Alyeska Pipeline Service Company

Dental Standard Plan

Pre-65 Retiree Participants

9001384

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA
An Independent Licensee of the Blue Cross Blue Shield Association

HOW TO CONTACT THE CLAIMS ADMINISTRATOR

Please call or write our customer service staff for help with the following:

- Questions about the benefits of this plan
- Questions about your claims
- Questions or complaints about care or services you receive
- Change of address or other personal information

CUSTOMER SERVICE

Mailing Address:

Premera Blue Cross Blue Shield of Alaska

For Claims Only
PO Box 91059

Seattle, WA 98111-9159

Physical Address:

Premera Blue Cross Blue Shield of Alaska
3800 Centerpoint Dr., Suite 940
Anchorage, AK 99503-5825

Phone Numbers:

Local and toll-free number: 800-508-4722 (TTY: 711)

Local and toll-free TTY number for the deaf and hard hearing:

800-842-5357

WHERE TO SEND CLAIMS

Mail Your Claims To

Premera Blue Cross Blue Shield of Alaska
PO Box 91059
Seattle, WA 98111-9159

DENTAL ESTIMATE OF BENEFITS

Premera Blue Cross
Attn: Dental Review
PO Box 91059, MS 173
Seattle, WA 98111-9159

Fax 425-918-5956

COMPLAINTS AND APPEALS

Premera Blue Cross Blue Shield of Alaska
Attn: Appeals Coordinator
PO Box 91102
Seattle, WA 98111-9202

Local and toll-free number:
800-722-1471
Fax: 425-918-5592

Online information about this dental care plan is at your fingertips whenever you need it

You'll find answers to most of your questions about this plan in this benefit booklet. You also can explore our website at **premera.com** anytime you want to:

- Learn more about how to use this plan
- Locate a dental care provider near you
- Get details about the types of expenses you're responsible for and this plan's benefit maximums
- Check the status of your claims
- Visit our health-information resource to gain knowledge about diseases, illnesses, medications, treatments, nutrition, fitness and many other health topics

You also can call our customer service staff at the numbers listed above. We're happy to answer your questions and appreciate any comments you want to share. In addition, you can get benefit, eligibility and claim information through our Interactive Voice Response system when you call customer service.

Group Name:	Alyeska Pipeline Service Company
Effective Date:	March 1, 2025
Group Number:	9001384
Plan:	Alaska Dental Standard – Pre 65 Retiree Participants
Certificate Form Number:	APSC25DR

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INTRODUCTION

This booklet is for members of the Alyeska Pipeline Service Company medical plan. This plan is self-funded by Alyeska Pipeline Service Company, which means that Alyeska Pipeline Service Company is financially responsible for the payment of plan benefits. Alyeska Pipeline Service Company ("the Group") has the final discretionary authority to determine eligibility for benefits and construe the terms of the plan.

Alyeska Pipeline Service Company has contracted with Premera Blue Cross Blue Shield of Alaska (Premera), an independent licensee of the Blue Cross Blue Shield Association, to perform administrative duties under the plan, including the processing of claims. Alyeska Pipeline Service Company has delegated to Premera Blue Cross Blue Shield of Alaska the discretionary authority to determine eligibility for benefits and to construe the terms used in this plan to the extent needed to perform our duties. Premera Blue Cross Blue Shield of Alaska does not insure the benefits of this plan. In this booklet Premera Blue Cross Blue Shield of Alaska is called the "Claims Administrator." The terms "we," "us," and "our" also refer to Premera Blue Cross Blue Shield of Alaska. This booklet replaces any other benefit booklet you may have.

HOW TO USE THIS BOOKLET

This booklet will help you get the most out of your benefits. Every section contains important information, but the ones below may be particularly useful:

- **WHAT DO I NEED TO KNOW BEFORE I GET CARE?** – important information that helps you understand about the benefits of this plan
- **WHAT ARE MY DENTAL BENEFITS?** – what's covered under this plan
- **EXCLUSIONS AND LIMITATIONS** – services that are either limited or not covered under this plan
- **WHO IS ELIGIBLE FOR COVERAGE?** – eligibility requirements for this plan
- **HOW DO I FILE A CLAIM?** – step-by-step instructions for claims submissions
- **COMPLAINTS AND APPEALS** – addresses and processes to follow if file a complaint or submit an appeal
- **DEFINITIONS** – many terms that have specific meanings under this plan. Example: The terms "you" and "your" refer to members under this plan.

WHAT DO I NEED TO KNOW BEFORE I GET CARE?

The covered services under this plan are classified as Class I - Diagnostic and Preventive, Class II - Basic, and Class III - Major. The lists of services that relate to each type are outlined in the following pages under ***Description of Covered Services***. These services are covered once all of the following requirements are met. It's important to understand all of these requirements so you can make the most of your dental benefits.

Benefits are available for the services described in this section that are furnished for a covered dental condition. "Covered dental condition" means a covered member's illness, injury or disease, or a dependent child's congenital malformation. Such services must meet all of the following requirements:

- They must be dentally necessary. See definition of "***Dentally Necessary.***)
- They must not be excluded from coverage under this plan
- They must be furnished by a licensed dentist (DMD or DDS), except that they may also be furnished by a dental hygienist or other individual, performing within the scope of their license as allowed by law. These services must be rendered under the supervision and guidance of a dentist. The above providers are called "dental care providers" in this booklet.

ALTERNATIVE TREATMENT

To determine benefits available under this plan, alternative procedures or services with different fees that are consistent with acceptable standards of dental practice in consultation with the attending dental provider are utilized. In all cases where there's an alternative course of treatment that is less costly, we'll only provide benefits for the treatment with the lesser fee. If you and your dental care provider choose a more costly treatment, you're responsible for the additional charges beyond those for the less costly alternative treatment.

DENTAL ESTIMATE OF BENEFITS

A dental estimate of benefits verifies, for the dental care provider and you, your eligibility and benefits. Because we consider alternative treatment at the time we review the dental estimate, our review may result in a lower cost of treatment and additional services under this benefit. It may also clarify, before services are rendered, treatment that isn't covered in whole or in part. This can protect you from unexpected out-of-pocket expenses.

A dental estimate of benefits isn't required in order for you to receive your dental benefits. However, we suggest that your dental care provider submit a dental estimate to us for any proposed dental services you are concerned about your out-of-pocket expenses, before your course of treatment begins.

The decision to deny, reduce, or end benefits for an otherwise covered service because that service isn't dentally necessary will be made by a Premera Blue Cross Blue Shield of Alaska employee or consultant who is a licensed dentist.

PLAN YEAR DENTAL DEDUCTIBLE

Class I - Diagnostic and Preventive covered services aren't subject to a plan year dental deductible. However, a plan year dental deductible does apply to covered Class II - Basic, Class III -Major and Orthodontia services. The dental deductible is the amount you must pay for Class II - Basic, Class III -Major and Orthodontia services per plan year before benefits are payable under this plan for those services. The amount credited toward the dental deductible won't exceed the allowed amount for the covered service.

For each member, the individual dental deductible amount is $25.

This plan has a plan year dollar maximum described below. We don't count allowed amounts that apply to your individual dental deductible toward that annual dollar maximum. However, the plan also has limits on how often some Class II - Basic or Class III -Major procedures can be covered in a specific period of time. If you receive services or supplies covered by a benefit that has such a limit, we do count the procedures that apply to your individual dental deductible toward that limit.

FAMILY DENTAL DEDUCTIBLE

We also keep track of the expenses applied to the individual dental deductible that are incurred by all enrolled family members combined. When the total equals $50 we will consider the individual dental deductible of every enrolled family member to be met for the year. The $50 is called the "family dental deductible." Only the amounts used to satisfy each enrolled family member's individual dental deductible will count toward the family dental deductible.

COINSURANCE

“Coinsurance” is a defined percentage of allowed amounts for covered services you receive. The benefit percentages provided by this plan and the remaining percentage you’re responsible for are referred to as “coinsurance.”

DENTAL BENEFIT MAXIMUM

The maximum amount of dental benefits available to any one member in a plan year is $3,000.

Under this Plan, Class I - Diagnostic and Preventive Services do not accrue towards the dollar maximum amount of dental benefits available.

Covered dental services requiring multiple treatment dates are considered incurred on the date the services are completed. This is known as the seat date. Amounts paid for such procedures will be applied to the dental benefit maximum based on the incurred date.

NETWORK PROVIDERS

For the most current information on network dental care providers, please refer to our website or contact customer service. You'll find this information on the inside front cover of this booklet.

This plan is designed to cover all dental care providers at the same benefit level. When you receive services from network providers, your claims will be submitted directly to us, and available benefits will be paid directly to the dental care provider. Network providers agree to accept our "allowed amount" (see ***Definitions***) as payment in full. You’re responsible only for any applicable plan year deductible, coinsurance, amounts that are in excess of stated benefit maximums, and charges for non-covered services.

Note: We will notify you at least 30 days prior to your provider’s termination date. When a termination for cause provides us less than 30 days’ notice, we will make a good faith effort to assure that a written notice is provided to you immediately.

Important Note: You're entitled to receive a provider directory automatically, without charge.

NON-NETWORK PROVIDERS

If you do not have access to a network provider within 50 miles of your home or decide not to use a network provider, you may choose any dental care provider. Your dental services will be paid at the same benefit level as network providers. However, if you receive services from non-network dental care providers, you’re responsible for amounts above the allowed amount in addition to any applicable plan year deductible, coinsurance, amounts that are in excess of stated benefit maximums, and charges for non-covered services. Amounts that are in excess of the allowed amount don’t accrue toward your plan year deductible if one applies.

You may be required to submit the dental claim yourself if your dental care provider doesn’t do this for you. See ***How Do I File A Claim?*** for instructions on submitting claims for reimbursement.

WHAT ARE MY DENTAL BENEFITS?

WHAT DO I PAY FOR COVERED SERVICES?

After you satisfy the required plan year deductible, you pay the following coinsurance per plan year, up to the dental benefit maximum. Dental services fall into 3 categories: Class I - Diagnostic and Preventive, Class II - Basic, Class III - Major and Implant services. **Note:** Diagnostic and preventive services do not accrue to dental benefit maximum.

