

**ALASKA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION
MEDICARE CARVEOUT PLAN**

This policy is issued to you by the Alaska Comprehensive Health Insurance Association in accordance with Alaska law. The premium you paid and the application you completed put this policy in force as of the Policy Date. A copy of your application is attached.

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PART A. 10-DAY RIGHT TO EXAMINE POLICY

We want you to fully understand and be entirely satisfied with your policy. If you are not satisfied for any reason, you may return this policy to us within 10 days of its receipt. We will then refund any premiums you have paid. This policy will then be considered never to have been issued.

PART B. PLEASE READ YOUR APPLICATION

Please read the copy of your application. If anything in it is not correct or if any past medical history has been left out, you should tell us. Your policy was issued on the basis that all information in the application is correct and complete. If not, your policy may not be valid.

**THIS IS A LIMITED POLICY-READ IT CAREFULLY
THIS POLICY IS RENEWABLE AS STATED IN PART C**

PART C.

RENEWAL AGREEMENT

Your policy will be renewed each time you pay the premium until the earliest of:

- (a) The date you become age 65;
- (b) The date the Maximum Benefit has been paid under this policy and any other policy providing like benefits to you by us;
- (c) The date you are no longer a Resident of Alaska;
- (d) 30 days after the date of our inquiry, and you fail to respond, regarding your place of Residency;
- (e) The date Alaska statues require cancellation of this policy;
- (f) The date you become eligible for medical coverage under another state or federal law, excluding Medicare, but including veteran's benefits, Native health care or Medicaid;
- (g) The date at the end of the waiting period for another health insurance policy, subscriber contract or benefit program including a self-insurance plan, health care trust or welfare trust. During this waiting period, this contract will only pay for coverage which is normally provided under this contract and which is not being covered by the new contract due to a pre-existing waiting period. This contract will pay secondary to any other benefits that might be provided by both the new contract and this contract.

You will receive notice of the date your premium is due. The premium must be paid on or before that date. However, this policy also includes a 31 day grace period following the premium due date during which the premium can be paid.

PART D.

PREMIUM CHANGE

Your premium is expected to change. The change will be based on your attained age and geographic location or on a revised schedule of rates, or both. We can apply revised rates only if the same revision is done on all of our policies, with the same provisions and benefits, issued to persons of the same classification. We will notify you of such premium change at least 30 days in advance of your renewal date.

PART E.

POLICY CHANGE

Any provision of this policy is subject to change (including changes in benefits), except when prohibited by Alaska law. You will receive written notice of any benefit changes at least 30 days before your policy renewal date. You will be notified of any accompanying premium change in accordance with the above premium change provision.

PART F.

DEFINITIONS

Administrator means an entity chosen to provide administrative services to the Association.

Alcoholism or Drug Abuse means an illness characterized by:

- (a) a physical and/or psychological dependency on alcohol or controlled substances; or
- (b) habitual lack of self-control in using alcohol or controlled substances to the extent that the insured person's health is substantially impaired or social or economic function is substantially disrupted.

Assignment means a doctor agrees to accept Medicare's fees as full payment.

PART F. (Continued)

DEFINITIONS

Calendar Year means the period beginning on January 1 and ending on December 31 of the same year. The first calendar year begins on the Policy Date and ends on December 31 of the same year.

Coinsurance means the percent of the Medicare approved amount that you have to pay after you pay the deductible for Part A and/or Part B.

Cosmetic or Reconstructive Surgery means any treatment or procedure performed primarily:

- (a) to improve physical appearance or to change or restore bodily form without materially correcting a bodily malfunction; or
- (b) to prevent or treat a mental or nervous disorder through a change in bodily form.

Custodial Care means services and supplies furnished to you mainly to help you in the activities of daily life. This includes board and room and other institutional care. You do not have to be disabled. Such services and supplies are custodial care without regard to:

- by whom they are prescribed; or
- by whom they are recommended; or
- by whom or by which they are performed.

Deductible means the amount you must pay for health care, before Medicare begins to pay, either each benefit period for Part A, or each year for Part B. These amounts can change every year.

Diabetes means insulin-dependant diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes.

