Alyeska Pipeline Service Company

Dental Standard Plan

Pre-65 Retiree Participants

9001384

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

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
P.O. Box 91059
Seattle, WA 98111-9159

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

Telephone Numbers:

Local and toll-free number: 1-800-508-4722 (TTY 711)

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 **www.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, 2021
Group Number:	9001384
Plan:	Alaska Dental Standard – Pre 65 Retiree Participants
Certificate Form Number:	APSC21DR

Discrimination is Against the Law

Premera Blue Cross Blue Shield of Alaska (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-508-4722 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-508-4722 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-508-4722 (TTY: 711) 번으로 전화해 주십시오.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 800-508-4722 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-508-4722 (телетайп: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-508-4722 (TTY：711）。

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 800-508-4722 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ ນມ ພ້ ອມໃຫ້ ທ່ ານ. ໂທຣ 800-508-4722 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-508-4722 （TTY:711）まで、お電話にてご連絡ください。

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 800-508-4722 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-508-4722 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-508-4722 (телетайп: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-508-4722 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-508-4722 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-508-4722 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-508-4722 (رقم هاتف الصم والبكم: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-508-4722 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-508-4722 (ATS: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-508-4722 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-508-4722 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-508-4722 (TTY: 711) تماس بگیرید.

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INTRODUCTION

This booklet is for members of the Alyeska Pipeline Service Company 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, 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 doesn't insure 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 one below may be particularly useful.

- **HOW TO CONTACT THE CLAIMS ADMINISTRATOR** – our website address, phone numbers, mailing addresses and other contact information are conveniently located inside the front cover
- **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 BENEFITS?** – what's covered under this plan
- **EXCLUSIONS** – 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 process to follow if you want to share ideas, ask questions, 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 Diagnostic and Preventive, Basic, and 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 (D.M.D. or D.D.S.), 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.

ESTIMATE OF DENTAL BENEFITS

An estimate of dental benefits verifies, for the dental care provider and you, your eligibility and benefits. Because we consider alternative treatment at the time we review the 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.

An estimate of benefits isn't required in order for you to receive your dental benefits. However, we suggest that your dental care provider submit an 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

Diagnostic and Preventive covered services aren’t subject to a plan year dental deductible. However, a plan year dental deductible does apply to covered Basic and Major services, and Orthodontia services. The dental deductible is the amount you must pay for Basic and Major services 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 Basic or 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 plan 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.

DENTAL BENEFIT MAXIMUM

The maximum amount of dental benefits available to any one member in a plan year is $3,000. **Please note:** Diagnostic and Preventive services do not accrue to the plan year dental maximum.

Benefits for covered services with multiple treatment dates are subject to the dental benefit maximum of the plan year in which the services are started.

However, if you receive dental implant services, the post insertion and the final crown or bridgework will be considered to be separate services, and those services will be calculated under the plan year limitation in which they are received.

NETWORK PROVIDERS

For the most current information on network dental care providers, please refer to our web site 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" (please see the "Definitions" section in this booklet) 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.

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

NON-NETWORK PROVIDERS

If you do not have reasonable access to a network provider 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. Please see the "How Do I File A Claim?" section in this booklet for instructions on submitting claims for reimbursement.

For the most current information on network dental care providers, please refer to our web site 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. However, the Group has made use of our contracts with local providers and a nationwide network of dental care providers who can provide preventive and specialty dental care services. 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" (please see the "Definitions" section in this booklet) 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.

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

WHAT ARE MY DENTAL BENEFITS?

WHAT DO I PAY FOR COVERED SERVICES?

Coinsurance

As used in this plan, "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."

