benefits will be processed under the following time frames:

- If the claim includes all of the information we need to process the claim, we will process it within 30 calendar days of receipt.
- If we need more information to process the claim, we will tell you or the provider who submitted the claim that we need more information. We will make that request within 30 calendar days of receipt.
- Once we receive the additional information, we will process your claim within 30 calendar days from the date we initially received the claim or 15 calendar days after we receive the information, whichever period is longer.

If we do not pay the claim or provide notice within the time frames stated above, interest shall accrue at a rate of 15% annually. Interest will not be paid if the amount of interest is \$1 or less.

When we process your claim, we will send a written notice explaining how the claim was processed. If the claim is denied in whole or in part, we will send a written notice that states the reason for the denial, and information on how to request an appeal of that decision.

At any time, you have the right to appoint someone to pursue the claim on your behalf. This can be a provider, doctor, lawyer, or a friend or relative. You must notify us in writing and give us the name, address, and telephone number where your appointee can be reached.

If a claim for benefits or an appeal is denied or ignored, in whole or in part, or not processed within the time shown in these claims procedures, you may have the right to file suit in a state or federal court.

Care Received Outside the United States

When you submit a claim for care you received outside the United States, please include whenever possible: a detailed description, in English, of the dental services received; the names and credentials of the treating providers, and dental records or chart notes.

To process your foreign claim, we will convert the foreign currency amount on the claim into US dollars for claims processing. We use a national currency converter (available at www.oanda.com) as follows:

- For professional outpatient services and other care with single dates of service, we use the exchange rate on the date of service.

SPECIAL NOTICE ABOUT CLAIMS PROCEDURE

If all you have to pay is a copay for a covered service or supply, your payment of the copay to your provider is not considered a claim for benefits. You can call customer service to get a paper copy of an Explanation of Benefits of the service or supply.

COMPLAINTS AND APPEALS

If at any time you have questions regarding your healthcare, you may contact customer service for assistance. They are here to serve you and answer questions.

If you disagree with a decision we made or feel dissatisfied, and would like us to formally review your concerns, you can file a complaint or appeal with Premera:

What Is A Complaint?

Other than denial of payment for medical services or nonprovision of medical services, a complaint is when you are not satisfied with customer service, quality, or access to medical service, and you want to share it with

Premera.

How to file a complaint

Call customer service at 800-722-1471 (TTY:711)

Send a fax to 425-918-5592

Send the details in writing to:

Premera Blue Cross Blue Shield of Alaska
PO Box 91102
Seattle, WA 98111-9202

For complaints received in writing, we will send a written response within 30 days.

What Is An Appeal?

An appeal is a request to review a specific decision or adverse benefit determination Premera has made.

An adverse-benefit determination means a decision to deny, reduce, terminate or a failure to provide or to make payment, in whole or in part for services. This includes:

- A member’s or applicant’s eligibility to be or stay enrolled in this plan or health insurance coverage
- A limitation on otherwise covered benefits
- A clinical review decision
- A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective

What you can appeal

Claims and prior authorization	Payment	Benefits or charges were not applied correctly, including a limit or restriction on otherwise covered benefits.
	Denied	Coverage of your service, supply, device or prescription was denied or partially denied. This includes prior authorization denials.

Appeal Levels

You have the right to two levels of appeals:

Appeal Level	What it means	Deadline to appeal
Level 1 (Internal)	This is your first appeal. Premera will review your appeal.	180 days from the date you were notified of our decision.
External	<p>If we deny your Level 1 appeal, you can ask for an Independent Review Organization (IRO) to review your appeal.</p> <p>OR</p> <p>You can ask for an IRO review if Premera has not made a decision by the deadline for the Level 1 appeal. There is no cost to you for an external appeal.</p>	<p>180 days from the date you were notified of our Level 1 decision.</p> <p>OR</p> <p>180 days from the date the response to your Level 1 appeal was due, if you did not get a response or it was late.</p>