Eligible Expense means the charges made for Covered Services or Supplies. A Physician has to order or prescribe the service or supply. An expense is considered incurred on the date the service or supply is received. The fact that a physician may prescribe, order, recommend or approve a service or supply does not, of itself, make it medically necessary or make the expense an Eligible Expense. Eligible Expenses do not include any charge:

- (a) for a service or supply which is not medically necessary; or
- (b) which is in excess of the usual, customary, reasonable or prevailing charge for a medical care procedure service or supply.

Emergency Admission means that the Physician admits the person to the hospital due to a sudden and unexpected change in the person's physical or mental condition which is severe enough to require immediate confinement as an inpatient in a hospital.

PART F. (Continued)

DEFINITIONS

Health Care Provider means a person licensed to provide health care services as required by the State.

Home Health Agency Services means any of the following services provided upon recommendation of a physician as part of a treatment plan:

- (a) intermittent or part-time nursing services of a registered professional nurse or a licensed practical nurse, that are provided to a person under the continued direction of the person's physician and within the limitation of the nurse's license;
- (b) nursing services that are provided to a person at the person's residence, including a residential care facility or adult boarding home; a hospital, skilled nursing facility or intermediate care facility is not considered a residence;
- (c) home health aide services that are prescribed by and under the continued direction of a physician and supervised by a professional nurse;
- (d) home health aide services that are provided to a person at the person's residence, as described in (b) of this paragraph;
- (e) physical and occupational therapy services, speech pathology, and audiology services that are prescribed by a physician and provided by or under the supervision of a qualified practitioner to a person, including one who is a patient in an intermediate care facility or skilled nursing facility.

Hospice Services means services provided under a coordinated comprehensive program of palliative and supportive care on a 24-hour, seven days per week basis for persons who have been diagnosed as terminally ill and their families by an interdisciplinary team of professionals or volunteers under an incorporated central administration that has a physician as medical director.

Hospital means a place that:

- (a) Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- (b) Is supervised by a staff of Physicians.
- (c) Provides 24 hour a day R.N. service.
- (d) Is licensed as a hospital in the jurisdiction where it is located;
- (e) Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home and;
- (f) Charges for its services

Medicaid means the medical assistance program operated by the state under Title XIX of the Federal Social Security Act.

Medicare means the federal government health insurance program established under Title XVIII of the Federal Social Security Act.

Medicare-Approved Amount means the fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier.

Medical Social Services means services rendered the patient under the direction of a physician by a qualified social worker holding a master's degree from an accredited school of social work, including assessment of the social; psychological and family problems related to or arising out of the covered person's disease and treatment, appropriate action and utilization of community resources to assist in resolving the problem, and participation in the development of treatment for the covered person.

PART F. (Continued)

DEFINITIONS

Medically Necessary Service or Supply means a service or supply which is necessary for the diagnosis, care or treatment of the physical or mental condition involved. It must be widely accepted professionally in the United States as effective, appropriate, and essential based upon recognized standards of the health care specialty involved. In no event will the following be considered to be necessary:

Those services rendered by a provider that do not require the technical skills of such a provider;
Those services and supplies furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family; to a person solely because he or she is an inpatient on any day on which the person's physical or mental condition could safely and adequately be diagnosed or treated while not confined; That part of the cost which exceeds that of any other service or supply that would have been sufficient to safely and adequately diagnose or treat the person's physical or mental condition.

Mental or Nervous Disorder means neurosis, psychoneurosis, psychopathy, psychosis, depression, mental or emotional disease or disorder or cognitive impairment of any kind including such psychiatric conditions caused by chemical imbalance or neurological or organic injury or sickness.

Non-Urgent Admission means it is not an Emergency Admission or an Urgent Admission.

Out-of-Pocket Expense Amount means the total amount of Eligible Expense in a Calendar Year that is applied as patient responsibility.

Physician means any of the following licensed practitioners who perform a service payable under this policy:

- (a) A doctor of medicine (MD), osteopathy (DO), surgical chiropody, podiatry, chiropractic (DC) or dentist (DDS);
- (b) A registered clinical psychologist;
- (c) A licensed clinical social worker; or
- (d) Where Alaska insurance law requires, any other licensed practitioner who:
 - (1) is acting within the scope of that license; and
 - (2) performs a service which is payable under this policy when performed by an MD.

A **Physician** does not include a person who lives with you or is part of your family (you, your spouse, or a child, brother, sister or parent of you or your spouse).

Preexisting Condition means a medical condition for which medical advice or treatment was recommended or received within 3 months prior to coverage under a health insurance plan that contains a preexisting conditions limitation.

