

City of Nome

PPO Plan

Where To Find The Answers To Your Questions

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SUMMARY OF BENEFITS

This Summary of Benefits describes the benefits available to All Employees.

The Summary of Benefits provides a general description of your benefits. It does not list all benefits included under the Plan. The Plan contains limitations and restrictions which are described in the Booklet and could reduce the benefits payable under the Plan. See the detailed description to determine what expenses are covered and what benefits will be payable.

GREAT-WEST PPO MEDICAL BENEFITS

Deductible

The calendar year deductible applies to all covered expenses except:

-expenses payable at 100%

Individual Calendar Year Deductible \$250.00

Family Calendar Year Deductible \$500.00

Per Occurrence Deductible for Non-network Services

For each inpatient Hospital confinement \$250.00

For facility charges for Outpatient Surgery \$250.00

Medical Management Program

Non-compliance Penalty per claim \$250.00

Percentage Payable after any Deductible

Pre-admission Testing 100%

Facility charges by a Childbirth Center 100%

Home Health Care 100%

Skilled Nursing facility 100%

Outpatient Surgery, including surgery performed in a Doctor's Office

- Network 90%

- Services outside the PPO Network Area 80%

- Non-network 70%

Preventive Care 100%

Hospital

- Network 90%

- Services outside the PPO Network Area 80%

- Non-network 70%

Physician charges for Hospital care and Surgery

- Network 90%

- Services outside the PPO Network Area 80%

- Non-network 80%

X-rays and lab tests

- Network 90%

- Services outside the PPO Network Area 80%

- Non-network 80%

Office Visits 80%

Outpatient Mental Health Conditions and Chemical Dependency Treatment

50%

Emergency Room Care	
- If surgery is not performed	80%
- If surgery is performed	
Network	90%
Non-network	70%
TMJ Treatment	50%
Spinal Adjustment Therapy	50%
Other Covered Expenses	80%

Individual Breakpoint	\$5,000.00
Family Breakpoint	\$10,000.00

Calendar Year Benefit Maximum

Home Health Care	1 visit per day up to 100 visits
Skilled Nursing Facility	90 days
Preventive Care	\$200.00
Inpatient Treatment of Mental Health Conditions and Chemical Dependency	20 days
Outpatient Treatment of Mental Health Conditions and Chemical Dependency	30 visits

Lifetime Benefit Maximum

Inpatient Treatment of Mental Health Conditions and Chemical Dependency	50 days
Outpatient Occupational, Speech and Hearing Therapy	\$1,000.00
TMJ Treatment	\$1,000.00

Maximum Benefit for all Covered Expenses

Lifetime benefit per Member	\$1,000,000.00
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PRESCRIPTION DRUG BENEFITS

Mail Order Drug Program	100% after \$20.00 copay
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DENTAL BENEFITS

Deductible

The Calendar Year deductible applies to all covered expenses except for Preventive Care.

Individual	\$50.00
Family	\$150.00

Percentage Payable after any Deductible

Preventive Care	100%
Basic Care	80%
Major Care	50%

Calendar Year Benefit Maximums

Preventive, Basic and Major Care	\$1,000.00
Adjusted Annual Maximum (This maximum is applied to the first calendar year of coverage for Members who become covered on or after July 1 of any year.)	\$500.00

VISION BENEFITS

Calendar Year Deductible	None
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Percentage Payable

Eye examinations	100%
Eyeglass lenses and frames or contact lenses	100%

Benefit Maximum (per 24-month period)

Eye examinations	\$60.00
Eyeglass lenses and frames or contact lenses	
-Single vision lenses	\$120.00
-Bifocal lenses	\$138.00
-Trifocal lenses	\$150.00
-Lenticular lenses	\$192.00

Lifetime Benefit Maximum

Contact lenses prescribed for medical reasons	\$360.00
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LIFE INSURANCE BENEFITS

The amount will be based on the following schedule:

Employees	\$20,000.00
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ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

The amount of AD&D Benefit that an Employee may receive is based on a Principal Sum. The amount of the Principal Sum is equal to the amount of Standard Life Insurance.

AD&D Benefit for the Loss of:

Amount Payable

Life	Principal Sum
Both hands or both feet or sight of both eyes	Principal Sum
One hand and one foot	Principal Sum
One hand or one foot and sight of one eye	Principal Sum
One hand or one foot	1/2 of Principal Sum
Sight of one eye	1/2 of Principal Sum

Loss of hands and feet means permanent dismemberment by severance through or above the wrist or ankle joints. Loss of sight means total and permanent loss of sight beyond remedy by surgical or other means.

REDUCTIONS IN LIFE INSURANCE AND AD&D BENEFIT

The amount of an Employee's Life Insurance and AD&D Benefit in effect at the time the Employee reaches age 65 will reduce by 35% at age 65, 55% at age 70, 70% at age 75, 80% at age 80 and 85% at age 85.

NOTICES

■ Women's Health and Cancer Rights Act

This Notice is required by the Women's Health and Cancer Rights Act of 1998 (WHCRA) to inform you, as a member of the Plan, of your rights relating to coverage provided through the Plan in connection with a mastectomy. As a Plan Member, you have rights to coverage provided in a manner determined in consultation with your attending Physician for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications to produce a symmetrical appearance, including lymphedema.

This coverage may be subject to deductible and copayment provisions, if your Plan includes such provisions. Additional details regarding this coverage are provided in the Plan. Keep this notice for your records and call your Plan Administrator for more information.

INTRODUCTION

■ About This Plan

City of Nome (the Employer) has established an Employee Welfare Benefit Plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). As of February 1, 2002, the benefits described in this booklet constitute the benefits available under the plan and are referred to collectively in this booklet as the Plan. The Plan will be maintained pursuant to the terms of this booklet. The Plan may be amended from time to time.

If a booklet was issued to you under the Employer's prior plan, this is your new booklet. This new booklet replaces your old booklet in its entirety. If you were covered under the replaced booklet on the day before the effective date of the Plan, you will be covered under this booklet as of the date shown above.

If on the date shown above you are not Actively at Work or your Dependent is confined in the Hospital, refer to *Will My Coverage Change?* under *WHEN COVERAGE BEGINS & ENDS* for details as to when a change in coverage will become effective.

Some of the benefits that form a part of the Plan and are described in this booklet are fully insured by Great-West Life & Annuity Insurance Company (Great-West), 8505 E. Orchard Road, Greenwood Village, CO 80111. Others are self-funded by the Employer.

Defined terms are capitalized throughout this booklet. These terms have a special meaning with respect to the coverage outlined in the booklet and are defined in the Glossary.

Insured Benefits

Life and AD&D Insurance

For insured benefits, this booklet becomes your certificate of insurance only if you complete the appropriate application forms and are approved for coverage by Great-West.

Great-West has full discretion and authority to determine the benefits and amounts payable and to construe and interpret all terms and provisions of this booklet.

Self-Funded Benefits

Medical, Prescription Drug, Dental and Vision Benefits

The Plan Administrator has complete authority to control and manage the Plan. The Plan Administrator has full discretion to determine eligibility, to interpret the Plan and to determine whether a claim should be paid or denied, according to the provisions of the Plan as set forth in this booklet.

The Employer is fully responsible for the self-funded benefits. Great-West processes claims and provides other services to the Employer related to the self-funded benefits. Great-West does not insure or guarantee the self-funded benefits.

Plan Modification/Termination

The Employer may:

- change the contributions a Member must pay for benefits; or
- amend or terminate the benefits provided to you in the Plan.

If the Plan is amended or terminated it will not affect coverage for services provided prior to the effective date of the change.

WHEN COVERAGE BEGINS & ENDS

■ When Will Coverage Begin?

The definition of Employee or Dependent will determine who is eligible for coverage under the Plan.

Coverage will begin after you have satisfied any eligibility waiting periods required by the Employer.

Before coverage can start, you must:

- Submit an application within 31 days after becoming eligible;
- Pay any required contribution; and
- For Life and AD&D Insurance, be Actively at Work on the eligibility date.

Coverage for a newly acquired Dependent will begin on the date you acquire the Dependent if you are covered and if you apply for coverage within 31 days after acquiring the new Dependent.

If the Dependent is an adoptive child, coverage will start:

- For an adoptive newborn, from the moment of birth if the child's date of placement is within 31 days after the birth; and
- For any other adoptive child, from the date of placement.

■ What If I Don't Apply On Time?

You are a late applicant under the Plan if you don't apply for coverage within 31 days of the date you become eligible for coverage. Your Dependent is a late applicant if you elect not to cover a Dependent and then later want coverage for that Dependent.

Medical, Prescription Drug, Dental and Vision Benefits

A late applicant may apply for coverage only during an Open Enrollment Period. The Plan Administrator can tell you when the Open Enrollment Period begins and ends. Coverage for a late applicant who applies during the Open Enrollment Period will begin on the first day of the month following the close of the Open Enrollment period.

For Medical, Prescription Drug, Dental and Vision benefits, a Member is *not* a late applicant if:

- You did not apply for coverage within 31 days of the eligible date because the Member was covered under another health insurance plan or arrangement and coverage under the other plan was lost as a result of:
 - Exhausting the maximum period of COBRA coverage; or
 - Loss of eligibility for the other plan's coverage due to legal separation, divorce, death of a spouse, termination of employment or reduction in the number of hours of employment; or
 - Termination of the employer's contribution for the other plan's coverage.