After you satisfy the required plan year deductible, you pay the following percentages of allowable charges per plan year, up to the dental benefit maximum. Dental services fall into these categories: Diagnostic and Preventive, Basic, and Major services and Implants. **Please 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 oral examinations are limited to 2 per plan year. Initial consultations, second opinion consultations and office visits count toward the limit for oral examinations.
- Emergency oral examinations. Services that are determined to be routine will be limited to 2 per plan year.
- Prophylaxis (cleaning, scaling, and polishing of teeth) is limited to 2 per plan year.
- Topical application of fluoride is covered for members age 19 or under only. They are limited to 2 treatments per plan year.
- Covered dental x-rays include either a complete series, panoramic x-ray or cone beam image once every 3 years. X-rays taken for root canal therapy are limited to 1 periapical x-ray per tooth.
- Space maintainers
- Sealants, for members age 20 or under, are limited to use on permanent teeth.

Class II - Basic Services

- Simple extractions
- Oral surgery consisting of surgical extractions, fracture and dislocation treatment, and diagnosis and treatment of cysts and abscesses
- Dentally necessary injectable drugs administered in a dental office
- Fillings, consisting of amalgam and composite resins on any given tooth surface are covered once in any 24 consecutive months.
- Treatment of periodontal and other diseases of the gums and tissues of the mouth. Periodontal scaling and root planing and sub-gingival curettage are limited to a total of 2 full-mouth treatments in any 12 consecutive months. Periodontal maintenance, as a follow-up to active periodontal treatment, including removal of bacterial flora, sub-gingival scaling, polishing, periodontal evaluation and review of oral hygiene, is limited to 1 visit every 3 consecutive months.
- Limited occlusal adjustments are covered once every 12 consecutive months as dentally necessary
- Endodontic (root canal) treatment
  - Benefits for root canals performed in conjunction with overdentures are limited to 2 per arch
  - 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
  - X-rays done in conjunction with a root canal. The primary periapical x-ray for diagnostic purposes is covered. Additional x-rays are limited to the allowance for the root canal therapy
- Repair and recementing of crowns, inlays, bridgework and dentures
- Emergency palliative treatment. We require a written description and/or office records of services provided.
- General anesthesia in a dental care provider's office, when dentally necessary.
- Nightguards and occlusal splints

Class III - Major Services

- Initial placement of inlays, onlays, laboratory-processed labial veneers, and crowns for decayed or fractured teeth when amalgam or composite resin fillings wouldn't adequately restore the teeth
- Replacement inlays, onlays, laboratory-processed labial veneers, and crowns
- Initial placement of dentures
- Initial placement of fixed bridgework (including inlays, onlays, and crowns to form abutments)
- Replacement dentures and fixed bridgework, but only when:
  - The existing denture or bridgework was installed at least 5 years before replacement;

- The replacement or addition of teeth is required to replace 1 or more additional teeth extracted after initial placement; or
- Repreparation of the natural tooth structure under the existing fixed bridgework is required as a result of an accidental injury to that structure, and such repair is performed within 12 months of the accidental injury as described under “Dental Care Services For Accidental Injuries.”

- Relining and rebasing of dentures when performed 6 or more months after denture installation. Charges for relines, rebases and adjustments performed during the first 6 months following denture installation are limited to the allowance for the denture.
- Tooth build-ups for covered onlays and crowns, including bridge abutments
- Precision attachments subject to our review for dental necessity

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).

Limitations

In addition to "Exclusions" 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
- Maxillofacial prosthetics
- Temporary, interim or provisional services for crowns, bridges or dentures

Dental Care Services For Accidental Injuries

When services are related to accidental injuries benefits are available for Basic and 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.

Please 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

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.

Covered Services And Supplies

Covered orthodontic services and supplies are:

- 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

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.

Limitations

In addition to "Exclusions" 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

This section of your booklet explains circumstances in which benefits of this plan are limited or not available. Benefits can also be affected by your eligibility. In addition, some benefits may also have their own specific limitations.

LIMITED AND NON-COVERED SERVICES

In addition to the specific limitations stated elsewhere in this plan, this plan doesn't cover:

Amounts Over The Allowed amount

This plan does not cover amounts over the allowed amount as defined by this plan. If you get services from a non-contracted provider, you will have to pay any amounts for your services that are over the allowed amount.

