City & Borough of Juneau
Bartlett Regional Hospital & Juneau School District

Dental Optima Plan

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PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Important Telephone Numbers

For Questions Regarding Your Dental Benefits and Claims:

- Premera Blue Cross Blue Shield of Alaska
  Local and toll-free number: 1-800-508-4722
  Local and toll-free TTY number
  for the hearing impaired: 1-800-842-5357
  Monday - Friday, 5:00 a.m. – 8:00 p.m.
  Pacific Time

For Care Management:

- Pre-Approval and Emergency Notification
  1-800-722-4714
  Monday - Friday, 8:00 a.m. - 4:30 p.m.
  Pacific Time

For Questions Regarding Eligibility for Enrollment:

- City & Borough of Juneau Division of Risk Management
  1-907-586-0323
  Monday - Friday, 8:00 a.m. - 4:30 p.m.
  Alaska Time Zone

To Contact Your Confidential Employee Assistance Program:

- 1-800-295-9059
- 1-800-697-0353

To Contact Your Plan's Consultant:

- AON Consulting Inc - Seattle
  1-206-467-4600
  Monday - Friday, 8:00 a.m. - 5:00 p.m.
  Pacific Time

Discrimination is Against the Law

Premera Blue Cross Blue Shield of Alaska (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-508-4722 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-508-4722 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-508-4722 (TTY: 711) 번으로 전화해 주십시오.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 800-508-4722 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-508-4722 (телетайп: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-508-4722 (TTY：711）。

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 800-508-4722 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ ນພ້ອມໃຫ້ ທ່ານ. ໂທຣ 800-508-4722 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-508-4722 （TTY:711）まで、お電話にてご連絡ください。

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 800-508-4722 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-508-4722 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-508-4722 (телетайп: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-508-4722 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-508-4722 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-508-4722 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-508-4722 (رقم هاتف الصم والبكم: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-508-4722 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-508-4722 (ATS: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-508-4722 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-508-4722 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-508-4722 (TTY: 711) تماس بگیرید.

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INTRODUCTION

Welcome to the City & Borough of Juneau/Bartlett Regional Hospital/Juneau School District Health Benefit Plan. Our program is designed to provide comprehensive protection for our employees and their covered family members. At the same time, the program has been designed to encourage the careful use of health care services.

We sincerely wish that you and your family enjoy good health, but in the event you need to use the Health Benefit Plan, the benefits are excellent. We believe it is one of the best programs available anywhere.

The City & Borough of Juneau/Bartlett Regional Hospital/Juneau School District Health Benefit Plan is an "in-network provider arrangement"; it is based on agreements that certain providers have made with Premera Blue Cross Blue Shield of Alaska.

The In-Network Provider program is designed to lower your out-of-pocket expense. Therefore, you are encouraged to use In-Network Providers.

Please take time to become familiar with the benefits the program offers. Many terms have specific meanings as used throughout the book. Please refer to the ***Definitions*** section at the end of the booklet for clarification. **We suggest you review this booklet carefully**.

Our program is administered by Premera Blue Cross Blue Shield of Alaska. If you have questions regarding your coverage or how benefits have been paid, Premera Blue Cross Blue Shield of Alaska encourages you to contact their Customer Service Department at:

Local and toll-free number: 1-800-508-4722
Local and toll-free TTY number for the
hearing impaired: 1-800-842-5357
Monday - Friday, 8:00 a.m. – 5:00 p.m.
Pacific Standard Time

Your claims correspondence can be sent to:

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

If at any time you have questions concerning your eligibility, please contact the CBJ Risk Management at (907) 586-0321.

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

SUMMARY OF YOUR BENEFITS

This is a summary of your costs for covered services. Your costs are subject to all of the following:

- The **allowed amount**. This is the most this plan allows for a covered service. For providers that do not have agreements with us, you are responsible for any amounts over the allowable charge.
- The **coinsurance**. This is a defined percentage of allowable charges for covered services and supplies you receive. The benefit level provided by this plan and the remaining percentage you are responsible for, not including required copays, are both referred to as "coinsurance."
- The **deductible**. This is the amount you must pay in each plan year for covered services and supplies before this plan provides certain benefits. The amount credited toward the plan year deductible doesn't include any copays required by this plan, and won't exceed the "allowable charge" for any covered service or supply.

