	Approved	Denied
Action taken	6/27/05	
Other:		
Verified by:		

COUNCIL ACTION MEMORANDUM **AM No. 05-31**

TITLE: **Council Approval Of The Award Of City Of Wasilla's Health Insurance To Premera Blue Cross Blue Shield Of Alaska With The Selection Of The Heritage Select $1,000 In Conjunction With Setting Up An Health Care Reimbursement Arrangement.**

Agenda of: June 27th, 2005 Date: June 17,2005
Originator: Ted Leonard

Route to:	Department	Signature/Date
	Police	
	Recreational and Cultural Services Library, Museum	
	Public Works Planning	
X	Finance *signature required	
X	Clerk	

REVIEWED BY MAYOR DIANNE M. KELLER:

FISCAL IMPACT: ☒ yes estimated cost $888,908 (Premium of $709,488 and cost of HRA $179,420) *or* ☐ no
Funds Available ☒ yes ☐ no
Account name/number: Various
Attachments: Council Minutes directing Mayor to sign Health Insurance Contract with $1,000 deductible and Premera Group Contract.

SUMMARY STATEMENT: The Mayor signed the Health Insurance Contract with Premera Blue Cross Blue Shield of Alaska with the selection of the Heritage Select $1,000 plan based on the motion passed by Council on June 13, 2005. Based on direction of the Council, City staff is in the process of setting up the Health Care Reimbursement plan based on the criteria set in the motion. The goal is to have the Health Care Reimbursement arrangement in place by July 1st, 2005. The staff will keep the council informed as the Health Care Reimbursement Arrangement plan is completed.

STAFF RECOMMENDED ACTION: Council approve award of insurance contract for Health Insurance coverage to Premera Blue Cross Blue Shield of Alaska.

Ted Leonard

From: Kristie Smithers
Sent: Friday, June 17, 2005 9:42 AM
To: Ted Leonard
Subject: motion

. NEW BUSINESS

A. Employee Health Insurance and Health Reserve Accounts

1. Ted Leonard, Director of Finance and Administrative Services

ne director of finance and administrative services reported that after meeting with approximately 84 out of 93 mployees regarding proposed plan changes to the city's health insurance benefit plan through Premera Blue ross, no negative comments were received regarding the proposed plan.

OTION: Council Member Lowe moved to direct the mayor to sign a health insurance contract with Premera Blue Cross with a $1,000 deductible plan to be combined with a Healthcare Reimbursement Arrangement (HRA) with a reserve of $1,750 for single coverage; $3,500 for employee/spouse coverage; $5,250 for employee/child coverage, and $5,250 for employee/family coverage; and to bring back an action memorandum for concurrence during the June 27th Regular Council Meeting.

ENERAL CONSENT: The motion passed without objection.

istie Smithers, MMC
asilla City Clerk
0 E. Herning Ave.
asilla, AK 99654
ffice: 907-373-9090
x: 907-373-9092
mithers@ci.wasilla.ak.us

Retain For Legal Files

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

GROUP CONTRACT
FOR
CITY OF WASILLA
(herein referred to as the Group)

PREMERA BLUE CROSS BLUE SHIELD OF ALASKA (herein also referred to as "we," "us," or "our") agrees to provide the benefits described in this Contract for eligible employees of the Group, as defined in this Contract, and their eligible dependents who are enrolled for coverage under this Contract. All benefits of this Contract are subject to the terms and conditions stated herein and any endorsements or riders included or issued thereafter. We have the authority to determine who is eligible for benefits and to construe the terms used in this Contract.

This Contract is delivered in, and is governed by, the laws of the state shown below, except to the extent preempted by federal law. This Contract is valid on the effective date indicated below only when signed by an officer of ours. Payment of the subscription charges indicates that the Group accepts this Contract.

Any existing group contract or agreement between the Group and us which is being replaced by this Contract is terminated when this one becomes effective.

CONTRACT EFFECTIVE DATE	July 1, 2005
GROUP NUMBER	9000117
STATE	AK
GROUP ADDRESS	290 E. Herning Avenue Wasilla, AK 99654-7091

Dianne M. Keller
Signed

Dianne M. Keller, Mayor
Title

6/14/05
Date

H. R. Brereton Barlow
H. R. Brereton Barlow

President and Chief Operating Officer
Premera Blue Cross Blue Shield of Alaska

April 15, 2005
Date

CONTRACT FORM NUMBER 1550Y

STANDARD PROVISIONS

Contract

The entire Contract between the Group and us consists of all of the following:

- The contract face page and "Standard Provisions";
- The attached benefit booklet(s);
- The Group's signed application which is kept on file with us (a copy is available upon request);
- The Funding Arrangement Agreement (Exhibit A) between the Group and us; and
- All attachments, endorsements and riders included or issued hereafter.

No agent of ours or any other entity is authorized to make any changes, additions or deletions to this Contract or to waive any provision of this Contract. Changes, alterations, additions or exclusions can only be done over the signature of an officer of ours.

No assignment of the Group's interest as a party to this Contract will be binding on us.

Contract Term And Renewal

The initial contract term begins on the contract's effective date and continues to the contract anniversary date, unless canceled or terminated in accordance with the terms of the Contract. If not so terminated, the Contract is kept in force during the initial term by the Group's payment of required subscription charges when due.

