Alaska Public Broadcasting Health Trust

Dental Optima Plan

4003399

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

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
P.O. 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: 1-800-508-4722 (TTY: 711)

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 Public Broadcasting Health Trust
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Plan:	Alaska Dental Optima
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TABLE OF CONTENTS

HOW TO CONTACT US ....(SEE INSIDE FRONT COVER OF THIS BOOKLET)

INTRODUCTION 1

WHAT DO I NEED TO KNOW BEFORE I GET CARE? 2

WHAT ARE MY DENTAL BENEFITS? 3

What Do I Pay For Covered Services? 3

Orthodontia 6

EXCLUSIONS 7

WHAT IF I HAVE OTHER COVERAGE? 11

Coordinating Benefits With Other Dental Care Plans 11

Subrogation And Reimbursement 12

WHO IS ELIGIBLE FOR COVERAGE? 13

Employee Eligibility 13

Dependent Eligibility 13

WHEN DOES COVERAGE BEGIN? 14

Enrollment 14

Special Enrollment 15

Open Enrollment 15

Changes In Coverage 15

Plan Transfers 16

WHEN WILL MY COVERAGE END? 16

Events That End Coverage 16

Contract Termination 16

HOW DO I CONTINUE COVERAGE? 17

Continued Eligibility For A Disabled Child 17

Leave Of Absence 17

Continuation Under USERRA 17

COBRA 18

HOW DO I FILE A CLAIM? 20

COMPLAINTS AND APPEALS 22

What You Can Appeal 22

Appeal Levels 23

OTHER INFORMATION ABOUT THIS PLAN 26

WHAT ARE MY RIGHTS UNDER ERISA? 28

DEFINITIONS 30

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's covered under this plan
- **EXCLUSIONS** – 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.

WHAT DO I NEED TO KNOW BEFORE I GET CARE?

The covered services under this plan are classified as Diagnostic and Preventive, Basic, and Major. The lists of 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. "Covered dental condition" means a covered member's illness, injury or disease, or a dependent child's congenital malformation. Such services must meet all of the following requirements:

- They must be dentally necessary (see definition of "Dentally Necessary")
- They must not be excluded from coverage under this plan
- They must be furnished by a licensed dentist (D.M.D. or D.D.S.), 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.)

ALTERNATIVE TREATMENT

To determine benefits available under this plan, alternative procedures or services with different fees that are consistent with acceptable standards of dental practice in consultation with the attending dental provider are utilized. In all cases where there's an alternative course of treatment that is less costly, we'll only provide benefits for the treatment with the lesser fee. If you and your dental care provider choose a more costly treatment, you're responsible for the additional charges beyond those for the less costly alternative treatment.

ESTIMATE OF DENTAL BENEFITS

An estimate of dental benefits verifies, for the dental care provider and you, your eligibility and benefits. Because we consider alternative treatment at the time we review the 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.

An estimate of benefits isn't required in order for you to receive your dental benefits. However, we suggest that your dental care provider submit an estimate to us for any proposed dental services you are concerned about your out-of-pocket expenses, before your course of treatment begins.

The decision to deny, reduce, or end benefits for an otherwise covered service because that service isn't dentally necessary will be made by a Premera Blue Cross Blue Shield of Alaska employee or consultant who is a licensed dentist.

CALENDAR YEAR DENTAL DEDUCTIBLE

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

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

This plan has an annual dollar maximum described below. We don't count allowed amounts that apply to your individual dental deductible toward that annual dollar maximum. However, the plan also has limits on how often some Basic or Major 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 do count the procedures that apply to your individual dental deductible toward that 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 allowed amounts for covered services you receive. The benefit percentages provided by this plan and the remaining percentage you're responsible for are referred to as "coinsurance."

DENTAL BENEFIT MAXIMUM

The maximum amount of dental benefits available to any one member in a calendar year is $1,500.

Covered dental services requiring multiple treatment dates are considered incurred on the date the services are completed. This is known as the seat date. Amounts paid for such procedures will be applied to the dental benefit maximum based on the incurred date.

Under this Plan, Class I - Diagnostic and Preventive Services do not accrue towards the dollar maximum amount of dental benefits available.

NETWORK PROVIDERS

For the most current information on 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 network providers, your claims will be submitted directly to us, and available benefits will be paid directly to the dental care provider. Network providers agree to accept our "allowed amount" (please 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.