DENTAL SERVICES	YOUR BENEFIT
MAXIMUM PLAN YEAR BENEFIT Applies to Class II and Class III services only	
• **Base Plan**	$2,000
• **Buy-Up Plan**	$3,000
Deductibles (applies to Class II and Class III services only) Any expenses applied to the deductible during the last three months of the plan year will not be carried over to meet the deductible requirement for the next year.	
• Per enrollee:	$50 per plan year.
• Per family:	$150 per plan year.

Reimbursement Percentage:

Class I - Diagnostic and Preventive	
• **Base Plan**	100% of the allowed amount. Not subject to the deductible.
• **Buy-Up Plan**	100% of the allowed amount. Not subject to the deductible.
Class II – Basic	
• **Base Plan**	80% of the allowed amount. Subject to the deductible.
• **Buy-Up Plan**	80% of the allowed amount. Subject to the deductible.
Class III – Major	
• **Base Plan**	50% of the allowed amount. Subject to the deductible.
• **Buy-Up Plan**	80% of the allowed amount. Subject to the deductible.
Orthodontia (Not covered under Base Plan)	
• **Buy-Up Plan** Lifetime maximum: $2,500	50% of the allowed amount. Subject to the deductible.

STARTING OUT IN THE PROGRAM

WHO IS ELIGIBLE FOR COVERAGE?

CBJ Employees

Start effective on the date of hire when an employee is eligible to enroll in the plan, and chooses to “enroll” in the plan, if they satisfy the following:

- They become an active full-time employee, including a new seasonal employee, who regularly works a minimum of 37 1/2 hours per week
- They become an active permanent/probationary: part-time employee, seasonal employee, or exempt employee working less than full time and who regularly works a minimum of 780 hours per year and a minimum of 15 hours per week, and they agree to pay their portion of the premium, which will be pro-rated depending on the number of hours worked per pay period
- They become an Assembly Member

For School District Employees

- For school district employees refer to your individual union contract

Bartlett Regional Hospital Employees

Start effective on the date of hire when an employee is eligible to enroll in the plan, and chooses to “enroll” in the plan, if they satisfy the following:

- They become an active-full-time employee, including a new seasonal employee, who regularly works a minimum of 72 hours per pay period
- They become an active permanent/probationary: part-time employee, or exempt employee working less than full time and who regularly works a minimum of 832 hours per year and a minimum of 16 hours per week, and they agree to pay their portion of the premium, which will be pro-rated depending on the number of hours worked per pay period

Dependent Eligibility

An “eligible dependent” is defined as one of the following:

- The lawful spouse of the employee, unless legally separated.
- An eligible child under 26 years of age. An eligible child is one of the following:
  - A natural offspring of either or both the employee or spouse
  - A legally adopted child of either or both the employee or spouse; or
  - A child “placed” with the employee for the purpose of legal adoption in accordance with state law. “Placed” for adoption means assumption and retention by the employee of a legal obligation for total or partial support of a child in anticipation of adoption of such child.
  - A minor 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.

CONTINUED ELIGIBILITY FOR A DISABLED CHILD

Coverage may continue beyond the limiting age shown in the ***Dependent Eligibility*** section 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 disability or physical handicap and is chiefly dependent upon the employee for support and maintenance
- The employee remains covered under this program
- The child's required contributions, if any, continue to be paid
- Within 31 days of the child reaching the limiting age, the employee furnishes the Claims Administrator with a "Request for Certification of Handicapped Dependent" form. The Plan Administrator must approve the request for certification for coverage to continue; and

- The employee provides the Claims Administrator with proof of the child's disability and dependent status when requested. The Claims Administrator will not ask for proof more often than once a year after the two-year period following the child's attainment of the limiting age.

WHEN DOES COVERAGE BEGIN?

ENROLLMENT

When the employee becomes eligible to enroll, they **must** complete an enrollment form or waive form (with proof of other coverage) and if necessary an affidavit of marriage for themselves and any eligible dependents within 30 days.

You or your eligible dependents may become eligible to enroll in this program on the following dates or may enroll once annually unless additional family status changes occur during the plan year:

- For the employee and existing eligible family members, the date the employee meets the employee eligibility requirements.
- For a spouse and eligible children that they meet the criteria outlined in the affidavit of marriage.
- For a natural newborn child born on or after the employee's effective date, the child's birth date.
- For an adoptive child, the date the child is placed with the employee for the purpose of legal adoption.