In this section you'll find a description of the services included in each category.

- Class I - Diagnostic and Preventive Services....0%
- Class II – Basic Services 20%
- Class III – Major Services.....30%
- Class IV – Implants and all Implant Related Services 30%

DESCRIPTION OF COVERED SERVICES

Class I - Diagnostic And Preventive Services

- Routine comprehensive and periodic oral examinations are limited to two per plan year. Professional consultations, periodontal evaluations and other office visits apply to this limit
- Prophylaxis (cleaning of teeth) is limited to two per plan year
- Topical application of fluoride is covered for members under the age of 20, and is limited to two treatments per plan year
- Dental x-rays include:
  - Bitewing x-rays
  - Either a panoramic x-ray or comparable cone beam or a complete full mouth series of x-rays, once every 36 consecutive months
  - Periapical x-rays
  - Occlusal x-rays
- Sealants, for members under the age of 20, on permanent molars only. Replacements limited to once every 24 consecutive months
- Oral pathology laboratory services, not including the removal of tissue sample, are covered when directly related to teeth and gums.
- Space maintainers
- Problem focused (including emergency) oral evaluations and re-evaluations are limited to two per plan year. See the definitions of ***Dental Emergency***.

Class II - Basic Services

- Simple extractions
- Therapeutic drug injections administered in a dental office
- Application of desensitizing medicament or resin
- Fillings, consisting of amalgam and composite resins on any given tooth surface are covered once in any 24 consecutive months.
- Prefabricated stainless steel, porcelain, ceramic, resin or other esthetic coated stainless steel crowns are limited to once per tooth every 24 consecutive months
- Protective restorations (sedative fillings)
- Repair or recement of inlays, onlays, crowns, bridgework and dentures are covered when services are performed done 6 or more months after initial placement
- Periodontal maintenance, as a follow-up to active periodontal treatment, is limited to 4 treatments per plan year.
- Surgical extractions of erupted or impacted teeth and removal of residual tooth roots
- Limited occlusal adjustments are limited to once every 12 consecutive months as dentally necessary
- Emergency palliative treatment. We require a written description and/or office records of services provided.
- Oral surgery related to the tooth and gum includes:
  - Oral excision of soft tissue or bone
  - Oral excision of intra-osseous lesions
  - Oral surgical incision
  - Alveoplasty or vestibuloplasty
- Anesthesia in a dental care provider's office, when dentally necessary. This benefit includes:
  - General or intravenous anesthesia in a dental care provider's office, when dentally necessary
  - Regional or terminal block anesthesia
  - Nitrous oxide
- Occlusal guard (nightguard) is limited to once every 36 consecutive months. Occlusal guard repair, reline and adjustments are limited to once every 12 consecutive months when services are performed done 6 or more months after initial placement of occlusal guard.

- Periodontal surgery is covered in the same quadrant once every 36 consecutive months
- Periodontal soft tissue grafts are covered in the same quadrant once every 26 consecutive months
- Non-surgical periodontal services of the gums and supporting structures include:
  - Periodontal scaling and root planing is limited to once per quadrant every 24 consecutive months
  - Full mouth debridement is limited to once every 36 consecutive months
  - Localized delivery of antimicrobial agents, subject to review
- Endodontic services of teeth with diseased or damaged nerves include:
  - Direct pulp cap
  - Pulpotomy
  - Endodontic (root canal) treatment is limited to once per tooth in a 2 plan year period: every 24 consecutive months
  - Retreatment of a root canal when services are done at least 12 months after the original procedure when performed by a different dental office
  - Open and drain (open and broach) (open and medicate) procedures may be limited to a combined allowance based on our review of the services rendered
  - Apexification, apicoectomy, periradicular surgery, and retrograde filling

Class III - Major Services

- Inlays, onlays, crowns and labial veneers for a tooth that is decayed, fractured or where there is significant loss of clinical crown and no other dentally appropriate restoration will restore the teeth
- Labial veneers are limited to anterior teeth and subject to review for dental necessity. Labial veneers are often considered cosmetic and not covered by this dental plan. For this reason, a dental estimate of your benefits is strongly recommended.
- Initial placement of a fixed bridge or denture. Replacement is limited to:
  - Once every 5 plan years from the original seat date and only if it is unserviceable and cannot be made serviceable
  - The replacement or addition of teeth is required to replace 1 or more additional teeth extracted after initial placement
- Reline, rebase and adjustments of dentures are covered when services are done 6 or more months after denture installation.
- Crown build-ups or post and cores for covered crowns
- Precision attachments

Class IV - Implants And Implant Related Services

Benefits are provided for implants and ALL implant related services.

Note: Covered services including implant abutment and/or crowns over the implants are covered only once in a 5 consecutive year period (5 years from the date of the installation of the prosthetic service).

High Risk Conditions

Additional dental coverage described in this section is provided when services or supplies listed in another benefit of this plan are performed in the treatment of the following high-risk conditions that may have a significant impact to your oral health:

- Cardiovascular disease
- Chronic obstructive pulmonary disease
- Diabetes
- Oral Cancer
- Pregnancy

These services are covered:

- One additional periodic oral evaluation or comprehensive oral evaluation or comprehensive periodontal evaluation per plan year

- One additional prophylaxis (cleaning) or periodontal maintenance per plan year
- One additional topical application of fluoride applied in the dental office per plan year

Note: When submitting a dental claim for this benefit, please be sure your dentist submits an appropriate diagnosis code on the dental claim form. Please go to https://www.cdc.gov/oralhealth/conditions/index.html for more information about the association of oral health and these high risk conditions.

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

- Study Models
- Photographic images
- Plaque control programs (oral hygiene instruction, dietary instruction and home fluoride kits)
- Duplicate appliances
- Cleaning of appliances
- Complete occlusal adjustment
- Periodontal splinting and/or crown and bridgework in conjunction with periodontal splinting
- Crowns and copings in conjunction with an overdenture
- Indirect pulp caps

Dental Care Services For Accidental Injuries

When services are related to accidental injuries benefits are available for Class II - Basic and Class III - Major services as follows:

Repreparation or repair of the natural tooth structure when it's required as a result of an accidental injury to that structure, and such repair is performed within 12 months of the accidental injury.

These services are only covered when they are:

- Necessary as a result of an accidental injury;
- Performed within the scope of the provider's license;
- Not required due to damage from biting or chewing;
- Performed within 12 months of the accident causing the injury; and
- Rendered on natural teeth that were free from decay and otherwise functionally sound at the time of the injury. "Functionally sound" means that the affected teeth:
  - Don't have extensive restoration, veneers, crowns or splints; or
  - Don't have periodontal disease or other condition that would cause the tooth to be in a weakened state prior to the injury.

Note: An accidental injury doesn't cover damage caused by biting or chewing, even if due to a foreign object in food.

If you have a medical plan with Premera Blue Cross Blue Shield of Alaska, benefits for dental care services related to an accidental injury are covered under the Dental Services benefits of the medical plan.

Extension Requests For Accidental Injury Services

If necessary services can't be completed within 12 months of an accidental injury, coverage may be extended if your dental care meets our extension criteria. We must receive extension requests within 12 months of the accidental injury date.

ORTHODONTIA

Covered Services And Supplies

Covered orthodontic services and supplies include only the following:

- Diagnostic services and supplies, including examinations, x-rays, models, and photographs
- Active treatment, including initial and subsequent necessary appliances
- Retention treatment, including necessary appliances

We reserve the right to review your dental records, including x-rays, models, and photographs, to determine if the requested services and supplies are within the limits of this benefit.

Benefits are available for the services and supplies described in this section subject to the following requirements:

- An existing orthodontic condition must be diagnosed as consisting of a handicapping malocclusion which is abnormal and which can be reduced or eliminated by correcting abnormally positioned teeth
- An expense for an orthodontic service or supply is incurred on the date the service is received or the supply is ordered

Any plan year deductibles and coinsurance of other benefits under this plan don't apply toward this benefit.

Benefits

After you satisfy the required plan year deductible, the plan pays 50% of allowable charges, up to the lifetime benefit maximum of $2,000 for each member, or until the member's total treatment plan, including retention treatment is paid, whichever occurs first.

In addition to ***Exclusions and Limitations*** this benefit doesn’t cover any of the following:

- Any replacement or repair to any appliance
- Charges beyond the month of termination of orthodontic services if such services are terminated for any reason before completion
- Further orthodontic services and supplies, after completion of the initial treatment plan, unless this benefit's lifetime maximum hasn't been reached
- Expenses incurred for orthodontic services or supplies when this benefit isn't in effect or when you're not covered under this benefit

EXCLUSIONS AND LIMITATIONS

In addition to services listed as not covered under ***Description of Covered Services***, this section lists the services that are either limited or not covered by this plan.

Amounts Over the Allowed Amount

Costs over the allowed amount as defined by this plan, for non-emergency services from a non-network, non-participating, or non-contracted provider.

Benefits from other sources

Services that are covered by other types of insurance or coverage, such as:

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

Benefits that have been exhausted

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

Broken or missed appointments

Case Management

Case management, presentation, or extensive treatment planning.

Charges for records or reports

Charges from providers for supplying records or reports not requested for utilization management.

Cleaning and inspection of appliance

Services to clean and inspect appliances such as complete and partial dentures.

Comfort or convenience items

- Personal services or items like meals for guests while hospitalized, long-distance phone, radio or TV, personal grooming and babysitting.
- Normal living needs, such as food, clothes, housekeeping and transport. This doesn't apply to chores done by a home health aide as prescribed in your treatment plan.
- Dietary assistance, including "Meals on Wheels"

Complications of a non-covered service

Includes follow-up services or effects of those services.