How To Submit An Appeal In Writing

Step 1. Get the form	<ul style="list-style-type: none"> Complete the Member Appeal Form, you can find it on premera.com or call customer service to request a copy. <p>If you need help submitting an appeal, or would like a copy of the appeals process, call customer service at 800-722-1471 (TTY:711).</p>
Step 2. Collect supporting documents	<ul style="list-style-type: none"> Collect any supporting documents that may help with your appeal. This may include chart notes, medical records, or a letter from your provider. Within 3 working days, we will confirm in writing that we have your request. If you would like someone to appeal on your behalf, including your provider, complete a Member Appeal Form with authorization, you can find it on premera.com. We can't release your information without this form.
Step 3. Send in my appeal	<p>To help process your appeal, be sure to complete the form and return with any supporting documents.</p> <p>Send your documents to: Premera Blue Cross Blue Shield of Alaska Attn: Appeals Coordinator PO Box 91102 Seattle, WA 98111-9202 Fax to 425-918-5592</p>

Note: You may also call customer service to verbally submit an appeal.

If you would like to review the information used for your appeal, please send us a request in writing to:

Premera Blue Cross Blue Shield of Alaska
Attn: Appeals Coordinator
 PO Box 91102
 Seattle, WA 98111-9202
 Fax: 425-918-5592

Appeal Response Time Limits

We'll review your appeal and send a decision in writing within the time limits below. The timeframes are based on what the appeal is about, not the appeal level. At each level, Premera representatives who have not reviewed the case before will review and make a decision. Medical review denials will be reviewed by a medical specialist.

Type of appeal	When to expect a response
Urgent appeals	No later than 72 hours. We will call, fax, or email you with the decision, and follow up in writing.
All other (internal) appeals	Within 30 days
External appeals	Urgent appeals within 72 hours Other IRO appeals within 45 days from the date the IRO gets your request

What if you have ongoing care?

Ongoing care is continuous treatment you are currently receiving, such as residential care, care for a chronic condition, in-patient care and rehabilitation.

If you appeal a decision that affects ongoing care because we've determined the care is not or no longer medically necessary, benefits will not change during the appeal period. Your benefits during the appeal period should not be taken as a change of the initial denial. If our decision is upheld, you must repay all amounts we paid for ongoing care during the appeal review.

What if it's urgent?

If your condition is urgent, you will get our response sooner. Urgent appeals are only available for services you are currently receiving or have not yet received. Examples of urgent situation are:

- You are requesting coverage for inpatient or receiving emergency care that you are currently receiving
- Your life or health is in serious danger, or a delay in treatment would cause you to be in severe pain that you cannot bear, as determined by our medical professionals or your treating physician

If your situation is urgent, you may ask for an expedited external appeal at the same time you request an expedited internal appeal.

External appeal

External review will be done by an Independent Review Organization (IRO).

<p>Step 1. Complete the form</p>	<p>We will send you an External Review Application form authorizing the release of your medical records to an IRO with the written decision of your internal appeal.</p> <ul style="list-style-type: none"> • External appeals are available only for decisions involving a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the service or treatment you received. • You must include the signed external appeal form you received from us. You may also include medical records and other information.
<p>Step 2. Collect supporting documents</p>	<ul style="list-style-type: none"> • Collect any supporting documents that may help with your external review. This may include medical records and other information. • You must file your request for external review with the Alaska Division of Insurance within 180 days of the date you got our internal appeal letter. You can request an extension of the 180-day deadline by sending the Alaska Division of Insurance a written request that includes the reason why you believe an extension should be granted.