We must receive completed enrollment applications and required subscription charges within 30 days of the date the applicant becomes eligible to enroll, or in the case of a spouse and eligible children acquired through marriage, 30 days from the date they become eligible to enroll as explained above. If we don't receive the enrollment application within 30 days of the date you became eligible, none of the dates above will apply. Please see ***Special Enrollment*** below.

For adoptive and natural newborn children we must receive completed enrollment applications and required subscription charges within 60 days of the date the applicant becomes eligible to enroll.

CBJ and Bartlett employees that do not enroll or waive coverage (with proof of other coverage) within the required days of the date the applicant becomes eligible to enroll, will automatically be enrolled on the Economy Plan with employee only coverage.

Children Covered Under Medical Child Support Orders Or Legal Guardianship

When we receive the completed enrollment application within 30 days of the date of the medical child support order or legal guardianship, coverage for an otherwise eligible child that is required under the order (by the court) 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 application for coverage. The enrollment application may be submitted by the subscriber, the child's custodial parent, a state agency administering Medicaid, or the state child support enforcement agency. When subscription charges being paid do not already include coverage for dependent children, such charges will begin from the child's effective date. Please contact your Group for detailed procedures.

Family and Medical Leave/Alaska Family Leave

The City & Borough of Juneau and Bartlett Regional Hospital/Juneau School District adheres to the provisions of the Family and Medical Leave Act (FMLA) and the Alaska Family Leave Act (AFLA) for all Employees that meet eligibility requirements.

Eligible Employees on Family Medical Leave Act who go into a leave without pay status will continue to receive health insurance benefits as if they were continuing to work; including an obligation to pay their share of the premium. Eligible Employees who have exhausted benefits under the FMLA but remain eligible for benefits under the AFLA and are in a leave without pay status are eligible for continuing health insurance benefits but are obligated to pay the full premium.

You have a right under the Family and Medical Leave Act (FMLA) for up to 18 weeks of unpaid leave in a 12-month period for the reasons listed below.

- For the birth of the employee's child or for the placement of a child with the employee through adoption or foster care
- When an employee is needed to care for the employee's child, spouse or parent who had a serious health condition

- When an employee is unable to perform the functions of his or her job due to a serious health condition.
- Due to a qualifying exigency or for care of an injured covered service member under the National Defense Authorization Act

  Employees who have worked for CBJ or Bartlett long enough to be eligible for coverage under the FMLA policy can, if absent for one of the reasons listed above, continue to receive health insurance benefits even if they run out of personal leave and go into Leave Without Pay. The employees' obligation to pay their share of the contribution continues, just the same as if they were working, but the employer will continue to pay its contribution towards the health benefits. When the FMLA is over, the employee will be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment unless the position has been laid off.

  If an employee chooses not to return to work following FMLA, the employee may be required to reimburse CBJ/Bartlett for health benefit contributions it made during the entire period of FMLA. Reimbursement may not be required if the failure to return to work is due to: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA; or 2) other circumstances beyond the employee's control.

For more information about the Family/Medical Leave Policy, please contact your Human Resources Department.

- **Bartlett Regional Hospital employees**: 907-796-8418
- **City and Borough employees**: 907-586-5250

Donation of Leave

CBJ Employees – Refer to your Personnel Policies or contact the Human Resources Department at 907-586-0321 for more information.

Bartlett Employees – Refer to your Human Resources Department at 907-796-8418.

Juneau School District – 907-823-1781

Re-Enrollment

If an employee terminates coverage during the plan year, and returns to work within that same plan year, all credits and deductibles previously satisfied will be reinstated.

Late Enrollment

If you decline enrollment for your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends.

When we receive the employee and/or dependent’s completed enrollment application and any required subscription charges within 30 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 30 days of the date prior coverage ended, refer to ***Enrollment***.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. Please contact your Plan Administrator for instructions on other special enrollments.

SPECIAL ENROLLMENT

Involuntary Loss Of Other Coverage

If an employee and/or dependent doesn't enroll in this plan or another plan sponsored by the Group when first eligible because they aren't required to do so, that 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 health coverage or a health insurance program at the time coverage under the Group's plan is offered
- The employee and/or dependent's coverage under the other group health coverage or health insurance program ended as a result of one of the following:
  - Loss of eligibility for coverage (including, but not limited to, the 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
- 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 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 be effective on the first day of the month following the date the other coverage was lost.