Benefits From Other Sources

This plan does not cover services that are covered by other insurance or coverage such as:

- Motor vehicle medical or motor vehicle no-fault
- 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 home owners' 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

Charges for Records or Reports

- Separate charges from providers for supplying records or reports, except those we request for utilization review
- Charges for case presentation or extensive treatment planning

Comfort or Convenience

This plan does not cover:

- Items that are mainly for your convenience or that of your family. For instance, this plan does not cover 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 does not apply to chores done by a home health aide as prescribed in your treatment plan.
- Meal or dietary assistance, including "Meals on Wheels"

Complications

- This plan does not cover complications of a non-covered service, including follow-up services or effects of those services, except services defined as emergency care. See ***Definitions***.

Cosmetic Services

- Treatment of congenital malformations, except when the patient is an eligible dependent child
- This plan does not cover drugs, services or supplies for cosmetic services. 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

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

Any service or supply that is determined to be experimental or investigational on the date it's furnished, and any direct or indirect complications and aftereffects thereof. The determination is based on the criteria stated in the definition of "Experimental/Investigational Services" (please see the "Definitions" section in this booklet).

If a service is determined to be experimental or investigational, and therefore not covered, you may appeal the decision. Please see the "Complaints and Appeals" section in this booklet for an explanation of the appeals process.

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 furnish to yourself or that are furnished to you by a provider who lives in your home or is related to you by blood, marriage, or adoption. Examples of such providers are your spouse, parent, or child.
- Services or supplies provided by volunteers

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.

Increase Of Vertical Dimension

Any service to increase or alter the vertical dimension.

Military and War-Related Conditions, Including Illegal Acts

This includes:

- Acts of war, declared or undeclared, including acts of armed invasion
- Service in the armed forces of any country, including the air force, army, coast guard, marines, national guard, navy, or civilian forces or units auxiliary thereto
- A member's commission of an act of riot or insurrection
- A member's commission of a felony or act of terrorism

Multiple Providers

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

No Charge Or You Don't Legally Have To Pay

- Services for which no charge is made, or services for which none would have been made if this plan weren't in effect
- Services for which you don't legally have to pay, unless benefits must be provided by law

Non-Standard Techniques

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

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 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 30 days after the date your coverage ended under this plan

Not Dentally Necessary

Services that aren't dentally necessary (see definition of "Dentally Necessary").

Orthodontia Services

Orthodontia, except as specified under "Orthodontia" in the "What Are My Benefits?" section.

Orthognathic Surgery (Jaw Augmentation or Reduction)

Jaw augmentation or reduction (orthognathic and/or maxillofacial), regardless of origin of the condition that makes the procedure necessary, including any direct or indirect complications and aftereffects thereof.

Outside The Scope Of A Provider's License Or Certification

Services or supplies that are outside the scope of the provider's license or certification, or that are furnished by a provider that isn't licensed or certified by the jurisdiction in which the services or supplies were received.

Prescription Drugs

Any prescription drugs or medicines. This includes vitamins, food supplements, and patient management drugs, such as premedication, sedation and nitrous oxide.

Temporomandibular Joint (TMJ) Disorders

Any dental services or supplies connected with the diagnosis or treatment of temporomandibular joint (TMJ) disorders, including any direct or indirect complications and aftereffects thereof.

Testing And Treatment Services

- Testing and treatment for mercury sensitivity or allergy-related
- Genetic or caries susceptibility tests

Tobacco Counseling

Tobacco counseling for the control or prevention of oral disease.

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 one of the following:

- Occupational coverage required 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 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.

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 his or her 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.

Please 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:
- 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.

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 over age 26 who is dependent on the retiree plan participant for support due to a developmental or physical disability that occurred while covered by the retiree or employee plan;
- 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 minor for whom the retiree plan participant has a legal guardianship.

Coverage may be continued for children who become developmentally or physically disabled while covered under the Dental Plan. Subject to Premera Blue Cross Blue Shield of Alaska’s approval, this extended coverage may be continued for as long as the condition lasts.

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

CHANGES IN COVERAGE

No rights are vested under this plan. 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 employees and dependents who become covered under this plan after the date the change becomes effective.