Cosmetic Services

- Drugs, services, or supplies for cosmetic services, including enamel microbrasion, odontoplasty, and bleaching of teeth
- Treatment of congenital malformations, except when the patient is an eligible dependent child
- This includes services performed to reshape normal structures of the body in order to improve or alter your appearance and not primarily to restore an impaired function of the body.
- Services and supplies rendered for cosmetic or aesthetic purposes, including any direct or indirect complications and aftereffects thereof, except as specified in the Orthodontia benefit

Counseling, Education or Training

Counseling education, or training in the absence of illness, injury, including but not limited to:

- Job help and outreach,
- Social or fitness counseling
- Acting as a tutor, helping a member with schoolwork, acting as an educational or other aide for a member while the member is at school, or providing services that are part of a school's individual education program or should otherwise be provided by school staff
- Private school or boarding school tuition
- Community wellness or a safety program

Counseling, Oral

Oral counseling, education or training, including:

- Nutritional counseling for control of dental disease
- Tobacco counseling for the control and prevention of oral diseases
- Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use disorder

Court-Ordered Services

Services that you must get to avoid being tried, sentenced or losing the right to drive when they are not medically or dentally necessary.

Dental Services Received From a:

- Dental or medical department maintained for employees by or on behalf of an employer; or
- Mutual benefit association, labor union, trustee or similar person or group

Dietary Services

Dietary planning or nutritional counseling for the control of dental caries, oral hygiene instruction and training in preventive dental care.

Experimental or Investigational Services

Experimental or investigational services or supplies, including any complications or effects of such services.

This does not apply to certain services that are part of an approved clinical trial.

Extra Or Replacement Items

- Extra dentures or other appliances, including replacements due to loss or theft

- Replacement of amalgam or resin-based composite fillings due to mercury or other allergic reactions

Facility Charges

Hospital and ambulatory surgical center care for dental procedures.

Family Members Or Volunteers

Services or supplies that you provide to yourself. It also doesn't cover a provider who is:

- Your spouse, mother, father, child, brother or sister
- Your mother, father, child, brother or sister by marriage
- Your stepmother, stepfather, stepchild, stepbrother or stepsister
- Your grandmother, grandfather, grandchild or their spouse
- A volunteer

Genetic or Caries Risk and Susceptibility Tests

Government Facilities

Services provided by a state or federal facility that are not emergency services or required by law or regulation.

Home-Use Products

Services and supplies that are normally intended for home use such as take home fluoride, toothbrushes, floss and toothpaste.

Home Visits

Dental visits or procedures received in a member's home.

Illegal Acts, Illegal Services, and Terrorism

Illness or injury you get while committing a felony, an act of terrorism, or an act of riot or revolt, as well as any service that is illegal under state or federal law.

Increase Of Vertical Dimension

Any service to increase or alter the vertical dimension.

Magnetic Resonance Imaging (MRI) and Ultrasounds

Maxillofacial Prosthetics

This plan does not cover maxillofacial prosthetics, this includes but is not limited to artificial replacement of the ear, nose, eyes, or other areas of the face.

Military Service and War

Illness or injury that is caused by or arises from:

- Acts of war, such as armed invasion, no matter if war has been declared or not
- Services in the armed forces of any country, including any related civilian forces or units.

Multiple Providers

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

Non-Covered Services

Services or supplies directly related to any non-covered condition.

- Ordered when this plan is not in effect or when the person is not covered under this plan.
- Provided to someone other than the ill or injured member.
- That are not listed as covered under this plan.
- Services and supplies for which no charge is made, for which none would have been made if this plan were not in effect, or for which you are not legally required to pay.
- Non-treatment charges, including charges for provider time.
- Transporting a member in place of a parent or other family member or accompanying the member to appointments or other activities outside the home, such as medical appointments or shopping.

- Doing housework or chores for the member or helping the member do housework or chores.

Non-Standard Techniques

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

Non-Treatment Facilities, Institutions or Programs

- Institutional care
- Housing
- Incarceration
- Programs from facilities that are not licensed to provide treatment for covered conditions. Examples are prisons, nursing homes and juvenile detention facilities.

Not Covered Under This Plan

- Services that are not listed in this booklet as covered or that are directly related to any condition, service or supply that isn't covered under this plan
- Services received or ordered when this plan isn't in effect, or when you aren't covered under this plan (including services and supplies started before your effective date or after the date coverage ends), except for Class III - Major services and root canals that:
  - Were started after your effective date and before the date your coverage ended under this plan; and
  - Were completed within 90 days after the date your coverage ended under this plan

Orthodontia Services

Orthodontia, except as specified under ***Orthodontia*** in ***What Are My Dental Benefits?***.

Orthognathic Surgery (Jaw Augmentation or Reduction)

Procedures to lengthen or shorten the jaw for cosmetic services not medically necessary. This includes services performed to reshape normal structures of the body in order to improve or alter your appearance and not primarily to restore an impaired function of the body. This does not apply to services that are determined to be medically necessary.

Prescription Drugs

Any prescription drugs or medicines, including drugs or medicines dispensed in the office for home use. This includes vitamins, food supplements, oral antibiotics, oral analgesics, fluoride and patient management drugs, such as premedication and sedation.

Provider's Licensing or Certification

Services that are outside the scope of the provider's license or certification or any unlicensed or uncertified providers**.**

Serious Adverse Events and Never Events

Serious Adverse Events are hospital injury(ies) caused by medical management that prolonged the hospitalization, and/or produces a disability at the time of discharge.

Never Events are events that should never occur, such as a surgery on the wrong patient, surgery on the wrong body part or a wrong surgery.

Members and this plan are not responsible for payment of services provided by providers for serious adverse events, never events and resulting follow-up care. Serious adverse events and never events are medical errors that are specific to a nationally published list. They are identified by specific diagnoses codes, procedure codes and specific present-on-admission indicator codes. Providers may not bill members for these services and members are held harmless.

Not all medical errors are defined as serious adverse events or never events. You can obtain a list of serious adverse events by contacting us or on the Center for Medicare and Medicaid Services (CMS) website.

Services or Supplies Not Dentally Necessary

Services or Supplies Not Medically Necessary

Services or supplies that are not medically necessary even if they're court-ordered. This also includes places of service, such as inpatient hospital care or stays.

Sleep Apnea

Services or supply for sleep apnea including sleep apnea appliance fabrication placement, adjustment, or repair

Temporary, Interim or Provisional Services

Temporary, interim or provisional services for crowns, bridges or dentures

Temporomandibular Joint (TMJ) Disorders

Treatment of TMJ disorders. TMJ disorders are problems with the lower jaw joint that have one or more of the features below:

- Pain in the muscles near the TMJ
- Internal derangements of the parts of the TMJ
- Arthritic problems with the TMJ
- The TMJ has a limited range of motion, or its range of motion is not normal

Testing And Treatment Services

Testing and treatment for mercury sensitivity or allergy-related

Work-Related Illness or Injury

Any illness or injury for which you get benefits under:

- Separate coverage for injuries on the job
- Worker's compensation laws
- Any other law that would repay you for an illness or injury you get on the job

However, this exclusion doesn't apply to sole proprietors, partners or executive officers who are full-time employees of the Group if they're exempt from the above laws and if the Group doesn't furnish them with workers' compensation coverage. They'll be covered under this plan for conditions arising solely from their occupations with the Group. Coverage is subject to the other terms and limitations of this plan.

WHAT IF I HAVE OTHER COVERAGE?

COORDINATING BENEFITS WITH OTHER DENTAL CARE PLANS

You may be covered under one or more other group or individual plans, such as one sponsored by your spouse's employer. This plan includes a "coordination of benefits" feature to handle such situations.

All of the benefits of this plan are subject to coordination of benefits. However, please note that benefits provided under this plan for allowable dental expenses will be coordinated separately from allowable medical expenses.

If you have other coverage besides this plan, we recommend that you submit your claim to the primary carrier first, then submit the claim to the secondary carrier with the primary carrier processing information. In that way, the proper coordinated benefits may be most quickly determined and paid.

If you are a member of the U.S. Military (active or retired) or you have dependents enrolled in the TRICARE program, this plan is the primary plan and TRICARE would be secondary, when required by federal law.

Definitions Applicable To Coordination Of Benefits

To understand coordination of benefits, it's important to know the meanings of the following terms:

- **Allowable Medical Expense** means the usual, customary and reasonable charge for any medically necessary health care service or supply provided by a licensed medical professional when the service or supply is covered at least in part under this plan. When a plan provides benefits in the form of services or supplies rather than

cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense.

- **Allowable Dental Expense** means the usual, customary and reasonable charge for any dentally necessary service or supply provided by a licensed dental professional when the service or supply is covered at least in part under this plan. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense.
- **Medical Plan** means all of the following health care coverages, even if they don't have their own coordination provisions:
  - Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization group or individual agreements issued by insurers, health care service contractors, and health maintenance organizations
  - Labor-management trusteed plans, labor organization plans, employer organization plans or employee benefit organization plans
  - Government programs that provide benefits for their own civilian employees or their dependents
  - Group coverage required or provided by any law, including Medicare. This doesn't include workers' compensation.
  - Group student coverage that's sponsored by a school or other educational institution and includes medical benefits for illness or disease
- **Dental Plan** means all of the following dental care coverages, even if they don't have their own coordination provisions:
  - Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization group or individual agreements issued by insurers, health care service contractors, and health maintenance organizations
  - Labor-management trusteed plans, labor organization plans, employer organization plans or employee benefit organization plans
  - Government programs that provide benefits for their own civilian employees or their dependents

Each contract or other arrangement for coverage described above is a separate plan. It's also important to note that for the purpose of this plan, we'll coordinate benefits for allowable medical expenses separately from allowable dental expenses, as separate plans.

Effect On Benefits

An important part of coordinating benefits is determining the order in which the plans provide benefits. One plan is responsible for providing benefits first. This is called the "primary" plan. The primary plan provides its full benefits as if there were no other plans involved. The other plans then become "secondary." When this plan is secondary, it will reduce its benefits for each claim so that the benefits from all medical plans aren't more than the allowable medical expense for that claim and the benefits from all dental plans aren't more than the allowable dental expense for that claim. Coordination of benefits applies only on a per-claim basis, and is not cumulative.

We will coordinate benefits when you have other health care coverage that is primary over this plan. Coordination of benefits applies whether or not a claim is filed with the primary coverage.