If we do not receive the employee and/or dependent's completed enrollment application within the required 60 days, you and/or your dependents may not enroll until the next group open enrollment period. Please see ***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 health 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 alone, enroll with some or all eligible dependents or change plans, if applicable.

Please note: If a newborn child is born to a dependent child of the subscriber or spouse, and the dependent child was not covered under the plan prior to the newborn's birth, the newborn is not eligible to be enrolled and no Special Enrollment event has occurred.

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.

Subscriber And Dependent Special Enrollment With Medicaid and Children's Health Insurance Program (CHIP) Premium Assistance

You and your dependents may have special enrollment rights under this plan if you meet the eligibility requirements described under ***When Does Coverage Begin?*** and:

- You qualify for premium assistance for this plan from Medicaid or CHIP; or
- You no longer qualify for health care coverage under Medicaid or CHIP.

If you and your dependents are eligible as outlined above, you qualify for a 60-day special enrollment period. This means that you must request enrollment in this plan within 60 days of the date you qualify for premium assistance under Medicaid or CHIP or lose your Medicaid or CHIP coverage.

Coverage under this plan for the eligible employee and any dependents will start on the first of the month following:

- The date the eligible employee and any dependents qualify for Medicaid or CHIP premium assistance; or
- The date the eligible employee and any dependents lose coverage under Medicaid or CHIP.

The eligible employee and any dependents may be required to provide proof of eligibility from the state for this special enrollment period.

If we don't receive the enrollment application within the 60-day period as outlined above, you will not be able to enroll until the next open enrollment period.

CHANGES IN COVERAGE

No rights are vested under this plan. The Group may change its terms, benefits, and limitations 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 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 set by the Group.

When you transfer from the Group's other plan, 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 date on which one of these events occurs:

- 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 45 days of the date the Group is notified of such event.

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.

PLAN TERMINATION

No rights are vested under this plan. The Group is not required to keep the plan in force for any length of time. The Group reserves the right to change or terminate this plan, in whole or in part, at any time with no liability. Plan changes are made as described in ***Changes In Coverage*** in this booklet. If the plan were to be terminated, you would only have a right to benefits for covered care you receive before the plan's end date.

HOW DO I CONTINUE COVERAGE?

CONTINUED ELIGIBILITY FOR A DISABLED CHILD

Coverage may continue beyond the limiting age shown in the ***Dependent Eligibility*** section 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 disability or physical handicap 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 the Group with a Request for Certification of Handicapped Dependent form. The Group must approve the request for certification for coverage to continue.
- The subscriber provides proof of the child's disability and dependent status when requested. Proof won't be requested more often than once a year after the 2-year period following the child's attainment of the limiting age.

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 web site 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 a monthly charge for it.

The plan will provide qualified members with COBRA coverage 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. 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 grandchildren have the same rights to COBRA coverage as covered 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.

  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.
- You must send your first payment to the Group no more than 45 days after the date you elected COBRA coverage
- Subsequent monthly payments must be paid to the Group

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 federal 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 web site at **www.dol.gov/ebsa**. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site.

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.

PLAN YEAR DENTAL DEDUCTIBLE

Diagnostic and Preventive covered services aren't subject to a plan year dental deductible. However, a plan 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 plan 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.

This plan has an annual dollar maximum. 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. See the ***Summary of Your Benefits*** for detail.

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 family deductible we will consider the individual dental deductible of every enrolled family member to be met for the year. Only the amounts used to satisfy each enrolled family member's individual dental deductible will count toward the family dental deductible.

DENTAL BENEFIT MAXIMUM

Benefits for covered services with multiple treatment dates are subject to the dental benefit maximum of the plan year in which the services are started. See the ***Summary of Your Benefits*** for detail.

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 web site 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 plan year deductible, coinsurance, amounts that are in excess of stated benefit maximums, and charges for non-covered services.

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 plan 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 plan 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.

COVERED SERVICES

DESCRIPTION OF COVERED SERVICES

Class I - Diagnostic And Preventive Services

- Routine oral examinations are limited to 2 per plan year. Initial consultations, second opinion consultations and office visits count toward the limit for oral examinations
- Prophylaxis (cleaning of teeth) is limited to 2 per plan year
- Topical application of fluoride is covered for members under the age of 20, and is limited to 2 treatments per plan year
- Dental x-rays, including either a complete series, cone beam or panoramic x-ray once every 36 consecutive months. X-rays taken for root canal therapy are limited to 1 periapical x-ray per tooth. Bitewings as dentally necessary.
- Sealants, on permanent first and second molars only. Replacements limited to every two years.
- Space maintainers, designed to preserve space for permanent teeth
- Emergency and other non-routine exams are limited to 2 per plan year. (Please see the "Definitions" section for the definition of a Dental Emergency.)