**Step 3.
Send in my external review
request**

- The Alaska Division of Insurance will provide your request to Premera within one working day. Premera will complete a preliminary review within five working days to determine whether the request is eligible for external appeal.
- For urgent external appeals, Premera will complete the preliminary review immediately. Premera will notify you, your authorized representative, and the Alaska Division of Insurance in writing of the results of our preliminary review within one day after we have completed it.
- If your request is eligible for external appeal, the Alaska Division of Insurance will assign an IRO to review your appeal. We will forward your medical records and other information to the IRO. If you have additional information on your appeal, you may send it to the IRO.
- If the request is not complete, Premera will notify you, your authorized representative, and the Alaska Division of Insurance in writing of what information or materials are needed to make the request complete.
- If the request is not eligible for external appeal, Premera will notify you or your authorized representative and the Alaska Division of Insurance in writing of the reasons why the request is not eligible for external review. If you do not agree with this decision, you may appeal to the Director of the Alaska Division of Insurance.

Once the IRO Decides:

For urgent appeals, the IRO will inform you and us immediately.

Premera will accept the IRO decision.

If the IRO:

- Reverses our decision, we will apply their decision quickly
- Stands by our decision, there is no further appeal. However, you may have other steps you can take under state or federal law, such as filing a lawsuit.

If you have questions about a denial of a claim or your appeal rights, you may call Customer Service at the number listed on your Premera ID card. Contact the Alaska Division of Insurance at any time during this process.

Alaska Division of Insurance

550 W 7th Ave., Suite 1560

Anchorage, Alaska 99501-3567

800-INSURAK (467-8725) (within Alaska)

907-269-7900 (outside Alaska)

Email: insurance@alaska.gov

Online: <https://www.commerce.alaska.gov/web/ins/>

If your plan is governed by the Federal Employee Retirement Income Security Act of 1974 (ERISA), you can also contact the Employee Benefits Security Administration of the US Department of Labor.

Employee Benefits Security Administration (EBSA)

866-444-EBSA (3272)

OTHER INFORMATION ABOUT THIS PLAN

This section tells you about how your Group's Contract and this plan are administered. It also includes information about federal and state requirements we must follow and other information we must provide to you.

Benefits Not Transferable

This plan's benefits are not transferable. This means no one except you has the right to receive the benefits of this plan. If you use plan benefits in a false or misleading way, we will cancel your plan. We may also take legal action against you.

Conformity With The Law

The Group Contract is issued and delivered in the state of Alaska and is governed by the laws of the state of Alaska, except to the extent pre-empted by federal law. If any provision of the Group Contract or any amendment is deemed to be in conflict with applicable state or federal laws or regulations, upon discovery of such conflict the Group Contract will be administered in conformance with the requirements of such laws and regulations as of their effective date.

Entire Contract

The entire contract between the Group and us consists of all of the following:

- The contract face page and **Standard Provisions**
- The Employer Agreement
- This benefit booklet(s)
- The Group's signed application
- All attachments, endorsements and riders included or issued hereafter

No change to this contract, including any change made by a producer of the Group, will be binding upon us unless it's in writing and approved with the signature of an officer of ours.

Evidence Of Medical or Dental Necessity

We have the right to require proof of medical or dental necessity for any services or supplies you receive before we provide benefits under this plan. You or your dental care providers may submit this proof. No benefits will be available if the proof isn't provided or acceptable to us.

Group As The Agent

Your Group is your agent for all purposes under this plan and not the agent of Premera Blue Cross Blue Shield of Alaska. Any action taken by your Group will be binding on you.

ID Card

If you need a replacement Premera ID card, call our customer service or visit our website at premera.com. If coverage under the contract terminates, your Premera ID card will no longer be valid.

Independent Contractors

All health care providers who provide services and supplies to a member do so as independent contractors. None of the provisions of this contract are intended to create, nor shall they be deemed or construed to create, any employment or agency relationship between us and the provider of service other than that of independent contractors. We are not legally responsible for any harm that comes to a member while in a provider's care. This includes, without limitation, any general damages, pain and suffering.