Here is the order in which the plans should provide benefits:

First: A plan that doesn't provide for coordination of benefits.

Next: A plan that covers you as **other than** a dependent.

Next: A plan that covers you as a dependent. For dependent children, the following rules apply:

When the parents **aren't** separated or divorced: The plan of the parent whose birthday falls earlier in the year will be primary, if that's in accord with the coordination of benefits provisions of both plans. Otherwise, the rule set forth in the plan that doesn't have this provision shall determine the order of benefits.

When the parents **are** separated or divorced: If a court decree makes one parent responsible for paying the child's health care costs, that parent's plan will be primary. Otherwise, the plan of the parent with custody will be primary, followed by the plan of the spouse of the parent with custody, followed by the plan of the parent who doesn't have custody.

If the rules above don't apply, the plan that has covered you for the longest time will be primary, except that benefits of a plan that covers you as a laid-off or retired employee, or as the dependent of such an employee, shall be determined after the benefits of any plan that covers you as other than a laid-off or retired employee, or as the dependent of such an employee. However, this applies only when other plans involved have this provision regarding laid-off or retired employees.

If none of the rules above determine the order of benefits, the plan that's covered the employee or subscriber for the longest time will be primary.

Right Of Recovery/Facility Of Payment

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

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

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

COORDINATING BENEFITS WITH MEDICARE

If you're also covered under Medicare, federal law may require this plan to be primary over Medicare. When this plan isn't primary, we'll coordinate benefits with Medicare.

THIRD PARTY RECOVERY

General

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

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

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

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

Definitions The following definitions shall apply to this section:

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

insurance, medical payments coverage from any source, or workers' compensation coverage. The third party may not be the actual party who caused the injury, and may include an insurer.

Note: For this section, a third party does not include other health care plans that cover you.

- **You** In this section, "you" includes any lawyer, guardian, or other representative that is acting on your behalf or on the behalf of your estate in pursuing a repayment from responsible third parties.

Exclusions

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

However, this exclusion doesn't apply to owners, partners or executive officers who are full-time employees of the Group if they're exempt from the above laws and if the Group doesn't furnish them with workers' compensation coverage. They'll be covered under this plan for conditions arising solely from their occupations with the Group. Coverage is subject to the other terms and limitations of this plan.

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

Reimbursement and Subrogation Rights

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

- The plan has the right to be repaid first and in full, without regard to lawyers' fees or legal expenses, make-whole doctrine, the common fund doctrine, your negligence or fault, or any other common law doctrine or state statute that the plan is not required to comply with that would restrict the plan's right to reimbursement in full. The reimbursement to the plan shall be made directly from the responsible third party or from you, your lawyer or your estate.
  - The plan shall also be entitled to reimbursement by asking for refunds from providers for the claims that it had already paid.
- The plan's right to reimbursement first and in full shall apply even if:
  - The recovery is not enough to make you whole for your injury.
  - The funds have been commingled with other assets. The plan may recover from any available funds without the need to trace the source of the funds.
  - The member has died as a result of the injury and a representative is asserting a wrongful death or survivor claim against the third party.
  - The member is a minor, disabled person, or is not able to understand or make decisions.
  - The member did not make a claim for medical expenses as part of any claim or demand

- Any party who distributes your recovery funds without regard to the plan's rights will be personally liable to the plan for those funds.
- In any case where the plan has the right to be repaid, the plan also has the right of subrogation. This means that the Plan Administrator can choose to take over your right to receive payments from any responsible third party. For example, the plan can file its own lawsuit against a responsible third party. If this happens, you must co-operate with the plan as it pursues its claim.

  The plan shall also have the right to join or intervene in your suit or claim against a responsible third party.
- You cannot assign any rights or causes of action that you might have against a third party tortfeasor, person, or entity, which would grant you the right to any recovery without the express, prior written consent of the plan.

Your Responsibilities

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

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

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

Reimbursement and Subrogation Procedures

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

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

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

WHO IS ELIGIBLE FOR COVERAGE?

RETIREE ELIGIBILITY

"Retiree" means a former Employee who:

- Has terminated employment with the Company (other than by reason of such former Employee's gross misconduct); and
- Prior to January 1, 2017, earned at least 10 years of Benefit Service and has reached age 55 or older; or
- On and after January 1, 2017, has at the time of termination of employment at least 15 years of Benefit Service and has reached age 60 or older; or
- Met the eligibility requirements established under the Alyeska Pipeline Separation Benefit Plan and SPD; and
- Is enrolled in the Employee Plan as of the date immediately preceding his or her termination of employment.

Enrollment for a "Retiree" and/or eligible dependents is performed by the Alyeska's Cobra Administrators under directly of Alyeska Compensation and Benefits. Coverage is effective on the first of the month following the date of employment termination. Payment for premium is required to Alyeska's Cobra Administrators.

A Retiree, if participating in the Dental plan for employees of Alyeska at the time of retirement, may choose to participate in the Dental plan. The decision to participate or not participate in the Dental Plan is irrevocable. If you decide to participate, you must enroll within 60 days from the date your employment with Alyeska terminates. You may terminate your Dental Plan coverage at any time; however, you cannot re-enter the plans.

The Plan is frozen to new Participants effective January 1, 2021. Employees hired or rehired (and not previously retired) on or after January 1, 2021 are not eligible to participate in the Plan.

DEPENDENT ELIGIBILITY

For the purposes of the Dental plan, an "eligible dependent" is defined as one of the following.

- A Retiree's Spouse who is under age 65;
- A married or unmarried natural or adopted child or stepchild until the child is age 26;
- A child, who pursuant to a Qualified Medical Child Support Order, must be recognized as a Dependent for the purpose of providing health coverage
- A legal dependent for whom the retiree plan participant has a legal guardianship.

Coverage under a QCMSO will become effective on the date of the order, if the enrollment information is completed within 60 days of the date of the QCMSO. Otherwise coverage will become effective on the date the enrollment form is received. The enrollment form may be submitted by the Retiree, custodial parent, or a state agency. If Dependent coverage was absent to the Retiree prior to the QCMSO, Retiree contributions for coverage will begin from the child's effective date.

Dependent coverage takes effect on the same date Retiree coverage becomes effective provided you have enrolled for Dependent and Retiree coverage. If your Dependent is otherwise eligible but is not enrolled in the Medical Plan within 30 days of your coverage effective date, your Dependent may only enroll if you have a "life event". Eligible Dependent will have the offer of coverage if the employee has met the requirements of Retiree and dies as either an active employee or as a Retiree.

If your Dependent, such as a Spouse, is also a Retiree of Alyeska, you may list them as an eligible Dependent when selecting coverage. A Spouse may also remain as a separate plan participant if he wishes.

ADDING/DROPPING DEPENDENTS

When you enroll in the Dental plan, you may enroll your Dependents. You may make changes to your elections only if you have a "life event."

Life events include:

- **Birth, adoption, marriage, divorce, death or loss of Dependent coverage.** In these cases, you may add or drop a Dependent's coverage within 30 days of the date he or she becomes eligible. Newborns are covered automatically for 30 days. To continue their coverage, you must enroll them within 30 days of birth.
- **Spouse and eligible child/children loses coverage under the plan.** In this case, you may add your spouse and eligible child/children to the Dental Plan. You may add your spouse and eligible child/children within 30 days of the first day he or she is eligible.

If you are **adding** a dependent, complete the appropriate enrollment form by contacting Alyeska's Cobra Administrator (see below).

If you are **dropping** coverage for yourself or a dependent you must contact Alyeska's Cobra Administrator.

Alyeska's Cobra Administrator:
Peak1 Administrator
1-877-404-9443

WHEN DOES COVERAGE BEGIN?

ENROLLMENT

Enrollment is effective the first of the month following the date of employment termination for those eligible as defined "retiree" or "eligible dependent" earlier in this section. For other enrollment see ***Open Enrollment*** and ***Special Enrollment.***

Dependents Acquired Through Marriage After The Subscriber's Effective Date

When Alyeska Pipeline Service Company receives the completed enrollment form within 30 days after the marriage, coverage will become effective on the date of marriage. If Alyeska Pipeline Service Company does not receive the enrollment form within 30 days of marriage, refer to ***Open Enrollment*** section.

Newborn And Adoptive Children

Natural newborn dependent children born on or after the subscriber's effective date will be covered from their date of birth. If the subscriber desires coverage of the newborn child to extend beyond the 30-day period following the newborn child's date of birth, Alyeska Pipeline Service Company must receive a completed enrollment form within the 30-day period following the date of birth.

Adoptive dependent children, including children acquired through legal guardianship, who are adopted or placed for adoption on or after the subscriber's effective date will be covered from their date of adoption or placement for adoption. Alyeska Pipeline Service Company must receive a completed enrollment form within the 30-day period following the dependent child's date of adoption or placement for adoption.

If Alyeska Pipeline Service Company does not receive the enrollment form within the 30-day period, initial coverage will be limited to the 30-day period referenced above. The child may then be enrolled at a later date, subject to the ***Open Enrollment*** provisions described later in this section.

Children Acquired Through Legal Guardianship

When we receive the completed enrollment application, any required premiums, and a copy of the guardianship papers within 60 days of the date legal guardianship began with the subscriber, coverage for an otherwise eligible child will begin on the date legal guardianship began. When the enrollment application isn't received by us within 60 days of the date legal guardianship began, refer to ***Open Enrollment*** below.

If the Group does not receive the Health Plans Form within the 30-day period, initial coverage will be limited to the 30-day period referenced above. The child may then be enrolled at a later date, subject to the ***Open Enrollment*** provisions described later in this section.

Children Covered Under Medical Child Support Orders

When Alyeska Pipeline Service Company receives the completed enrollment form within 30 days of the date of the medical child support order, coverage for an otherwise eligible child that is required under the order will become effective on the date of the order. Otherwise, coverage will become effective on the date Alyeska Pipeline Service Company receives the enrollment form for coverage. When premiums being paid don't already include coverage for dependent children, such charges will begin from the child's effective date. Please contact your Group for detailed procedures.