After the initial term, this Contract will continue in force on a month-to-month basis by the Group's payment of required subscription charges when due, unless it is changed or terminated in accordance with the contract change and termination provisions stated elsewhere in this Contract.

Funding Arrangement Agreement (Exhibit A)

The contract period, subscription charges and contract termination provisions are set forth in the Funding Arrangement Agreement (Exhibit A) between the Group and us, which is attached to and made part of this Contract.

Certificate Of Health Coverage

We agree to provide the Group with information regarding an enrollee's coverage period under this program when coverage terminates.

The Group agrees to provide a Certificate of Health Coverage to enrollees upon termination from the group's health plan and upon request, to comply with all provisions required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and state law.
The term "descriptive materials" includes, without limitation, any type of circular, leaflet, booklet, summary, handbook, letter or form that describes in whole or in part any of the terms, conditions and/or provisions of this Contract.

Contract Modifications

In addition to the modification provisions stated in the "Contractual Rates" section of the Funding Arrangement Agreement (Exhibit A), we may modify the subscription charges, benefits, or any other provisions of this Contract by giving 30 days' advance written notice to the Group prior to the end of the contract term.

The Group may reject the modification by written notice delivered to us at least 15 days before the modification is to take effect. Rejection of a modification will terminate the Contract on the last date for which subscription charges

were paid. If notice is not given to us by the Group by the required time, the Contract will be renewed as modified, provided all required subscription charges are paid when due.

Any contract modifications requested by the Group and agreed to by us will become effective on the Group's contract effective date that coincides with or next follows the date of the request.

ASSOCIATION REQUIREMENTS

The Group is responsible for all of the obligations listed below. The Group has the right to delegate any of the obligations and duties as stated in "Delegation" later in this subsection.

General Responsibilities

- The Group must establish a minimum employer unit size. The minimum number of employees must be at least 10.
- Each Association Employer may establish its own participation and contribution requirements. However, the Group is responsible to ensure that those requirements comply, at a minimum, with the following:

	Employees	Dependents
Minimum Employer Contribution	75%*	None
Minimum Participation	75%*	None

* If the employer contribution is 100% for employees or dependents, 100% of the affected employees or dependents must be enrolled.

The Group is responsible to monitor each Association Employer's participation and contribution to make sure that the Group's requirements continue to be met throughout the term of the Contract. If an Association Employer has members who are continuing this plan's coverage as directed by COBRA, they do not count toward the participation minimums.

- The Group must notify us of any changes to its by-laws or articles of incorporation within 30 days of the date the change becomes effective.
- The Group is responsible for keeping accurate records relating to this Contract and all Association Employers covered by this Contract. The records must contain all the information needed by us to administer this Contract.

Compliance Responsibilities

As part of the general obligations stated in "Compliance With Law" in this Contract, the Group must comply with the specific requirements mandated by law described below. For all obligations below that are based on workforce size and other requirements of individual Association Employers, the Group is responsible to know the requirements, how the applicable law requires size to be measured, and to ensure that Association Employer status is determined in compliance with the applicable requirements. All references to specific laws are deemed to include all current amendments and regulatory requirements for such laws.

- The Group must notify us whether the Group is a "bona fide association" as defined by the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such notice must be given as part of the initial coverage negotiations between us and the Group. The Group must notify us of any changes to its "bona fide" status no less than 60 days before such changes take effect.
- The Group must notify us whether each Association Employer is subject to regulation under the Federal Employee Retirement Income Security Act of 1974 (ERISA) and the continued coverage requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). For existing Association Employers that are effective on the Group's original effective date, such notice must be given prior to that effective date. For Association Employers who begin participation in this plan after the Group's original effective date, such notice must be given prior to the Association Employer's effective date.
- The Group must notify us no later than January 1 of each year of any changes in Association Employers' COBRA status for that year.

- The Group must notify us at time of initial enrollment if any enrolled Association Employers are "large group health plans" as defined by federal Medicare secondary payer requirements. The Group also agrees to notify us no later than January 1 of each year whether at least one Association Employer that qualifies as a "large group health plan" for that upcoming year is enrolled in the plan.
- The Group must apply to Medicare for small Association Employers to be exempt from the federal Medicare secondary payer requirements that protect the "working aged" as defined by Medicare. The Group is responsible for notifying exempt members of the exemption as required by Medicare.
- All financial transactions under this Contract must comply with the financial transaction standards set by HIPAA.
- As part of members' enrollment, the Group is responsible to furnish information on members' prior coverage for the purpose of crediting the plan's pre-existing condition waiting period.

Administrative Responsibilities

- The Group is responsible for the accurate and timely administration of this Contract's eligibility requirements for Association Employers and members.
- The Group is responsible to ensure that Association Employers and other third parties to which it delegates obligations under this Contract comply with the requirements of this Contract.

  The Group must execute a written agreement with each Association Employer that sets forth the requirements for coverage under this Contract and requires the Association Employer to comply with those requirements. This agreement must allow us to perform audits as set forth in "Premera Blue Cross Blue Shield of Alaska Rights" later in this section and address any other delegated duties under this Contract as described in "Delegation" later in this section.