Prostate Cancer Screening Test means a prostate antigen blood test or another test that is equivalent or better in cancer detection, if recommended by a Physician.

Prostheses means and includes the initial and subsequent prosthetic devices pursuant to an order of your Physician.

Reconstruction means any initial and subsequent reconstructive surgeries or prosthetic devices, and follow-up care determined necessary by the Physician.

Renewal Date means the date on which any premium is due to keep this policy in full force and effect.

PART F. (Continued)

DEFINITIONS

Resident means (i) is physically present in the state of Alaska, has lived in the state of Alaska for at least the 12 consecutive months immediately preceding the application for a state plan, and intends to remain permanently in the state of Alaska; or (ii) is not physically present in the state of Alaska if the person lived in the state of Alaska for at least nine of the 12 months immediately preceding application for a state plan and the person's absence from the state of Alaska is for medical treatment or education.

Symmetrical Appearance means that, in addition to prosthetic devices and reconstructive surgery for the diseased breast on which that the mastectomy was performed, prosthetic devices and reconstructive surgery for a healthy breast is also covered if, in the opinion of the physician, this surgery is necessary to achieve normal symmetrical appearance.

Terminally Ill means:

- (a) determined by a physician to have a terminal sickness with no reasonable prospect of cure; and
- (b) expected by a physician to have less than six months to live.

Third Party means another person or organization.

Usual, Customary, Reasonable or Prevailing Charge means the charge for a medical care procedure, service, or supply item that is the lowest of the following amounts:

- (a) the billed amount for the medical service provider's actual charge;
- (b) the charge usually made by that provider for performing that procedure or service or for providing the supply item; or
- (c) the customary charge, based on a profile of charges made for the same medical procedure, service, or supply item in the same geographical area by other providers that have performed the same procedure or service or can provide the same supply item; or
- (d) the Medicare approved amount.

Urgent Admission means the Physician admits the person to the hospital due to:

- the onset of or change in a disease; or
- the diagnosis of a disease; or
- an injury caused by an accident; which while not needing an emergency admission, is severe enough to require confinement as an inpatient in a hospital within 2 weeks from the date the need for the confinement becomes apparent.

We, Our or Us means the Alaska Comprehensive Health Insurance Association.

You or Your means the Insured named on the Schedule. If the Insured is a minor, any rights under this policy will belong to the Insured's parent or legal guardian.

PART G.

PRE-EXISTING CONDITIONS LIMITATIONS

Your policy will not cover expenses incurred during the first 6 months after its Policy Date for a pre-existing condition. We will pay only for expenses incurred after such 6-month period. Payment will be in accord with the provisions of this policy. However, if you had coverage under another medical plan or policy (“prior plan”) which was involuntarily terminated, or you are converting from another ACHIA policy, and you apply for coverage under this policy within 31 days after such involuntary termination from coverage under the “prior plan”, the above limitation as to a pre-existing condition will apply only for a period of time equal to 6 months less the time you were covered under the “prior plan”.

PART H.

BENEFITS

BENEFIT OVERVIEW

This plan coordinates benefits with Medicare. This plan is the secondary payer and Medicare is the primary payer for all benefits for Covered Services that are also covered by Medicare. This plan is the primary payer for the benefits not covered by Medicare, but which are covered by the ACHIA plan.

LIFETIME MAXIMUM

The Maximum Benefit is \$3,000,000. It is the amount payable during your lifetime for all Eligible Expenses incurred by you while insured under this policy and/or any other policy issued to you by us for all sickness or injuries, or combination thereof.

DEDUCTIBLE

The Deductible means the initial amount of Eligible Expense you must incur each calendar year before benefits can be provided. Benefits are not payable for Eligible Expenses that are used to satisfy the Deductible. Only expenses covered by ACHIA which are not covered by Medicare, or any patient responsibility arising from the Medicare Explanation of Benefits and/or from the ACHIA coordination of benefits with Medicare, shall be applied to your ACHIA deductible, coinsurance or Out-of-Pocket maximums.

The Deductible is \$1,000. Eligible Expenses are applied toward the individual Deductible in the year in which they are incurred. Eligible Expenses incurred in the last three months of the year which were applied to meet the Deductible are also applied in an equal amount toward the individual Deductible required for the next year.