You must have stated in writing that the other health coverage was the reason you declined coverage under this Plan, but only if the Employer required such a statement and notified you of the consequences of the requirement when you declined coverage.

- You did not apply to cover your spouse or a Dependent child within 31 days of the date you became eligible to do so and later are required by a qualified court order to provide coverage under this Plan for that person.
- You did not apply to cover yourself or an eligible Dependent within 31 days of the date you became eligible to do so and later experience a change in family status because you acquire a Dependent through marriage, birth or adoption. In this case, you may apply for coverage.

If you apply within 31 days of the date:

- Coverage is lost under the other plan, as described above, coverage will start on the day after coverage is lost under the other plan.
- A court order was issued, coverage will start on the court ordered date.
- You acquire a new Dependent, coverage will start:

- In the case of marriage, on the date of marriage.
- In the case of birth or adoption, on the date of birth, adoption or placement for adoption.

Life and AD&D Insurance

Late applicants must provide Great-West with Proof of Good Health at their own expense. Coverage for a late applicant will begin on the date Great-West approves Proof of Good Health.

■ **What If I Was Covered for Health Benefits Under the Employer's Prior Plan?**

A Member who had similar coverage under the Employer's prior plan on the date of its termination will be covered under this Plan on the Plan effective date. Any waiting period under this Plan will be reduced by the part of the waiting period that had been satisfied under the prior plan. "Health benefits" mean medical, prescription drug, dental and vision benefits.

If a Member was on COBRA or any other continuation coverage or extension of benefits under the prior plan and that plan terminated, coverage will be provided for that Member until the earlier of:

- The date on which coverage would end under the terms of the Plan; or
- The last day of the period for which coverage would have been provided had the prior plan not terminated.

If a Member was covered under any extension of benefits under the prior plan, the benefits provided under this Plan will be the same as those provided by the prior plan, less any amount paid under the prior plan.

If you were on Family and Medical Care Leave on the effective date of this Plan and you were covered under the Employer's prior plan on the date of its termination, then you will become covered for the benefits provided under this Plan as of its effective date.

Deductible and Breakpoint Credits

Any amount a Member has already paid toward the calendar year medical deductible under the prior medical plan will be applied to this Plan's calendar year medical deductible.

Any benefit maximums under this Plan will be reduced by the amount paid under the prior plan in the calendar year in which your Employer transfers claims processing to Great-West.

Any amount of covered expenses a Member has already used to satisfy any calendar year breakpoint under the prior medical plan will be applied to this Plan's calendar year breakpoint.

Special Benefits for Pre-Existing Conditions

These benefits apply if a Member would not be eligible for coverage under the Plan because of the pre-existing conditions limitation and is not eligible for benefits under the prior plan because expenses were incurred after termination of that plan.

The amount of benefits will be the lesser of the amount that would have been paid under the prior plan if it had stayed in force and the amount that would have been paid under this medical Plan if it did not have a pre-existing conditions limitation.

Any length of time a Member has already satisfied toward the pre-existing conditions limitation waiting period of the prior plan will be carried over to this medical Plan.

■ **Will My Coverage Change?**

If the Employer amends the benefits or amounts provided under the Plan, a Member's coverage will change on the effective date of the amendment. If a Member changes classes, coverage will begin under the new class the first day of the month coinciding with or next following the date the Member's class status changes.

For Life and AD&D Insurance, if you are an active Employee and you are not Actively at Work when either of these changes occurs, the change in your coverage will not take place until you return to work with the Employer for one full day. This does not apply to Medical, Prescription Drug, Dental and Vision Benefits.

All claims will be based on the benefits in effect on the date the claim was incurred.

■ **When Will My Coverage End?**

Your coverage will end on the earliest of the following dates:

- The date the Employer terminates the benefits described in this booklet.
- If you are Exempt, the date you are no longer eligible or the last day of the month coinciding with or next following the date your Service ends.
- If you are Classified, the date you are no longer eligible or the last day of the month coinciding with or next following the date your Service ends.
- The due date of the first contribution toward your coverage that you or the Employer fails to make.
- The date Loss of Residence occurs.

Your Dependent coverage will end on the earliest of the following dates:

- The date your coverage ends; or
- Loss of Residence occurs; or
- The date your Dependent is no longer eligible for benefits; or
- The due date of the first contribution toward Dependent coverage that you or the Employer fails to make.

■ **Can I Continue or Convert My Coverage If I Become Ineligible?**

If you become ineligible for coverage under the Plan, you may be able to continue coverage for certain benefits.

Continuation of Life Insurance during an Illness, Approved Leave of Absence or Temporary Layoff

If your Service ends due to Illness, Life Insurance will continue for 12 months after your Service ends.

If your Service ends due to approved leave of absence or temporary layoff, Life Insurance will continue for 31 days after the date your Service terminates.

Your coverage will end sooner than stated above if you and/or your Employer fails to pay for this continuation coverage. There is no continuation for AD&D benefits.

Continuation of Coverage during Family and Medical Care Leave

If the Employer approves your Family and Medical Care Leave, coverage under the Plan will continue during your leave. Contributions must be paid by you and/or the Employer. If contributions are not paid, your coverage will cease.

However, on the date you return to work, coverage will be on the same basis as that provided for any active Member on that date. If you have questions about Family and Medical Care Leave, see the Plan Administrator.

Continuation under COBRA for Medical, Prescription Drug, Dental and Vision Coverage

A Member may be eligible to continue coverage under COBRA. Qualifying events determine eligibility for COBRA coverage and the length of continuation.

Termination of your Service for any reason except gross misconduct is a qualifying event. For a covered Dependent, a qualifying event includes termination of your Service, your becoming entitled to Medicare, and your death, divorce or legal separation. The date a Dependent no longer meets the definition of Dependent is also a qualifying event.

When the qualifying event is termination of your Service, COBRA coverage may be extended for a Member who qualifies for Social Security disability benefits. However, the Member's disability must have existed on the date of the qualifying event or have begun within the first 60 days of COBRA coverage.

When a qualifying event occurs, the Employer or a representative of the Employer must give you the necessary COBRA election form. You must complete and return this form to the Employer or his or her representative within 60 days of the later of the date the Member loses coverage or the date the Member receives the COBRA election forms.

If a Member receives a Social Security disability determination, the Member must notify the Employer or his or her representative within 60 days of the determination and before the end of the initial 18 month COBRA coverage period in order to extend COBRA coverage to 29 months.

If you have questions about COBRA, see the Plan Administrator.

Extension of Medical and Prescription Drug Benefits

A Member who is Totally Disabled on the date he or she becomes ineligible for continuation of coverage or continuation under COBRA may still be eligible for extended benefits for the disabling condition only. These benefits are extended:

- During the course of that Total Disability.

- Under the same benefit provisions as if coverage had not ended.
- Upon termination of the Member's coverage under this Plan, for 90 days, as long as this Plan is still in force.

You do not have to pay for extended benefits.

Conversion of Life Insurance Benefits

If all or part of your group term life insurance ends, you may apply for an individual life insurance policy.

Proof of Good Health is not required. You must apply for the life conversion coverage within 31 days after your life insurance coverage ends. You are entitled to written notice of your right to convert. If you do not receive written notice within 16 days of the date your coverage ends, the 31 days will be extended to the earlier of:

- 91 days after the date coverage ends; and
- 15 days after the date on which you receive written notice.

The policy will be one of Great-West's standard conversion policies and will not contain a disability benefit or an accidental death benefit. The amount of coverage chosen can never be more than your current amount of insurance. The amount of the premium will depend on your age and class of risk.

You are allowed 31 days to apply for the individual policy. If you die within this period, your beneficiary will receive a death benefit. The amount of this benefit will be the maximum amount of group term life insurance which you would have been eligible to convert under this provision.

However, if the amount of your insurance had been reduced during this 31-day period because of age or retirement, the death benefit will be the amount of your group term life insurance before the reduction. This death benefit is payable even if you had not applied for an individual policy.

Employee Conversion of Life Insurance Benefits

If the group policy is still in force, you may convert all or part of your insurance to an individual policy if your coverage ends. If your coverage reduces due to age or retirement you may convert up to the amount of the reduction.

If the group policy is terminated or amended you may convert your life insurance if all or part of your coverage ends. However:

- You must have been insured under the group policy for at least five consecutive years; and
- The amount of the individual policy will be the lesser of \$2,000.00 and the current amount of your group term life insurance.

If your insurance is being continued under the disability benefit, you may convert your coverage if your coverage ends or reduces due to age or retirement. You may convert this coverage even if the group policy is not in force.

Conversion of AD&D Benefits

Conversion coverage is not available for AD&D benefits.

■ **Can Coverage Be Reinstated?**

If your coverage ended because of termination of your Service, it will be reinstated on the date you return to work with the Employer. You must return within 3 month(s) to be reinstated.

On the date you return to work, coverage for you and your eligible Dependents will be on the same basis as that provided for any other active Employee and his or her Dependents as of that date. However, any restrictions on your coverage that were in effect before your reinstatement will still apply.

Coverage for a Military Reservist who returns from active duty will be reinstated as required under the Uniformed Services Employment & Re-employment Rights Act.

Coverage for a Member whose coverage ended due to Loss of Residence will be reinstated:

- for an Employee, on the day after completing 30 consecutive days of Work in the United States or Puerto Rico;
- for a Dependent, on the day after completing 30 consecutive days residence in the United States or Puerto Rico.