  We have the right to review and approve the Group's standard Association Employer agreements. Any changes to those agreements that pertain to coverage under this Contract must be approved by us before the changes take effect. The Group is responsible to enforce the terms of its agreements with Association Employers.
- The Group must forward eligibility and rate information to us within the time frames specified in this Contract.
- The Group is responsible to certify and rate all prospective employers using procedures and standards we set. Any prospective employer that does not meet our underwriting requirements can only be enrolled with our Underwriting Department's express advance approval.
- The Group is also responsible to recertify and rerate all renewing Association Employers using procedures and standards we set. Any Association Employers that do not meet the underwriting guidelines must be approved by our Underwriting Department before a renewal rate is quoted to the Association Employer.

Premera Blue Cross Blue Shield of Alaska Rights

- We have the right to request, inspect, or audit the Group's records and the records of any current or former Association Employer related to the sale or administration of the plan. The Group agrees to authorize access for us to records of any third party engaged by the Group to perform business functions related to the sale or administration of the plan that we may determine we need in order to perform audits agreed upon by us and the Group. Such audits will be performed during the regular business hours of the party being audited. Audits will include, but are not limited to:
  - Audits of prospective sales and renewal activity, no more often than once per calendar quarter.
  - Audits of eligibility administration, no more often than twice annually.
  - Payroll audits of Association Employers to ensure compliance with the Group's participation guidelines.

  Our waiver or delay of any of the above audits does not waive our right to conduct subsequent audits in accordance with the time limits above.
- We have the right to conduct a retrospective review of new Association Employers 90 days after the Association Employer's original effective date under this plan. The review will compare member count at 90 days to member count on the Association Employer's original effective date. We have the right to perform a payroll audit of the Association Employer and re-rate as needed if the member count differential is more than 10%. If, upon this review, we find that an Association Employer does not meet the requirements for coverage in this Contract, we

reserve the right, subject to statutory and regulatory provisions, to rescind that Association Employer's coverage retroactive to its original effective date.

- Our Underwriting Department has the sole right to review and approve exceptions to standard eligibility requirements. The Group is responsible to request and obtain our approval of such exceptions before the exceptions are made. We will not be bound for exceptions made without our express approval. When requesting exceptions, the Group will remain responsible for compliance with applicable state and federal employment nondiscrimination requirements. Our approval of an exception is not intended and should not be construed to be verification that the exception is in compliance with such requirements.
- Prior to the effective date of this plan, the Group agrees to provide information to us of the delegation of its obligations under this contract, specifying the obligations delegated and the parties to which those obligations are delegated. The Group also agrees to inform us as soon as reasonably possible of any changes in the obligations delegated or the delegates.

Delegation

The Group has the right to delegate some or all of its obligations under this Contract to Association Employers and/or one or more other third parties, called "delegates" in this provision. The requirements below apply:

- The Group must enter into a written contract with each delegate that includes all of the following:
  - It must specify the duties to be performed by the delegate and applicable time frames.
  - It must require the delegate to comply with all requirements and time frames set forth in this Contract that pertain to the administrative obligations being delegated.
  - It must allow us to perform audits, as set forth in "Premera Blue Cross Blue Shield of Alaska Rights" earlier in this subsection, of the duties that the Group has contracted with the delegate to perform.

  If Association Employers are delegates, the requirements above can be included in the Group's standard Association Employer agreements.

The BlueCard® Program

The BlueCard program we make available to your enrollees who live or travel outside Alaska and Washington or in Clark County, Washington is described in "The BlueCard Program" in the benefit booklet part of this contract. Whenever enrollees access health care services outside Alaska and Washington or in Clark County, Washington, the claim for those services may be processed through BlueCard and presented to us for payment. Payment is made according to the terms and limitations of your contract and network access rules in the BlueCard Policies then in effect. Under BlueCard, when enrollees receive covered services within the area served by another Blue Cross and/or Blue Shield Licensee (called the "Host Blue" in this section), Premera Blue Cross Blue Shield of Alaska remains responsible for fulfilling our obligations under this contract. The Host Blue will only be responsible for such services as contracting with providers and handling all interaction with contracting providers. The Host Blue must perform these duties in accordance with applicable BlueCard Policies. The financial terms of BlueCard are described generally in the benefit booklet. Note: The methods employed by a Host Blue to determine a negotiated price, as described in the benefit booklet, will vary among Host Blues based on the terms of each Host Blue's provider contracts.

Under BlueCard, recoveries from a Host Blue or from contracting providers of a Host Blue can arise in several ways. Examples are antifraud and abuse audits, provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of any fees, will be applied in accordance with applicable BlueCard Policies. Any such recoveries will be applied as an adjustment to the Group's claims experience.

Group Records

The Group is responsible for keeping accurate records relating to this Contract. The records must contain all the information needed by us to administer this Contract. We have the right to request, inspect, or audit the Group's records at any reasonable time during regular business hours.

Confidentiality Of Enrollee Information

The parties acknowledge that Premera Blue Cross Blue Shield of Alaska is subject or will be subject to various federal and state privacy laws that may prohibit, limit, or otherwise restrict its ability to disclose to the Group any protected personal information, including, but not limited to, individually identifiable health information.