Independent Corporation

The subscriber hereby expressly acknowledges the understanding that this contract constitutes a contract solely between the subscriber's Group and Premera Blue Cross Blue Shield of Alaska.

The subscriber further acknowledges and agrees that the Group has not entered into this Group contract based upon representations by any person other than us, and that no person, entity, or organization other than us shall be held accountable or liable to the Group for any of our obligations to the Group created under this contract. This provision shall not create any additional obligations whatsoever on our part other than those obligations created under other provisions of this contract.

Intentionally False Or Misleading Statements

If this plan's benefits are paid in error due to any intentionally false or misleading statements, we'll be entitled to recover these amounts.

If you make any intentionally false or misleading statements on any application or enrollment form that affects your acceptability for coverage, we may:

- Deny your claim
- Reduce the amount of benefits provided for your claim
- Void your coverage under this plan (void means to cancel coverage back to its effective date as if it had never existed at all.) Your coverage cannot be voided based on a misrepresentation you made unless you have performed an act or practice that constitutes fraud; or made an intentional misrepresentation of material fact that affects your acceptability for coverage.

Finally, intentionally false or misleading statements on any group form required by us, which affect the acceptability of the Group or the risks to be assumed by us, may cause the rescinding of the Group Contract for this plan. Such recoveries will not be sought more than 365 days from the date we discovered, or could have reasonably discovered the intentionally false or misleading statements.

Legal Action

No action at law or in equity shall be brought to recover under this contract before the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this contract. No action shall be brought after the expiration of three years after the written proof of loss is required to be furnished.

Limitations Of Liability

We're not legally responsible for any of the following:

- Situations such as epidemics or disasters that prevent members from getting the care they need
- The quality of services or supplies received by members, or the regulation of the amounts charged by any provider, since all those who provide care do so as independent contractors
- Providing any type of hospital, medical, dental, vision, or similar care
- Harm that comes to a member while in a provider's care
- Amounts in excess of the actual cost of services and supplies
- Amounts in excess of this plan's maximums. This includes recovery under any claim of breach.
- General or special damages including without limitation, alleged pain, suffering, mental anguish or consequential damages

Member Cooperation

You must cooperate with us in a timely and appropriate way as we manage and provide benefits. You must also cooperate with us if there is a lawsuit.

Nonwaiver

No delay or failure when exercising or enforcing any right under this contract shall constitute a waiver or relinquishment of that right and no waiver or any default under this contract shall constitute or operate as a waiver of any subsequent default. No waiver of any provision of this contract shall be deemed to have been made unless and until such waiver has been reduced to writing and signed by the party waiving the provision.

Notice Of Information Use And Disclosure

We may collect, use or disclose certain information about you. This protected personal information (PPI) may include dental information, or personal data such as your address, telephone number or Social Security number. We may receive this information from or release it to dental care providers, insurance companies or other sources.

This information is collected, used or disclosed for conducting routine business operations such as:

- Determining your eligibility for benefits and paying claims. (Genetic information is not collected or used for enrollment purposes.)
- Coordinating benefits with other dental care plans
- Conducting care management, case management or quality reviews

- Fulfilling other legal obligations that are specified under the Group Contract

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

To safeguard your privacy, we take care to ensure that your information remains confidential by having a company confidentiality policy and by requiring all employees to sign it.

If a disclosure of PPI isn't related to a routine business function, we remove anything that could be used to easily identify you or we obtain your prior written authorization.

You have the right to request inspection and /or amendment of records retained by us that contain your PPI. Please contact our customer service department and ask that a representative mail a request form to you.

Notice Of Other Coverage

As a condition of receiving benefits under this plan, you must notify us of:

- Any legal action or claim against another party for a condition or injury for which we provide benefits, and the name and address of that party's insurance carrier.
- The name and address of any insurance carrier that provides:
 - Personal injury protection (PIP)
 - Underinsured motorist coverage
 - Uninsured motorist coverage
- Any other insurance under which you are or may be entitled to recover compensation
- The name of any other group or individual insurance plans that cover you

Notices

Any notice we're required to submit to the Group or subscriber will be considered to be delivered if mailed to the Group or subscriber, at the most recent address appearing on our records. We'll use the date of postmark in determining the date of our notification. If you or your Group is required to submit notice to us, it will be considered delivered on the postmark date or the date we receive it, if not postmarked.