Court-Ordered Dependent Coverage

When Alyeska Pipeline Service Company receives the completed enrollment form within 30 days of the date of the court order, coverage for a lawful spouse and/or dependent children will become effective on the date of the order. Otherwise, coverage will become effective when Alyeska Pipeline Service Company receives the enrollment form for coverage. When premiums being paid don't already include coverage for a spouse and/or dependent children, such charges will begin from the dependent's effective date.

SPECIAL ENROLLMENT

Involuntary Loss Of Other Coverage

If an retiree and/or dependent doesn't enroll in this plan or another plan sponsored by Alyeska Pipeline Service Company when first eligible because they aren't required to do so, that retiree and/or dependent may later enroll in this plan outside of the annual open enrollment period if each of the following requirements is met:

- The retiree and/or dependent were covered under group health coverage or a health insurance program at the time coverage under Alyeska Pipeline Service Company 's plan is offered
- The retiree and/or dependent's coverage under the other group health coverage or health insurance program ended as a result of one of the following:
  - Loss of eligibility for coverage (including, but not limited to, the result of legal separation, divorce, death, termination of employment, or the reduction in the number of hours of employment)
  - Termination of employer contributions toward such coverage
  - The retiree and/or dependent were covered under COBRA at the time coverage under this plan was previously offered and COBRA coverage has been exhausted.

An eligible retiree who qualifies as stated above may also enroll all eligible dependents. When only an eligible dependent qualifies for special enrollment, but the eligible retiree is not enrolled in any of Alyeska Pipeline Service Company's plans or is enrolled in a different plan sponsored by Alyeska Pipeline Service Company, the retiree is also allowed to enroll in this plan in order for the dependent to enroll.

When Alyeska Pipeline Service Company receives your and/or dependent's completed enrollment form and any premiums within 30 days of the date such other coverage ended, coverage under this plan will become effective on the first of the month following receipt of your enrollment form.

When Alyeska Pipeline Service Company does not receive your completed enrollment form within 30 days of the date prior coverage ended, refer to ***Open Enrollment***.

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

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

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

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

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

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

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

If we don’t receive the enrollment application within the 60-day period as outlined above, you will not be able to enroll until the next open enrollment period. Please refer to ***Open Enrollment*** below.

OPEN ENROLLMENT

If you're not enrolled when you first become eligible, or as allowed under ***Special Enrollment***, you cannot be enrolled until Alyeska Pipeline Service Company's next "open enrollment" period. An open enrollment period occurs once a year unless otherwise set by Alyeska Pipeline Service Company. During this period, eligible retirees can enroll or drop their dependent’s coverage under this plan.

CHANGES IN COVERAGE

Alyeska Pipeline Service Company may change its terms, benefits, and limitations at any time. Changes to this plan will apply as of the date the change becomes effective to all members and to eligible retirees and dependents who become covered under this plan after the date the change becomes effective.

The exception is inpatient confinements described in ***Extended Benefits*** under ***How Do I Continue Coverage***. Changes to this plan won't apply to inpatient stays which are covered under that provision.

PLAN TRANSFERS

Subscribers (with their enrolled dependents) may be allowed to transfer to this plan from another plan offered by Alyeska Pipeline Service Company. Transfers also occur if Alyeska Pipeline Service Company replaces another plan with this plan. All transfers to this plan must occur during open enrollment or on another date set by Alyeska Pipeline Service Company.

When you transfer from Alyeska Pipeline Service Company's other plan, and there's no lapse in your coverage, the following provisions that apply to this plan will be reduced to the extent they were satisfied and/or credited under the prior plan:

- Out-of-pocket maximum
- Benefit maximums

In the event an retiree enrolls for coverage under a different group health care plan also offered by Alyeska Pipeline Service Company, enrollment for coverage under this plan can only be made during Alyeska Pipeline Service Company 's next open enrollment period.

WHEN WILL MY COVERAGE END?

EVENTS THAT END COVERAGE

Coverage will end without notice, except as specified under "Extended Benefits," on the last day of the month in which one of these events occurs:

- You are no longer a Retiree;
- You stop making required contributions;
- You die or;
- The Dental Plan ends; or
- For fraud or intentional misrepresentation of material fact under the terms of the coverage by the subscriber or the subscriber's dependents.

Your Dependent's coverage will stop on the last day of the month if:

- Your coverage ends; or
- Your Dependent is no longer eligible (e.g., divorce, age limitations).

Under certain circumstances, you or your Dependents may continue coverage beyond the time when it would normally end. See "Extension of Coverage" (COBRA) in this SPD for more information.

The subscriber must promptly notify Alyeska Pipeline Service Company when an enrolled family member is no longer eligible to be enrolled as a dependent under this plan.

Note: Effective July 1, 2014, once a retiree or their spouse reaches the age of 65, that person will no longer be eligible for coverage. Coverage will end the last day of the month prior to their 65th birthday. When the retiree or spouse's 65th birthday is on the first of the month, coverage will end on the day prior to that person's Medicare eligible start date due to age. Contact Alyeska Pipeline Service Company for more information on the Retiree Medicare Eligible Reimbursement Health Plan available for the retiree or spouse at age 65.

PLAN TERMINATION

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

HOW DO I CONTINUE COVERAGE?

CONTINUED ELIGIBILITY FOR A DISABLED CHILD

Generally, disabled dependent children will be permitted to receive coverage under the Plan until the disabled dependent child attains age 26. However, unmarried children who are dependent on the Retiree-Plan Participant for support due to a mental or a physical disability, became disabled prior to attaining age 26 and the date that

coverage under the Plan would otherwise terminate, is incapacitated or incapable of self-sustaining employment, was covered under the Plan as a disabled dependent child after attaining age 26 but prior to May 1, 2023, and receives disability-based Medicare coverage as of May 1, 2023, may receive coverage under the Plan after attaining age 26.

However, a child who was covered under the Plan as a disabled dependent child after attaining age 26 but prior to May 1, 2023 and who does not receive disability-based Medicare coverage by May 1, 2023 will be permitted to continue to receive coverage under the Plan if the child: (a) is entitled to Social Security disability benefits by May 1, 2023; and (b) receives disability-based Medicare coverage by May 1, 2025.

Such coverage for disabled dependent children who have attained age 26 will terminate after the first of the following occurs:

- May 1, 2023 if the disabled dependent child does not receive Social Security disability benefits by May 1, 2023;
- May 1, 2025 if the disabled depending child does not receive disability-based Medicare coverage by May 1, 2025;
- The date that the Retiree dies;
- The date that the Retiree is no longer eligible for coverage under any employee benefit plan that (a) is sponsored by the Company and (b) offers medical coverage;
- The date that the disabled dependent child attains age 65;
- The date that the disabled dependent child is no longer disabled; or
- You elect for the disabled dependent child’s coverage to end.

COBRA

When group coverage is lost because of a "qualifying event" shown below, federal laws and regulations known as "COBRA" require Alyeska Pipeline Service Company to offer qualified members an election to continue their group coverage for a limited time. Under COBRA, a qualified member must apply for COBRA coverage within a certain time period and may also have to pay the premiums for it.

The plan will provide qualified members with COBRA coverage when COBRA's enrollment and payment requirements are met. But, coverage is provided only to the extent that COBRA requires and is subject to the other terms and limitations of this plan. Alyeska Pipeline Service Company, **not us**, is responsible for all notifications and other duties assigned by COBRA to the "plan administrator" within COBRA's time limits.

The following summary of COBRA coverage is taken from COBRA. Members' rights to this coverage and obligations under COBRA automatically change with further amendments of COBRA by Congress or interpretations of COBRA by the courts and federal regulatory agencies.

Qualifying Events and Length of Coverage

Please contact Alyeska Pipeline Service Company immediately when one of the qualifying events highlighted below occurs. The continuation periods listed extend from the date of the qualifying event.

Alyeska Pipeline Service Company must offer the covered spouse or children an election to continue coverage for up to 36 consecutive months if their coverage is lost because of 1 of 4 qualifying events:

- **The subscriber dies.**
- **The subscriber and spouse legally separate or divorce.**
- **The subscriber becomes entitled to Medicare.**
- **A child loses eligibility for dependent coverage.**

Alyeska Pipeline Service Company must offer the retired subscriber and covered dependents an election to continue their retiree coverage if that coverage is lost because Alyeska Pipeline Service Company filed for bankruptcy. COBRA also considers coverage to have been lost due to this qualifying event if the retiree group coverage was substantially eliminated at any time between 1 year before the bankruptcy proceeding commenced and 1 year after it commenced.

Under this qualifying event, the retired subscriber may continue coverage for up to the rest of his or her life. The retired subscriber's covered spouse and children may continue for up to 36 months after the retired subscriber's death or until they lose eligibility as dependents, whichever occurs first. (If the retired subscriber died before the bankruptcy, but his or her spouse is still covered under this plan when the bankruptcy filing occurred, that surviving spouse may continue coverage for up to the rest of his or her life.)

Conditions of COBRA Coverage

For COBRA coverage to become effective, all of the requirements below must be met:

You Must Give Notice Of Some Qualifying Events

The plan will offer COBRA coverage only after Alyeska Pipeline Service Company receives timely notice that a qualifying event has occurred. The subscriber or affected dependent must notify Alyeska Pipeline Service Company in the event of a divorce, legal separation, or child's loss of eligibility as a dependent.

If the required notice is not given or is late, the qualified member loses the right to COBRA coverage. The subscriber or affected dependent has 60 days in which to give notice to Alyeska Pipeline Service Company. The 60-day notice period starts on the **later** of: 1) the date of the qualifying event, or 2) the date the qualified member would lose coverage as a result of the event.

Important Note: Alyeska Pipeline Service Company must tell you where to direct your notice and any other procedures that you must follow. If Alyeska Pipeline Service Company informs you of its notice procedures after the notice period start date above for your qualifying event, the notice period will not start until the date you're informed by Alyeska Pipeline Service Company.