Please Note: 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.

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

NON-NETWORK PROVIDERS

If you do not have access to a network provider within 50 miles of your home or decide not to use a network provider, you may choose any dental care provider. Your dental services will be paid at the same benefit level as network providers. However, if you receive services from non-network dental care providers, you're responsible for amounts above the allowed amount 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 allowed amount 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. Please see the "How Do I File A Claim?" section in this booklet for instructions on submitting claims for reimbursement.

WHAT ARE MY DENTAL BENEFITS?

WHAT DO I PAY FOR COVERED SERVICES?

After you satisfy the required calendar year deductible, you pay the following coinsurance per calendar year, up to the dental benefit maximum. Dental services fall into 3 categories: Diagnostic and Preventive, Basic, and Major services. In this section you'll find a description of the services included in each category.

- 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 examinations are limited to two per calendar year. Professional consultations, periodontal evaluations and other office visits apply to this limit
- Prophylaxis (cleaning of teeth) is limited to two per calendar year
- Topical application of fluoride is covered for members under the age of 20, and is limited to two treatments per

calendar year

- Dental x-rays include:
  - Bitewing x-rays
  - 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
- Sealants, for members under the age of 20, on permanent molars only. Replacements limited to once every 24 consecutive months
- Oral pathology laboratory services, not including the removal of tissue sample, are covered when directly related to teeth and gums.
- Space maintainers, for members under the age of 20
- Problem focused (including emergency) oral evaluations and re-evaluations are limited to two per calendar year. Please see the "Definitions" section for the definition of a Dental Emergency.

Class II - Basic Services

- Simple extractions
- Therapeutic drug injections administered in a dental office
- Application of desensitizing medicament or resin
- Fillings, consisting of amalgam and composite resins on any given tooth surface are covered once in any 24 consecutive months.
- Prefabricated stainless steel, porcelain, ceramic, resin or other esthetic coated stainless steel crowns are limited to once per tooth every 24 consecutive months
- Protective restorations (sedative fillings)
- Repair or recement of inlays, onlays, crowns, bridgework and dentures are covered when services are performed done 6 or more months after initial placement
- Periodontal maintenance, as a follow-up to active periodontal treatment, is limited to 4 treatments per calendar year.
- Surgical extractions of erupted or impacted teeth and removal of residual tooth roots
- Limited occlusal adjustments are limited to once every 12 consecutive months as dentally necessary
- Emergency palliative treatment. We require a written description and/or office records of services provided.
- 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
- Anesthesia in a dental care provider's office, when dentally necessary. This benefit includes:
  - General or intravenous anesthesia in a dental care provider's office, when dentally necessary
  - Regional or terminal block anesthesia
  - Nitrous oxide
- 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 performed done 6 or more months after initial placement of occlusal guard.
- 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
- Non-surgical periodontal services of the gums and supporting structures include:
  - Periodontal scaling and root planing is limited to once per quadrant every 24 consecutive months
  - Full mouth debridement is limited to once every 36 consecutive months

- Localized delivery of antimicrobial agents, subject to review
- Endodontic services of teeth with diseased or damaged nerves include:
  - Direct pulp cap
  - Pulpotomy
  - • Endodontic (root canal) treatment is limited to once per tooth every 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, apicoectomy, periradicular surgery, and retrograde filling

Class III - Major Services

- 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 5 calendar years from the original seat date.
- 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, an estimate of your dental 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
- Reline, rebase and adjustments of dentures are covered when services are done 6 or more months after denture installation.
- Crown build-ups or post and cores for covered crowns are limited to once every 5 calendar years.
- Implants and implant services. Replacement of implant/abutment supported crowns, dentures, and bridges are limited to once every 5 calendar years from the original seat date.
- Precision attachments
- 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
- Non-surgical periodontal services of the gums and supporting structures include:
  - Periodontal scaling and root planing is limited to once per quadrant every 24 consecutive months
  - Localized delivery of antimicrobial agents, subject to review
- Endodontic services of teeth with diseased or damaged nerves include:
  - Direct pulp cap
  - Pulpotomy
  - Endodontic (root canal) treatment is limited to once per tooth every 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, apicoectomy, periradicular surgery, and retrograde filling

Limitations

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

- Study Models
- Photographic images
- Plaque control programs (oral hygiene instruction, dietary instruction and home fluoride kits)

- Duplicate appliances
- Cleaning of appliances
- Complete occlusal adjustment
- Periodontal splinting and/or crown and bridgework in conjunction with periodontal splinting
- Crowns and copings in conjunction with an overdenture
- Indirect pulp caps

Dental Care Services For Accidental Injuries

When services are related to accidental injuries benefits are available for Basic and Major services as follows:

Repreparation or repair of the natural tooth structure when it's required as a result of an accidental injury to that structure, and such repair is performed within 12 months of the accidental injury.