RATE OF PAYMENT

If, while you are covered under this policy, you incur Eligible Expenses due to an injury or sickness, other than Mental or Nervous Disorders, we will pay 80% of such Eligible Expenses in excess of the Deductible after any and all coordination with Medicare adjustments and payments have been done. However, when in a Calendar Year, you reach the Out-of-Pocket Expense Amount of \$2,500 (which includes the deductible), we will pay at the rate of 100% of Eligible Expenses for the remainder of the same Calendar Year. This 100% will apply unless otherwise stated. If the charge is not covered by Medicare, but is an Eligible Expense under your ACHIA plan, we will pay 80% of such Eligible Expenses in excess of the Deductible. However, when in a Calendar Year, you reach the Out-of-Pocket Expense Amount, we will pay at the rate of 100% of Eligible Expenses for the remainder of the same Calendar Year. This 100% will apply unless otherwise stated.

For Mental or Nervous Disorders, benefits are payable at the rate of 50% after the Deductible, for Eligible Expenses incurred for the inpatient or outpatient treatment of a mental or nervous disorder. The maximum benefit payable for all Eligible Expenses incurred during any one calendar year for outpatient treatment is \$ 4,000. For inpatient treatment, the benefits are payable at 50% with no out-of-pocket maximum. Payments you make for treatment of Mental or Nervous Disorders do not count towards the Out-of-Pocket Maximum and no Out-of-Pocket Maximum applies for inpatient treatment of Mental or Nervous Disorders.

PART H. (Continued) BENEFITS

In the coordination of payments when the provider accepts Medicare assignment, total payment is limited to the Medicare approved amount. In the case of a provider who does not accept Medicare assignment, total payment is limited to 115% of the Medicare approved amount. If the provider does not accept Medicare assignment and the insured contracts privately with the provider, ACHIA will not pay any part of the charges, except upon review or appeal. Exceptions may include circumstances where there is no provider who accepts Medicare within a reasonable distance to travel.

COVERED SERVICE AND SUPPLIES

1. Daily room and board and other hospital services and supplies. When you are confined in a private room, Eligible Expenses will not include room and board charges in excess of the most common semiprivate room charge of the hospital where the confinement takes place, unless a private room is prescribed as medically necessary by a physician.
2. Professional services that are rendered by a physician or by a registered nurse at the physician's direction, other than services for dental conditions.
3. Legend drugs and medicines requiring a physician's prescription.
4. Services of skilled nursing facility for not more than 120 days in a calendar year.
5. Hospice services for up to six months in a calendar year.
6. Use of radium or other radioactive materials.
7. Home health agency services up to a maximum of 270 visits in a calendar year provided the services commence within seven days following confinement in a hospital or skilled nursing facility of at least three consecutive days for the same condition, except that in the case of an individual diagnosed by a physician as terminally ill with a prognosis of six months or less to live, the home health agency services may begin regardless of whether the covered person was previously confined or, if the covered person was confined, regardless of the seven-day period, and the benefit for medical social services may not exceed \$ 200 each calendar year. The seven day confinement requirement can be waived by the Association or its administrator. Such determination will be based on the circumstances and solely at the discretion of the Association.
8. Outpatient chemotherapy.
9. Oxygen.
10. Anesthetics and its administration.
11. Nondental prosthesis and maxillo-facial prosthesis used to replace any anatomic structure lost during treatment for head and neck tumors or additional appliances essential for the support of the prosthesis.
12. Rental, or purchase if purchase is more cost effective than rental, of durable medical equipment that has no personal use in the absence of the condition for which it was prescribed.
13. Diagnostic X-rays and laboratory tests.
14. Oral surgery for excision of partially or completely unerupted impacted teeth or excision of a tooth root without the extraction of the entire tooth.

PART H. (Continued) Benefits

Covered Services and Supplies (Continued)