The Member must return to the United States or Puerto Rico within three months of the date the Loss of Residence occurred to be reinstated. Coverage will be on the same basis as that being provided for any other active Employee and his or her Dependents on the date coverage is reinstated. However, any restrictions on the coverage that were in effect before reinstatement will continue to apply.

GREAT-WEST PPO MEDICAL BENEFITS

■ How Does the Plan Work?

The PPO includes a nationwide network of Hospitals and a Medical Management Program. Care given in a network Hospital is payable at a higher level than care given in a non-network Hospital.

A Member can call Member Services for the names of network Hospitals.

Members who use a non-network provider may reduce their out-of-pocket expenses by choosing a provider participating in the MultiPlan network. MultiPlan is a supplemental network available to Members who choose to use a provider outside the network. Call Member Services for the names of providers who are participating in the MultiPlan network, or access www.multiplan.com. MultiPlan providers are considered non-network providers under this Plan, therefore, the Member is responsible for pre-treatment approval for hospital admissions and surgery outside the Doctor's office.

Out of Town Care

If a Member is out of town and needs non-emergency care, the Member should contact Member Services for help in locating a network provider. Since the PPO network is nationwide, the Member may be able to see a network provider and receive a higher level of benefits.

If a Member is outside the PPO network area, benefits will be payable as shown on the Summary of Medical Benefits.

Emergency Care

If emergency care is needed, go to the nearest medical facility. Coverage for emergency care is available 7 days a week, 24 hours a day.

Great-West administers a prudent layperson emergency policy. You are experiencing an emergency if you have a sudden onset of acute symptoms and believe that if you don't get immediate care, it may result in serious jeopardy to your health. Some examples are chest pain, difficulty in breathing and uncontrolled bleeding.

Medical Management (MM) Program

Before a Member is hospitalized or has surgery outside the Doctor's office, the Member's Doctor must call Medical Management for pre-treatment authorization. This telephone number is on the ID card.

Medical Management will determine:

- The medical necessity of the care;
- The appropriate location for the care to be provided; and
- If admitted to a Hospital, the appropriate length of stay.

If hospitalization or surgery is required because of an emergency, the Member's Doctor must call MM within two days after care is given.

If a Member's Doctor does not get pre-treatment authorization, or if a Member does not follow the recommended care plan, a \$250.00 non-compliance penalty will be applied to the Member's claim. The non-compliance penalty cannot be applied toward the calendar year deductible or breakpoint.

The MM Program provides Hospital discharge planning and identifies patients who might benefit from the Case Management Program.

The Case Management Program (CM) helps Members with serious illnesses manage their health care. The goal of the CM program is to develop alternative treatment plans that will help these Members obtain the type of care needed *outside* of a Hospital setting. Members who choose to participate in this program are assigned a case manager to help coordinate care.

If a Member and the Member's Doctor decide that the recommended alternative treatment plan is right for the Member, it will be covered on the same basis as the care and treatment for which it is substituted. This will be the case even if the alternate treatment plan includes care that is not otherwise covered under the Plan.

Calendar Year Deductible

A calendar year deductible is the amount of covered medical expenses that must be satisfied before the Plan begins to pay benefits.

Any expenses that were incurred in the last three months of a calendar year and used to satisfy the deductible for that year will also be applied to the deductible for the next calendar year.

Allowable Covered Expenses

All medical benefits are subject to allowable covered expense guidelines.

Network providers have agreed to a set fee schedule. Members are not responsible for expenses over the scheduled amount for covered services. Members are responsible for any applicable copays, deductibles, and coinsurance.

For non-network providers, the allowable covered expense is determined by usual and customary charge guidelines. The usual and customary charge for each service or supply received will be the lesser of the fee usually charged by a provider and the fee usually charged by other providers in the same geographical area for these services and supplies. The Member must pay any amount over usual and customary charges.

■ **What's Covered?**

The Summary of Medical Benefits located in the front of the booklet shows the payment percentage and deductible amount applicable to various covered expenses. Any benefit maximums applied to specific covered expenses and calendar and lifetime benefit maximums for *all* covered expenses are also shown on the Summary of Medical Benefits.

If the Plan pays benefits at less than 100%, you must pay the remaining percentage of covered services. This amount is in addition to any deductible amount.

Services must be Medically Necessary as defined in the Glossary. Unless otherwise noted for a particular service, services must be required as a result of symptoms of illness. Expenses are covered only if incurred while the Member is covered for these medical benefits.

Hospital Care and Surgery

The Plan covers semi-private room and board and ICU expenses as well as other inpatient and outpatient services, supplies and Doctor's charges. Hospital and Doctor charges for infant care through the first seven days of life are covered if you have elected Dependent coverage.

Skilled Nursing Facility

The Plan covers care in a licensed skilled nursing facility. Care must be such that it requires the skills of technical or professional personnel, is needed on a daily basis and cannot be provided in the patient's home or on an outpatient basis. Care must be required for a medical condition which is expected to improve significantly in a reasonable period of time and the Member must continue to show functional improvement.

Coverage is limited to the usual charge of the facility for semi-private care. This amount includes room and board and all other services.

Office Visits

The Plan covers most services and supplies in a Doctor's office.

Preventive Care

The Plan covers periodic physical exams by a Doctor for a Member who is at least eight days of age. This includes x-ray and lab services if part of the annual physical exam, necessary immunizations and booster shots.

The Plan covers an annual pelvic exam, Pap smear and mammogram.

Benefits are payable up to the maximum shown in the Summary of Benefits.

Preventive care x-ray and lab tests are not subject to the calendar year deductible and will be payable under the Preventive Care payment percentage as shown in the Medical Summary of Benefits.

Reconstructive Surgery following a Mastectomy

The Plan covers reconstruction of the breast on which a mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications related to all stages of mastectomy, including lymphedemas.

Treatment is to be determined by the attending Doctor, in consultation with the patient. Benefits will be payable on the same basis as for any other surgery covered under the Plan.

Other Reconstructive Surgery

The Plan covers reconstructive surgery when the primary purpose is to improve function of the underlying structures or to restore large skin defects due to port wine stain. Surgery to correct significant congenital defects is covered only if the defect interferes with bodily function (not psychological function). Reconstructive surgery performed as a result of trauma or disease is covered when reconstruction begins within one year of the trauma or illness (except for reconstructive surgery as a result of a mastectomy). Secondary or tertiary reconstructive procedures may be covered more than one year later, but only when the planning for these procedures (as noted in the Member's medical records) takes place within one year of the trauma or illness.

Maternity Coverage

The Plan covers prenatal, childbirth and postnatal care. Coverage for you and your baby, if dependent coverage is elected, includes a Hospital stay of 48 hours following a normal vaginal delivery and 96 hours following a C-section. The 48/96 hours begin following delivery of the last newborn in case of multiple-births. When delivery takes place outside a hospital, the 48/96 hours begin at the time of inpatient admission. The Hospital stay may be less than the 48-hour or 96-hour minimum if a decision for early discharge is made by the attending Doctor in consultation with the mother.

Pre-authorization is not required for the 48/96-hour Hospital stay. However, authorization is needed for a longer stay than as described above.

As soon as a Member finds out that she is pregnant, she or her Doctor should contact Member Services so they can help her identify and avoid risks during pregnancy and obtain the prenatal care she needs. They can also direct her to appropriate facilities.

Treatment of TMJ and Related Disorders

The Plan covers treatment of temporomandibular disorders and craniofacial muscle disorders.

Treatment of Mental Health Conditions and Chemical Dependency

The Plan covers inpatient and outpatient treatment of mental health conditions, alcoholism, drug addiction and other chemical dependency.

Spinal Adjustment and Treatment

The Plan covers expenses for services related to spinal adjustment.

Home Health Care

The Plan covers home health care visits when services are provided by a licensed home health care agency. Services must be prescribed as an alternative or a follow-up to inpatient Hospital care. The Member must be restricted from leaving home due to a medical condition.

Care must be such that it cannot be learned or performed by the average, non-medically trained person. Care must be provided by technical or professional personnel or by home health aides working along with technical or professional personnel. Care must be required for a medical condition which is expected to improve significantly in a reasonable period of time.

Hospice Care

The Plan covers hospice care if prescribed by a Doctor and the Member's life expectancy is six months or less.

Other Medical Services and Supplies

The Plan covers:

- Non-disposable medical equipment appropriate for use within a Member's home. Covered equipment must be able to withstand repeated use and be used to treat an illness. Replacement of equipment is covered only when required as a result of normal usage.

- Nursing services.
- Ambulance services.
- General anesthesia and associated facility charges for dental procedures when determined to be Medically Necessary.
- Custom-designed orthotics when prescribed by a Doctor and required for all normal, daily activities.
- Physical therapy rehabilitation to restore function and prevent disability following acute disease, injury or loss of body part with the expectation of significant improvement within two months. Covered therapy includes exercise, heat, cold, electricity, ultrasound and massage to improve circulation, strengthen muscles, encourage return of motion and train Members to perform the activities of daily living.
- Services and supplies required for the treatment of diabetes and diabetes self-management education programs.
- Outpatient Occupational, Speech and Hearing Therapy.
Occupational therapy means rehabilitation to attain the maximum level of physical and psycho-social independence following acute disease, injury or loss of body part with the expectation of significant improvement within two months. This includes fine motor coordination, perceptual-motor skills, sensory testing, adaptive/assistive equipment, activities of daily living and specialized upper extremity and hand therapies.
Speech therapy means restoration of speech due to impairment following a recent physiological disturbance or injury, such as CVA, tracheostomy, swallowing disorders, laryngectomy and neuromuscular disease, with the expectation of significant improvement within two months.
- Prescription drugs, except oral contraceptives, when received as an outpatient.
- Reasonable costs associated with a search for a matched unrelated donor when the transplant is certified by us as Medically Necessary and is performed at a facility approved by and affiliated with the National Marrow Donor Program.

