P.O. Box 1090

Great Bend, KS 67530

www.achia.com

Read the ACHIA Policy Carefully — This outline of coverage provides a very brief description of the important features of the ACHIA policy. This brochure is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both the covered person and the ACHIA. It is, therefore, important that a covered person

Alaska Comprehensive Health Insurance Association

The Legislature of the State of Alaska has created a Comprehensive Health Insurance Association (ACHIA) to offer residents of the State, through participation of health insurance companies, a program of health insurance. The program is designed to provide health insurance to high risk individuals who are unable to find or who are denied health insurance due to medical condition in the private market and to those individuals who have had prior health insurance coverage and meet the federal rules for eligibility described below.

This brochure describes the benefits, exclusions, eligibility and application procedures under the ACHIA program.

Eligibility Requirements

Coverage is available to persons under any one of three separate sets of rules:

Medical: Under the *high risk rules* a person is eligible for coverage if:

a) one of the following apply:

1) the person is physically present in Alaska, has lived in Alaska for at least the 12 consecutive months immediately before applying for coverage under this plan, and intends to remain permanently in Alaska; or

2) the person is not physically present in Alaska, but has lived in Alaska for at least 9 of the 12 months immediately before applying for coverage under this plan and the person's absence from Alaska is for medical treatment or education;

b) the person is not eligible to be covered under a small employer (2-50 employees) health insurance plan;

c) the person is not eligible for medical coverage under a federal or state program including Medicaid, veteran's benefits, or native health care;

d) the person is not eligible for coverage under another health benefit program including a self-insurance plan, health care trust or welfare trust

e) the person does not have other health insurance coverage; and

f) at least one of the following apply:

1) the person has received from at least one health insurer notice of rejection for health insurance dated within the last six months;

2) the person has one of the listed conditions in this brochure;

3) the person has received restrictive riders that substantially reduce coverage.

Even if a person is covered by Medicare, the person may still be eligible for coverage under this plan.

Federal: Under the *federal rules* a person is eligible for coverage if:

a) the person is domiciled in the state of Alaska;

b) the person has at least 18 months of prior health insurance coverage without a 90 day or more break in such coverage;

c) the person's most recent health insurance coverage was under a group plan;

d) the person is not eligible for other group health insurance coverage, Medicare or Medicaid;

e) the person's most recent health insurance coverage was not terminated due to nonpayment of premium or fraud;

f) the person has elected and exhausted any COBRA or similar coverage; and

g) the person does not have other health insurance coverage.

Under the Health Coverage Tax Credit federal program a person is eligible for ACHIA coverage if:

a) the person is a displaced worker under the Trade Adjustment Assistance Act; or

b) the person receives a pension managed by the Pension Benefit Guaranty; and

c) the person is eligible for HCTC as determined by the federal HCTC program.

Eligible Medical Conditions: *If a person has any of the specific conditions listed below and meets the Eligibility Requirements listed in this brochure, the person has the right to obtain coverage under the plan without having to submit a rejection notice.*

Acquired Immune Deficiency Syndrome (AIDS)
Alzheimers
Angina Pectoris
Anorexia Nervosa
Arteriosclerosis Obliterans
Artificial Heart Valve
Ascites
Brain Tumors
Cardiomyopathy
Cerebral Palsy
Chronic Pancreatitis
Cirrhosis of the Liver
Coronary Insufficiency
Coronary Occlusion
Crohn's Disease
Cystic Fibrosis
Dermatomyositis
Diabetes
Epilepsy
Friederich's Disease
Heart Disorders
Hemophilia
Hepatitis C (Active)
HIV+
Hodgkin's Disease
Huntington's Chorea
Hydrocephalus
Intermittent Claudication
Kidney Failure
Lead Poisoning with Cerebral Involvement
Leukemia
Lupus Erythematosus Disseminate
Malignant Tumor (treated within last 4 years)
Mental Retardation
Metastatic Cancer
Motor or Sensory Aphasia
Multiple or Disseminated Sclerosis
Muscular Atrophy or Dystrophy
Myasthenia Gravis
Myotonia
Obesity - Morbid
Open Heart Surgery
Paraplegia or Quadriplegia
Parkinson's Disease
Peripheral Arteriosclerosis (treated within last 3 yrs)
Poliomyelitis
Polycystic Kidney
Polyarteritis (periarteritis nodosa)
Postero-lateral Sclerosis
Psychotic Disorders
Rheumatoid Arthritis
Sickle Cell Anemia
Silicosis
Splenic Anemia (True Banti's Syndrome)
Still's Disease
Stroke (CVA)
Syringomyelia
Tabes Dorsalis (locomotor ataxia)
Thalassemia (Cooley's or Mediterranean Anemia)
Topectomy and Lobotomy
Ulcerative Colitis
Wilson's Disease