Recovery Of Claims Overpayments

We have the right to recover amounts we have overpaid in error. Such amounts may be recovered from the subscriber or any other payee, including a provider. Or, such amounts may be deducted from future benefits of the subscriber or any of their dependents (even if the original payment wasn't made on that member's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a provider who doesn't have a contract with us. Such recoveries will not be sought more than 365 days after adjudication of the original claim.

Right To And Payment Of Benefits

Benefits of this plan are available only to members. In accordance with the law, we may pay the benefits of this plan to:

- The subscriber
- A provider
- Another health insurance carrier
- The member
- Another party legally entitled under federal or state medical child support laws
- Jointly to any of the above

Payment to any of the above satisfies our obligation as to payment of benefits.

Note: You have the right to request the plan to assign payment of benefits to the provider who furnished your care. If you would like to request an assignment of payment call our customer service department at the number listed inside the front cover of this booklet.

Venue

All suits and legal proceedings, including arbitration proceedings, brought against us by you or anyone claiming any right under this plan must be filed:

- Within 3 years of the date we denied, in writing, the rights or benefits claimed under this plan, or of the completion date of the independent review process if applicable.
- In a mutually agreed upon location in the state of Alaska.

Workers' Compensation Insurance

This contract doesn't replace, affect or supplement any state or federal requirement for the Group to provide workers' compensation insurance, employer's liability insurance, or other similar insurance. When an employer is required by law to provide or has the option to provide workers' compensation insurance, employer's liability insurance, or other similar insurance and doesn't provide such coverage for its employees, the benefits available under this plan won't be provided for illnesses and/or injuries arising out of the course of employment that are or would be covered by such insurance, unless otherwise excepted under the ***Exclusions and Limitations*** section.

WHAT ARE MY RIGHTS UNDER ERISA?

The Group has an employee welfare benefit plan that is subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA). This employee welfare benefit plan is called the **ERISA Plan** in this section. The insured Premera Blue Cross Blue Shield of Alaska plan described in this booklet is part of the ERISA Plan.

When used in this section, the term **ERISA Plan** refers to the Group's employee welfare benefit plan. The "ERISA Plan administrator" is the Group or an administrator named by the Group. Premera Blue Cross Blue Shield of Alaska isn't the ERISA Plan administrator.

As a participant in an employee welfare benefit plan, the subscriber has certain rights and protections. This statement explains those rights.

ERISA provides that all plan participants shall be entitled to:

- Examine without charge, at the ERISA Plan administrator's office and at other specified locations (such as work sites and union halls), all documents governing the ERISA Plan, including insurance contracts and collective bargaining agreements. Please note that our contract with the Group by itself doesn't meet all the requirements for an ERISA plan document. If the ERISA Plan is required to file an annual report with the US Department of Labor, plan participants shall be entitled to examine a copy of its latest annual report (Form 5500 Series) filed and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the ERISA Plan administrator, copies of documents governing the operation of the ERISA Plan, including insurance contracts and collective bargaining agreements and updated summary plan descriptions. (Please note that this booklet by itself does not meet all the requirements for a summary plan description.) If the ERISA Plan is required to file an annual report with the US Department of Labor, plan participants shall be entitled to obtain copies of the latest annual report (Form 5500 Series). The administrator may make a reasonable charge for the copies.
- Receive a summary of the ERISA Plan's annual financial report, if ERISA requires the ERISA Plan to file an annual report. The ERISA Plan administrator for such plans is required by law to furnish each participant with a copy of this summary annual report.
- Continue dental care coverage for yourself, spouse or dependents if there's a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your ERISA Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. Premera Blue Cross Blue Shield of Alaska is a fiduciary only with respect to claims processing and payment. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the ERISA Plan and don't receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the ERISA Plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials weren't sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the ERISA Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that ERISA Plan fiduciaries misuse the ERISA Plan's money, or if you're discriminated against for asserting your rights, you may seek assistance from the US Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you're successful the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Note: Under ERISA, the ERISA Plan administrator is responsible for furnishing each participant and beneficiary with a copy of the summary plan description.