15. Services of a licensed physical therapist rendered under the direction of a physician.
16. Transportation by a local ambulance operated by licensed or certified personnel to the nearest health care institution for treatment of the disease or injury and round trip transportation by air to the nearest health care institution for treatment of the disease or injury if the treatment is not available locally; if the patient is a child under 12 years of age, the transportation charges of a parent or legal guardian accompanying the child may be paid if the attending physician certifies the need for the accompaniment.
17. Confinement in a licensed or certified facility establishment primarily for the treatment of alcohol or drug abuse or in a part of a hospital used primarily for this treatment, for a period of at least 45 days within any calendar year.
18. Diagnosis or treatment of a mental or nervous disorder, subject to a maximum benefit for outpatient treatment of \$4,000 in any calendar year. Mental or nervous disorders do not include anything that relates to or that results from alcoholism or drug abuse.
19. Second surgical opinions.
20. Outpatient treatment of alcoholism or drug abuse while you are insured under this policy and/or any like policy issued to you by us subject to the following maximums:
 - Not more than \$16,380 is payable in any 2 consecutive calendar years.
 - Not more than \$32,750 is payable during your lifetime.Treatment includes, but is not limited to: (a) detoxification; (b) medical or psychiatric evaluation; (c) activity or family therapy; (d) counseling; or (e) prescription drugs and supplies.
21. One annual pap smear cancer screening test for a female insured person who is age 18 or older.
22. One baseline mammography for insured persons who is at least 35 years of age but less than 40 years of age. One mammography every two years for insured persons who is at least 40 years of age but less than 50 years of age. One routine mammography each calendar year to insured persons age 50 or over, except benefits will be paid without regard to age or any calendar year limit if the insured person or the insured person's parent or sibling have a history of breast cancer, upon referral by a physician.
23. One annual prostate screening test for a male insured person provided:
 - (a) the insured person is at least age 35 but less than age 40 and is considered high risk; or
 - (b) the insured person is age 40 or olderHigh Risks means a person who is an African-American or who has a family history of prostate cancer.
24. Formulas necessary for the treatment of phenylketonuria (PKU).
25. Treatment in connection with one of the following complications of pregnancy to the same extent as for disease: surgical operations for extrauterine pregnancy or for other complications requiring intra abdominal surgery after termination of pregnancy; pernicious vomiting of pregnancy (hyperemesis gravidarum); and toxemia with convulsions (eclampsia of pregnancy).
26. The cost of treating diabetes, including medication, equipment, supplies, outpatient self-management training or education, and medical nutrition therapy, if diabetes treatment is prescribed by a health care provider. Coverage for the cost of diabetes outpatient self-management training or education and for the

cost of medical nutrition therapy is provided only if provided by a health care provider with training in the treatment of diabetes.

27. If you have received surgical or medical benefits under this policy for a mastectomy and you are currently receiving benefits in connections with a mastectomy, we will provide coverage for:
1. Reconstruction of the breast on which the mastectomy has been performed.
 2. Surgery and reconstruction on the other breast to produce a symmetrical appearance.
 3. Prostheses and physical complications of all stages of mastectomy, including lymphoma.

PART I.

EXCEPTIONS AND LIMITATIONS

We will not pay for:

- (a) care for an injury or disease:
 - (1) arising out of and in the course of an employment subject to a workers' compensation or similar law or where the benefit is available to be provided under a workers' compensation policy or equivalent self-insurance to a sole proprietor, business partner, or corporation officer; or
 - (2) to the extent benefits are payable without regard to fault under a coverage statutorily required to be contained in a motor vehicle or other liability insurance policy or equivalent self-insurance;
- (b) treatment for reconstructive or cosmetic purposes other than a surgery for the prompt repair of an accidental injury sustained while covered under this policy or for replacement of an anatomic structure removed during treatment of tumors;
- (c) travel, other than transportation provided under Covered Services and Supplies;
- (d) private room accommodations to the extent charges are in excess of the institution's most common charge for a semiprivate room;
- (e) services or articles to the extent that the charge exceeds the usual, customary, reasonable or prevailing charge;
- (f) services or articles that are determined not to be medically necessary, except for the fabrication or placement of any prosthesis specifically provided;
- (g) services or articles that are not within the scope of the license or certificate of the institution or individual rendering the services or articles;
- (h) services or articles furnished, paid for or reimbursed directly by or under any law or a government;

PART I. (Continued)