The exception is inpatient confinements described 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
- Plan year deductible. Please note: We will credit expenses applied to your prior plan's plan year deductible **only** when they were incurred in the current plan year.

If the Group offers multiple health care plans and you're enrolled under one of the Group's other health care plans, enrollment for coverage under this plan can only be made during the Group's open enrollment period.

In the event an employee 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.

Please 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

No rights are vested under this plan. 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

Coverage may continue beyond the limiting age shown in "Dependent Eligibility" for a dependent child who cannot support himself or herself because of a developmental or physical disability. The child will continue to be eligible if all the following are met:

- The child became disabled before reaching the limiting age.
- The child is incapable of self-sustaining employment by reason of developmental disability or physical handicap and is chiefly dependent upon the subscriber for support and maintenance.
- The subscriber remains covered under this plan.
- The child's required charges, if any, continue to be paid.
- Within 31 days of the child reaching the limiting age, the subscriber furnishes us and Alyeska Pipeline Service Company with a Request for Certification of Handicapped Dependent form. Alyeska Pipeline Service Company must approve the request for certification for coverage to continue.
- The subscriber provides us with proof of the child's disability and dependent status when requested. Proof won't be requested more often than once a year after the 2-year period following the child's attainment of the limiting age.

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 a monthly charge 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 monthly payment to Alyeska Pipeline Service Company no more than 45 days after the date you elected COBRA coverage.
- Subsequent monthly 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 the "When Does Coverage Begin" section. 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 any charge required for it has been paid in the monthly period in which the first of the following occurs:

- The applicable continuation period expires.

- The next monthly charge 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 **www.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 Alyeska Pipeline Service Company (these are shown on the subscriber's identification card)
- Name, address, and IRS tax identification number of the provider
- Information about other insurance coverage
- Procedure codes (ADA) 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 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.

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 www.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

We know healthcare doesn't always work perfectly. Our goal is to listen, take care of you, and make it simple. If it does not go the way you expect, you have two options:

- Complaints – you can contact customer service if you have a complaint, we may ask you to send the details in writing. We will send a written response within 30 days.
- Appeals – is a request to review specific decisions we have made

You can appeal the following adverse benefit determinations (see ***Definitions***):

- Benefits or charges were not applied correctly
- A decision regarding your eligibility to enroll or stay in the plan, including rescissions
- A decision by the plan that services were experimental, investigative, or not medically necessary

HOW TO SUBMIT AN APPEAL

After you are notified of an adverse benefit determination, you can request an internal appeal. Your plan includes two levels of internal appeals.

- **Level I internal appeal** People who were not part of the initial decision will review your appeal. Medical or dental review denials will be reviewed by a medical or dental specialist. We must receive your internal appeal request within 180 days of the date you were notified of our initial decision. You can request an extension of the 180-day deadline by sending us a written request that includes the reason why you believe an extension should be granted. If you are not satisfied with the decision, you may request a Level II internal appeal.
- **Level II internal appeal** will be reviewed by a panel of people who were not part of the Level I internal appeal. Medical and dental review denials will be reviewed by a medical or dental specialist. You may take part in the level II panel meeting in person or by phone. Please call us for more details about this process. Once the Level II review is complete, we will provide you with a written determination. If you are not satisfied with the final internal appeal decision, you may be eligible to request an ***External Appeal***, as described below.

WHO CAN APPEAL?

You can appeal yourself or choose someone, including your doctor or dentist, to appeal on your behalf. If you choose someone else, complete an Authorization for Appeals form located on **premera.com**. We can't release your information without this form.

HOW TO APPEAL

You can call Customer Service or you can write to us at the address listed inside the front cover of this book. By sending your appeal in writing, you can provide more details about your appeal. This may include chart notes, medical or dental records or a letter from your doctor. Within 3 working days, we will confirm in writing that we have your request.

If you need help filing an appeal, or would like a copy of the appeals process, please call Customer Service. You can also get a description of the appeals process by visiting our website.

If you would like to review the information used for your appeal, please contact Customer Service. The information will be sent as soon as possible and free of charge.