If you have any questions about your employee welfare benefit plan, you should contact the ERISA Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the ERISA Plan administrator, you should contact either:

- The office of the Employee Benefits Security Administration, US Department of Labor, 300 Fifth Avenue, Suite 1110, Seattle, WA 98104; or
- The Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, US Department of Labor, 200 Constitution Ave. NW, Washington, DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 866-444-3272.

DEFINITIONS

The terms listed throughout this section have specific meanings under this plan.

Accidental Injury

Physical harm caused by a sudden and unforeseen event at a specific time and place. Accidental injury does not mean any of the following:

- An illness, except for infection of a cut or wound
- Dental injuries caused by biting or chewing
- Over-exertion or muscle strains

Adverse Benefit Determination

An adverse benefit determination means a decision to deny, reduce, terminate or a failure to provide or to make payment, in whole or in part for services. This includes:

- A member's or applicant's eligibility to be or stay enrolled in this plan or health insurance coverage
- A limitation on otherwise covered benefits
- A clinical review decision
- A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective
- A decision related to compliance with protections against balance billing as defined by federal and state law

Allowable Charge

The allowable charge shall mean one of the following:

- **Dental Care Providers Who Have Agreements With Us**

The amount for medically necessary services and supplies these providers have agreed to accept as payment is either the fee that we have negotiated as a "reasonable allowance" for medically necessary covered services and supplies or the provider's billed charge, whichever is less. These providers agree to seek payment from us when they furnish covered services to you. You'll be responsible only for any applicable calendar year deductibles, coinsurance, charges in excess of the stated benefit maximums, and charges for services and supplies not covered under this plan.

Your liability for any applicable calendar year deductibles, coinsurance and amounts applied toward benefit maximums will be calculated on the basis of the allowable charge. In no event will your liability exceed what would have been charged in the absence of insurance.

Every 6 months, we review the reasonable allowance for dental care services and supplies by examining the range of charges and fees for the same or similar services and supplies billed by providers within each geographical area. We use 12 months of claims experience data during this process.

The reasonable allowance won't be less than the 80th percentile of billed or accepted charges or contracted rates.

- **Dental Care Providers Who Don't Have Agreements With Us**

The allowable charge will be no less than the 90th percentile of fees for the geographical area.

When you receive services from dental care providers that don't have agreements with us, your liability is for any amount above the allowable charge, and for any applicable calendar year deductibles, coinsurance, amounts in excess of stated benefit maximums and charges for non-covered services and supplies.

Every 6 months, we review the reasonable allowance for dental care services and supplies by examining the range of charges and fees for the same or similar services and supplies billed by providers within each geographical area. We use 12 months of claims experience data during this process.

Benefit

What this plan provides for a covered service. The benefits you get are subject to this plan's cost-shares.

Benefit Booklet

Benefit booklet describes the benefits, limitations, exclusions, eligibility and other coverage provisions included in this plan and are part of the entire contract.

Calendar Year

The period of 12 consecutive months that starts each January 1, at 12:01 a.m. and ends on the next December 31, at midnight.

Claim

A request for payment from us according to the terms of this plan.

Comprehensive Oral Evaluation

Comprehensive oral evaluations include complete dental/medical history and general health assessment, complete thorough evaluation of extra-oral and intra-oral hard and soft tissue; the evaluation and recording of dental caries, missing or unerupted teeth, restoration, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screenings.

