ALASKA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION
ASSOCIATION PLAN

This policy provides coverage for Alaska residents who are otherwise medically uninsurable or for residents who are federally defined eligible individuals. If you are obtaining this policy as a result of being a federally defined eligible individual, you must have applied for this Association Plan within 90 days of termination of your prior coverage. 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. That date is shown on the Schedule. A copy of your application is attached.

CERTIFICATION REQUIREMENT: If you require confinement in a hospital, days in the hospital must be certified for full policy benefits to be available. See Part J.

Table of Contents

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;
(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.

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.

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.

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.

Federally Defined Eligible Individual means a person enrolling in the Association Plan:

(a) for whom, as of the date on which the individual seeks coverage under the Association Plan, the aggregate of the periods of Creditable Coverage is 18 months or more and whose most recent prior Creditable Coverage was under a group health plan, government plan, or church plan;
(b) who does not have other health insurance coverage;
(c) who is not eligible for coverage under:
- a group health plan;
- Title XVIII, Part A or B, of the Social Security Act, 42 U.S.C. 1395c through 1395i-442 U.S.C. 1395j through 1395w-4
- A state plan under Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, or successor program; and
- Denali KidCare

(d) for whom the most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud;
(e) who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, elected that coverage; and
(f) who has exhausted continuation coverage under the COBRA continuation provision or program described in Subsection (e) if the individual elected the continuation coverage described in Subsection (e).

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.

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.

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, eating disorder, 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**.

Physician means any of the following licensed practitioners who performs 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 a 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).

Pre-existing 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 pre-existing 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.

Resident means (a) except for a federally defined eligible individual, an individual who (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; (b) for a federally defined eligible individual, an individual who is legally domiciled in the state of Alaska.

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 an amount equal to ar greater than the 95th percentile 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.
(d) You are responsible for any amount billed for a healthcare service or supply item that excees the amount of final payment.

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 LIMITATIAONS

If you have obtained this Plan as a result of being a Federally Defined Eligible Individual, there are no pre-existing conditions limitations.

Otherwise, 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 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

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.

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, (and you pay the remaining 20%); however, when in a Calendar Year, you reach The Out-of-Pocket Expense Amount shown in the Schedule, 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.

Out-of-Pocket Expense means any Eligible Expenses which are incurred but not reimbursable because of the Deductible and coinsurance. Coinsurance for Mental or Nervous Disorders does not count towards the Out-Of-Pocket maximum.

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.

The Deductible is shown in the Schedule. 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.

COVERED SERVICES 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

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.

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 up to 45 days within any calendar year.

18. Diagnosis or treatment of a mental or nervous disorder, subject to the Mental or Nervous Disorder Limits shown below.

19. Second surgical opinions.

20. Outpatient treatment of alcoholism or drug abuse, subject to the Alcoholism or Drug Abuse Outpatient Maximums shown below.

21. Preventive care examinations (adult routine medical exam, men's and women's health exam, well child visits)

22. Immunizations for adults as recommended by the U.S. Preventative Services Task Force on the date the service is incurred

23. Immunizations for children (under age 19) as recommended by the American Academy of Pediatrics on the date the service is incurred

24. The following Preventive Screenings:

A. Urinalysis and Blood Tests, including the following:

(1) Complete blood count (or component parts) testing

(2) Urinalysis testing

B. Cancer Screening including the following:

(1) Cervical cancer – annual Pap smears

(2) Prostate cancer – annual prostate specific antigen (PSA) screening

(3) Colorectal cancer
a. flexible sigmoidoscopy and barium enema, or
b. colonoscopy
c. fecal occult blood test (FOBT)
d. double contrast barium
e. CT colonography (virtual colonoscopy)
f. fecal immunochemical test (FIT)
g. stool DNA test (sDNA)

(4) Mammography screening as follows:

a. baseline mammogram for Covered Person at least 35 but less than 40 years of age;
b. One mammogram every two years for Covered Person at least 40 but less than 50 years of age;
c. An annual mammogram for Covered Person at least 50 years of age;
d. A mammogram at any age for a Covered Person with a history of breast cancer or whose parent or sibling has a history of breast cancer, upon referral by a Health Care Practitioner.