Alyeska Pipeline Service Company must notify qualified members of their rights under COBRA. If the Group Alyeska Pipeline Service Company has named a third party as its plan administrator, the plan administrator is responsible to notify members on behalf of the group Alyeska Pipeline Service Company. In such cases, Alyeska Pipeline Service Company has 30 days in which to notify its plan administrator of a loss of retiree coverage because Alyeska Pipeline Service Company filed for bankruptcy. The plan administrator then has 14 days after it receives notice of a qualifying event from a qualified member as stated above or from Alyeska Pipeline Service Company in which to notify qualified members of their COBRA rights.

If Alyeska Pipeline Service Company itself is the plan administrator, it has more than 14 days in which to give notice for certain qualifying events. Alyeska Pipeline Service Company must furnish the notice required because of a loss of retiree coverage because Alyeska Pipeline Service Company filed for bankruptcy no later than 44 days after the **later** of 1) the date of the qualifying event, or 2) the date coverage would end in the absence of COBRA. For all other qualifying events, the 14-day notice time limit applies.

You Must Enroll And Pay On Time

- You must elect COBRA coverage no more than 60 days after the **later** of 1) the date coverage was to end because of the qualifying event, or 2) the date you were notified of your right to elect COBRA coverage.

  Each qualified member will have an independent right to elect COBRA coverage. Subscribers may elect COBRA coverage on behalf of their spouses, and parents may elect COBRA coverage on behalf of their children.
- You must send your first premium payment to Alyeska Pipeline Service Company no more than 45 days after the date you elected COBRA coverage.
- Subsequent monthly premium payments must also be made to Alyeska Pipeline Service Company.

Adding Family Members

Eligible family members may be added after the continuation period begins, but only as allowed under ***Special Enrollment*** or ***Open Enrollment*** in ***When Does Coverage Begin?***. Family members added after **COBRA** begins aren't eligible for further coverage if they later have a qualifying event.

Keep Alyeska Pipeline Service Company Informed Of Address Changes

In order to protect your rights under COBRA, you should keep Alyeska Pipeline Service Company informed of any address changes. It is a good idea to keep a copy, for your records, of any notices you send to Alyeska Pipeline Service Company.

When COBRA Coverage Ends

COBRA coverage will end on the last day for which premiums have been paid in the monthly period in which the first of the following occurs:

- The applicable continuation period expires.
- The next monthly premium isn't paid when due or within the 30-day COBRA grace period.

- You become covered under another group health care plan after the date you elect COBRA coverage. However, if the new plan contains an exclusion or limitation for a pre-existing condition, coverage doesn't end for this reason until the exclusion or limitation no longer applies.
- You become entitled to Medicare after the date you elect COBRA coverage. (This doesn't apply to retirees and their dependents who are continuing retiree coverage as a result of a bankruptcy filing.)
- Alyeska Pipeline Service Company ceases to offer group health care coverage to any employee.

If You Have Questions

Questions about your plan or your rights under COBRA should be addressed to the plan contacts provided by Alyeska Pipeline Service Company. For more information about your rights under ERISA, COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at **dol.gov/ebsa**. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

Continuation Under USERRA

The Uniformed Services Employment And Reemployment Rights Act (USERRA) protects the job rights (including enrollment rights on employer-provided health care coverage) of individuals who voluntarily or involuntarily leave employment positions to undertake military service. If you leave your job to perform military service, you have the right to elect to continue existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are re-employed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

Contact your employer for information on USERRA rights and requirements. You may also contact the U.S. Department of Labor at 1-866-4-USA-DOL or visit its website at **www.dol.gov/vets**. An online guide to USERRA can be viewed at **www.dol.gov/elaws/vets/userra**.

HOW DO I FILE A CLAIM?

Many providers will submit their bills to us directly. However, if you need to submit a claim to us, follow these simple steps:

Step 1

Complete a Subscriber Claim Form. A separate Subscriber Claim Form is necessary for each patient and each provider. Subscriber Claim Forms are available from us.

Step 2

Attach the itemized bill. The itemized bill must contain all of the following information.

- Names of the subscriber and the member who incurred the expense
- Identification numbers for both the subscriber and the Group (these are shown on the subscriber's identification card)
- Name, address, and IRS tax identification number of the provider
- Information about other insurance coverage
- American Dental Association (ADA) Current Dental Terminology (CDT) procedure codes for each service
- Dates of service and itemized charges for each service rendered
- If the services rendered are for treatment of an accidental injury, the date, time, location, and a brief description of the accident

Step 3

If you're also covered by Medicare, and Medicare is primary, you must attach a copy of the "Explanation of Medicare Benefits."

Step 4

Check that all required information is complete. Bills received won't be considered to be claims until all necessary information is included.

Step 5

Sign the Subscriber Claim Form in the space provided.

Step 6

Mail your claims to the address listed inside the front cover of this booklet

You should submit all claims within 90 days of the start of service or within 30 days after the service is completed. We must receive claims:

- Within 365 days of discharge for hospital or other medical facility expenses, or within 365 days of the date on which expenses were incurred for any other services or supplies; or
- For members who have Medicare, within 90 days of the process date shown on the Explanation of Medicare Benefits, whichever is greater.

We won't provide benefits for claims we receive after the later of these 2 dates, nor will we provide benefits for claims which were denied by Medicare because they were received past Medicare's submission deadline.

CLAIMS PROCEDURE

Claims for benefits will be processed under the following time frames:

- If the claim includes all of the information we need to process the claim, we will process it within 30 calendar days of receipt.
- If we need more information to process the claim, we will tell you or the provider who submitted the claim that we need more information. We will make that request within 30 calendar days of receipt.
- Once we receive the additional information, we will process your claim within 30 calendar days from the date we initially received the claim or 15 calendar days after we receive the information, whichever period is longer.

If we do not pay the claim or provide notice within the time frames stated above, interest shall accrue at a rate of 15% annually. Interest will not be paid if the amount of interest is $1 or less.

When we process your claim, we will send a written notice explaining how the claim was processed. If the claim is denied in whole or in part, we will send a written notice that states the reason for the denial, and information on how to request an appeal of that decision.

At any time, you have the right to appoint someone to pursue the claim on your behalf. This can be a provider, doctor, lawyer, or a friend or relative. You must notify us in writing and give us the name, address, and telephone number where your appointee can be reached.

If a claim for benefits or an appeal is denied or ignored, in whole or in part, or not processed within the time shown in these claims procedures, you may have the right to file suit in a state or federal court.

Care Received Outside the United States

When you submit a claim for care you received outside the United States, please include whenever possible: a detailed description, in English, of the dental services received; the names and credentials of the treating providers, and dental records or chart notes.

To process your foreign claim, we will convert the foreign currency amount on the claim into US dollars for claims processing. We use a national currency converter (available at oanda.com) as follows:

- For professional outpatient services and other care with single dates of service, we use the exchange rate on the date of service.

COMPLAINTS AND APPEALS

If at any time you have questions regarding your healthcare, you may contact customer service for assistance. They are here to serve you and answer questions. If you disagree with a decision we made or feel dissatisfied, and would like us to formally review your concerns, you can file a complaint or appeal with Premera.

WHAT IS A COMPLAINT?

Other than denial of payment for medical services or non-provision of medical services, a complaint is when you are not satisfied with customer service, quality, or access to medical service, and you want to share it with Premera.

How to file a complaint	Send the details in writing to:
Call customer service at 800-722-1471 (TTY:711) **Send a fax** to 425-918-5592	Premera Blue Cross Blue Shield of Alaska PO Box 91102 Seattle, WA 98111-9202

For complaints received in writing, we will send a written response within 30 days.

WHAT IS AN APPEAL?

An appeal is a request to review a specific decision or an adverse benefit determination Premera has made.

An adverse-benefit determination means a decision to deny, reduce, terminate or a failure to provide or to make payment, in whole or in part for services. This includes:

- A member's or applicant's eligibility to be or stay enrolled in this plan or health insurance coverage
- A limitation on otherwise covered benefits
- A clinical review decision
- A decision that a service is experimental, investigative, not medically or dentally necessary or appropriate, or not effective

What you can appeal

Claims and prior authorization	Payment	Benefits or charges were not applied correctly, including a limit or restriction on otherwise covered benefits.
	Denied	Coverage of your service, supply or device was denied or partially denied. This includes prior authorization denials.

Appeal Levels

You have the right to three levels of appeals:

Appeal Level	What it means	Deadline to appeal
Level 1 (Internal)	This is your first appeal. Premera will review your appeal.	180 days from the date you were notified of our decision.
Level 2 (Internal)	If we deny your Level 1 appeal, you can appeal a second time. Premera will review your appeal.	60 days from the date you were notified of our Level 1 appeal decision.
External	If we deny your Level 1 appeal, you can ask for an Independent Review Organization (IRO) to review your appeal. OR You can ask for an IRO review if Premera has not made a decision by the deadline for the Level 1 appeal. There is no cost to you for an external appeal.	180 days from the date you were notified of our Level 1 appeal decision. OR 180 days from the date the response to your Level 1 appeal was due, if you did not get a response or it was late.

HOW TO SUBMIT AN APPEAL IN WRITING

Step 1. **Get the form**	• Complete the **Member Appeal Form**, you can find it on **premera.com** or call customer service to request a copy. If you need help submitting an appeal, or would like a copy of the appeals process, call customer service
Step 2. **Collect supporting documents**	• Collect any supporting documents that may help with your appeal. This may include chart notes, medical records, or a letter from your provider. Within 3 working days, we will confirm in writing that we have your request. • If you would like someone to appeal on your behalf, including your provider, complete a **Member Appeal Form** with authorization, you can find it on **premera.com**. We can't release your information without this form.
Step 3. **Send in my appeal**	To help process your appeal, be sure to complete the form and return with any supporting documents. **Send your documents to:** Premera Blue Cross Blue Shield of Alaska Attn: Appeals Coordinator PO Box 91102 Seattle, WA 98111-9202 Fax to 425-918-5592

Note: You may also call customer service to verbally submit an appeal.