Class II - Basic Services

- Simple extractions
- Dentally necessary injections administered in a dental office
- Fillings, consisting of amalgam and composite resins on any given tooth surface:

- Periodontal maintenance, as a follow-up to active periodontal treatment, including removal of bacterial flora, sub-gingival scaling, and polishing. Prophylaxis (cleaning) is not covered in conjunction with periodontal maintenance.
- Emergency palliative treatment. We require a written description and/or office records of services provided.
- Oral surgery, including surgical extractions of erupted or impacted teeth
  - Excision or removal of a tumor or cyst, incision or drainage of an abscess. These procedures must be related to tooth structure or gingival tissue.
  - Surgical procedures necessary for the placement of dentures
- General or intravenous anesthesia in a dental care provider's office, when dentally necessary
- Osseous surgery (surgical periodontal treatment)
- Non-surgical treatment of periodontal and other diseases of the gums and tissues of the mouth:
  - Periodontal scaling and root planing and sub-gingival curettage
  - Full mouth debridement
  - Limited occlusal adjustments as dentally necessary
  - Localized delivery of antimicrobial agents, subject to review
- Endodontic (root canal) treatment is limited to once per tooth in a 2 plan year period:
  - Retreatment of a root canal when services are performed at least 12 months after the original procedure
  - Benefits for root canals performed in conjunction with overdentures are limited to 2 per arch
  - 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
  - For root canals and retreatment of root canals, the service start date is the date the canal is opened. The service completion date is the date the canal is filled.
  - X-rays done in conjunction with a root canal are included in the fee for the root canal
- Repair of crowns, inlays, bridgework and dentures when services are performed at least 6 months after the initial placement
- Pulp cap/pulp therapy
- Nightguards (for treatment of bruxism only).
- Nitrous oxide - provided in a dental provider’s office are covered when administered in connection with a covered Class II or Class III dental service

Class III - Major Services

- Initial placement of inlays, onlays, labial veneers, and crowns for decayed or fractured teeth, if dentally necessary, when amalgam or composite resin fillings wouldn't adequately restore the teeth (see definition of "Dentally Necessary"). Crowns, inlays and onlays consisting of porcelain, ceramic, or resin, performed on second or third molars will be limited to what would have otherwise been allowed for a full gold crown. For inlay, onlays, crowns and labial veneers the service start date is the preparation date. The completion date is the seat date.
- Replacement inlays, onlays, labial veneers and crowns, but only when:
  - The existing restoration was seated at least 5 plan years before replacement
- Initial placement of dentures and fixed bridges (including inlays, onlays and crowns to form abutments). For dentures the service start date is the impression date and fixed bridges the service start date is the preparation date. The completion date is the seat or delivery date.
- Replacement of dentures and fixed bridges (including inlays, onlays and crowns to form abutments) are covered but only when:
  - The existing denture or bridgework was installed at least 5 plan years before replacement and only then if it's unserviceable and can't be made serviceable
- Reline, rebasing and adjustments of dentures are covered when services are performed 6 or more months after denture installation
- Tooth crown and core build-ups for covered crowns, including bridge abutments, when dentally necessary.

- Recementing of crowns, inlays and bridgework when services are received at least 6 months after the initial placement
- Stainless steel crowns on permanent and non-permanent molars
- Implants and implant related services, subject to review for dental necessity
- Replacement of implants including implant abutment and/or implant prosthetics, but only when:
  - The existing implant, implant abutment and/or implant crown was installed at least 5 years before replacement. For implant supported crowns the service start date is the preparation date. The completion date is the seat date.
- Precision attachments subject to review for dental necessity

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
- Nightguards and occlusal splints
- Periodontal splinting and/or crown and bridgework in conjunction with periodontal splinting
- Crowns and copings in conjunction with an overdenture
- Indirect pulp caps
- Maxillofacial prosthetics
- Temporary, interim or provisional services for crowns, bridges or dentures

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

- 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.

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

- Orthodontia services and supplies are not provided under the **Base Plan** unless medically necessary
- 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

This section of your booklet explains circumstances in which benefits of this plan are limited or not available. Benefits can also be affected by your eligibility. In addition, some benefits may also have their own specific limitations.