Congenital Anomaly

A marked difference from the normal structure of an infant's body part that's present from birth.

Contract

Contract describes the benefits, limitations, exclusions, eligibility and other coverage provisions included in this plan.

Cosmetic Services

Services that are performed to reshape normal structures of the body in order to improve or alter your appearance and not primarily to restore an impaired function of the body.

Cost Share

The part of healthcare costs that you have to pay. These are deductibles, coinsurance, and copayments.

Covered Service

A service, supply or drug that is eligible for benefits under the terms of this Plan.

Dental Care Provider

A state licensed:

- Doctor of Medical Dentistry (DMD)
- Doctor of Dental Surgery (DDS)

The benefits of this plan are available if professional services are provided by a state-licensed dentist, a dental hygienist under the supervision of a licensed dentist, or other individual performing within the scope of their license or certification, as allowed by law and this plan's benefits would be payable if the covered service were provided by a "dental care provider" as defined above.

Dental Emergency

A condition requiring prompt or urgent attention due to trauma and/or pain caused by a sudden unexpected injury, acute infection or similar occurrence.

Dentally Necessary and Dental Necessity

Those covered services which are determined to meet all of the following requirements:

- Appropriate and consistent with authoritative dental or scientific literature
- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of a disease, accidental injury, or condition harmful or threatening to the member's dental health, unless provided for preventive services when specified as covered under this plan
- Not primarily for the convenience of the member, the member's family, the member's dental care provider or another provider

Dependent

The subscriber's spouse or domestic partner and any children who are on this plan.

Effective Date

The date your coverage under this plan begins.

Eligibility Waiting Period

The length of time that must pass before a subscriber or dependent is eligible to be covered under the dental care plan. If a subscriber or dependent enrolls under the **Special Enrollment** provisions of this plan or enrolls on a date other than when first eligible to enroll, any period prior to such enrollment isn't considered an eligibility waiting period, unless all or part of the initial eligibility waiting period hadn't been met.

Emergency Medical Condition (also called "Emergency")

A medical condition, mental health, or substance use disorder condition which manifests itself by acute symptoms of sufficient severity, including, but not limited to, severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in 1) placing the health of the individual (or with respect to a pregnant member, the member's health or the unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

Examples of an emergency medical condition are severe pain, suspected heart attacks and fractures. Examples of a non-emergency medical condition are minor cuts and scrapes.

Emergency Services

- A medical screening examination to evaluate an emergency that is within the capability of the emergency department of a hospital, including ancillary service routinely available to the emergency department. Emergency services are also provided by a behavioral health emergency service provider, including a crisis stabilization unit, triage facility, mobile rapid response crisis team, and an agency certified by the Department of Health.
- Examination and treatment as required to stabilize a patient to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital. Stabilize means to provide such medical, mental health or substance use disorder treatment necessary to ensure that, within reasonable medical probability that no material deterioration of an emergency condition is likely to result from the transfer of the patient from a facility; and for a pregnant member in active labor to perform the delivery.
- Ambulance transport, as needed, in support of the services above.

Endorsement

A document that is attached to and made a part of this contract. An endorsement changes the terms of the contract.

Enrollment Date

For the subscriber and eligible dependents who enroll when the subscriber is first eligible, the enrollment date is the subscriber's date of hire. There is one exception to this rule. If the subscriber was hired into a class of employees to which the Group doesn't provide coverage under this plan, but was later transferred to a class of employees to which the group does provide coverage under this plan, the enrollment date is the date the subscriber enters the eligible class of employees. (For example, the enrollment date for a seasonal employee who was made permanent after six months would be the date the employee started work as a permanent employee.) For subscribers who don't enroll when first eligible and for dependents added after the subscriber's coverage starts, the enrollment date is the effective date of coverage.