■ Is There a Limit On My Expenses?

The breakpoint maximums are shown in the Summary of Medical Benefits.

Calendar Year Breakpoint

If in any one calendar year a Member's covered expenses reach the individual breakpoint, all other covered expenses for that Member during the rest of that calendar year will be payable at 100%. No more than the individual breakpoint per Member will be applied to the family breakpoint.

Covered expenses for outpatient care of mental health conditions and chemical dependency treatment, services related to spinal adjustment and treatment of TMJ and related disorders will *not* be payable at 100%, even if a Member has reached the breakpoint.

Expenses Excluded from the Breakpoint

Expenses that are not applied toward the breakpoint include expenses:

- for services and supplies not covered under this Plan.
- used to satisfy any deductible amounts.
- for outpatient care of mental health conditions and chemical dependency.
- for services related to spinal adjustment.
- for treatment of TMJ and related disorders.
- that are payable at 100%.

PRESCRIPTION DRUG BENEFITS

The prescription drug benefits are provided through the Mail Order Drug Program. The Mail Order Drug Program lets Members order larger quantities of maintenance drugs through the mail to lower their out-of-pocket costs.

Covered drugs require the written prescription of a Doctor and approval by the FDA. Drugs must be purchased from a licensed pharmacist or Doctor. Benefits are payable only for drugs required for the treatment of illness, when received as an outpatient and while covered for these benefits.

Some drugs may have dispensing limits which are primarily based on FDA recommendations.

Mail Order Drug Program

The Mail Order Drug Program covers costs for home delivery and expenses for prescription maintenance drugs required for treatment of illness. Prescription maintenance drugs are drugs prescribed by the Doctor on an ongoing basis. This includes expenses for insulin.

With this program, a Member may buy through the mail up to 90-day supplies of insulin and covered maintenance prescription drugs. Ask the Employer for a mail order drug brochure.

Ask the Doctor to prescribe needed medications for a 90-day supply, plus refills. If a Member is presently taking medications, the Member should ask the Doctor for a new prescription.

If a Member's prescription is for a brand name drug but a generic equivalent is available, the Member will be sent the generic drug unless the Doctor has written DAW (Dispense as Written) on the prescription.

If Medication is Needed Immediately

If medication is needed immediately, the Member should ask the Doctor for two prescriptions. The first should be for a 14-day supply that the Member can have filled at a local PCS pharmacy. The second prescription should be mailed to the Mail Order Drug Program with the copay.

DENTAL BENEFITS

Allowable Covered Expenses

All dental benefits are subject to allowable covered expense guidelines.

The allowable covered expense is determined by usual and customary guidelines. The usual and customary charge for each service or supply received will be the lesser of the fee usually charged by a Dentist and the fee usually charged by other Dentists in the same geographical area for these services and supplies. The Member must pay any amount over usual and customary charges.

Pre-Treatment Plan

For specialist care and any other dental care expected to cost \$300 or more, ask the Dentist to prepare a treatment plan and send it to the address shown on the Plan ID card.

The Member and the Dentist will receive an explanation of benefits (EOB) that details the benefits payable under the Plan. The pre-determination of benefits is valid for 90 days.

■ What's Covered?

The Summary of Dental Benefits located in the front of the booklet shows the payment percentage and deductible amount applicable to various covered expenses.

If the Plan pays benefits at less than 100%, you must pay the remaining percentage of covered services.

Services must be necessary for the diagnosis, prevention or correction of dental disease, defect or injury. Services must be recommended or prescribed by a licensed Dentist or Doctor, or performed by a dental assistant or dental hygienist working under the direct supervision of a Dentist.

The Plan covers only the least costly procedure that will produce satisfactory results. Expenses are covered only if incurred and completed while a Member is covered for these dental benefits.

Preventive Care

Members may receive the following services twice each calendar year, but not more than once in any five-month period:

- Oral examination.
- Cleaning of teeth.
- Bite wing x-rays.
- Topical application of fluoride solution for Dependent children.

Preventive treatment also includes:

- Sealants for children; and

- A full-mouth series of x-rays once in any 36-month period.

Basic Care

Basic care includes:

- Extractions and alveolectomy at the time of tooth extraction.
- Amalgam, silicate, acrylic, and composite fillings. Silicate, acrylic, and composite fillings are covered only for teeth in front of the first bicuspid.
- Dental surgery.
- X-ray and lab services required for dental procedures.
- General anesthesia required for dental surgery.
- Care for relief of dental pain.
- Drugs that require a Dentist's written prescription, including medication given at the Dentist's office.
- Consultations required by the attending Dentist.
- Relines and rebases to existing dentures.
- For Members age 14 and under, habit-breaking appliances.
- For Members age 14 and under, space maintainers for missing primary teeth.
- Endodontic and Periodontic Care.

Major Care

Major care includes:

- Crowns, inlays and onlays.
- Fixed bridge restorations.
- Removable partial or complete dentures.
- Repairs to existing dentures.
- Initial placement of full or partial dentures or bridgework, including abutments, but only if they are needed to replace natural teeth pulled after coverage begins.
- Replacement of existing full or partial dentures, bridgework or crowns; or the addition of teeth, inlays, onlays, crowns or gold restorations to these appliances only if:
 - The existing appliance cannot be repaired or restored to use; and
 - The Member has been covered at least 12 months.
 - At least five years have passed since the last placement; or
 - The replacement:
 - * Replaces an existing temporary appliance that was placed after the date on which the Member became covered; and
 - * Is placed within 12 months after a temporary appliance was placed; or
 - * The replacement:
 - Is needed because of the pulling of additional natural teeth or accidental injury to natural teeth (except for chewing injuries) while covered; and
 - Is completed within 12 months of the extraction or Accidental Injury.

If a Member has a partial denture, and a natural tooth adjacent to that denture is pulled while the Member is covered, the addition of another tooth to the Member's denture is covered.

VISION BENEFITS

The Summary of Vision Benefits located in the front of the booklet shows the payment percentage applicable to various covered expenses.

If the Plan pays benefits at less than 100%, you must pay the remaining percentage of covered services.

Eye Exams

The Plan covers eye exams.

Eyeglass Lenses and Frames or Contact Lenses

The Plan covers eyeglass lenses and frames or contact lenses. Maximum amounts payable includes the cost of tinting, photograying and hardening of lenses.

LIFE INSURANCE BENEFITS

■ **Standard Life Insurance**

If you die from any cause while covered under the life insurance Plan, your amount of standard life insurance will be paid to your beneficiary. The amount will be based on the schedule shown in the front of this booklet.

■ **How Do I Name a Beneficiary?**

A beneficiary is the person who will receive payment of the life insurance amount if you die. You should name a beneficiary when you first apply for insurance. Unless legally restricted, you can change the beneficiary at any time by giving Great-West written notice. The beneficiary's consent is not required unless the designation of the beneficiary is irrevocable.

Naming or changing a beneficiary must be in writing, signed by you and filed with Great-West at its Executive Offices.

If a named beneficiary dies before you, the amount of the life insurance that beneficiary would have received will be paid to any remaining named beneficiaries who survive you, unless you have specified otherwise on your application or state law does not allow this.

When there are two or more named beneficiaries the life insurance will be divided in equal shares, unless you have specified otherwise.

Subject to state law, if no named beneficiary survives you or if you have not named a beneficiary, the amount of insurance will be paid to your surviving spouse; if none, then to your surviving child or children; if none, then to your surviving parent or parents; if none, then to your surviving brothers or sisters; if none, then to your estate.

■ **How Will Benefits Be Paid?**

Proof of death must be sent to Great-West. Great-West will pay the amount of insurance (the death benefit) to the beneficiary.

- If any person has incurred expenses related to your last illness or death, Great-West can deduct up to \$250.00 from the death benefit to pay the person who incurred these expenses.
- The life insurance will be paid to the beneficiary. Prior to your death, you may elect to have your life insurance paid to your beneficiary in any manner to which Great-West agrees.
- If you do not elect an optional payment method prior to your death, then after your death the beneficiary may elect to have the life insurance paid to him or her in any manner to which Great-West agrees.

Payments will not be made more than once a year unless each payment is at least \$25.00.

■ **What If I Become Disabled?**

After you have been Totally Disabled for 9 consecutive months, insurance for yourself may be continued without further premium payment. To qualify for this benefit:

- You must become Totally Disabled while insured under this life insurance Plan;
- Your Total Disability must continue without interruption for at least 9 months;
- You must be under age 60 when you become Totally Disabled;
- You must send proof of your Total Disability to Great-West within 12 months of the start of the disability; and
- If you have converted to an individual policy under this Plan, you must surrender it. See "Conversion of Life Insurance Benefits" in the section entitled "When Coverage Begins & Ends." All premiums paid for the individual policy after you have been Totally Disabled for 9 months will be returned. If you die during this 9 month period, the amount of insurance will be paid under either this life insurance Plan or the individual policy but *not* under both.