LIMITED AND NON-COVERED SERVICES

In addition to the specific limitations stated elsewhere in this plan, this plan doesn't cover:

Amounts Over The Allowed amount

This plan does not cover amounts over the allowed amount as defined by this plan. If you get services from a non-contracted provider, you will have to pay any amounts for your services that are over the allowed amount.

Benefits From Other Sources

This plan does not cover services that are covered by other insurance or coverage such as:

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

Benefits That Have Been Exhausted

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

Broken or Missed Appointments

Charges for Records or Reports

- Separate charges from providers for supplying records or reports, except those we request for utilization review
- Charges for case presentation or extensive treatment planning

Comfort or Convenience

This plan does not cover:

- Items that are mainly for your convenience or that of your family. For instance, this plan does not cover personal services or items like meals for guests while hospitalized, long-distance phone, radio or TV, personal grooming, and babysitting
- Normal living needs, such as food, clothes, housekeeping and transport. This 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 complications of a non-covered service, including follow-up services or effects of those services, except services defined as emergency care. See ***Definitions***.

Cosmetic Services

- 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

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

Any service or supply that is determined to be experimental or investigational on the date it's furnished, and any direct or indirect complications and aftereffects thereof. The determination is based on the criteria stated in the definition of "Experimental/Investigational Services" (please see the "Definitions" section in this booklet).

If a service is determined to be experimental or investigational, and therefore not covered, you may appeal the decision. Please see the "Complaints and Appeals" section in this booklet for an explanation of the appeals process.

Extra Or Replacement Items

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

Facility Charges

Hospital and ambulatory surgical center care for dental procedures.

Family Members Or Volunteers

- Services or supplies that you furnish to yourself or that are furnished to you by a provider who lives in your home or is related to you by blood, marriage, or adoption. Examples of such providers are your spouse, parent, or child.
- Services or supplies provided by volunteers

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.

Increase Of Vertical Dimension

Any service to increase or alter the vertical dimension.

Military and War-Related Conditions, Including Illegal Acts

This includes:

- Acts of war, declared or undeclared, including acts of armed invasion
- Service in the armed forces of any country, including the air force, army, coast guard, marines, national guard, navy, or civilian forces or units auxiliary thereto
- A member's commission of an act of riot or insurrection
- A member's commission of a felony or act of terrorism

Multiple Providers

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

No Charge Or You Don't Legally Have To Pay

- Services for which no charge is made, or services for which none would have been made if this plan weren't in effect
- Services for which you don't legally have to pay, unless benefits must be provided by law

Non-Standard Techniques

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

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

Not Dentally Necessary

Services that aren't dentally necessary (see definition of "Dentally Necessary").

Orthodontia Services

For members taking the **Base Plan**, orthodontia, including casts, models, x-rays, photographs, examinations, appliances, braces, and retainers, unless medically necessary. However, this exclusion doesn't apply to extractions incidental to orthodontic services. This exclusion also does not apply to members taking the **Buy-Up Plan**.

Orthognathic Surgery (Jaw Augmentation or Reduction)

Jaw augmentation or reduction (orthognathic and/or maxillofacial), regardless of origin of the condition that makes the procedure necessary, including any direct or indirect complications and aftereffects thereof.

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. This includes vitamins, food supplements, and patient management drugs, such as premedication, sedation and nitrous oxide.

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
- Genetic or caries susceptibility tests

Tobacco Counseling

Tobacco counseling for the control or prevention of oral disease.

Work-Related Conditions

Any illness, condition or injury arising out of or in the course of employment, for which the member is entitled to receive benefits, whether or not a proper and timely claim for such benefits has been made under one of the following:

- Occupational coverage required or voluntarily obtained by the employer
- State or federal workers' compensation acts
- Any legislative act providing compensation for work-related illness or injury

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.

Right Of Recovery/Facility Of Payment

The plan has the right to recover any amount it overpaid. The plan may recover these amounts from your provider, other insurance companies, service plans, or other organizations. Also, if another plan makes a payment that this plan should have made, the plan has the right to pay the other plan directly. Such payment will be considered a benefit under this plan.

This plan will provide a minimum of 30 calendar days' notice of the recovery. You have the right to challenge the recovery.

This plan will not initiate any recovery more than 365 days after the original claim is settled, unless the plan has a clear and documented reason to believe that fraud was committed or there was other intentional misconduct. This plan has the right to appoint a third party to act on its behalf in recovery efforts.