C. Infectious Diseases:

(1) Tuberculin skin testing with purified protein derivative
(2) Chlamydia Antibody
(3) Hepatitis Antigen

D. Metabolic, Nutrition, and Endocrine:

(1) Glucose Testing
(2) Hemoglobin Testing

E. Heart and Vascular Disease:

(1) Lipid Panel

(2) Lipoprotein
(3) Cholesterol

F. Musculoskeletal Disorder:

(1) Bone Density testing

25. Formulas necessary for the treatment of phenylketonuria (PKU).

26. 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).

27. 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.

ALCOHOLISM OR DRUG ABUSE OUTPATIENT MAXIMUMS
Benefits payable for Eligible Expenses incurred for the treatment of alcoholism or drug abuse while you are insured under this policy and/or any like policy issued to you by us are 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.

MENTAL OR NERVOUS DISORDER LIMITS
The maximum benefit payable for all Eligible Expenses incurred during any one calendar year for outpatient treatment is $4,000. Mental or nervous disorders do not include anything that relates to or that results from a person's alcoholism or drug abuse.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998
If you have received surgical or medical benefits under this policy for a mastectomy and you are currently receiving benefits in connection with a mastectomy, we will provide coverage for:
1. Reconstruction of the breast on which the mastectomy has been performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
3. Prostheses and physical complications of all stages of mastectomy, including lymphademas.

DEPENDENTS PROVISIONS
Each Covered Person must independently meet the eligibility requirements for coverage under this contract. However, Your children born while this contract is in force will be covered automatically from birth until (a) the 31st day following birth or (b) the first day of the second month following birth, whichever is longer. Benefits are payable for medically diagnosed congenital defects and birth abnormalities during the period of automatic coverage. Expenses incurred after the end of the automatic coverage will be covered only if your child meets the eligibility requirements on his or her own accord for coverage by us.

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 then 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;
(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, experimental except during an approved clinical trial as defined in AS 21.42.415, 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, 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 vision exams, routine dental exams, routine hearing exams;
(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.

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. CERTIFICATION FOR HOSPITAL ADMISSIONS

If:

You become confined in a hospital as a full-time inpatient; and
It has not been certified that any day of such confinement is necessary;

Eligible Expenses incurred for hospital services and supplies on any day not certified during the confinement will be paid as follows:

If certification has been requested and denied:

No benefits will be paid for hospital board and room.
Benefits for all other hospital services and supplies will be paid in accordance with policy provisions.

If certification has not been requested and the confinement (or any day of such confinement) is not necessary:

No benefits will be paid for board and room.
Benefits payable, in the absence of this provision, for all other hospital services and supplies may be reduced by $ 300.

If certification has not been requested and the confinement (or any day of such confinement) is necessary:

Benefits payable, in the absence of this provision, for hospital board and room and for all other hospital services and supplies may be reduced by $ 300.

Whether or not a day of confinement is certified, no benefit will be paid for expenses excluded by any other terms of this policy.

Certification of days of confinement can be obtained as follows:

If the admission is a non-urgent admission, you must get the days certified by calling the toll-free telephone number on the Schedule. This must be done at least 14 days before the date you are scheduled to be confined as a full-time inpatient. If the admission is an emergency or an urgent admission, you, your physician, or the hospital must get the days certified by calling the toll-free telephone number on the Schedule.

This must be done:

Before the start of a confinement as a full-time inpatient which requires an urgent admission**;** or not later than 48 hours following the start of a confinement as a full-time inpatient which requires an emergency admission; unless it is not possible for the physician to request certification within that time. In that case, it must be done as soon as reasonably possible. In the event the confinement starts on a Friday or Saturday, the 48- hour requirement will be extended to 72 hours.

If, in the opinion of your physician, it is necessary for you to be confined for a longer time than already certified, you, the physician, or the hospital may request that more days be certified by calling the toll-free number on the Schedule. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the hospital. A copy will be sent to you and to the physician.

PART K. NON-DUPLICATION OF BENEFITS

This plan is the last payor 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 benefits 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 thereunder. Benefits due from this plan may be reduced or refused as an offset against any amount otherwise recoverable. The time frame for recovery is three years from the date of service.

PART L. 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 M. HOW TO FILE A CLAIM

CLAIM FORMS: When the Administrator receives your notice, they will send you forms for filing proof of loss within 10 days. 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 N. PAYMENT OF CLAIMS

All benefits will be paid within 30 days of receipt of a clean claim. If the claim is denied or is not paid, notification will be made within 30 days from the date the Administrator receives the proof of loss. Payment will be made within 15 days of receipt of additional information for other than a clean claim. If the claims are not paid within the time limit, interest will accrue at an interest rate of 15% per year.