Clerical Error

In the event of a clerical error by the Group in keeping records pertaining to the initial enrollment of an enrollee under this Contract, we will provide retroactive enrollment, subject to an appropriate subscription charge adjustment. The period of retroactive enrollment will be limited to the date the enrollee's coverage would have been validly in force, in accordance with the terms and conditions of the Group Contract, not to exceed a 12-month period from the date the Group notifies us of the clerical error.

In the event of a clerical error by the Group in keeping records pertaining to the disenrollment of an enrollee under this Contract, we will provide retroactive disenrollment, subject to an appropriate subscription charge adjustment. The period for retroactive disenrollment will be limited to the first subscription charge due date that falls on or after the disenrollment date, not exceeding 90 days from the date the Group notifies us of the clerical error.

Enrollment and disenrollment which are delayed for COBRA enrollees and for reasons other than clerical error by the Group are explained in the subscriber's benefit booklet.

Compliance With Law

The Group shall comply fully with all applicable state, federal, and local laws and regulations, including notice and disclosure requirements, in carrying out its responsibilities under the contract. These include, but are not limited to, compliance with the Internal Revenue Code, the Employee Retirement Income Security Act of 1974 (ERISA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Family and Medical Leave Act of 1993 (FMLA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and Alaska Regulation 3 AAC 28.462.

Venue

All suits or legal proceedings brought against us by you or anyone claiming any right under this program must be filed:

- Within 3 years of the date we denied, in writing, the rights or benefits claimed under this program; and
- In the State of Alaska, or the state in which you are employed or reside.

COBRA

As directed by the Federal Consolidated Omnibus Budget Reconciliation Act of 1985, (referred to in this Contract as "COBRA"), most employers with 20 or more employees must offer members who meet COBRA's "qualified beneficiary" criteria an election to continue their group coverage. The Group is responsible to determine if it's required to comply with COBRA at the time of initial application and renewal of this Contract.

The Group must fulfill all the obligations and responsibilities regarding continued coverage that are assigned by COBRA to the employer, plan sponsor or administrator, and to the "group health plan." We aren't the COBRA plan administrator, and our actions pertaining to COBRA continued coverage won't be construed as relieving the Group of its responsibility under COBRA. Nothing contained herein is intended to serve as legal advice. The Group should consult its legal advisors as to the scope and applicability of COBRA.

The COBRA provisions outlined in the employee benefit booklet are a summarization of the requirements of the COBRA law. If there's a discrepancy between this summary and federal law, federal law will prevail.

When requested by the Group, we'll provide continued coverage under this Contract, but only to the extent that members are entitled to continue group coverage under the COBRA law, and only to the extent required by the COBRA law. In addition, all the requirements listed below must be met in order for the plan to provide COBRA coverage:

- The Group is subject to COBRA on the date of the qualifying event. If the Group wasn't subject to COBRA on the effective date of this Contract, the Group must notify us as soon as possible if it will become subject to COBRA on the next January 1. If the Group's workforce shrinks during the calendar year, the Group must also notify us as soon as possible that it will no longer be subject to COBRA on the next January 1.
- The Group complies with all the requirements assigned by COBRA to the employer, plan sponsor, plan administrator or group health plan that pertain to that qualified beneficiary. This includes all of COBRA's notice requirements and the time limits set by COBRA for each. If the Group appoints a third party to perform COBRA notices or other administrative tasks, that party's failure to meet COBRA's standards will be deemed a failure of the Group.
- The qualified beneficiary elects and pays for COBRA coverage within the time limits set by COBRA, and the application and required subscription charges are submitted to us with the Group's next billing.
- The required subscription charges continue to be paid when due or within the 30-day COBRA grace period. The Group must submit qualified beneficiaries' subscription charges with its regular monthly subscription charge payment.
- This Contract remains in force. The Group acknowledges that even after this Contract is terminated, COBRA may require the Group to offer continuation unless the Group ceased to offer group health care coverage to any employee.

The Group will terminate the coverage for any qualified beneficiary who doesn't elect COBRA continuation.

Subscriber Eligibility

The following employees of CITY OF WASILLA are eligible to enroll as subscribers under this contract:

Elected Officials

On the date the official is sworn into office.

All Other Employees

- An active full-time employee who regularly works a minimum of 40 hours a week, provided such employee has completed a 30-day probationary period. The probationary requirement does not apply to employees returning to work from a leave without pay or layoff.

- An active part-time employee who regularly works a minimum of 20 hours a week, provided such employee has completed a 30-day probationary period. The probationary requirement does not apply to employees returning to work from a leave without pay or layoff.

Inaccurate And Unapproved Descriptive Materials

The Group will indemnify, defend and hold us harmless for any claims, damages, judgments and expenses (including attorney's fees) based on or arising out of, directly or indirectly, descriptive materials written, created, designed or printed by the Group, or on the Group's behalf by any third party when such descriptive materials:

- Are used without prior review and written approval by us; and
- Inaccurately reflect any of the terms, conditions and/or provisions of this Contract.

The term "descriptive materials" includes, without limitation, any type of circular, leaflet, booklet, summary, handbook, letter or form that describes in whole or in part any of the terms, conditions and/or provisions of this Contract.