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.

THIRD PARTY RECOVERY

General

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

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

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

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

Definitions The following definitions shall apply to this section:

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

  Please Note: For this section, a third party does not include other health care plans that cover you.
- **You** In this section, "you" includes any lawyer, guardian, or other representative that is acting on your behalf or on the behalf of your estate in pursuing a repayment from responsible third parties.

Exclusions

- **Benefits From Other Sources** – Benefits are not available under this plan when coverage is available through:
  - Any type of excess coverage
  - Any type of liability insurance, such as home-owner's coverage or commercial liability coverage
  - Any type of no-fault coverage, such as Personal injury protection (PIP) coverage, Medical Payment coverage or Medical Premises coverage
  - Boat coverage
  - Motor vehicle medical or motor vehicle no-fault
  - School or athletic coverage
- **Work-Related Conditions** – Any illness, condition or injury arising out of or in the course of employment, for which the member is entitled to receive benefits, whether or not a proper and timely claim for such benefits has been made under:
  - Occupational coverage required of or voluntarily obtained by the employer
  - State or federal workers compensation acts
  - Any legislative act providing compensation for work-related illness or injury

However, this exclusion doesn't apply to owners, 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.

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

Reimbursement and Subrogation Rights

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

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

The plan shall also have the right to join or intervene in your suit or claim against a responsible third party.

- You cannot assign any rights or causes of action that you might have against a third party tortfeasor, person, or entity, which would grant you the right to any recovery without the express, prior written consent of the plan.

Your Responsibilities

- If any of the requirements below are not met, the plan shall:
- You must notify Premera Blue Cross Blue Shield of Alaska of the existence of the injury immediately and no later than 30 days of any claim for the injury.
- You must notify the third parties of the plan's rights under this provision.
- You must cooperate fully with the plan in the recovery of the benefits advanced by the plan and the plan's exercise of its reimbursement and subrogation rights. You must take no action that would prejudice the plan's rights. You must also keep the plan advised of any changes in the status of your claim or lawsuit.
- If you hire a lawyer, you must tell Premera Blue Cross Blue Shield of Alaska right away and provide the contact information.

  Neither the plan nor Premera Blue Cross Blue Shield of Alaska shall be liable for any costs or lawyer's fees you must pay in pursuing your suit or claim. You shall defend, indemnify and hold the plan and Premera Blue Cross Blue Shield of Alaska harmless from any claims from your lawyer for lawyer's fees or costs.
- You must complete and return to the plan an Incident Questionnaire and any other documents required by the plan.

  Claims for your injury shall not be paid until Premera Blue Cross Blue Shield of Alaska receives a completed copy of the Incident Questionnaire when one was sent.
- You must tell Premera Blue Cross Blue Shield of Alaska if you have received a recovery. If you have, the plan will not pay any more claims for the injury unless you and the plan agree otherwise.
- You must notify the plan at least 14 days prior to any settlement or any trial or other material hearing concerning the suit or claim.

Reimbursement and Subrogation Procedures

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

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

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

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.

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

We know healthcare doesn't always work perfectly. Our goal is to listen, take care of you, and make it simple. If it does not go the way you expect, you have two options:

- Complaints – you can contact customer service if you have a complaint, we may ask you to send the details in writing. We will send a written response within 30 days.
- Appeals – is a request to review specific decisions we have made

You can appeal the following adverse benefit determinations (see ***Definitions***):

- Benefits or charges were not applied correctly
- A decision regarding your eligibility to enroll or stay in the plan, including rescissions
- A decision by the plan that services were experimental, investigative, or not medically necessary

HOW TO SUBMIT AN APPEAL

After you are notified of an adverse benefit determination, you can request an internal appeal. Your plan includes two levels of internal appeals.

- **Level I internal appeal** People who were not part of the initial decision will review your appeal. Medical or dental review denials will be reviewed by a medical or dental specialist. We must receive your internal appeal request within 180 days of the date you were notified of our initial decision. You can request an extension of the 180-day deadline by sending us a written request that includes the reason why you believe an extension should be granted. If you are not satisfied with the decision, you may request a Level II internal appeal.
- **Level II internal appeal** will be reviewed by a panel of people who were not part of the Level I internal appeal. Medical and dental review denials will be reviewed by a medical or dental specialist. You may take part in the level II panel meeting in person or by phone. Please call us for more details about this process. Once the Level II review is complete, we will provide you with a written determination. If you are not satisfied with the final internal appeal decision, you may be eligible to request an ***External Appeal***, as described below.