If you qualify for this disability waiver of premium benefit, you must send proof of the continuance of your Total Disability to Great-West when requested.

The amount of life insurance continued will be the amount in effect under this Plan on the date you became disabled. However, the amount of insurance may reduce or terminate due to age or retirement according to the provisions of the Plan that were in effect on the date you became Totally Disabled.

This life insurance Plan does not have to be in force at the time of death for life insurance to be paid.

Your disability waiver of premium benefit will terminate:

- On the date you recover from your Total Disability; or
- If you do not send Great-West proof of the continuance of your Total Disability when requested.

■ **Is the Amount of My Insurance Reduced As I Grow Older?**

Your amount of standard life insurance will be reduced according to the schedule shown in the front of this booklet.

■ **Life Insurance Benefits If Terminally Ill**

Any Accelerated Benefit that you receive may be treated as taxable income and may affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax and/or legal advisor before you apply for an Accelerated Benefit.

If you are terminally ill, you may apply to receive a portion of your life insurance as an Accelerated Benefit. In order to do this, you must be covered under this Plan and you must give Great-West satisfactory proof of having a Qualifying Medical Condition.

Qualifying Medical Condition means you are terminally ill, with a life expectancy of 12 months or less. In considering a request for an Accelerated Benefit, Great-West at its expense, may require that you be examined by a Doctor of its choice.

To apply for an Accelerated Benefit you must:

- contact your Employer for the appropriate application form; and
- send your application to Great-West along with a statement from your Doctor certifying the Qualifying Medical Condition.

For purposes of this benefit, the Doctor cannot be:

- yourself; or
- a person who is part of your immediate family (your parent, spouse, sibling or child); or
- a person who lives with you.

The request for an Accelerated Benefit must be made by the terminally ill insured person. However, if he or she is legally incapacitated or a minor child, the request must be made by a person with legal authority to act on the insured person's behalf.

You may request an Accelerated Benefit of up to 50% of the amount of your life insurance to a maximum of \$100,000.00. The minimum Accelerated Benefit is \$1,000.00.

The amount of the Accelerated Benefit available to you will be based on the amount of life insurance coverage provided to you by Great-West under this Plan when you request the Accelerated Benefit.

For any life insurance scheduled to reduce within 36 months of the date of application for the Accelerated Benefit, the amount of the Accelerated Benefit will be based on the reduced amount.

The Accelerated Benefit will be paid in a lump sum and is available only one time while covered by Great-West. If you recover from your Qualifying Medical Condition after receiving an Accelerated Benefit, Great-West will not ask you for a refund of the Accelerated Benefit. However, your amount of life insurance will be reduced as described below.

After payment of the Accelerated Benefit, the amount of your life insurance coverage under this Plan will be reduced by the amount of the Accelerated Benefit. If the Accelerated Benefit amount is equal to or exceeds the amount of life insurance in force at the time of your death, no additional amounts of life insurance will be payable upon your death.

Anyone approved for an Accelerated Benefit may also be approved for disability waiver of premium. (See “What If I Become Disabled?”) Anyone already on disability waiver of premium when approved for an Accelerated Benefit, will continue on premium waiver.

No Accelerated Benefit will be paid if:

- All or part of your insurance must be paid to your children or your spouse or former spouse as part of a court approved divorce decree, separate maintenance agreement, or property settlement agreement.
- You are married and live in a community property state, unless you provide us with a signed statement from your spouse consenting to payment of the Accelerated Benefit.
- You have made an assignment of all or part of your life insurance, unless you provide Great-West with a signed statement from your assignee consenting to payment of the Accelerated Benefit.
- You have filed for bankruptcy, unless you provide Great-West with written approval from the bankruptcy court for payment of the Accelerated Benefit.
- You have previously received an Accelerated Benefit while covered under this Plan.

■ Other Information About Life Insurance

Absolute Assignment

You can transfer all your rights of ownership in your life insurance. This is known as absolute assignment. Great-West is not responsible for the validity or effect of any assignment.

To assign your life insurance, notify your Employer, who will contact Great-West for an assignment form. Great-West will not recognize an assignment until the original assignment form has been noted at its Executive Offices.

Collateral Assignment

You cannot assign your insurance as collateral for a loan.

Proof of Age

Before benefits are paid, Great-West may request proof of age. An adjustment may be made if:

- The Member's age was misstated; and
- A different premium rate would have been charged for the person's true age.

The difference between the premiums actually paid, and those that should have been paid, will be calculated. Any difference will be paid:

- By your Employer to Great-West, if the age was understated; and
- By Great-West to your Employer, if the age was overstated.

AD&D BENEFITS

Your AD&D benefits are payable if you are in an Accident while covered under this AD&D Plan and suffer a loss:

- Within 90 days of the Accident and
- As a result of the Accident.

The amount of AD&D benefits that you may receive is based on a Principal Sum. The amount of your Principal Sum is equal to the amount of your Standard Life Insurance. (See “Standard Life Insurance” in the Life Insurance section of this booklet.) Great-West will pay all or part of the Principal Sum according to the AD&D Benefit table shown in the front of this booklet.

Only one of the amounts, the largest, will be paid for all injuries that result from any one Accident.

Loss of hands and feet means permanent dismemberment by severance through or above the wrist or ankle joints. Loss of sight means total and permanent loss of sight beyond remedy by surgical or other means.

If you die, the benefit will be paid to the beneficiary you name for life insurance. If you suffer any other loss, the benefit will be paid to you.

To claim AD&D benefits, written proof of loss must be sent to Great-West as soon as reasonably possible. In any case, the proof required must be given no later than 15 months from the date of loss unless the claimant was legally incapable of doing so.

Your amount of AD&D Principal Sum is subject to the same age-based reductions as your life insurance.

BENEFIT LIMITATIONS

Pre-Existing Conditions Limitation for Medical Benefits

This section will *not* apply to a child placed with you for adoption.

A pre-existing condition is an illness or any related condition for which a Member received services, supplies or medication during the 3 months before the enrollment date of the Member under this medical Plan.

A pre-existing condition is not:

- A pregnancy existing on the enrollment date.
- Genetic information.

Benefits are payable for services, supplies and medication received for a pre-existing condition if they are received 12 months after the enrollment date for the Member.

For a late applicant as described in the section, "What If I Don't Apply On Time?", benefits will be payable for services, supplies and medication for a pre-existing condition only if they are received on or after the date which is 18 months after the person's enrollment date.

"Enrollment date" means:

- The first day of the Employee's Service with the Employer, if you apply for coverage for yourself and/or your eligible Dependents within the 31-day period when you are first eligible.
- The date the person becomes covered under this Plan, if you apply for coverage for yourself and/or your eligible Dependents after the 31-day period when you are first eligible. This will also be the case for any newly acquired Dependents.

Portability of Coverage

A person will receive credit toward this Plan's Pre-Existing Condition Limitation periods for the time covered under another health plan, but only if the person was covered, under another health plan that meets the definition of "Creditable Coverage", within the 63-day period just before his or her enrollment date under this Plan. Any eligibility waiting period that the person must satisfy under this Plan will not be considered in determining the 63-day period.

If the person was covered:

- For a period of time under Creditable Coverage that is greater than the time periods referred to in the Pre-Existing Conditions Limitation, then the Pre-Existing Conditions Limitation periods will not apply to the person.
- For a period of time under Creditable Coverage that is less than the time periods referred to in the Pre-Existing Conditions Limitation, then the Pre-Existing Conditions Limitation periods will be reduced by the number of consecutive days that the person was covered under Creditable Coverage.

However, for a child who became covered under Creditable Coverage within 31 days of birth, the Pre-Existing Conditions Limitation periods will not apply regardless of how long the child was covered under Creditable Coverage.

It is your responsibility to provide information about Creditable Coverage in order for the Pre-Existing Conditions Limitation under this Plan to be reduced or waived.

Dental Limitations for Late Applicants

If dental coverage starts more than 31 days after the Member became eligible, then no benefits are payable for Basic and Major treatment received within 12 months after coverage starts.

Benefits are payable for accidental injury to natural teeth that occurs after coverage starts.

Medical Benefit Limitations

No amount will be payable for:

- Services that are not Medically Necessary.

- Custodial care of a Member whose health is stabilized and whose current condition is not expected to significantly or objectively improve or progress over a specified period of time. Custodial care does not seek a cure, can be provided in any setting and may be provided between periods of acute or intercurrent health care needs.