These services are only covered when they are:

- 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;
- Performed within 12 months of the accident causing the injury; 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; or
  - Don't have periodontal disease or other condition that would cause the tooth to be in a weakened state prior to the injury.

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

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.

Extension Requests For Accidental Injury Services

If necessary services can't be completed within 12 months of an accidental injury, coverage may be extended if your dental care meets our extension criteria. We must receive extension requests within 12 months of the accidental injury date.

ORTHODONTIA

Covered Services And Supplies

Covered orthodontic services and supplies include only the following:

- Diagnostic services and supplies, including examinations, x-rays, models, and photographs
- Active treatment, including initial and subsequent necessary appliances
- Retention treatment, including necessary appliances

We reserve the right to review your dental records, including x-rays, models, and photographs, to determine if the requested services and supplies are within the limits of this benefit.

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

- An existing orthodontic condition must be diagnosed as consisting of a handicapping malocclusion which is abnormal and which can be reduced or eliminated by correcting abnormally positioned teeth
- An expense for an orthodontic service or supply is incurred on the date the service is received or the supply is ordered

Any calendar year deductibles and coinsurance of other benefits under this plan don't apply to this benefit.

Benefits

Benefits are provided at of the allowable charge up to a lifetime maximum of 0 for each member, or until the member's total treatment plan, including retention treatment is paid, whichever occurs first.

Limitations

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

- Any replacement or repair to any appliance
- Charges beyond the month of termination of orthodontic services if such services are terminated for any reason before completion
- Further orthodontic services and supplies, after completion of the initial treatment plan, unless this benefit's lifetime maximum hasn't been reached
- Expenses incurred for orthodontic services or supplies when this benefit isn't in effect or when you're not covered under this benefit

EXCLUSIONS

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 allowed amount as defined by this plan, for non-emergency services from a non-network, non-participating, or non-contracted provider.

Benefits From Other Sources

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

- Motor vehicle medical or 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

Case Management

Case management, presentation, or extensive treatment planning.

Charges for Records or Reports

- Charges from providers for supplying records or reports not requested for utilization management.

Cleaning and Inspection of Appliance

- Services to clean and inspect appliances such as complete and partial dentures.

Comfort or Convenience

- 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 does not apply to chores done by a home health aide as prescribed in your treatment plan.
- Meal or dietary assistance, including "Meals on Wheels"

Complications

- This plan does not cover any complications of a non-covered service, including follow-up services or effects of those services.

Cosmetic Services

- Drugs, services, or supplies for cosmetic services, including enamel microabrasion, odontoplasty, and

bleaching of teeth
- Treatment of congenital malformations, except when the patient is an eligible dependent child
- This plan does not cover drugs, services or supplies for cosmetic services. 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.
- Services and supplies rendered for cosmetic or aesthetic purposes, including any direct or indirect complications and aftereffects thereof, except as specified in the Orthodontia benefit

Counseling, Education or Training

Counseling or training in the absence of illness including:
- 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

Counseling, Oral

Oral counseling, education or training, including:
- Nutritional counseling for control of dental disease
- Tobacco counseling for the control and prevention of oral diseases
- Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance abuse

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

Dietary Services

Dietary planning or nutritional counseling for the control of dental caries, oral hygiene instruction and training in preventive dental care.

Experimental or Investigational Services

Experimental or investigational, see Definitions. This plan also does not cover any complications or effects of such non-covered services.

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

This plan does not cover services that you provide to yourself. It also does not 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

Genetic or Caries Risk and Susceptibility Tests

Government Facilities

This plan does not cover services provided by a non-contracted state or federal facility that are not emergency care unless 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.

Magnetic Resonance Imaging (MRI) and Ultrasounds

Maxillofacial Prosthetics

This plan does not cover maxillofacial prosthetics, this includes but is not limited to artificial replacement of the ear, nose, eyes, or other areas of the face.