Preexisting Condition Exclusion

A preexisting condition is a sickness or condition:

a) which manifested itself within the three-month period immediately before the effective date of coverage in a way that would cause an reasonably prudent person to seek diagnosis, care or treatment ; or

b) for which medical advice, care or treatment was recommended by or received from a health care provider within the three-month period immediately before the effective date of coverage.

Expenses incurred by a person for a preexisting condition during the first six months after the effective date of coverage are not covered if the person is eligible for coverage only under the *high risk rules*. However, if the person had coverage under a health insurance policy (prior plan) which was involuntarily terminated and the person applies for coverage under this plan within 31 days after such termination, the six month waiting period will be reduced by the amount of time the person was covered under the prior plan.

If a person is eligible for coverage under the *federal rules*, no preexisting condition exclusion applies.

Description of Benefits

There are several different comprehensive plans offered by ACHIA. The primary differences between the plans are the annual deductible and the associated out-of-pocket limits. The annual deductible is the amount that a person must pay each calendar year for eligible expenses before the plan pays benefits. The out-of-pocket expense limit is the maximum amount, including the annual deductible that a person must pay in any calendar year.

With the exception of the $1,000 deductible indemnity plan, the Medicare carveout and the two Medicare supplement plans, all ACHIA plans pay 80% of the billed charges once a person has satisfied the annual deductible, as long as the person received treatment either from a preferred hospital or from a hospital that is not preferred when the person does not have reasonable access to a preferred hospital. If a person has reasonable access to a preferred hospital and chooses to receive treatment from a hospital that is not preferred, ACHIA will pay only 60% of the usual and customary charges. After a person has paid charges equal to the out-of-pocket expense limit, ACHIA will pay 100% instead of 80% or 60%.

For those covered under Medicare, ACHIA offers two Medicare supplement plans. The two Medicare supplement plans are standardized Plan A and Plan F. If a person is not enrolled in Part B of Medicare, benefits under these plans will not include benefits normally paid by Medicare. In any case, these plans do not cover basic drugs whether the person has Medicare Part D or not. However, drugs covered

under Medicare Part B are covered under these plans.

For those under 65 and covered under Medicare, ACHIA offers a Medicare carveout plan. The plan coordinates the benefits of the ACHIA $1,000 deductible non-PPO plan with Medicare. This plan differs from the non-PPO plan in that it does not cover drugs whether a person has Medicare Part D or not. However, drugs covered under Medicare Part B are covered under this plan. The Medicare carveout plan pays 80% of the charges not covered by Medicare (but covered under the ACHIA plan) once the $1,000 deductible has been satisfied, and pays 100% of the charges not covered by Medicare (but covered under the ACHIA plan) after the person and Medicare have paid charges equal to the out-of-pocket expense limit including the deductible.

In no case will ACHIA pay more than the balance due to the provider.

Mental or Nervous Disorder Limits

For eligible expenses incurred for treatment of mental or nervous disorder, 50% is covered after the deductible. The maximum benefit payable in a calendar year for outpatient treatment is $4,000. Mental or nervous disorders do not include treatment related to or that results from a person's alcoholism or drug abuse.

Alcoholism or Drug Abuse Outpatient Maximums

The maximum benefit payable for treatment of alcoholism or drug abuse under this plan is $16,380 in any two consecutive calendar year periods and $32,750 during a person's lifetime. These maximums will be adjusted every three years.

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.

Case Management

ACHIA benefits include the services of a nurse case manager. ACHIA participants are encouraged to call the case manager with any health-related questions. The case manager will troubleshoot and problem-solve to customize a care plan for each person's unique situation. 1-888-290-0616.

Lifetime Maximum

The maximum benefit a person is eligible to receive under this plan for all sickness and injuries combined is $3,000,000.