If you would like to review the information used for your appeal, please send us a request in writing to:

Premera Blue Cross Blue Shield of Alaska

Attn: Appeals Coordinator

PO Box 91102

Seattle, WA 98111-9202

Fax: 425-918-5592

APPEAL RESPONSE TIME LIMITS

We'll review your appeal and send a decision in writing within the time limits below. The timeframes are based on what the appeal is about, not the appeal level. At each level, Premera representatives who have not reviewed the case before will review and make a decision. Medical or dental review denials will be reviewed by a medical or dental specialist.

Type of appeal	When to expect a response
Urgent appeals	No later than 72 hours. We will call, fax, or email you with the decision, and follow up in writing.
All other (internal) appeals	Within 30 days
External appeals	• Urgent appeals within 72 hours • Other IRO appeals within 45 days from the date the IRO gets your request

WHAT IF YOU HAVE ONGOING CARE?

Ongoing care is continuous treatment you are currently receiving.

If you appeal a decision that affects ongoing care because we've determined the care is not or no longer medically or dentally necessary, benefits will not change during the appeal period. Your benefits during the appeal period should not be taken as a change of the initial denial. If our decision is upheld, you must repay all amounts we paid for ongoing care during the appeal review.

WHAT IF IT'S URGENT?

If your condition is urgent, you will get our response sooner. Urgent appeals are only available for services you are currently receiving or have not yet received. Examples of urgent situation are:

- Your life or health is in serious danger or a delay in treatment would cause you to be in severe pain that you cannot bear, as determined by our medical professionals or your treating dental specialist
- You are requesting coverage for inpatient or receiving emergency services that you are currently receiving

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

EXTERNAL APPEAL

External reviews will be done by an Independent Review Organization (IRO).

Step 1.
Complete the form
	We will send you an External Review Application Form authorizing the release of your medical records to an IRO with the written decision of your internal appeal.
	• External appeals are only available for decisions involving a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the service or treatment you received.
	• An external appeal is also available for decisions related to Premera's compliance with protections established by the No Surprises Act (NSA) such as:
	  • Cost-sharing and surprise billing for emergency services
	  • Cost-sharing and surprise billing protections related to care your received from non-network (non-participating) providers at participating facilities
	  • Your condition to receive notice and provide informed consent to waive NSA protections; and
	  • If a claim for care received is coded correctly and accurately reflects the treatments received, and the associated NSA protections related to your cost-sharing and surprise billing.
	• You must include the signed **External Review Application Form** you received from us. You may also include medical records and other information.

Step 2. **Collect supporting documents**	• Collect any supporting documents that may help with your external review. This may include medical records and other information. • You must file your request for external review with the Alaska Division of Insurance within 180 days of the date you got our internal appeal letter. You can request an extension of the 180-day deadline by sending the Alaska Division of Insurance a written request that includes the reason why you believe an extension should be granted.

Step 3. **Send in my external review request**	• The Alaska Division of Insurance will provide your request to Premera within one working day. Premera will complete a preliminary review within five working days to determine whether the request is eligible for external appeal. • For urgent external appeals, Premera will complete the preliminary review immediately. Premera will notify you, your authorized representative, and the Alaska Division of Insurance in writing of the results of our preliminary review within one day after we have completed it. • If your request is eligible for external appeal, the Alaska Division of Insurance will assign an IRO to review your appeal. We will forward your medical records and other information to the IRO. If you have additional information on your appeal, you may send it to the IRO. • If the request is not complete, Premera will notify you, your authorized representative, and the Alaska Division of Insurance in writing of what information or materials are needed to make the request complete. • If the request is not eligible for external appeal, Premera will notify you or your authorized representative and the Alaska Division of Insurance in writing of the reasons why the request is not eligible for external review. If you do not agree with this decision, you may appeal to the Director of the Alaska Division of Insurance.

ONCE THE IRO DECIDES

For urgent appeals, the IRO will inform you and the plan immediately.

Premera will accept the IRO decision.

If the IRO:

- Reverses our decision, we will apply their decision quickly
- Stands by our decision, there is no further appeal. However, you may have other steps you can take under state or federal law, such as filing a lawsuit.

If you have questions about a denial of a claim or your appeal rights, you may call customer service at the number listed on your Premera ID card.

If your plan is governed by the Federal Employee Retirement Income Security Act of 1974 (ERISA), you can contact the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor. The phone number is 866-444-EBSA (3272).

OTHER INFORMATION ABOUT THIS PLAN

This section tells you about how your Group's Contract and this plan are administered. It also includes information about federal and state requirements we must follow and other information we must provide to you.

Conformity With The Law

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

Evidence Of Dental Necessity

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

ID Card

If you need a replacement Premera ID card, call our customer service or visit our website at premera.com. If coverage under the contract terminates, your Premera ID card will no longer be valid.

Intentionally False Or Misleading Statements

If this plan's benefits are paid in error due to any intentionally false or misleading statements, the plan is entitled to recover these amounts.

If you make any intentionally false or misleading statements on any application or enrollment form that affects your acceptability for coverage, we may, as directed by the Group:

- Deny your claim
- Reduce the amount of benefits provided for your claim
- Rescind your coverage under this plan. (Rescind means to cancel coverage back to its effective date as if it had never existed at all).

Limitations Of Liability

The plan, the Group, and Premera Blue Cross Blue Shield of Alaska are not liable for any of the following:

- Situations such as epidemics or disasters that prevent members from getting the care they need
- The quality of services or supplies received by members, or the regulation of the amounts charged by any provider, since all those who provide care do so as independent contractors
- Providing any type of dental care
- Harm that comes to a member while in a provider's care
- Amounts in excess of the actual cost of services and supplies
- Amounts in excess of this plan's maximums. This includes recovery under any claim of breach.
- General or special damages including, without limitation, alleged pain, suffering, mental anguish or consequential damages

Member Cooperation

You're under a duty to cooperate with us and the Group in a timely and appropriate manner in our administration of benefits. You're also under a duty to cooperate with us and the Group in the event of a lawsuit.

Notice Of Information Use And Disclosure

We may collect, use or disclose certain information about you. This protected personal information (PPI) may include dental information, or personal data such as your address, phone number or Social Security number. We may receive this information from or release it to dental care providers, insurance companies or other sources.

This information is collected, used or disclosed for conducting routine business operations such as:

- Underwriting and determining your eligibility for benefits and paying claims
- Coordinating benefits with other dental care plans
- Conducting care management, case management or quality reviews
- Fulfilling other legal obligations that are specified under the plan and our administrative service contract with the Group

This information may also be collected, used or disclosed as required or permitted by law.

To safeguard your privacy, we take care to ensure that your information remains confidential by having a company confidentiality policy and by requiring all employees to sign it.

If a disclosure of PPI isn't related to a routine business function, we remove anything that could be used to easily identify you or we obtain your prior written authorization.

You have the right to request inspection and /or amendment of records retained by us that contain your PPI. Please contact our customer service department and ask that a representative mail a request form to you.

Notice Of Other Coverage

As a condition of receiving benefits under this plan, you must notify us of:

- Any legal action or claim against another party for a condition or injury for which we provide benefits, and the name and address of that party's insurance carrier
- The name and address of any insurance carrier that provides:
  - Personal injury protection (PIP)
  - Underinsured motorist coverage
  - Uninsured motorist coverage
  - Any other insurance under which you are or may be entitled to recover compensation

- The name of any other group or individual insurance plans that cover you

Notices

We may be required to send you certain notices. We will consider such a notice to be delivered if we mail or email it to your most recent mailing or email address in our records. The date of the postmark or email is the delivery date.

If you are required to send notice to us, the postmark date will be the delivery date. If not postmarked, the delivery date will be the date we receive it.

Recovery Of Claims Overpayments

On behalf of the plan, we have the right to recover amounts the plan paid that exceed the amount for which the plan is liable. Such amounts may be recovered from the subscriber or any other payee, including a provider. Or, such amounts may be deducted from future benefits of the subscriber or any of their dependents (even if the original payment wasn't made on that member's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a provider who doesn't have a contract with us.

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

Right To And Payment Of Benefits

Benefits of this plan are available only to members. In accordance with the law, the benefits of this plan may be paid to:

- The subscriber
- A provider
- Another health insurance carrier
- The member
- Another party legally entitled under federal or state medical child support laws
- Jointly to any of the above

Payment to any of the above satisfies the plan's obligation as to payment of benefits.

Venue

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

- Within 1 year of the date the rights or benefits claimed under this plan were denied
- In a mutually agreed upon location

WHAT ARE MY RIGHTS UNDER ERISA?

Name Of Plan

Alyeska Retiree Dental Plan for Operating Company Employees

Plan Number

519

Plan Group Number

9001384

The Group has an employee welfare benefit plan that is subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA). This employee welfare benefit plan is called the "ERISA Plan" in this section.

When used in this section, the term "ERISA Plan" refers to the Group's employee welfare benefit plan. The "ERISA Plan administrator" is the Group or an administrator named by the Group. Premera Blue Cross Blue Shield of Alaska is **not** the ERISA Plan administrator.

As a participant in an employee welfare benefit plan, the subscriber has certain rights and protections. This statement explains those rights.

ERISA provides that all plan participants shall be entitled to:

- Examine without charge, at the ERISA Plan administrator's office and at other specified locations (such as work sites and union halls), all documents governing the ERISA Plan, including insurance contracts and collective bargaining agreements. If the ERISA Plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to examine a copy of its latest annual report (Form 5500 Series) filed and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the ERISA Plan administrator, copies of documents governing the operation of the ERISA Plan, including insurance contracts and collective bargaining agreements and updated summary plan descriptions. If the ERISA Plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to obtain copies of the latest annual report (Form 5500 Series). The administrator may make a reasonable charge for the copies.
- Receive a summary of the ERISA Plan's annual financial report, if ERISA requires the ERISA Plan to file an annual report. The ERISA Plan administrator for such plans is required by law to furnish each participant with a copy of this summary annual report.
- Continue dental care coverage for yourself, spouse or dependents if there's a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your ERISA Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the ERISA Plan and don't receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the ERISA Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials weren't sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the ERISA Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that ERISA Plan fiduciaries misuse the ERISA Plan's money, or if you're discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you're successful the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Note: Under ERISA, the ERISA Plan administrator is responsible for furnishing each participant and beneficiary with a copy of the summary plan description.