Independent Corporation

The Group hereby expressly acknowledges, on behalf of itself and all of its eligible employees and their eligible dependents, its understanding that the Group Contract constitutes a contract solely between the Group and Premera Blue Cross Blue Shield of Alaska. We are an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association") permitting us to use the Blue Cross and Blue Shield Service Marks in the State of Alaska. The Group expressly acknowledges that we are not contracting as the agent of the Association and that the Association has no obligation under the Group Contract.

The Group further acknowledges and agrees that it has not entered into the Group Contract based upon representations by any person other than us, and that no person, entity or organization other than us shall be held accountable or liable to the Group for any of our obligations to the Group created under the Group Contract. This provision shall not create any additional obligations whatsoever on our part other than those obligations created under other provisions of the Group Contract.

Rights Of Assignment

Notwithstanding any other provision in this Contract, and subject to any limitations of state or federal law, in the event that Premera Blue Cross Blue Shield of Alaska merges or consolidates with another corporation or entity, or does business under another name or jointly with another entity, or transfers this Contract to another corporation or entity, this Contract shall remain in full force and effect in accordance with its terms, and bind the Group and the successor corporation or other entity. In such event, we guarantee that all our obligations under this Contract will be performed by the successor entity.

Severability, Construction and Interpretation

This Contract and any questions concerning the validity, construction, interpretation, and enforcement of this Contract or the benefits provided herein shall be governed by the laws of the State of Alaska, except to the extent pre-empted by federal law.

Should any part, term or provision of this Contract be held by the courts to be illegal or in conflict with any law of the State of Alaska, the validity of the remaining portion shall not be affected.

EXHIBIT A

FULLY INSURED FUNDING ARRANGEMENT AGREEMENT to the Group Health Care Contract ("the Contract") between

PREMERA BLUE CROSS BLUE SHIELD OF ALASKA (hereinafter also referred to as "we," "us," or "our")

AND

STATE OF ALASKA POLITICAL SUBDIVISION (hereinafter called the Group)

Effective: July 1, 2005 through June 30, 2006

This Funding Arrangement Agreement is a part of Contract Form No. 1550Y, effective July 1, 2005, and includes the following Group Number:

Group No. 9000082 - 9000131

All the Group Numbers listed above shall be pooled together for establishment of Contractual Rates, pooling of experience, billing and calculation of late charges.

I. DEFINITIONS

For purposes of this Contract, the following definitions apply:

Contract Period

The term "Contract Period" means the period from 12:01 a.m. on July 1, 2005 to midnight on June 30, 2006.

Contractual Rate

The term "Contractual Rate" means the rates set forth as such in Attachment A for the Contract Period.

Contractual Revenue

The term "Contractual Revenue" means the total of the Contractual Rate for each rate classification multiplied by the number of employees in each such classification for each month in the Contract Period. Contractual Revenue does not include Customization Fees, if such fees are charged for this Plan.

Contribution and Participation Requirements

The term "Contribution Requirement" means the percentage or dollar amount contribution the employer will make toward the cost of employee and/or dependent coverage. The term "Participation Requirement" means the minimum percentage or number of employees and/or

dependents that must be enrolled under the Plan. The Contribution and Participation Requirements are set forth in the Attachment A.

Customization Fee

The term "Customization Fee" means the fee that applies if the Group requests either of the following:

1. A Plan benefit configuration that we have not determined to be standard for the plan type and filed as standard with the state regulators as required.

2. An off-anniversary benefit change, regardless of whether the desired benefit is standard for the plan type. The Customization Fee for each off-anniversary change shall be $2,000.

For purposes of Customization Fees, "benefits" include eligibility, termination, continuation and benefit payment provisions, benefit terms, limitations, and exclusions, funding arrangement changes, and any other standard provisions of the Plan. Fees are computed based on current administrative costs to implement and administer the benefit.

Customization Fees assessed on this Plan as of its effective date are set forth in Attachment A. Off-anniversary Customization Fees will be invoiced separately to the Group.

Enrollee

The term "Enrollee" means any subscriber, member, employee, former employee, spouse, former spouse, dependent, former dependent, beneficiary or any other individual who may be entitled to benefits under the terms of the Contract.

Grace Period

The term "Grace Period" means the period of time (see Attachment A) from the date a monthly Contractual Rate is due (due date) during which the Group may make the required payment and the Contract will not be terminated for nonpayment.

Group

The term "Group" means the employer, or a group or association of employers, actively engaged in business that is a party to this Contract. The Group is the "plan sponsor" for purposes of 29 U.S.C. Section 1161 et seq. and the "plan administrator" for purposes of 29 U.S.C. Section 1002(16) (a) and 26 U.S.C. Section 4980B(g) (3). All participating employers and segmented employers who are members of the Group shall be treated as one entity for purposes of this Contract, including the establishment of Contractual Rates, billing, and calculation of late charges.

Plan

The term "Plan" means the benefits, terms, and limitations set forth in the Contract between the Group and us which is funded all or in part through this Funding Arrangement Agreement.

II. CONTRACTUAL RATES (MONTHLY SUBSCRIPTION CHARGES)

A. Contractual Rates

The monthly Contractual Rates for the Contract Period are set forth in Attachment A.

