ALASKA COMPREHENSIVE HEALTH INSURANCE ASSOCIATION
MEDICARE SUPPLEMENT PLAN F

The premiums you paid, the application you complete and our reliance on your answers to the application questions have put this policy in force on the Effective Date. You must be eligible for and covered by both Medicare Part A and B to be eligible for this plan. This plan does not duplicate benefits paid by Medicare. The deductible and coinsurance amounts for Medicare Supplement insurance benefits paid by this plan will automatically change when Medicare's deductibles and coinsurance requirements change. Any provision of this policy is subject to change except where prohibited by Alaska law. We will provide at least 30 days prior notice of any such change.

NOTICE TO BUYER: THIS POLICY MAY NOT FULLY COVER ALL OF YOUR MEDICAL EXPENSES.

30 DAY RIGHT TO EXAMINE YOUR COVERAGE: Please read this policy. If you decide you do not want this coverage, you may return this policy within 30 days after receiving it. If returned, this policy will be considered as if it had never been issued. We will refund your premium minus any claims paid during this period. If you received claim payments in excess of the premium paid, no refund of premium will be made.

RENEWAL PROVISION: We will renew this policy each time you pay us the premium. It must be paid by the date it is due or during the 31 days that follow or your coverage will terminate.

PREMIUM INFORMATION

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 any premium change at least 30 days in advance of the effective date of the premium change.

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DEFINITIONS

Benefit Period - that period of time as defined by Medicare for the determination of eligibility for Medicare Part A benefits.

A **Calendar Year** - begins on January 1 and ends on December 31.

Effective Date – The date shown on the Schedule that indicates the first day of coverage under this policy.

Lifetime Reserve Day(s) – You have a lifetime reserve of 60 days for Medicare Part A inpatient hospital care. These days may be used whenever more than 90 days of inpatient hospital care are needed in a Medicare Benefit Period.

Medicare - (a) the hospital (Part A) and medical (Part B) insurance program established by Title XVIII of Social Security Act of 1965; or (b) Title I, Part I of Public Law 89-97, as Enacted by 89th Congress of the United States and known as the Health Insurance Act for the Aged, as then constituted or later amended.

Medicare Eligible Expenses - expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare. When Medicare does not provide coverage for a service, this plan may provide reimbursement. In those circumstances, payment under this plan will be based upon what Medicare would have paid if the service were covered. We reserve the right to make a determination of what is an eligible expense when Medicare does not provide coverage.

Medicare Part B Deductible – The amount You must pay each Calendar Year before Part B of Medicare pays benefits for Part B Medicare Eligible Expenses.

Physician - a physician as defined by Medicare.

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

You or **Your** - the Insured named on the Schedule.

COVERED BENEFITS

We will pay benefits for the following items subject to all the terms and conditions of this plan. For all of the following benefits, if you are not enrolled in Part B of Medicare, we will pay benefits as if you were enrolled and as if Medicare paid benefits. This policy will pay secondary to Medicare for Medicare Eligible Expenses incurred and remaining after Medicare has paid as primary, which result in patient responsibility on the Medicare explanation of benefits form.

Inpatient Hospital Stays - We will pay for the following benefits for covered inpatient hospital stays that begin on or after the effective date of this policy:

1. Medicare Part A inpatient hospital deductible amount per Medicare Benefit Period.

2. Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st through 90th day in any Medicare Benefit Period.

3. Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare for each Medicare Lifetime Reserve Day used.

4. Upon exhaustion of the Medicare hospital inpatient coverage, including the Lifetime Reserve Days, the Part A Medicare Eligible Expenses incurred for hospitalization, paid at the Diagnostic Related Group (DRG) outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days.

If you have enrolled in this plan within 6 months of initially becoming eligible for benefits under Medicare Part B, the requirement that your hospital stay begin on or after the effective date of this policy does not apply. In no event, however, will any benefits be paid for any period of a hospital stay that occurs prior to the effective date of this policy.

Blood – We will pay benefits under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood for equivalent quantities of packed red blood cells as defined under federal regulations unless replaced in accordance with federal regulations.

Part B Medicare Eligible Expenses – We will pay benefits for the coinsurance amount of Medicare Eligible Expenses under Part B, regardless of hospital confinement. This coverage does include payment of the coinsurance as represented on the Medicare explanation of benefits as patient responsibility. This is generally 20% since Medicare generally pays 80% of the Medicare approved charges. Services may include physician services, inpatient or outpatient medical and surgical services and supplies, physical therapy, speech therapy, diagnostic tests and durable medical equipment. Only those charges determined by Medicare to be Medicare Eligible Expenses will be covered under this policy.

Skilled Nursing Facility Stays – We will pay the coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period, for post-hospital skilled nursing facility stays eligible under Medicare Part A. Both the hospital stay and the skilled nursing stay must begin on or after the Effective Date of this policy. If you have enrolled in this plan within 6 months of initially becoming eligible for benefits under Medicare Part B, the requirement that your Hospital stay begin on or after the Effective Date does not apply.

Part B Deductible – We will pay the Medicare Part B deductible amount per Calendar Year regardless of hospital confinement.

100% of the Medicare Part B Excess Charges – We will pay the difference between the actual Medicare Part B charge as legally billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare approved Part B charge. This is known as Part B Excess.

Foreign Travel Medical Emergency Care – We will pay benefits for 80% of the billed charges for the Medicare Eligible Expenses to the extent not covered by Medicare, incurred for medically necessary emergency hospital, physician and medical care you receive outside the United States. Benefits are subject to the following limitations:

(a) Benefits are payable only for emergency care which would have been covered by Medicare if provided in the United States.

(b) Coverage is limited to care beginning during the first 60 consecutive days of each trip outside the United States.