Custodial care includes any skilled or non-skilled health services or personal comfort and convenience services. Care may include supervision of participation of a preventive or protective care. This includes assistance with, performance of, or supervision of:

- walking, transferring or positioning in bed and range of motion exercises;
- self-administered medications;
- meal preparation and feeding, by utensil, tube or gastronomy;
- oral hygiene, skin and nail care, toilet use, routine enemas;
- nasal oxygen applications, dressing changes, maintenance of indwelling bladder catheters, general maintenance of colostomy, ileostomy, gastronomy, tracheostomy and casts.
- Special nursing services if those same services could be provided by the regular nursing staff of any Hospital in which the Member is confined.
- Charges by a Doctor for any phone call or interview during which the Member is not examined.
- Confinement, treatment, services or materials for educational or training problems or learning disorders.
- Outpatient physical, occupational or speech therapy for non-acute injuries, diseases or conditions that are not reasonably expected to result in significant clinical improvement within two months. This includes developmental progress in skills such as sitting, walking, talking and learning that compare unfavorably to measured results from standardized tests of others of the same age.
- Services or supplies which are primarily for the Member's education, training or development of skills needed to cope with an injury or sickness, except as specifically provided in the Plan.
- Any expense or charge associated with exercise equipment.
- Travel or transportation expenses, except for ambulance services, even if to reach a network facility.
- Plastic or reconstructive surgery and all related expenses, except when surgery is Medically Necessary or required following a mastectomy.
- Gene manipulation therapy.
- The reversal of any sterilization procedure.
- Massage.
- Surgical procedures for the improvement of vision when vision can be corrected through the use of glasses or contact lenses.
- Eyeglasses, contact lenses, eye exams to assess visual acuity or the fitting of glasses and lenses.
- Dental services other than treatment of Accidental Injury to natural teeth within six months after the Accident. Chewing injuries are not considered an Accidental Injury.
- Non-prescription drugs or medicines, or drugs or medicines that are not approved by the Food and Drug Administration.
- Treatment for the purpose of weight loss, unless the Member is morbidly obese.
- Programs related to smoking cessation.
- Osteotomy, orthognathic surgery, maxillofacial orthopedics or related treatment for deformities caused by anything other than cancer or trauma.
- Hearing aids or the fitting of hearing aids.
- Abortions, unless the life of the mother would be endangered if the fetus were carried to term; or a fetal or chromosomal abnormality exists which was diagnosed prior to the abortion.
- Oral contraceptives, when taken for the purposes of birth control.
- The cost or fitting of contraceptive devices.

- Any family planning procedure that requires outside intervention, such as, but not limited to, artificial insemination, in-vitro fertilization, GIFT or ZIFT.
- Infertility treatment.
- Tubal ligations.
- Vasectomies.

Prescription Drug Benefit Limitations

No amount will be payable for:

- Therapeutic devices and appliances, except as specifically provided under the Plan.
- Over-the-counter drugs and supplies.
- Allergy serums.
- Oral Contraceptives.

Dental Benefit Limitations

No amount will be payable for:

- Dental appliances which have been lost, mislaid or stolen.
- Dental care that does not have ADA endorsement.
- Dental care provided to correct any birth defect or developmental malformation which does not interfere with function.
- Care of craniofacial muscle disorders and temporomandibular disorders.
- That part of any covered dental expense that is payable under any other section of this booklet, unless:
 - Benefits are payable under both this dental benefit and any medical benefits; and
 - It is to the Member's advantage to have benefits paid under dental benefits rather than under medical benefits.
- Orthodontic treatment.
- Dental care that is cosmetic in nature.
- Services not necessary for the diagnosis, prevention or care of dental disease, defect or injury.
- Dental care provided for dietary planning for the control of dental disease or for plaque control or for oral hygiene instructions.
- Customized dental procedures.
- Crowns for teeth that are restorable by other means or for the purpose of periodontal splinting.
- Take-home fluoride solutions.
- Local analgesics.

Vision Benefit Limitations

No amount will be payable for:

- Safety glasses.
- Radial keratotomy.
- Orthoptics, vision training, or medical or surgical treatment of the eye.
- Artificial eyes.

AD&D Benefit Limitations

No amount will be payable for any loss caused by or in connection with:

- Intentionally self-inflicted injury.
- War or any act relating to war.
- Any form of disease.
- Physical or mental infirmity.
- The medical or surgical treatment of a disease or infirmity.

- Suicide.
- Potomac poisoning.
- Bacterial infections.
- Commission of a felony.

General Benefit Limitations

No amount will be payable for:

- Experimental or Investigational treatment or procedures.
- Anti-obesity drugs and formulas.
- Broken appointments.
- Care provided by a government health plan or for which there would be no cost if the Member did not have coverage. If the Member is entitled to benefits under a state-sponsored medical assistance program, benefits under the Plan will be paid to the state.
- Expenses incurred for care provided by your or your spouse's immediate or extended family.
- Care received for an illness that is a result of war or engaging in a riot or insurrection.
- Except for AD&D, an accidental injury that occurs while working for pay or profit.
- A sickness for which the Member can receive benefits under any Worker's Compensation or similar law.

CLAIMS & LEGAL ACTION

■ How To File Claims

Medical, Dental and Vision Benefits

Members who present their ID card when using a network provider will not have to file a claim. The ID card contains all the information network providers need to bill Great-West for the balance directly.

For other services, Members must file a claim. Ask the Employer for a claim form.

An Explanation of Benefits (EOB) will be sent to the Member showing how the claim was paid.

For expenses incurred outside the United States and Puerto Rico, the Member must pay the bill and file a claim.

Prescription Drug Benefits

Members who purchase drugs at a PCS pharmacy and present their ID card will receive preferred pricing from the pharmacy. The Member will pay the pharmacist the preferred price for the drug and the pharmacy will then file the claim electronically. An Explanation of Benefits (EOB) will be sent to you showing how the claim was paid. A check for any amount payable to you will be attached to the EOB. The only time a claim will need to be filed for reimbursement is when drugs are purchased at a pharmacy that is *not* a PCS pharmacy, or when the Member does not show the ID card. Ask the Employer for a claim form. Complete this claim form, attach your prescription drug receipt, and mail it to the Benefit Payment Office listed on the claim form. Whether the PCS pharmacy submits the claim or you file the claim yourself, benefits will be processed subject to the provisions of the Plan. This includes any deductible, co-payment percentage, coverage limitations and benefit maximums.

With the first Mail Order drug order, the Member should complete the member profile form found in the Mail Service brochure. Ask the Employer for a copy of this brochure.

Life Insurance Benefits

The beneficiary should contact the Employer for the claim form. Proof of death must be sent to Great-West. After the claim is processed, Great-West will pay the amount of insurance (the death benefit) to the beneficiary(ies).

AD&D Benefits

You or your beneficiary should contact the Employer for the claim form.

■ If A Claim Is Denied

If any benefits are denied the Member will be sent a written notice. This notice will state the reasons for the denial, the reference to the Plan provisions on which the denial is based and what is needed to complete the claim.

The Member must be given notice of claim denial within 90 days after the claim is filed. If special circumstances require more than 90 days, another 90 days will be allowed. If an extension is needed, the Member will be notified before the end of the initial 90-day period.

Claim Review Procedures

The Member or Doctor can request a review of any denied claim, or the status of a pending claim by contacting the Benefit Payment Office by letter or by calling the toll-free number on the ID card.

A Member Services Representative will respond to all inquiries within two working days. If the information does not satisfy the Member or Doctor, a request for a claims review will be forwarded to the Member Services Supervisor.

Upon receiving the Member's request for a claims review, Great-West will:

- Let the Member or Doctor know within 20 days who may be contacted in respect to the claims review;
- Notify the Member or Doctor within 30 days of the final disposition of the claims review.

If the Member's claims review is not resolved within one week it will be forwarded to the regional Benefit Payment Manager for review and resolution.

If the Member's claims review is not resolved by the Benefit Payment Manager, it will be forwarded to the Benefit Payment Review Department located at Great-West's Executive Office in Greenwood Village, Colorado.

The Benefit Payment Review staff may consult with Great-West's:

- Medical Director (Dental Consultant if the claims review is of dental origin);
- Law Department;

to assist them in the claims review process.

The Member or Doctor will be notified of the result of the claims review within 30 days of filing of the request for review.

Final Appeals Process

For self-funded benefits, the Plan Administrator has the exclusive and full discretion and authority to determine the benefits and amounts payable and to construe and interpret all terms and provisions of this booklet.

For insured benefits, Great-West has full discretion and authority to determine the benefits and amounts payable and to construe and interpret all terms and provisions of this booklet.

If a Member or Doctor is not satisfied with the final disposition of the claims review process, the Member can initiate an appeal by giving written notice within 60 days after receipt of the written claim denial. This appeal must be filed before the Member may file a lawsuit.

The Member or anyone authorized to act on the Member's behalf may appeal the claim and ask to examine any pertinent documents. The Member should submit in writing the reasons why the claim should not have been denied, as well as any other information, questions or comments.

Appeals must be submitted in writing:

- To Great-West for insured benefits;
- To the Plan Administrator for self-funded benefits.

The Member will be notified of the final decision within 60 days after receipt of a request for review. If special circumstances require an extension, a further 60 days will be allowed.

■ What If a Member Has Other Health Coverage?

A Member may be covered under more than one health plan. For example, coverage may be under this Plan and also under a group health plan sponsored by the Employee's spouse's employer. If this type of duplicate coverage occurs, this Plan uses a method called Coordination of Benefits (COB) to determine which plan pays benefits first on a claim (is primary) and which plan pays second (is secondary). Under COB, total payments from both plans will never be more than the expenses actually incurred.

The benefits provided by the plans listed below are considered in coordinating benefits:

- This Plan;

- Any other group insurance or prepayment plan, including automobile fault or no-fault insurance; Health Maintenance Organizations (HMOs); Blue Cross/Blue Shield;
- Any labor-management trusteed plan, union welfare plan, employer organization plan or employee benefit organization plan;
- Any government plan or statute providing benefits for which COB is not prohibited by law;
- Any individual automobile no-fault insurance plan.

Which Plan Is Primary?