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
- This includes the air force, army, coast guard, marines, National Guard and Navy. It also includes any related civilian forces or units. However, this exclusion does not apply to members of the U.S. military (active or retired) or their dependents enrolled in the TRICARE program. This plan will be primary to TRICARE for these members when required by federal law

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 Charges

- Charges for provider travel time
- Transporting a member in place of a parent or other family member or accompanying the member to appointments or other activities outside the home, such as medical appointments or shopping. Doing housework or chores for the member or helping the member do housework or chores.
- Arrangements in which the provider lives with the member

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, except as specified under "Orthodontia" in the "What Are My Benefits?" section.

Orthognathic Surgery (Jaw Augmentation or Reduction)

Procedures to lengthen or shorten the jaw except when required for a temporomandibular joint disorder, injury, sleep apnea or congenital anomaly.

Outside The Scope Of A Provider's License Or Certification

Services or supplies that are outside the scope of the provider's license or certification, or that are furnished by a provider that isn't licensed or certified by the jurisdiction in which the services or supplies were received.

Prescription Drugs

Any prescription drugs or medicines, including drugs or medicines dispensed in the office for home use. This includes vitamins, food supplements, oral antibiotics, oral analgesics, and fluoride and patient management drugs, such as premedication and sedation.

Provider's Licensing or Certification

This plan does not cover services that the provider's license or certification does not allow him or her to perform. It also does not cover a provider that does not have the license or certification that the state requires.

Serious Adverse Events and Never Events

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.

Serious Adverse Event means a hospital injury caused by medical management (rather than an underlying disease) that prolonged the hospitalization, and/or produces a disability at the time of discharge

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

Not all medical errors are defined as serious adverse events or never events. You can obtain a list of serious adverse events and never events by contacting us at the number listed in the front of this booklet or on the Centers for Medicare and Medicaid Services (CMS) website at www.cms.hhs.gov.

Services or Supplies for which You Do Not Legally Have to Pay

Services and supplies for which no charge is made, for which none would have been made if this plan were not in effect, or for which you are not legally required to pay.

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.

Sleep Apnea

Services or supply for sleep apnea including sleep apnea appliance fabrication placement, adjustment, or repair

Temporary, Interim Or Provisional Services

Temporary, interim or provisional services for crowns, bridges or dentures

Temporomandibular Joint (TMJ) Disorders

Any dental services or supplies connected with the diagnosis or treatment of temporomandibular joint (TMJ) disorders, including any direct or indirect complications and aftereffects thereof.

Testing And Treatment Services

- Testing and treatment for mercury sensitivity or allergy-related

Work-Related Illness or Injury

This plan does not cover 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.

However, this exclusion doesn't apply to sole proprietors, partners or executive officers who are full-time employees of the Group if they're exempt from the above laws and if the Group doesn't furnish them with workers' compensation coverage. They'll be covered under this plan for conditions arising solely from their occupations with the Group. Coverage is subject to the other terms and limitations of this plan.

WHAT IF I HAVE OTHER COVERAGE?

COORDINATING BENEFITS WITH OTHER DENTAL CARE PLANS

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.

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.
- **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 trusteed 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 trusteed 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.

COORDINATING BENEFITS WITH MEDICARE

If you're also covered under Medicare, federal law may require this plan to be primary over Medicare. When this plan isn't primary, we'll coordinate benefits with Medicare.

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 is a party other than you or us. This party includes a UIM carrier because it stands in the shoes of a third party tort feasor 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 are 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 your damages in the recoveries that you received. Our right of recovery is not subject to reduction for reasonable 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. 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 must also 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.

WHO IS ELIGIBLE FOR COVERAGE?

Employee Eligibility

Under this large employer dental benefit plan, to be an "eligible employee" you must:

- Be a regular and active employee, owner, partner, or corporate officer of the Group who is paid on a regular basis through the Group's payroll system, and reported by the Group for Social Security purposes;
- Regularly work the minimum hours required by the Group; and
- Satisfy a 30-day probationary period

DEPENDENT ELIGIBILITY

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

- The lawful spouse of the subscriber, 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 enroll only as a subscriber.
- The domestic partner of the subscriber. All rights and benefits afforded to a "spouse" under this plan will also be afforded to an eligible domestic partner. 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"; the term "termination of the domestic partnership" shall be used in place of "legal separation" and "divorce."
- An eligible child under 26 years of age who is unmarried and primarily dependent upon the subscriber for support, except as provided for in the ***How Do I Continue Coverage? Continued 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 legal dependent for whom the subscriber or spouse has a legal guardianship. There must be a court order signed by a 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.
- A newborn child of a covered dependent.