Covered Services and Supplies

a) Daily semiprivate room and board and other hospital services and supplies
b) Professional services that are rendered by a physician or by a registered nurse at the physician's direction
c) Prescription drugs and medicines requiring a physician's prescription; [Not covered for Medicare carveout or Plan A or Plan F unless covered by Medicare Part B.]
d) Services of a skilled nursing facility for not more than 120 days in a policy year
e) Home health agency services up to a maximum of 270 visits in a calendar year.
f) Hospice services for up to six months in a calendar year
g) Use of radium or other radioactive materials
h) Outpatient chemotherapy
i) Oxygen
j) Anesthetics and its administration
k) Nondental prosthesis and maxillofacial 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
l) 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
m) Diagnostic X-rays and laboratory tests
n) Oral surgery for excision of partially or completely unerupted impacted teeth or excision of a tooth root without the extraction of the entire tooth
o) Services of a licensed physical therapist rendered under the direction of a physician
p) Transportation by a local ambulance operated by licensed or certified personnel to the nearest health care institution for treatment of the illness or injury and round trip transportation by air to the nearest health care institution for treatment of the illness 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
q) Confinement in a licensed or certified facility established 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
r) Diagnosis or treatment of a mental or nervous disorder rendered during the year subject to the Mental or Nervous Disorder Limits
s) Second surgical opinions
t) One routine mammography each calendar year to insured persons age 35 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 mother or sister have a history of breast cancer
u) Treatment of alcoholism or drug abuse, subject to the Alcoholism or Drug Abuse Outpatient Maximums
v) Formulas necessary for the treatment of phenylketonuria (PKU)
w) Treatment for 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)

x) One Pap smear including attendant physicians office visit per calendar year for covered females age 18 or older and one prostrate screening test per year for covered males age 35 or older as provided by state law.

Exclusions & Limitations

The following is a brief listing of expenses not covered under this plan and may not reflect the full extent of the policy limitations:

a) Confinement or expenses incurred while a person's policy is not in force,

b) Injuries or disease caused at place of employment subject to workers' compensation benefits,

c) Injuries or disease caused in a motor vehicle accident subject to auto insurance coverage or other liability,

d) Reconstructive or cosmetic surgery,

e) Services that exceed the reasonable to customary charges,

f) Services that are deemed not to be medically necessary,

g) Services that are not within the scope of the providers license or certificate,

h) Eyeglasses, contact lenses, or hearing aids or the fitting of them,

i) Dental care not specially covered,

j) Services of a registered nurse or physician that resides in the covered person's home,

k) Experimental procedure, service, drugs and other supplies,

l) Services for which the patient was not charged,

m) Self-inflicted injury or sickness, suicide or attempted suicide,

n) Treatment of obesity,

o) Treatment for craniomandibular or temporomandibular joint (TMJ) disorders,

p) Promotion of fertility,

q) Vocational training,

r) Expenses associated with pregnancy and childbirth except as described above,

s) Services of a resident physician or intern,

t) Charges for or related to sex change surgery or gender identity disorders,

u) Routine physical, vision, dental, hearing or preventive exams,

v) Acupuncture therapy.

w) For Medicare carveout and Medicare Supplement Plan A and Plan F, basic prescription drugs unless covered under Medicare Part B

Certification of Hospital Admissions

Inpatient hospital confinement should be precertified by calling (800) 318-6776.

Renewal and Termination Agreement

An ACHIA policy will be renewed each time a person pays the required premium by the due date or within the 31-day grace period. Premiums may be paid monthly or quarterly.

Applications and Inquiries

Alaska Comprehensive Health Insurance Association
Benefit Management, Inc.
2015-16th Street
P.O. Box 1090
Great Bend, KS 67530
Tele: (888) 290-0616 Fax (620) 793-1199
E-mail: Inquiries: ACHIA@bmikansas.com
Applications may be downloaded at www.achia.com

Complaints

The ACHIA has established a grievance committee to review and resolve any complaints a person may have regarding the person's ACHIA coverage. If a person has contacted the administrator and has not received satisfactory resolution, the person is encouraged to write a detailed description of the person's complaint and send to:

Grievance Committee

Alaska Comprehensive Health Insurance Association
P.O. Box 1090
Great Bend, KS 67530, or

Cecil D. Bykerk
Executive Director – ACHIA
9643 Oak Circle
Omaha, NE 68124-2767
(402) 501-8701

If, after the grievance committee has reviewed a person's complaint, the person still has not received a satisfactory resolution, the person may wish to contact the Division of Insurance at:

Alaska Division of Insurance
550 West 7th Avenue, Suite 1560
Anchorage, AK 99501-3567
Phone (907) 269-7900 or (800) 467-8725
Fax (907) 269-7910

TDD (907) 465-5437