Certain rules are used to determine which of the plans will be primary. This is done by using the first of the following rules that applies:

- A plan with no COB provision will determine its benefits before a plan with a COB provision.
- A plan that covers a person other than as a Dependent will determine its benefits before a plan that covers the person as a Dependent.
- When a claim is made for a Dependent child who is covered by more than one plan, in most cases the birthday rule will be used to determine the order of benefits. Under the birthday rule:
 - the plan of the parent whose birthday falls earlier in a year will be primary; but
 - if both parents have the same birthday, the plan that covered the parent longer will be primary.

However:

- If the other plan does not have the birthday rule, then the plan that covers the child as a Dependent of the male parent will be primary.
- If the parents are legally separated or divorced, benefits for the child will be determined in this order:
 - * first, the plan of the parent with custody of the child will pay its benefits;
 - * then, the plan of the spouse of the parent with custody of the child will pay its benefits; and
 - * finally, the plan of the parent not having custody of the child will pay its benefits.

However, if there is a court decree stating which parent is responsible for the health care expenses of the child, then a plan covering the child as a Dependent of that parent will be primary.

If a court decree states that the parents have joint custody of the child, but does not specify which parent has responsibility for the child's health care expenses, benefits will be determined on the same basis as for a child whose parents are not separated or divorced.

- A plan that covers a person as:
 - a laid-off or retired employee; or
 - a Dependent of such an employee; or
 - a continuee under a state or Federal law;
 will determine its benefits after the benefits of any other plan covering that person as an employee. If one of the plans does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.
- When a claim is made for an Employee's Dependent who is also covered under Medicare and as a retiree under his employer's plan:
 - the plan covering the person as a Dependent will determine its benefits prior to Medicare; and
 - the plan covering the person as a retiree will determine its benefits after Medicare.
- If none of the above rules establishes the order of payment, the plan covering the person for a longer period of time will be primary.

What If This Plan Is Primary?

If this Plan is primary, it will determine its benefits without considering other coverage. The Member should submit the claim first to the Benefit Payment Office listed on the claim form. When the explanation of benefits is received from this Plan, send it, along with the claim and itemized bills, to the secondary plan.

What If This Plan Is Secondary?

Submit the Member's claim first to the primary plan. After the other plan has determined its benefits, send the explanation of benefits from the other plan, along with the Member's claim, to the Benefit Payment Office listed on the claim form.

If this Plan is secondary, it pays the lesser of:

- the allowable expenses that were not reimbursed under the other plan; and
- the amount this Plan would have paid if there were no other coverage.

The COB provision is applied throughout the calendar year.

When the COB provision reduces the benefits payable under this Plan:

- each benefit will be reduced proportionately; and
- only the reduced amount will be charged against any benefit limits under this Plan.

A credit savings may be established if this Plan is secondary. A credit savings is the difference between the benefits this Plan would pay if there were no other coverage and the benefits this Plan actually paid. Credit savings may be used to provide 100% rather than partial payment of allowable expenses that are incurred by the same person within the same calendar year.

Allowable expenses for a Member are any necessary, usual and customary items of expense, at least part of which is covered under at least one of the plans covering the person.

Allowable expenses will not include the difference between the cost of a private Hospital room and a semi-private Hospital room unless the patient's stay in a private Hospital room is Medically Necessary.

When the benefits of a government plan are taken into consideration, the allowable expense is limited to the benefits provided by that plan.

How Will Benefits Be Affected By Medicare?

The following applies to you if you are an active Employee and you or your spouse becomes eligible for Medicare **due to age**. You and your Dependents will continue to be eligible for the benefits provided under this medical Plan. This Plan will coordinate benefits with Medicare. If:

- Your Employer employed at least 20 full-time or part-time employees during at least 20 calendar weeks of the preceding or current calendar year, then this medical Plan will be considered the Member's primary coverage, and Medicare will be considered the Member's secondary coverage. This means that benefits under this medical Plan will be payable first, and then Medicare will determine the remaining expenses it will pay.
- Your Employer employed fewer than 20 full-time or part-time employees during at least 20 calendar weeks of the preceding or current calendar year, then Medicare will be considered primary, and this medical Plan will be considered secondary.

The following applies to you if you are an active Employee and you or your Dependents become eligible for Medicare **due to disability**. You and your covered Dependents will continue to be eligible for the benefits provided under this medical Plan. This Plan will coordinate benefits with Medicare. If:

- Your Employer employed at least 100 full-time or part-time employees during 50% or more of the Employer's business days during the previous calendar year, then coverage under this medical Plan will be considered the primary coverage, and Medicare will be considered the secondary coverage. This means that the benefits payable under this medical Plan will be payable first, and then Medicare will determine the remaining expenses it will pay.
- Your Employer employed fewer than 100 full-time or part-time employees during 50% or more of the Employer's business days during the previous calendar year, Medicare will be considered the primary coverage, and coverage under this Plan will be considered the secondary coverage.

If A Member Becomes Eligible for Medicare Due to End-Stage Renal Disease (ESRD)

Under Medicare law, a Member must complete a waiting period, typically three months, before becoming eligible for Medicare solely because of ESRD. During this waiting period, this Plan will pay benefits and Medicare will not pay any benefits.

After the waiting period, for the first 30 months of eligibility for Medicare Part A benefits solely due to ESRD, this Plan will pay its benefits first (primary payer) and Medicare will pay its benefits second (secondary payer). After that, if the Member is still eligible for Medicare due to ESRD, Medicare will be the primary payer and this Plan will be the secondary payer.

In certain circumstances, such as a kidney transplant, the 30-month time frame that this Plan will be the primary payer may be less as defined by the Medicare guidelines for determining primary payer.

If the Member becomes eligible for Medicare due to ESRD after Medicare became the primary payer under any other provision of Medicare law or this Plan, Medicare will be the primary payer and this Plan will be the secondary payer.

Treatment must be rendered in a Medicare-approved facility in order to be covered under this Plan.

A Member is eligible for Medicare when:

- the Member is covered under Medicare; or
- the Member is not covered under Medicare due to:
 - the Member's refusal of Medicare coverage;
 - the Member's voluntary termination of Medicare coverage; or
 - the Member's failure to apply for Medicare coverage.

■ **Provision for Subrogation and Right of Recovery**

An Other Party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to an Illness incurred by a Member (i.e. a Covered Person). A Covered Person is defined to also include the Member's legal representative.

An Other Party is defined to include, but is not limited to, any of the following:

- the party or parties who caused the Illness;
- the insurer or other indemnifier or guarantor or indemnifier of the party or parties who caused the Illness;
- the Covered Person's own insurer (for example, in the case of uninsured, underinsured, medical payments or no-fault coverage);
- a worker's compensation insurer;
- any other person, entity, policy or plan that is liable or legally responsible in relation to the Illness.

Benefits may also be payable under the Plan in relation to the Illness. When this happens, Great-West may, at its option:

- subrogate, that is, take over the Covered Person's right to receive payments from the Other Party. The Covered Person will transfer to Great-West any rights he or she may have to take legal action arising from the Illness to recover any sums paid under the Plan on behalf of the Covered Person;
- recover from the Covered Person any benefits paid under the Plan from any payment the Covered Person is entitled to receive from the Other Party.

The Covered Person must cooperate fully with Great-West in asserting its subrogation and recovery rights. The Covered Person will, upon request from Great-West, provide all information and sign and return all documents necessary to exercise Great-West's rights under this provision.

Great-West will have a first lien upon any recovery, whether by settlement, judgment, mediation or arbitration, that the Covered Person receives or is entitled to receive from any of the sources listed above. This lien will not exceed:

- the amount of benefits paid by Great-West for the Illness, plus the amount of all future benefits which may become payable under the Plan which result from the Illness. Great-West will have the right to offset or recover such future benefits from the amount received from the Other Party; or
- the amount recovered from the Other Party.

If the Covered Person:

- makes any recovery from any of the sources described above; and
- fails to reimburse Great-West for any benefits which arise from the Illness;

then:

- the Covered Person will be personally liable to Great-West for the amount of the benefits paid under this Plan; and
- Great-West may reduce future benefits payable under this Plan for any Illness by the payment that the Covered Person has received from the Other Party.

Great-West's first lien rights will not be reduced due to the Covered Person's own negligence; or due to the Covered Person not being made whole; or due to attorney's fees and costs.

For clarification, this provision for subrogation and right of recovery applies to any funds recovered from the Other Party by or on behalf of:

- an Employee's minor covered Dependent;
- the estate of any Covered Person; or
- on behalf of any incapacitated person.

■ Other Information A Member Needs to Know

Incontestability of Life Insurance and AD&D Benefits

After the Plan has been in force for 2 years, its validity can only be contested due to non-payment of premiums. During the first 2 years a Member is covered under this Plan, only a written statement signed by the Member can be used to contest the validity of the coverage. After the Member's coverage has been in force for 2 years during the Member's lifetime, no statement by the Member can be used to contest the validity of the Member's coverage.

Proof of Claim

Send written claim to Great-West as soon as reasonably possible. A Member must submit a written claim no later than 15 months from the date the claim is incurred, unless legally incapable of doing so, to:

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY

Benefit Payments Office

P.O. Box 97313

Bellevue, WA 98009

1-800-685-1010

Payment of Claims

Benefits payable under the Plan will be paid as soon as the claim is received and processed.

For life insurance, the death benefit will be paid to the beneficiary(ies).

For other benefits, the benefits will be paid to the Member, if living. If not, benefits will be paid to the Member's estate. If any benefit is payable to the Member's estate or to a person who cannot give a valid release, then Great-West can pay up to \$1,000.00 to any relative it considers to be entitled to such payment. The Member may request in writing that payments under the Plan be made directly to the person providing the services.