(c) Benefits are subject to a $250.00 calendar year deductible.

(d) Benefits under this part are subject to a $50,000.00 lifetime maximum for all illnesses and injuries.

For this benefit, Emergency Care means care needed immediately because of an injury or illness of sudden and unexpected onset.

PREEXISTING CONDITION LIMITATION

Expense resulting from a preexisting condition is not covered unless it is incurred 6 months or more after the Effective Date. A preexisting condition is one for which medical advice was given or treatment was recommended by or received from a provider of health care services within 3 months before your Effective Date. 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 of your coverage under the "prior plan", the above limitation as to a preexisting condition will apply only to the excess, if any, of 6 months over the time you were covered under the "prior plan".

EXCEPTIONS AND LIMITATIONS

We will not pay for benefits for:

(a) Any stay or service for which a charge is normally not made when there is no insurance or for which you have no legal obligation to pay;
(b) Any stay or service that does not meet the Medicare program standards; all of Medicare's conditions, limitations and exclusions apply unless otherwise specifically stated within this policy;
(c) Charges in excess of Medicare Eligible Expenses. This policy will not cover expenses for services or supplies in excess of what Medicare determines or would have determined as a covered service and a Medicare Eligible Expense;
(d) expense incurred before the Effective Date;
(e) expense incurred which is paid for by Medicare or which would have been paid by Medicare had a claim for services been submitted to Medicare;
(f) Any stay, service, supply or facility provided by a hospital or other institution owned or operated by a national government, or any other government, unless payment of the charge is required by law; or
(g) Any expenses for which you are entitled to any benefits under workers' compensation or similar law.

RIGHT TO SUSPENSION AND REINSTITUTION

Benefits and premiums under your policy shall be suspended at your request for a period, not to exceed 24 months, in which you have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act (Medicaid). You must notify us within 90 days after you become entitled to such assistance.

Upon receipt of timely notice, we will return that portion of the premium for the period of time you are eligible for Medicaid. Your refunded premiums will be reduced by the amount of claims paid for the period you are eligible.

If you lose entitlement to assistance during a period of suspension, this policy will be automatically reinstituted. This will be effective that date of termination of the entitlement. You must provide us with notice of the loss of the entitlement within 90 days after the date of the loss. Upon reinstitution:

(a) there will be no additional waiting period with respect to treatment of preexisting conditions;

(b) coverage will be substantially equivalent to coverage in effect before the date of the suspension; and

(c) premiums will be classified on terms that are at least as favorable to you as the premium classification terms that would have applied to you had the coverage not been suspended.

HOW TO FILE A CLAIM

Proof of Loss - Benefits are payable when we receive satisfactory proof of loss. Proof of your loss must be furnished no later than 15 months from the date of loss , except in the absence of legal capacity.

Payment of Claims - All benefits will be paid to you or your estate as soon as we receive proof of loss. Benefits unpaid at your death will be paid to your estate. Any payment made in good faith will fully discharge us to the extent of the payment.

Medical Records – When you submit a claim, any provider who provided care may release to Us all medical information and records which relate to the claim, and We have the right to receive and review such information and records. We will treat all such information and records as confidential in accordance with applicable state and federal laws and regulations.

TERM AND TERMINATION OF COVERAGE

Term - Your coverage starts on the Effective Date at 12:01 a.m., Standard time where you live. It ends at 12:01 a.m. the same standard time, on the First Renewal Date. Each time you renew your policy by paying the premium within the 31-day grace period, the new term begins when the old term ends.

Termination of Coverage – Coverage will terminate on the earliest of the following events: (a) failure to pay premium within the grace period; (b) you become covered by another health insurance policy or subscriber contract; (c) you are eligible to be covered by Medicaid unless coverage is suspended pursuant to the terms of this policy; or (d) you cease to be a resident of Alaska. Upon ceasing to be a resident of Alaska, you coverage will remain in effect for a period covered by payments made while still a resident.

GENERAL POLICY PROVISIONS

Entire Contract; Changes - This policy, and any attachments, is the entire contract of insurance. No agent may change it in any way. Only the ACHIA Board of Directors can approve a change. Any such change must be shown in your policy.

Time Limit on Certain Defenses -Your application is part of your policy. Up to 2 years after the date your coverage if effective, misstatements in it may be used to void coverage or to deny a claim.
No claim for loss commencing after 6 months from the date of issue of your policy shall be reduced or denied on the ground that a disease or physical condition existed within 3 months prior to the effective date or coverage.

Grace Period - Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. This policy stays in force during your grace period.

Lapse and Reinstatement - Your policy will lapse if you do not pay your premium before the end of the grace period. If we later accept a premium and do not require an application for reinstatement that payment will put this policy back in force. If we require an application for reinstatement, this policy will be put back in force when we approve it. The reinstated policy only covers loss due to an injury that is received after the date of reinstatement or a sickness that begins more than 10 days after the date of reinstatement. In all other respects you and we have the same rights under this policy as were effect before it lapsed, unless special conditions are added in connection with the reinstatement. Premium accepted in connection with this provision will be used for a period for which premium has not been paid, but not for any period more than 60 days before the date of reinstatement.

Legal Actions - You can not bring a legal action to recover under your policy for at least 60 days after you have given us written proof of loss. You can not start such action more than 3 years after the date proof of loss is required.

Cessation of Medicare Coverage – If you cease to be insured under either Part A or Part B of Medicare, We will pay benefits as if you remained insured under both Part A and Part B of original Medicare.

Effect of Change of Plan – If, on the Effective Date, you have changed to a new plan from any other policy issued by Us (the prior plan), no benefits will be paid under your new plan to the extent that benefits are payable under your prior plan.

Non-Duplication of Benefits – Only one type of benefit provided in this plan is payable for any covered stay or service.