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 in the "Who Is Eligible For Coverage?" section. When enrollment is timely, coverage for the employee and enrolled dependents will become effective on the first of the month that coincides with or next follows 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 probationary period ends, if one is required by the Group; or
- 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. Please 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, 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.

Newborn And Adoptive Children

Natural newborn dependent children born on or after the subscriber's effective date will be covered from their date of birth. However, if payment of additional subscription charges is required to provide coverage for a newborn child, and the subscriber desires coverage of the newborn child to extend beyond the 31-day period following the newborn child's date of birth, we must receive a completed enrollment application and the required additional subscription charges within the 60-day period following the date of birth.

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.

Dependent children under the age of 2 are exempt from enrolling in the dental plan. The subscriber may choose to enroll children under the age 2 if enrolling within 60 days of the date of birth or adoption, or during the groups open enrollment.

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:
  - 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 under 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 who 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 without enrolling any eligible dependents.

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

No rights are vested under this plan. 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 who 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:
  - 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; or
  - 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 his or her marriage to the subscriber is annulled, or when he or she becomes legally separated or divorced from the subscriber.
- For a child when he or she no longer meets the requirements for dependent coverage shown in the "Who Is Eligible For Coverage?" section.
- For a grandchild of the subscriber or spouse when his or her 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

No rights are vested under this plan. 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 45 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
- In the case of a plan that is made available only through a bona fide association, the employer's membership in the association ceases and coverage is terminated uniformly without regard to a member's health
- 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 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 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 shown in "Dependent Eligibility" for a dependent child who cannot support himself or herself because of a developmental or physical disability. The child will continue to be eligible if all the following 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 and is chiefly dependent upon the subscriber for support and maintenance.
- The subscriber remains 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 furnishes us with 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. We won't ask for proof more often than once a year after the 2-year period following the child's attainment of the limiting age.

LEAVE OF ABSENCE

Coverage for a subscriber and enrolled dependents may be continued for up to 90 days when the Group 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.

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 U.S.

Department of Labor at 1-866-4-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**.

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.

Please 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 1 of 2 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.

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. **Please 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 or Medicare entitlement. 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 or Medicare entitlement 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 U.S. 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; or
- 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 2 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 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.

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 non-provision 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 an 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 or device 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	If we deny your Level 1 appeal, you can ask for an Independent Review Organization (IRO) to review your appeal. OR 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.	180 days from the date you were notified of our Level 1 appeal decision. OR 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.

HOW TO SUBMIT AN APPEAL IN WRITING

Step 1. **Get the form**	• Complete the **Member Appeal Form**, you can find it on **premera.com** or call customer service to request a copy. 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)
Step 2. **Collect supporting documents**	• Collect any supporting documents that may help with your appeal. This may include chart notes, medical records, or a letter from your doctor. 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**	To help process your appeal, be sure to complete the form and return with any supporting documents. **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

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

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 or dental review denials will be reviewed by a medical or dental 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.

If you appeal a decision that affects ongoing care because we've determined the care is not or no longer medically or dentally 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:

- 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 dental specialist
- You are requesting coverage for inpatient or receiving emergency services that you are currently receiving

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

HOW TO ASK FOR AN EXTERNAL REVIEW

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

Step 1.
Complete the form
	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.
	
	• External appeals are only available 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.
	• An external appeal is also available for decisions related to Premera's compliance with protections established by the No Surprises Act (NSA) such as:
	  • Cost-sharing and surprise billing for emergency services
	  • Cost-sharing and surprise billing protections related to care your received from non-network (non-participating) providers at participating facilities
	  • Your condition to receive notice and provide informed consent to waive NSA protections; and
	  • If a claim for care received is coded correctly and accurately reflects the treatments received, and the associated NSA protections related to your cost-sharing and surprise billing.
	• You must include the signed **External Review Application Form** you received from us. You may also include medical records and other information.

Step 2. **Collect supporting documents**	• 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 the plan 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 if you have any concerns or need help filing an appeal.