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 therefrom.

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 O. 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 P. 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.

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 at your correct age, there will no coverage under it. In such case, the Administrator will refund all premiums paid less the amount of all claims paid.

Third-party Payment of Premium: Your employer may not pay premiums for this policy.

ACHIA GRIEVANCES AND APPEALS

A. <u>General Grievance and Appeal Rights</u>.

1. If you are aggrieved by one of our actions or decisions, you may pursue up to three levels of appeals. The first is to the Administrator, the second is to our Grievance Committee and the third is to an external review organization.

B. <u>Formal Appeal Process</u>.

1. **Appeal to the Administrator.**

   a. You must notify the Administrator of your request for appeal within 180 days of the event giving rise to the appeal
   b. Within five business days, the Administrator will respond to you in writing confirming receipt of the appeal request, the date it was received, the nature of the complaint and the resolution requested.
   c. The Administrator will investigate the complaint, consider all information submitted by you, and make its decision within 18 working days of receipt of the complete information needed to respond to the appeal.
   d. The Administrator will notify you of its decision in writing and inform you of any further appeal options. In the case of emergency services, a decision will be communicated as soon as is practicable but in any event not later than 24 hours after receiving the request.
   e. The written notice will explain the decision and any supporting coverage or clinical reasons and will specifically refer to any supporting documents. The Administrator **must** make its decision within 18 working days of its receipt of the complete information needed to respond to the appeal.
   f. If a complaint involves denial of coverage of a service, and you provide written notice to the Administrator of a need for a speedy appeal process because the regular appeals process timelines could seriously jeopardize your life, health, or ability to regain maximum function, the Administrator will provide its written decision within 72 hours of receipt of the appeal request. Such appeal must be reviewed by a person who holds the same professional license as the health care provider who is treating you.

2. **Appeal to the ACHIA Grievance Committee.**

   a. You must notify the Administrator of your request for appeal to our Grievance Committee within 90 days of an adverse decision by the Administrator and include a written description of the complaint.
   b. Within five business days, the Administrator will respond to you in writing confirming receipt of the appeal request, the date it was received, the nature of the complaint and the resolution requested. Within two business days of sending this notice, the Administrator will forward the appeal, with all relevant information from its files, to our Grievance Committee.
   c. Our Grievance Committee will investigate the complaint, consider all information submitted by you, and make its decision within 18 working days of its receipt of the complete information needed to respond to the appeal. The Grievance Committee may engage independent medical and legal experts to assist in the review process. Such appeal must be reviewed by a person who holds the same professional license as the health care provider who is treating you.
   d. Our Grievance Committee will notify you of its decision in writing and inform you of any further appeal options. The written notice will explain the decision and any supporting coverage or clinical reasons and will specifically refer to any supporting documents. Our

Grievance Committee **must** make its decision within 18 working days of its receipt of the complete information needed to respond to the appeal.

e. If a complaint involves denial of coverage of a service, and you provide written notice to the Administrator of a need for a speedy appeal process because the regular appeals process timelines could seriously jeopardize your life, health, or ability to regain maximum function, our Grievance Committee will provide its written decision within 72 hours of its receipt of the appeal request.

3. **External Review Appeal.**

a. If the Grievance Committee affirms a decision to deny, modify, reduce or terminate coverage of or payment for health services, you may appeal the decision to an Independent Review Organization (IRO) by notifying the Administrator within 30 days of receipt of the Grievance Committee's written decision.
b. The Administrator will gather all relevant documents and deliver them to the IRO within three business days of receiving your request for appeal.
c. The IRO, made up of persons not associated with ACHIA or the Administrator, will review the complaint and make a decision. The IRO will provide its decision in writing to you and the Administrator within 21 working days, or within 72 hours in the case of an expedited appeal, of your request for appeal. ACHIA will pay the charges for the IRO's review and written report.
d. The External Review Appeal process shall meet the requirements as provided by AS 21.07.050-060. The decision of the IRO is binding unless the aggrieved part appeals the decision to the superior court within 6 months of the IRO 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:

Executive Director
Alaska Comprehensive Health Insurance Association