EXCEPTIONS AND LIMITATIONS

- (i) services or articles for custodial care or designed primarily to assist an individual in the activities of daily living;
- (j) charges that would not have been made if no insurance existed or that the covered individual is not legally obligated to pay;
- (k) eyeglasses, contact lenses, or hearing aids or the fitting of them;
- (l) dental care not specifically covered;
- (m) services of a registered nurse or physician who ordinarily resides in the covered individual's home, or who is a member of the covered individual's family or the family of the covered individual's spouse;
- (n) procedures, services, drugs and other supplies that are, as determined by the Administrator, experimental or still under clinical investigation by health professionals;
- (o) services and supplies for which the patient was not charged;
- (p) for any loss or expense or charge which results, whether the insured person is sane or insane, from:
 - (1) an intentionally self-inflicted injury or sickness; or
 - (2) suicide or attempted suicide;
- (q) any loss or expense or charge which results from appetite control, food addictions, eating disorders (except for documented cases of bulimia or anorexia that meet standard diagnostic criteria as determined by the Administrator, and present significant symptomatic medical problems) or any treatment of obesity;
- (r) the promotion of fertility including (but not limited to):
 - (1) fertility tests;
 - (2) reversal of surgical sterilization; and
 - (3) any attempts to cause pregnancy by hormone therapy, artificial insemination in vitro fertilization and embryo transfer or any similar treatment or method;
- (s) treatment of craniomandibular or temporomandibular joint (TMJ) disorders;
- (t) marital, family, child, social adjustment, pastoral, financial or sexual counseling;
- (u) vocational counseling; outreach; and job training, education or special education whether or not given in a facility that also provides medical or psychiatric treatment;
- (v) expenses associated with normal childbirth or normal pregnancy;
- (w) care, treatment, services or supplies that are not prescribed, recommended and approved by your attending physician;
- (x) services of a resident physician or intern rendered in that capacity;
- (y) charges for or related to any eye surgery mainly to correct refractive errors;
- (z) charges for or related to sex change surgery or to any treatment of gender identity disorders;
- (aa) routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations or other preventive services and supplies;
- (bb) acupuncture therapy. Not excluded is acupuncture when it is performed by a physician as a form of anesthesia in connection with surgery that is covered under this policy;
- (cc) charges for or in connection with speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as the result of a disease or injury;
- (dd) Services covered by Medicare.

Any exclusion above will not apply to the extent that coverage is specifically provided by name in this policy; or coverage is required under any applicable law.

PART J.

NONDUPLICATION OF BENEFITS

This plan is the last payer of benefits whenever any other benefit is available. Benefits otherwise payable under this policy shall be reduced by all amounts paid or payable, or reimbursement directly by or under:

- (a) the laws of the United States, including Medicare;
- (b) military service-connected disability payments;
- (c) medical services provided for members of the Armed Forces and their dependents or employees of the Armed Forces of the United States;
- (d) hospital or medical services paid or payable pursuant to any state or federal law or program;
- (e) a workers' compensation or occupational disease law;
- (f) automobile medical payment or liability insurance, whether provided on the basis of Fault or No fault coverage;
- (g) any other form of health insurance or health benefit plan, whether insured or otherwise;
- (h) any third-party liability, settlement, judgment or award.

We reserve the right of recovery for any payments we made for a loss that is payable by other insurance coverage, health plans or governmental programs. We may also recover payments that we made for losses not covered under your policy or in excess of the benefits provided hereunder. Benefits due from this plan may be reduced or refused as an offset against any amount otherwise recoverable.

PART K.

SUBROGATION/REIMBURSEMENT

As a condition to payment of benefits under this policy for expenses you incur due to an injury or disease caused by the act or omission of a third party:

- (a) To the extent of benefits paid by us, we shall have the right to pursue your rights of recovery against such third party.
- (b) We shall have the right to recover from you amounts received by judgment, settlement, or otherwise from such third party or his or her insurance carrier.
- (c) You agree to execute and deliver any documents that are required, and do whatever else is necessary to secure such rights.

PART L.

HOW TO FILE A CLAIM

NOTICE OF CLAIM: You must give the Administrator written notice of a claim within 20 days after it starts or as soon as you can. You may give the notice or you may have someone do it for you. The notice should give your name and policy number as shown on the back page. The notice should be mailed to the Administrator. This does not waive the certification requirements for hospital confinement as shown in Part J.

CLAIM FORMS: When the Administrator receives your notice, they will send you forms for filing proof of loss within. If these forms are not sent to you in 15 days, you will have met the proof of loss requirements if, in 90 days after the loss began, you give the Administrator a written statement of what happened.

PROOF OF LOSS: You must give the Administrator written proof of your loss in 90 days or as soon as you can. Proof must, however be furnished within 3 years, except in the absence of legal capacity.

PART M.