If you have any questions about your employee welfare benefit plan, you should contact the ERISA Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the ERISA Plan administrator, you should contact either:

- The office of the Employee Benefits Security Administration, U.S. Department of Labor, 300 Fifth Ave, Suite 1110, Seattle, WA 98104; or
- The Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave. N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272.

DEFINITIONS

The terms listed throughout this section have specific meanings under this plan.

Accidental Injury

Physical harm caused by a sudden, unexpected event at a certain time and place. Accidental injury does not mean any of the following:

- An illness, except for infection of a cut or wound
- Dental injuries caused by biting or chewing
- Over-exertion or muscle strains

Adverse Benefit Determination

An adverse benefit determination means a decision to deny, reduce, terminate or a failure to provide or to make payment, in whole or in part for services. This includes:

- A member's or applicant's eligibility to be or stay enrolled in this plan or health insurance coverage
- A limitation on otherwise covered benefits
- A clinical review decision
- A decision that a service is experimental, investigative, not medically or dentally necessary or appropriate, or not effective
- A decision related to compliance with protections against balance billing as defined by federal and state law

Allowed amount

The allowed amount shall mean one of the following:

- **Dental Care Providers Who Have Agreements With Us**

  The amount for dentally necessary services and supplies these providers have agreed to accept as payment is either the fee that we have negotiated as a “reasonable allowance” for dentally necessary covered services and supplies or the provider’s billed charge, whichever is less. These providers agree to seek payment from us when they furnish covered services to you. You’ll be responsible only for any applicable plan year deductibles, coinsurance, charges in excess of the stated benefit maximums, and charges for services and supplies not covered under this plan.

  Your liability for any applicable plan year deductibles, coinsurance and amounts applied toward benefit maximums will be calculated on the basis of the allowed amount. In no event will your liability exceed what would have been charged in the absence of insurance.

  Every 6 months, we review the reasonable allowance for dental care services and supplies by examining the range of charges and fees for the same or similar services and supplies billed by providers within each geographical area. We use 12 months of claims experience data during this process.

  The reasonable allowance won’t be less than the 80th percentile of billed or accepted charges or contracted rates.

- **Dental Care Providers Who Don’t Have Agreements With Us**

  The allowed amount will be no less than the 80th percentile of fees for the geographical area.

  When you receive services from dental care providers that don’t have agreements with us, your liability is for any amount above the allowed amount, and for any applicable plan year deductibles, coinsurance, amounts in excess of stated benefit maximums and charges for non-covered services and supplies.

  Every 6 months, we review the reasonable allowance for dental care services and supplies by examining the range of charges and fees for the same or similar services and supplies billed by providers within each geographical area. We use 12 months of claims experience data during this process.

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

Benefit

What this plan provides for a covered service. The benefits you get are subject to this plan's cost-shares.

Benefit Booklet

Benefit booklet describes the benefits, limitations, exclusions, eligibility and other coverage provisions included in this plan and is part of the entire contract.

Congenital Anomaly

A marked difference from the normal structure of an infant's body that's present from birth.

Claim

A request for payment from us according to the terms of this plan.

Comprehensive Oral Evaluation

Comprehensive oral evaluations include complete dental/medical history and general health assessment, complete thorough evaluation of extra-oral and intra-oral hard and soft tissue; the evaluation and recording of dental caries, missing or unerupted teeth, restoration, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, and oral cancer screenings.

Contract

Contract describes the benefits, limitations, exclusions, eligibility, and other coverage provisions included in this plan.

Cosmetic Services

Services that are performed to reshape normal structures of the body in order to improve or alter your appearance and not primarily to restore an impaired function of the body.

Cost-share

The part of healthcare costs that you have to pay. These are deductibles, coinsurance, and copayments.

Covered Service

A service, supply or drug that is eligible for benefits under the terms of this plan.

Dental Care Provider

A state-licensed:

- Doctor of Medical Dentistry (DMD)
- Doctor of Dental Surgery (DDS)

The benefits of this plan are available if professional services are provided by a state-licensed denturist, a dental hygienist under the supervision of a licensed dentist, or other individual performing within the scope of their license or certification, as allowed by law and this plan's benefits would be payable if the covered service were provided by a "dental care provider" as defined above.

Dental Emergency

A condition requiring prompt or urgent attention due to trauma and/or pain caused by a sudden unexpected injury, acute infection or similar occurrence.

Dentally Necessary or Dental Necessity

Those covered services and supplies that a dentist, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of dental practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
- Not primarily for the convenience of the patient, dentist, or other dental care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease

For those purposes, "generally accepted standards of dental practice" means standards that are based on authoritative dental or scientific literature.

Decisions regarding dental necessity are based on the criteria stated above. If you disagree with a decision that has been made, you have the right to additional review. See the ***Complaints and Appeals*** section in this booklet for an explanation of the appeals process.

- Dependent
- The subscriber's spouse or domestic partner and any children who are on this plan.
- Effective Date
- The date your coverage under this plan begins.

Eligibility Waiting Period

The length of time that must pass before a subscriber or dependent is eligible to be covered under the dental care plan. If a subscriber or dependent enrolls under the ***Special Enrollment*** provisions of this plan or enrolls on a date other than when first eligible to enroll, any period prior to such enrollment isn't considered an eligibility waiting period, unless all or part of the initial eligibility waiting period hadn't been met.

Emergency Medical Condition (also called "Emergency")

A medical condition, mental health, or substance use disorder condition which manifests itself by acute symptoms of sufficient severity, including, but not limited to, severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in 1) placing the health of the individual (or with respect to a pregnant member, the member's health or the unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

Examples of an emergency medical condition are severe pain, suspected heart attacks and fractures. Examples of a non-emergency medical condition are minor cuts and scrapes.

Emergency Services

- A medical screening examination to evaluate an emergency that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department
- Further medical examination and treatment to stabilize the member to the extent the services are within the capabilities of the hospital staff and facilities, or if necessary, to make an appropriate transfer to another medical facility. "Stabilize" means to provide medical, mental health, or substance use disorder treatment of the medical emergency as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the member from a medical facility.
- Ambulance transport as needed in support of the services above

Endorsement

A document that is attached to and made a part of this contract. An endorsement changes the terms of the contract.

Experimental/Investigative Services

A treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria:

- A drug or device which cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and does not have approval on the date the service is provided.
- It is subject to oversight by an Institutional Review Board.
- There is no reliable evidence showing that the service is effective in clinical diagnosis, evaluation, management or treatment of the condition.
- It is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy.
- Evaluation of reliable evidence shows that more research is necessary before the service can be classified as equally or more effective than conventional therapies.
- Reliable evidence means only published reports and articles in authoritative medical and scientific literature and assessments and coverage recommendations published by the Blue Cross Blue Shield Association Technical Evaluation Center (TEC).

Explanation of Benefits

An explanation of benefits is a statement that shows what you will owe and what we will pay for healthcare services received. It's not a bill.

Group

The entity that sponsors this self-funded plan.

Hospital

A healthcare facility that meets all of these criteria:

- It operates legally as a hospital in the state where it is located.
- It has facilities for the diagnosis, treatment and acute care of injured and ill persons as inpatients.
- It has a staff of providers that provides or supervises the care.
- It has 24-hour nursing services provided by or supervised by registered nurses.

A facility is *not* considered a hospital if it operates mainly for any of the purposes below:

- As a rest home, nursing home, or convalescent home
- A residential treatment center or health resort
- To provide hospice care for terminally ill patients
- To care of the elderly
- To treat substance use disorder or tuberculosis

Illness

A sickness, disease, or medical condition.

Injury

Physical harm caused by a sudden event at a specific time and place. It is independent of illness, except for infection of a cut or wound.

Large Employer

An employer, including a person, firm, corporation, partnership, association, or political subdivision, that is actively engaged in business, that employed an average of at least 51 employees on the business days during the preceding calendar year and that employs at least 2 employees on the first day of a dental benefit year.

Lifetime Maximum

The maximum amount that Premera will provide during your lifetime.

Medically Necessary and Medical Necessity

Services a provider, exercising prudent clinical judgment, would use with a patient to prevent, evaluate, diagnose or treat an illness, injury, disease or its symptoms. These services must:

- Agree with generally accepted standards of medical practice;
- Be clinically appropriate in type, frequency, extent, site and duration. They must also be considered effective for the patient's illness, injury or disease;
- Not be mostly for the convenience of the patient, physician, or other health care provider. They do not cost more than another service or series of services that are at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature. This published evidence is recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Member (also called "You" and "Your")

A person covered under this plan as an employee, subscriber or dependent.

Orthodontia

The branch of dentistry that specializes in the correction of tooth arrangement problems, including poor relationships between the upper and lower teeth (malocclusion).

Plan

The benefits, terms and limitations stated in this contract.

Plan Year

The period of 12 consecutive months that starts each March 1 at 12:01 a.m. and ends on the last day in February at midnight.

Premiums

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

Services

Procedures, surgeries, consultations, advice, diagnosis, referrals, treatment, supplies, drugs, devices, technologies or places of service.

Specialist

A provider who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse

- An individual who is legally married to the subscriber.
- An individual who is a domestic partner of the subscriber.

Subscriber

An enrolled employee of the Group. Coverage under this plan is established in the subscriber’s name.

Temporomandibular Joint (TMJ) Disorders

TMJ disorders include those disorders which have one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.

Visual Oral Screenings or Assessments

Performed by a licensed dentist or dental hygienist under the supervision of a licensed dentist to determine the need for sealants, fluoride treatment, and/or when triage services are provided in settings other than dental offices or dental clinics.

We, Us and Our

Premera Blue Cross Blue Shield of Alaska, in the state of Alaska.

where to send claims

MAIL YOUR CLAIMS TO:

Premera Blue Cross Blue Shield of Alaska

PO Box 91059

Seattle, WA 98111-9159

www.premera.com