B. Adjustments to Contractual Rates

The Contractual Rates set forth in II.A. above will remain in effect until the end of the Contract Period, and during any extension thereof granted by us, or until the Contract is terminated, if earlier, with the following exceptions:

1. Should any federal, state or local authority mandate a change in benefits, eligibility or procedure or impose or change a tax or assessment on us or the Plan during the Contract Period or any extension of the Contract Period, whether by statute, regulation, interpretation or otherwise, we may increase the Contractual Rates set forth in Attachment A, as of the date specified in our notice to the Group or its agent.

2. We may increase the Contractual Rates during the Contract Period by giving thirty (30) days advance written notice to the Group or its agent, if we determine that the basis upon which we assumed the risk is materially changed for any reason, including, but not limited to, the following:

   a. A benefit change requested by the Group.

   b. A fluctuation of ten (10) percent or more in the number of Enrollees as set forth on the census information included in Attachment A which is herein incorporated by reference and made a part of this Contract.

   c. A change in the amount of the employer's contribution on behalf of each Enrollee.

   d. A change in procedure agreed to by the Group and us, including any change in our reporting requirements.

   e. A change in the Group's health care plans and/or carriers from those set forth in Attachment A.

   f. The addition of Enrollees, with our prior approval, who live outside Alaska and Washington.

   g. The addition of a dual, triple, or multiple choice option or a change in the plan choices offered by a dual, triple or multiple choice group.

   Any such revision to current subscription charges will take effect on the date specified in the notice.

III. PAYMENTS

A. Monthly Payments

During the Contract Period, we will bill the Group based upon the previous month's eligibility. The Group shall provide us with updated eligibility information and it shall be liable for, and shall pay to us on or before the first day of each month, an amount equal to the total of the monthly Contractual Rates set forth in Attachment A on behalf of the Enrollees included on the updated eligibility list.

B. Late Payments

A Grace Period (see Attachment A) after the due date shall be allowed to the Group for payment of the monthly Contractual Rates. If payment is not received by us by the end of the Grace

Period, the Contract may automatically terminate on the subscription charge due date. No benefits will be paid for otherwise eligible expenses incurred on any day for which payment has not been made. If a partial payment has been received, we may, at our discretion, return the payment or provide benefits for those Enrollees for whom payment has been made. Acceptance by us of late or partial payment shall not be construed as a waiver of our right to demand timely payment or to terminate this Contract for nonpayment.

C. Late Charges

We reserve the right to invoke the provision below for all groups covered by this Fully Insured funding arrangement. We will notify all such groups 30 days in advance of the date that we will begin invoking this provision. We will then charge late charges on payments that are not received within any Grace Period that falls on or after the date stated in the notice.

If a payment is not received by us by the end of the Grace Period, the Group will pay us a daily late charge. This late charge is calculated from the due date, rather than from the end of the Grace Period. The late charge is based on the average prime rate posted by Bank of America/Nations Bank during the Contract Period, plus two (2) percent on the amount of the late payment for the number of days late. Late charges will not be assessed against any partial payment that is retained by us. Late charges are in addition to Contractual Revenue and they are calculated and billed at the end of the Contract Period or upon termination of the Contract, if earlier.

D. Customization Fees

Customization Fees for custom benefits that take effect on the effective date shown on the Face Page of this Contract are due and payable prior to that effective date. Customization Fees for off-anniversary benefit changes are due and payable prior to the effective date of the change.

IV. CONTRIBUTION AND PARTICIPATION REQUIREMENTS

A. The Group must pay a percentage of the cost of the Contractual Rate under this Contract for employees and a percentage of the eligible employees must be enrolled (see Attachment A).

B. The Group must pay a percentage of the cost of the Contractual Rate under this Contract for dependents and a percentage of the eligible dependents must be enrolled (see Attachment A).

C. For purposes of this Section IV, eligible Enrollees are individuals who satisfy the Contract's eligibility requirements, except for any contribution requirement.

We reserve the right to terminate this Contract, in accordance with Section VI.B.2., if the Group fails to maintain the contribution and participation requirements stated herein.

V. ACCOUNTING

A. Accounting

No annual or final accountings will be performed. Gains and losses will be absorbed by us.

B. Reporting

Within one hundred twenty (120) days of the end of the Contract Period, we shall provide information to the Group for preparing Form 5500's; the Group shall be solely responsible for insuring timely filing of the Form 5500's.

VI. CONTRACT TERMINATION

This Contract is guaranteed renewable. However, this Contract will automatically terminate if subscription charges are not paid when due; coverage will end on the last day for which payment was made. This Contract may also terminate as indicated below.

A. **The Group** may terminate this Contract:

1. upon 30 days' advance written notice to us on any subscription charge due date.

2. by rejecting, in writing, the contract changes we make after the initial term. The written rejection must reach us at least 15 days before the changes are to start. This Contract will end on the last date for which subscription charges were paid.