Experimental and Investigational Services

A treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria:

- A drug or device which cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and does not have approval on the date the service is provided.
- It is subject to oversight by an Institutional Review Board
- There is no reliable evidence showing that the service is effective in clinical diagnosis, evaluation, management or treatment of the condition.
- It is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy.
- Evaluation of reliable evidence shows that more research is necessary before the service can be classified as

equally or more effective than conventional therapies.

Reliable evidence means only published reports and articles in authoritative medical and scientific literature and assessments.

Explanation of Benefits

An explanation of benefits is a statement that shows what you will owe and what we will pay for healthcare services received. It's not a bill.

Group

A small employer, including a person, firm, corporation, partnership, or political subdivision, that is actively engaged in business and is a party to the Group Contract. The "Group" is responsible for collecting and paying all subscription charges, receiving notice of additions and changes to employee and dependent eligibility and providing such notice to us, and acting on behalf of its employees.

Hospital

A healthcare facility that meets all of these criteria:

- It operates legally as a hospital in the state where it is located.
- It has facilities for the diagnosis, treatment and acute care of injured and ill persons as inpatients.
- It has a staff of providers that provides or supervises the care.
- It has 24-hour nursing services provided by or supervised by registered nurses.

A facility is *not* considered a hospital if it operates mainly for any of the purposes below:

- As a rest home, nursing home, or convalescent home
- As a residential treatment center or health resort
- To provide hospice care for terminally ill patients
- To care for the elderly
- To treat substance abuse or tuberculosis

Illness

A sickness, disease, or medical condition.

Injury

Physical harm caused by a sudden event at a specific time and place. It is independent of illness, except for infection of a cut or wound.

Limited Oral Evaluation – Problem Focused

A limited oral evaluation – problem focused is an evaluation limited to a specific oral health problem or complaint and may include evaluation of a specific dental problem or oral health complaint, dental emergency and referral for other treatment.

Medically Necessary and Medical Necessity

Services a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of dental or medical within scope of practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of dental or medical within scope of practice" means standards that are based on credible scientific evidence published in peer reviewed dental or medical literature generally recognized by the relevant dental or medical community, provider specialty society recommendations and the views of provider practicing in relevant clinical areas and any other relevant factors.

Member (also called “You” and “Your”)

Any person covered under this plan as a subscriber or dependent.

Plan

The benefits, terms and limitations stated in the contract between us and the Group.

Provider (Dental Care Provider)

A dentist or other dental care professional named in this plan that is licensed or certified as required by the state in which the services were received to provide a dental service or supply, and who does so within the lawful scope of that license or certification. Not all services they provide are covered under this plan. See **Covered Services** and **Exclusions and Limitations** for additional information.

Service Area

Service area means within the state of Alaska.

Services

Procedures, surgeries, consultations, advice, diagnosis, referrals, treatment, supplies, drugs, devices, technologies, or places of service.

Small Employer

A small employer is an employer who employed an **average** of at least two but not more than 50 common law employees on business days during the preceding calendar year and that employs at least two common law employees on the first day of the current dental plan benefit year.

Specialist

A provider who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse

- An individual who is legally married to the subscriber.
- An individual who is a domestic partner of the subscriber.

Subscriber

An enrolled employee of the Group. Coverage under this plan is established in the subscriber's name.

Subscription Charge

The monthly rates we establish as consideration for the benefits offered under this contract.

Temporomandibular Joint (TMJ) Disorders

TMJ disorders include those disorders which have one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.

Visit

A visit is one session of consultation, diagnosis, or treatment with a provider. We count multiple visits with the same provider on the same day as one visit. Two or more visits on the same date with different providers count as separate visits.

We, Us and Our

Premera Blue Cross Blue Shield of Alaska in the state of Alaska.

where to send claims

MAIL YOUR CLAIMS TO:

Premera Blue Cross Blue Shield of Alaska

P.O. Box 91059

Seattle, WA 98111-9159

www.premera.com

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