WHO CAN APPEAL?

You can appeal yourself or choose someone, including your doctor or dentist, to appeal on your behalf. If you choose someone else, complete an Authorization for Appeals form located on **premera.com**. We can't release your information without this form.

HOW TO APPEAL

You can call Customer Service or you can write to us at the address listed inside the front cover of this book. By sending your appeal in writing, you can provide more details about your appeal. This may include chart notes, medical or dental records or a letter from your doctor. Within 3 working days, we will confirm in writing that we have your request.

If you need help filing an appeal, or would like a copy of the appeals process, please call Customer Service. You can also get a description of the appeals process by visiting our website.

If you would like to review the information used for your appeal, please contact Customer Service. The information will be sent as soon as possible and free of charge.

WHAT HAPPENS WHEN 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 HAPPENS WHEN IT'S URGENT

If your condition is urgent, we will handle your appeal in an expedited (fast) manner. Examples of urgent situation are:

- Your life or health is in serious danger or you are in pain that you cannot bear, as determined by our medical or dental specialist
- You are inpatient or receiving emergency care

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

Urgent appeals are only available for services you are currently receiving or have not yet received.

WHAT HAPPENS NEXT

Your appeal is reviewed and a decision is provided within the time limits below

Type of appeal	When to expect notification of a decision
Expedited appeals	No later than 72 hours. We will call, fax, or email you with the decision, and follow up in writing.
Other Appeals	Within 30 days

If we stand by our decision or we do not follow the process above you can request an external appeal. External appeal is available only for decisions involving a judgment as to the medical or dental necessity, appropriateness, health care setting, level of care, or effectiveness of the service or treatment you received.

EXTERNAL APPEAL

External appeals will be done by an Independent Review Organization (IRO). There is no cost to you for an external appeal.

- We will send you an external appeal request form authorizing the release of your medical records to an IRO with the written decision of your internal appeal. You may also write to us directly to request an external appeal.
- 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.
- You must include the signed external appeal form you received from us. You may also include medical or dental records and other information.
- 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 or your authorized representative, and the Alaska Division of Insurance in writing of the results of our preliminary review within one business day after we have completed.
- 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 your 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.

WHAT HAPPENS NEXT

Once the external appeal is done, the IRO will let you and the plan know their decision within the time limits below.

- For urgent external appeals no later than 72 hours after receiving the request
- For all other appeals, within 45 days from the date the IRO gets your request.

ONCE A DECISION IS MADE

For urgent appeals, the IRO will inform you and the plan immediately. We will follow up with a written decision by mail. For all other appeals, we will send you a written decision by mail.

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.

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

If any provision of the plan or any amendment is deemed to be in conflict with applicable state or federal laws or regulations, upon discovery of such conflict the plan will be administered in conformance with the requirements of such laws and regulations as of their effective date.

Evidence Of Dental Necessity

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

Intentionally False Or Misleading Statements

If this plan's benefits are paid in error due to any intentionally false or misleading statements, the plan is 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, as directed by the Group:

- 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).

Limitations Of Liability

The plan, the Group, and Premera Blue Cross Blue Shield of Alaska are 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 dental 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 and the Group in a timely and appropriate manner in our administration of benefits. You're also under a duty to cooperate with us and the Group 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 plan and our administrative service contract with the Group

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 are 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

On behalf of the plan, we have the right to recover amounts the plan paid that exceed the amount for which the plan is liable. 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.

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

Right To And Payment Of Benefits

Benefits of this plan are available only to members. In accordance with the law, the benefits of this plan may be paid 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 the plan's obligation as to payment of benefits.

Venue

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

- Within 3 years of the date the rights or benefits claimed under this plan were denied
- In a mutually agreed upon location

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 plan 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 plan 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 plan 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.

We reserve the right to determine the amount allowed for any given service or supply unless otherwise specified in the Group's administrative services agreement with us.

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.

The entity that sponsors this self-funded plan.

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 plan 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.

Plan Year

The period of 12 consecutive months that starts each July 1 at 12:01 a.m. and ends on the next June 30 at midnight.

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 to be paid by the member that are set by the Group as a condition of the member's coverage under the 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.

where to send claims

MAIL YOUR CLAIMS TO:

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P.O. Box 91059
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