Alaska Division of Insurance

550 W 7th Ave., Suite 1560

Anchorage, Alaska 99501-3567

1-800-INSURAK (467-8725) (within Alaska)

1-907-269-7900 (outside Alaska)

Email: insurance@alaska.gov

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

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.

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"
- This benefit booklet
- 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 over the signature of an officer of ours.

Evidence Of Dental Necessity

We have the right to require proof of 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 www.premera.com. If coverage under the contract terminates, your Premera ID card will no longer be valid.

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, at our option:

- Deny your claim
- Reduce the amount of benefits provided for your claim
- Rescind your coverage under this plan. (Rescind means to cancel coverage back to its effective date as if it had never existed at all).

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.

Limitations Of Liability

We're not liable 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're under a duty to cooperate with us in a timely and appropriate manner in our administration of benefits. You're also under a duty to cooperate with us in the event of a lawsuit.

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:

- Underwriting and determining your eligibility for benefits and paying claims
- 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 his or her 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. We will give written notice to the subscriber, or any other payee, including a provider at least 30 calendar days before the insurer seeks recovery of an overpayment. The notice will include how to identify the specific claim and the specific reason for the recovery. You have the right to challenge the recovery of overpayment. 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.

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

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" 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 is **not** 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 U.S. 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 U.S. 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 U.S. 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.

Please 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, U.S. Department of Labor, 1111 Third Ave. Suite 860, MIDCOM Tower, Seattle, WA 98101-3212; or
- The Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave. N.W., Washington, D.C. 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 1-866-444-3272.

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. It's independent of illness, except for infection of a cut or wound. **Please Note:** An accidental injury doesn't include damage caused by biting or chewing, even if due to a foreign object in food.

Allowed amount

The allowed amount shall mean one of the following:

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

  The amount for dentally 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 dentally 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 allowed amount. 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 allowed amount will be no less than the 80th 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 allowed amount, 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.

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.

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

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

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

results as to the diagnosis or treatment of that patient's illness, injury or disease

For those purposes, "generally accepted standards of dental practice" means standards that are based on authoritative dental or scientific literature.

Decisions regarding dental necessity are based on the criteria stated above. If you disagree with a decision that has been made, you have the right to additional review. See the "What If I Have A Question or An Appeal" section in this booklet for an explanation of the appeals process.

Dentist

One who is licensed to provide services in the state where the services are rendered as a:

- Doctor of Medical Dentistry (D.M.D.); or
- Doctor of Dental Surgery (D.D.S).

Effective Date

The date on which your coverage under this plan begins. If you re-enroll in this plan after a lapse in coverage, the date that the coverage begins again will be your effective date.

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.

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/Investigational Services

Experimental or investigational services include a treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria:

- A drug or device that can't be lawfully marketed without the approval of the U.S Food and Drug Administration, and hasn't been granted such approval on the date the service is provided.
- The service is subject to oversight by an Institutional Review Board.
- No reliable evidence demonstrates that the service is effective, in clinical diagnosis, evaluation, management or treatment of the condition.
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy.
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

Reliable evidence includes but isn't limited to reports and articles published in authoritative peer reviewed medical and scientific literature, and assessments and coverage recommendations published by the Blue Cross Blue Shield Association Technical Evaluation Center (TEC).

Decisions regarding experimental or investigational services are based on the criteria stated above. If you disagree with a decision that has been made, you have the right to additional review. See the " What If I Have A Question or An Appeal" section in this booklet for an explanation of the appeals process.

Group

A large employer, including a person, firm, corporation, partnership, or political subdivision, that's 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.

Large Employer

An employer, including a person, firm, corporation, partnership, association, or political subdivision, that is actively engaged in business, that employed an average of at least 51 employees on the business days during the preceding calendar year and that employs at least 2 employees on the first day of a dental benefit year.

Member (also called "You" and "Your")

A person covered under this plan as an employee, subscriber or dependent.

Orthodontia

The branch of dentistry that specializes in the correction of tooth arrangement problems, including poor relationships between the upper and lower teeth (malocclusion).

Plan (also called "This Plan" or "The Plan")

The benefits, terms and limitations set forth in the Contract between us and the Group, of which this booklet is a part.

Provider (also called "Covered Provider" or "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.

Subscriber

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

Subscription Charges

The monthly rates we set as consideration for the benefits offered in this plan.

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.

We, Us and Our

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