WHAT HAPPENS WHEN 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 HAPPENS WHEN IT'S URGENT

If your condition is urgent, we will handle your appeal in an expedited (fast) manner. Examples of urgent situation are:

- Your life or health is in serious danger or you are in pain that you cannot bear, as determined by our medical or dental specialist
- You are inpatient or receiving emergency care

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

Urgent appeals are only available for services you are currently receiving or have not yet received.

WHAT HAPPENS NEXT

Your appeal is reviewed and a decision is provided within the time limits below

Type of appeal	When to expect notification of a decision
Expedited appeals	No later than 72 hours. We will call, fax, or email you with the decision, and follow up in writing.
Other Appeals	Within 30 days

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 1-866-444-EBSA (3272).

OTHER INFORMATION ABOUT THIS PLAN

This section tells you about how this plan is administered. It also includes information about federal and state requirements we and Alyeska Pipeline Service Company must follow and other information that must be provided to you.

Conformity With The Law

If any provision of Alyeska Pipeline Service Company Contract 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 benefits under this plan are provided. 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.

Intentionally False Or Misleading Statements

If this plan's benefits are paid in error due to any intentionally false or misleading statements, the plan will be entitled to recover these amounts. See the "Right Of Recovery" section.

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 Alyeska Pipeline Service Company:

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

Limitations Of The Plan's Liability

The Claims Administrator, Alyeska Pipeline Service Company and the Plan 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 hospital, medical, dental, vision or similar 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 Alyeska Pipeline Service Company in a timely and appropriate manner in our administration of benefits. You're also under a duty to cooperate with us and Alyeska Pipeline Service Company 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, telephone 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; and,
- Fulfilling other legal obligations that are specified under the plan and our administrative services contract with Alyeska Pipeline Service Company

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 group or individual insurance plans that cover you

Notices

Any notice we're required to submit to Alyeska Pipeline Service Company or subscriber will be considered to be delivered if mailed to Alyeska Pipeline Service Company or subscriber, at the most recent address appearing on our records. We'll use the date of postmark in determining the date of our notification. If you are required to submit notice to us, it will be considered delivered on the postmark date or the date we receive it, if not postmarked.

Right Of Recovery

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 his or her 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.

Right To And Payment Of Benefits

Benefits of this plan are available only to members. Except as required by law, we won't honor any attempted assignment, garnishment or attachment of any right of this plan. In addition, members may not assign a payee for claims, payments or any other rights of this plan. At our option only, we have the right to direct the benefits of this plan 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 or legal proceedings, including arbitration proceedings, brought against us, the plan, or Alyeska Pipeline Service Company by you or anyone claiming any right under this plan must be filed:

- Within three years of the date we denied, in writing, the rights or benefits claimed under this plan, or of the completion date of the independent review process if applicable; and
- In a mutually agreed upon location.

Workers' Compensation Insurance

This contract doesn't replace, affect or supplement any state or federal requirement for Alyeska Pipeline Service Company to provide workers' compensation insurance, employer's liability insurance, or other similar insurance. When an employer is required by law to provide or has the option to provide workers' compensation insurance, employer's liability insurance, or other similar insurance and doesn't provide such coverage for its employees, the benefits available under this plan won't be provided for illnesses and/or injuries arising out of the course of employment that are or would be covered by such insurance, unless otherwise excepted under the "What's Not Covered?" section.

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.

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, telephone 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

Any notice we're required to submit to the Group or subscriber will be considered to be delivered if mailed to the Group or subscriber, at the most recent address appearing on our records. We'll use the date of postmark in determining the date of our notification. If you are required to submit notice to us, it will be considered delivered on the postmark date or the date we receive it, if not postmarked.