Legal Actions

A Member may bring a legal action to recover under the Plan. Such legal action may be brought no sooner than 60 days, and no later than 3 years, after the time written proof of loss is required to be given under the terms of the Plan.

Conformity with Statutes

For Life Insurance and AD&D Benefits, the Plan is amended to comply with the minimum requirements of the state in which the Plan is issued.

Physical Examinations and Autopsy

Great-West, at its own expense, has the right to have the person for whom a claim is pending examined as often as reasonably necessary. Great-West may also have an autopsy done where it is not against the law.

Benefit Payments to a Representative of a Minor

In the case of a minor child who otherwise qualifies as a Dependent under the Plan, if the child designates a representative, then the Plan must pay benefits on behalf of that child to his or her representative, even if that person is

not covered under the Plan. The person must:

- Submit written notice that he or she is the representative of the child on whose behalf the claim is made; and
- Provide evidence that the person qualifies to be paid the benefits.

Relationship Between Great-West and Network Providers

Providers under contract with Great-West are independent contractors. Network providers are neither agents nor employees of Great-West, nor is Great-West, or any employee of Great-West, an agent or employee of Network providers. Great-West will not be responsible for any claim or demand on account of damages arising out of, or in any way connected with, any injuries suffered by the Member while receiving care from any Network provider or in any Network provider's facilities.

■ **ERISA General Information**

The following information is required by the Employee Retirement Income Security Act of 1974 (ERISA).

The address of the Plan Sponsor/Employer is 102 Division, Nome, AK 99762. The telephone number is (907) 443-6621.

The Employer Identification Number (EIN) is 92-6000084. The Plan Number assigned by the Plan Sponsor is 501.

The Agent for Service of Legal Process is the Plan Trustee or the Plan Administrator, Dana Handleland, Payroll Technician.

The Plan provides Life and AD&D Insurance, Medical, Prescription Drug, Dental and Vision Benefits.

See the section, "About This Plan" for more information about the Insured and Self-Funded benefits.

Great-West Life & Annuity Insurance Company provides Contract Administration.

The eligibility requirements, termination provisions and a description of the circumstances which may result in disqualification, ineligibility, or denial or loss of any benefits are described in this booklet.

Contributions are determined by the Employer. Employee contributions, if any, for a time period for which the Employee is not covered under the Plan may be refunded by the Employer. Please see your Plan Administrator for details.

The fiscal records of the Plan are maintained on the basis of Plan years ending June 30.

Claims

Procedures to be followed in presenting claims for benefits and what to do when claims are denied in whole or in part are described in the "How To File Claims" section of this booklet.

■ **Statement of ERISA Rights**

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

However, Employers with fewer than 100 Employees at the beginning of the Plan Year are not required to:

- **allow examination of the Annual Report or Plan Description; or**
- **furnish copies of the Plan Description, Annual Report, or any Terminal Report.**
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.
- **Receive a summary of the Plan's annual financial report except as described below. The Plan Administrator is required by law to furnish each participant with a copy of this Summary of the Annual Report. Employers with fewer than 100 Employees at the beginning of the Plan Year are not required to furnish a copy of the Summary of the Annual Report.**

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 Plan, called "fiduciaries" of the Plan, have a duty

to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not 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. If Plan fiduciaries misuse the Plan's money or if you are 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 the court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (e.g. if it finds your claim is frivolous). If you have any questions about your Plan, contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

GLOSSARY

The following defined terms have a special meaning with respect to the benefits outlined in this booklet. On each page where they appear throughout this booklet, they are capitalized.

Accident/Accidental Injury

A sudden and unforeseen event from an external agent or trauma, resulting in injuries to the physical structure of the body. It is definite as to time and place and it happens involuntarily or, if the result of a voluntary act, entails unforeseen consequences. It does not include harm resulting from disease.

Actively at Work

Employment on an active and full-time basis at the Employer's usual place of business.

Creditable Coverage

Coverage under a group health plan, individual health insurance coverage, Medicare, Medicaid or other public health plans, CHAMPUS, a medical program of the Indian Health Service or of a tribal organization or the Peace Corps, state health benefit risk pools and the Federal Employee Health Benefit Plan (FEHBP).

Dentist

A person licensed to practice dentistry.

Dependent

- Your legal spouse;
- Any unmarried child under the age of 19; or
- An unmarried child under the age of 23 if he or she is a full-time student. Before paying a claim, the Plan may require proof that this child is a full-time student.

For medical, prescription drug, dental and vision benefits, these age limits do not apply to a child who is covered under the Plan and who cannot support himself or herself due to a physical handicap or mental retardation. At reasonable intervals, but not more often than annually, the Plan may require a Doctor's certificate as proof of the child's handicap.

The term "child" means:

- Your children. This includes any legal step-child, adopted child or foster child.
- Any natural child of your minor Dependent.

For a child to be considered a Dependent he or she must be chiefly dependent upon you for financial support. This requirement is waived if the child is eligible for coverage because of a Qualified Medical Child Support Order, or, if state law so requires, a non-qualifying court order or an administrative order of any state agency.

Your Dependents must live in the United States or Puerto Rico to be eligible for coverage.

Doctor/Physician

A person licensed to practice medicine or osteopathy. This also includes any other practitioner of the healing arts if:

- He or she performs a service within the scope of his or her license and for which this Plan provides coverage; and
- State law requires such practitioner to be covered.

Employee

A person classified as All Employees by the Employer, who is in the Service of the Employer and is a resident of the United States or Puerto Rico.

Employer

- City of Nome; and
- Any affiliated companies listed in the application of the Employer. The Employer may add an affiliated company after the effective date of the Plan. For that company only, the effective date of the Plan will be considered to be the effective date of the amendment that adds that company.

Experimental or Investigational

A drug, device, medical treatment or procedure which:

- Cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) or other governmental agency and such approval has not been granted at the time of its use or proposed use; or
- Is the subject of a current investigational new drug or new device application on file with the FDA; or
- Is being provided pursuant to:
 - A Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial; or
 - A written protocol which describes among its objectives, determinations of safety, toxicity, effectiveness, or effectiveness in comparison to conventional alternatives;
- Is being delivered, or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations particularly those of the FDA or the Department of Health and Human Services (HHS);
- In the predominant opinion among experts:
 - As expressed in the published, authoritative literature, is substantially confined to use in research settings;
 - Is subject to further research in order to define safety, toxicity, effectiveness, or effectiveness compared with conventional alternatives; or
 - Is experimental, investigational, unproven or is not a generally acceptable medical practice; or
- Is not a covered service under Medicare because it is considered investigational or experimental as determined by the Health Care Financing Administration (HCFA) of HHS;
- Is provided concomitantly to a treatment, procedure, device or drug which is experimental, investigational, unproven Treatment; or
- Has not been performed at least ten (10) times and reported on in United States peer review medical literature.

Great-West's Medical Director may, in his/her sole discretion, determine that a drug, device, medical treatment or procedure which is deemed experimental or investigational under the above criteria, should nonetheless not be deemed experimental or investigational.

Hospital

An institution licensed as a Hospital by the proper authority of the state in which it is located. An institution recognized as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). This does not include any institution that is used primarily as a place for treatment of alcoholism or substance abuse, unless required by state law, a clinic, convalescent home, rest home, home for the aged, nursing home, custodial care facility, or training center.

Illness

An Accidental Injury, a bodily or mental disorder, a pregnancy, or any birth defect of a newborn child. Conditions that exist and are treated at the same time or are due to the same or related causes are considered to be one Illness.

Loss of Residence

Being outside the United States or Puerto Rico for more than 60 days. However, a Member will continue to be eligible for the benefits provided under this Plan if he or she is temporarily outside of the United States or Puerto Rico:

- On vacation;
- To study; or
- To conduct business for your Employer;

For a period of up to, but not exceeding, 60 continuous days.

Medically Necessary

Any service or supply for diagnosis or treatment that is:

- Prescribed by a Doctor to be necessary and appropriate; and
- Non-experimental or non-investigational; and
- Not in conflict with accepted medical or surgical practices prevailing in the geographic area where, and at the time when, the service or supply is ordered.

Medical necessity does not include any service or supply that is for the psychological support, education or vocational training of the Member. Medical necessity does not include implant of any artificial organ for any reason whatsoever.

Medicare

Title 18 of the United States Social Security Act of 1965 as amended from time to time and the coverage provided under it. This includes coverage provided under Medicare+Choice plans.

Member

An Employee and any covered Dependent.

Plan

City of Nome (the Employer) has established an Employee Welfare Benefit Plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). The benefits described in this booklet constitute benefits available under the plan and are referred to collectively in this booklet as “the Plan.”

Proof of Good Health

Written evidence that the person meets Great-West’s general underwriting standards. Such evidence includes but is not limited to medical evidence.

Service

Work with the Employer on an active, full-time and full pay basis for at least 30.00 hours per week.

Totally Disabled and Total Disability

Life Insurance

Being under the care of a Doctor and prevented by Illness from working for pay or profit in any job for which you are or may become suited by reason of education, training or experience.

Employee Medical Benefits

Being under the care of a Doctor and prevented by Illness from performing your regular work.

Dependent Benefits

Being under the care of a Doctor and prevented by Illness from engaging in substantially all of the normal activities of a person of the same age and sex who is in good health.

You and Your

An Employee.