B. **We** may terminate this Contract, **upon 30 days' advance written notice to the Group if**:

1. fraud or other intentional misrepresentation of material fact is made by the Group, as explained in "General Provisions." Under such circumstances, this Contract may be rescinded back to its effective date;

2. the Group fails to meet the minimum participation or contribution requirements stated in its signed application and/or the Attachment A or any eligibility requirement stated in the Group Contract;

3. in the case of a network plan, the Group no longer has any Enrollees who reside or work in Alaska or Washington;

4. in the case of a plan that is made available only through a bona fide association, the employer's membership in the association ceases and coverage is terminated uniformly without regard to an Enrollee's health;

5. we discontinue offering a particular type of benefit plan in the group market providing, we satisfy the requirements of any applicable law.

6. we discontinue offering and renewing all health or dental care plans in the group market, providing we satisfy the requirements of any applicable law.

VII. OTHER PROVISIONS

A. Assignment

No assignment of the Group's interest hereunder may be made without our prior written consent and any such assignment shall be void.

B. Trademark

We reserve the right to, the control of, and the use of the words "Premera Blue Cross Blue Shield of Alaska," "Premera Blue Cross" and all symbols, trademarks and service marks existing or hereafter established. The Group shall not use such words, symbols, trademarks or service marks in advertising, promotional materials, materials supplied to Enrollees or otherwise without our prior written consent that shall not be unreasonably withheld.

C. Notice

Any notice required or permitted to be given by this Contract shall be in writing and shall be deemed delivered three (3) days after deposit in the United States mail, postage fully prepaid, return receipt requested.

D. Credit Worthiness

Evidence of credit worthiness, which is satisfactory to us, may be required at any time during the Contract Period as we deem necessary.

E. The BlueCard® Program

The BlueCard program we make available to your Enrollees who live or travel outside Alaska and Washington or in Clark County, Washington is described in "The BlueCard Program" in the benefit booklet part of this contract. Whenever Enrollees access health care services outside Alaska and Washington or in Clark County, Washington, the claim for those services may be processed through BlueCard and presented to us for payment. Payment is made according to the terms and limitations of your Contract and network access rules in the BlueCard Policies then in effect. Under BlueCard, when Enrollees receive covered services within the area served by another Blue Cross and/or Blue Shield Licensee (called the "Host Blue" in this section), Premera Blue Cross Blue Shield of Alaska remains responsible for fulfilling our obligations under this contract. The Host Blue will only be responsible for such services as contracting with providers and handling all interaction with contracting providers. The Host Blue must perform these duties in accordance with applicable BlueCard Policies. The financial terms of BlueCard are described generally in the benefit booklet. Note: The methods employed by a Host Blue to determine a negotiated price, as described in the benefit booklet, will vary among Host Blues based on the terms of each Host Blue's provider contracts.

Under BlueCard, recoveries from a Host Blue or from contracting providers of a Host Blue can arise in several ways. Examples are antifraud and abuse audits, provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of any fees, will be applied in accordance with applicable BlueCard Policies. Any such recoveries will be applied as an adjustment to the Group's claims experience.

The parties have signed as duly authorized officers and have hereby executed this Contract. If the monthly Contractual Rates for the Contract Period, set forth in Attachment A, are received by us but this Contract is not signed and returned to us by the effective date stated herein, we will assume the Group's concurrence and the Group will be bound by its terms.

ATTACHMENT A
to the Fully Insured Funding Arrangement Agreement
between
PREMERA BLUE CROSS BLUE SHIELD OF ALASKA
(hereinafter also referred to as "we," "us," or "our")
and
Alaska Political Subdivisions

Effective: 1-Jul-2005 through 30-Jun-2006

GRACE PERIOD

Ten (10) Days

BROKERAGE FEES AND COMMISSIONS

The Contractual Rates include brokerage fees and commissions equal to 1.80 percent of the Contractual Rate.

CONTRACTUAL RATES (MONTHLY SUBSCRIPTION CHARGES)

The monthly Contractual Rates for the Contract Period are as follows:

Group No. 10000005

	Rate Classification			
	E	ES	ESC	EC
Plan 100	$493.67	$1,128.60	$1,570.62	$926.66
Plan 250	$399.09	$912.71	$1,270.14	$756.51
Plan 500	$361.78	$827.36	$1,151.38	$685.80
Plan 1000	$308.52	$704.17	$980.00	$584.35

(These rates include RX, Vision, and Dental coverage.)

CONTRIBUTION AND PARTICIPATION REQUIREMENTS

	Employer Contribution	Participation
Employees	same as current	same as current
Dependents	same as current	same as current

ACCOUNTING PROCEDURES

No annual accountings are performed under this funding arrangement. We absorb all gains and losses.

NUMBER OF ENROLLEES

The Contractual Rates are based on the following:

Number of Active Enrollees:

Employees	Spouses	Children
1245	525	944

Other carriers offered: None

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Summary of Contract Changes

GROUP NAME: **State of Alaska Political Subdivision**
RENEWAL DATE: **July 1, 2005**

Federal ERISA and HIPAA regulations require the Plan Sponsor (the group) to notify employees of material modifications and material reductions to their group health plan. To ensure compliance with these regulations, please provide your employees with any benefit changes listed below.

Sections within this document may require your input or initials; if so, please return a copy of the completed Renewal Letter to your Marketing Coordinator.

Women's Health Act Annual Notice

As required by the Women's Health and Cancer Rights Act of 1998, your plan provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Refer to your benefit booklet for more information.