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 his or her 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 3 years 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

This 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 Alyeska Pipeline Service Company's employee welfare benefit plan. The "ERISA Plan administrator" is Alyeska Pipeline Service Company or an administrator named by Alyeska Pipeline Service Company. 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. (Please note that our contract with Alyeska Pipeline Service Company by itself doesn't meet all the requirements for an ERISA plan document.) 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. (Please note that this booklet by itself does not meet all the requirements for a summary plan description.) 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. You may review copies of these texts and the annual financial report of the Plan filed with the IRS, during normal business hours. If you work outside the Anchorage area, or if you want the official Plan texts mailed to you, send a written request to: Alyeska Pipeline Service Company, Compensation & Benefits – PO Box 196660, MS 536, Anchorage, Alaska 99519.
- 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. Alyeska Pipeline Service Company has delegated to us the discretionary authority to determine eligibility for benefits and to construe the terms used in the plan to the extent stated in our administrative services contract with Alyeska Pipeline Service Company. 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.

Please 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 1280, 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. We have the discretionary authority to determine the terms used in this plan.

Accidental Injury

Physical harm caused by a sudden and unforeseen event at a specific time and place. It's independent of illness, except for infection of a cut or wound. **Please Note:** An accidental injury doesn't include damage caused by biting or chewing, even if due to a foreign object in food.

Allowable Charge

The allowable charge shall mean one of the following depending on whether the dental care provider is participating or non-participating:

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

  The amount for dentally necessary services and supplies these providers have agreed to accept as payment in full pursuant to the applicable agreement between us and the provider. 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 allowable charge.

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

  The allowable charge will be the maximum allowable charge as determined by {OURNAME} in the area where the services were provided, but in no case higher than the 90th percentile of provider fees in that geographic area.

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

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.

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

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 "What If I Have A Question or An Appeal" section in this booklet for an explanation of the appeals process.

Dentist

One who is licensed to provide services in the state where the services are rendered as a:

- Doctor of Medical Dentistry (D.M.D.); or
- Doctor of Dental Surgery (D.D.S).

Effective Date

The date on which your coverage under this plan begins. If you re-enroll in this plan after a lapse in coverage, the date that the coverage begins again will be your effective date.

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.

Enrollment Date

For the subscriber and eligible dependents who enroll when the subscriber is first eligible, the enrollment date is the subscriber's date of hire. There is one exception to this rule. If the subscriber was hired into a class of employees to which Alyeska Pipeline Service Company doesn't provide coverage under this plan, but was later

transferred to a class of employees to which Alyeska Pipeline Service Company does provide coverage under this plan, the enrollment date is the date the subscriber enters the eligible class of employees. (For example, the enrollment date for a seasonal employee who was made permanent after six months would be the date the employee started work as a permanent employee.). For subscribers who don't enroll when first eligible and for dependents added after the subscriber's coverage starts, the enrollment date is the effective date of coverage.

Experimental/Investigational Services

Experimental or investigational services include a treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria as determined by us:

- A drug or device that can't be lawfully marketed without the approval of the U.S Food and Drug Administration, and hasn't been granted such approval on the date the service is provided.
- The service is subject to oversight by an Institutional Review Board.
- No reliable evidence demonstrates that the service is effective, in clinical diagnosis, evaluation, management or treatment of the condition.
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy.
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

Reliable evidence includes but isn't limited to reports and articles published in authoritative peer reviewed medical and scientific literature, and assessments and coverage recommendations published by the Blue Cross Blue Shield Association Technical Evaluation Center (TEC).

Group

Alyeska Pipeline Service Company

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 (also called "This Plan" or "The Plan")

Alyeska Pipeline Service Company's self-funded plan described in this booklet.

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.

Provider (also called "Covered Provider" or "Dental Care Provider")

A dentist or other dental care professional named in this plan that is licensed or certified as required by the state in which the services were received to provide a dental service or supply, and who does so within the lawful scope of that license or certification.

Subscriber

An enrolled employee of Alyeska Pipeline Service Company. Coverage under this plan is established in the subscriber's name.

Subscription Charges

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.

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.

We, Us and Our

Means Premera Blue Cross Blue Shield of Alaska.

where to send claims

MAIL YOUR CLAIMS TO:

Premera Blue Cross Blue Shield of Alaska
P.O. Box 91059
Seattle, WA 98111-9159

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