PAYMENT OF CLAIMS

All benefits will be paid as soon as the Administrator receives acceptable proof of loss, including the Medicare Explanation of Benefits, and within 30 working days for claims not in dispute. If the claim is denied or is deemed to be in dispute, notification will be made within 15 working days from the date the Administrator receives the proof of loss.

Any benefits for hospital, medical or surgical services which you have assigned will be paid to the hospital or the provider of the services. If you have not assigned the benefits, or requested in writing that you be paid, the Administrator, at their option, will pay you, the hospital or the provider of the services.

Upon the payment of a claim under this policy, any premiums then due and unpaid or covered by note or written order may be deducted there from.

Benefits unpaid at your death which would have otherwise have been paid directly to you will be paid to your beneficiary (your estate if no beneficiary is named).

PART N.

TERM OF COVERAGE

Your coverage starts on the policy Date at 12:01 a.m., Alaska Time. It ends at 12:01 a.m., on the same standard time, on the First Renewal Date, unless otherwise terminated in accord with Part C. Each time you renew your policy by paying the premium by no later than the end of the 31-day grace period, the new term begins when the old term ends. Upon ceasing to be a resident, previously purchased coverage remains in effect for the period covered by payments made while a resident.

PART O.

GENERAL PROVISIONS

Entire Contract; Changes: This policy, your application and any riders are the entire contract of insurance. No agent may change it in any way. Only the Alaska Comprehensive Health Insurance Association can approve a change. Any such change must be shown in your policy.

Time Limit on Certain Defenses: After two years from the date you become covered under this policy, the Administrator cannot use misstatements, except fraudulent misstatements in your application, to void coverage or deny a claim for loss that happens after the two-year period.

The above provision applies to riders attached to this policy. In applying them the word "rider" will be used for the word "policy".

Grace Period: You can pay your premium during the 31 days after the date it is due. This 31-day period is the grace period. Your policy is in force during this time. If the Administrator does not receive your payment during the grace period, your policy will lapse and no benefits will be paid for the period after the policy premium due date.

Reinstatement: The Administrator does not provide for the reinstatement of this policy if it lapses due to nonpayment of premium. If you mail or deliver a premium to the Administrator after the grace period, it will be returned to you as soon as it is determined that the premium is late.

You may reapply for coverage under the Alaska Comprehensive Health Insurance Association Plan if you again become (or remained) eligible and you voluntarily terminated this previous policy. Nonpayment of premium constitutes a voluntary termination.

PART O. (Continued)

GENERAL PROVISIONS

Cancellation by You: You may cancel this policy at any time by giving written notice to the Administrator. It will be effective upon receipt of your notice or on a later date that you may specify. Upon cancellation or upon death, the Administrator will promptly return any unearned premium which will be based on a pro rata calculation. Cancellation will not affect an existing claim.

Physical Examinations: The Administrator, at its expense, has the right to have an insured person examined when and as often as is reasonable during the handling of a claim.

Misstatement of Age: The premium for this policy is based on age. If your age was misstated in the application, it may result in the premium being changed. If this policy would not have been issued or renewed at your correct age, there will not be coverage under it. In such case, the Administrator will refund all affected premiums paid less the amount of all claims paid.

Grievance Procedures: If your claim is denied or partly denied, you will receive a written notice of the denial, together with the specific reason for the denial, from the Administrator. You may request a review of any denial within 60 days after receiving the denial notice.

The Administrator will complete the review within 10 days of receiving your request. If the review cannot be completed within the 10 days, the Administrator will provide you with an explanation for the delay.

This review decision can be appealed to the Grievance Committee of the Alaska Comprehensive Health Insurance Association if you are not satisfied with the Administrator's decision.

Legal Action: You cannot start a legal action to recover under your policy until 60 days after you have filed your proof of loss. No such legal action may be brought after two years from the time your written proof of loss is required to be filed.

Conformity with State Statues: This policy shall be construed in accordance with the laws of the State of Alaska.

This policy is signed for us by:



Chairman of the Board
Alaska Comprehensive Health Insurance Association

Medicare Supplement Prescription Drug Benefit Elimination Rider

This Rider is made a part of the Policy to which it is attached. It is subject to all Policy provisions not in conflict with the provisions of this Rider.

The following provision is deleted from the **COVERED SERVICES AND SUPPLIES** section of your policy:

3. Legend drugs and medicines requiring a physician's prescription.
20. (e) prescription drugs and supplies.

SAMPLE