Changes

If the state or federal government mandates any additional change in benefits or if Premera Blue Cross Blue Shield of Alaska revises benefits or provisions after this renewal is issued, a supplemental notice will be provided.

The following changes will be made at renewal:

Regulatory Directives

Chemical Dependency Maximum

The maximum benefit for chemical dependency treatment in any 24-month period has been raised to $14,495. The lifetime maximum for this benefit has been raised to $28,985.

COBRA

The COBRA heading has been renamed and revised in the *How Do I Continue Coverage* section. Most changes are to help groups comply with new regulations published by the Department of Labor in May 2004. These regulations address the content and timing of various notices required by COBRA. You, your subscribers and affected dependents, and your plan administer are all impacted by the notice requirements.

- We have rearranged and reformatted some of the text in the section to match the model initial COBRA notice provided in the regulations. We have expanded the discussion of the

notice that subscribers and affected dependents must provide the Group of certain events that may trigger COBRA rights. Some of these events are divorce, legal separation, and a child's loss of dependent status. If notice of these events is not given to the Group or is late, the affected member will lose the right to COBRA coverage. The Group must notify members of the notice requirement, where to send the notice, and what steps to follow.

- We have added a provision from the model initial COBRA notice that reminds members enrolled in COBRA coverage to keep the Group informed of address changes. We have also added a provision about where to direct questions about COBRA and other federal mandates that affect group health plans.
- We have also clarified that a subscriber's Medicare entitlement is a qualifying event for dependents only if it would cause a dependent who is not on COBRA coverage to lose coverage under the plan.
- We have also clarified if the Group itself is the plan administrator responsible for sending COBRA election notices to qualified members, the Group has 44 days in which to send the COBRA election notice if the qualifying event is a subscriber's termination of employment, reduction in hours, or Medicare entitlement. Please note that the 44-day period starts on the later of 1) the date of the event or 2) the date coverage would end as a result of the event in the absence of COBRA.

Other Changes That Affect Your Benefits

Air or Surface Transportation

We have changed the name of the Air Transportation benefit to Air or Surface Transportation to clarify that other commercial surface transportation may also be covered. We also added a list of the items not covered under this benefit

Diagnostic Services

- We have added EKGs to the list of some examples of what's covered under this benefit.

Emergency Room Care

- We have clarified that emergency room based diagnostic services are covered under the Diagnostic Services benefit, and not the Emergency Room Care benefit.

Exclusions

- The "Charges For Records or Reports" exclusion has been revised to clarify that it refers to providers' charges. We have revised the "Orthodontia" exclusion to clarify that we exclude coverage for orthodontia, regardless of reason or origin of condition.

Hearing Aids

- We have removed an incorrect requirement that only one hearing aid purchase is covered every three calendar years. More than one purchase can be covered if the dollar maximum hasn't been reached.

- We have removed the requirement that the employee, subscriber or any qualified dependent must provide us with a written certificate from an examining physician of the need for a hearing aid. We also removed the requirement that any repairs, servicing, and alteration of hearing aid equipment had to have been for hearing aids purchased under this benefit.

Hospital Outpatient Care
We have revised the Hospital Outpatient Care benefit to clarify that diagnostic services done in the hospital outpatient department are covered under the Diagnostic Services benefit, and not the Hospital Outpatient Care benefit.

Mental Health Care
- We revised the coverage criteria under the Mental Health Care benefit to make it clearer.

Phenylketonuria (PKU) Dietary Formula
We have removed the limit of five cases per month from the Phenylketonuria (PKU) Dietary Formula benefit. The benefit will cover PKU formula when medically necessary.

Prescription Drugs
- Under the Clinical Pharmacy Management heading, we have clarified that we may limit benefits for a dispensed amount, drug or dosage as medically appropriate for a specific course of drug treatment.

Professional Visits and Services
In the Professional Visits and Services benefit, we have revised the Biofeedback text to clarify that benefits are provided only for uses not deemed experimental or investigational under this benefit.

Rehabilitation Therapy And Chronic Pain Care
- In the Rehabilitation Therapy benefit, we have replaced the reference to "physiatrist," in the provision that addresses inpatient care, with a reference to physicians specializing in physical medicine and rehabilitation.

Temporomandibular Joint (TMJ) Disorder
We have revised this benefit to clarify that only medical services related to TMJ will be covered.

Changes That Do Not Affect Your Benefits

Acupuncture and Nutritional Therapy
We have revised these benefits to spell out more clearly what amounts the member is responsible for when acupuncture is not done in an office setting.

Benefits
We have clarified when inpatient care is considered medically necessary and covered under the "What Are My Benefits" heading.

Claim Filing

We have simplified the text that explains how to file a claim.

Definitions
The definition of *Enrollment Date* has been expanded to reflect the additional conditions when an eligible employee and any eligible dependents can enroll for coverage under the plan.

- We have revised the definition of *Plan* for clarity.
- We have added some new defined terms to the *Definitions* section of your booklet:
  - Orthodontia
  - Subscriber
  - Subscription Charges

Dental Benefit
We have clarified in the *What Are My Dental Benefits?* section that if the benefit maximum is reached, benefits for dental care related to an accidental injury to the teeth are available under the Dental Services benefit in the *Medical Benefits* section of the booklet.

Prescription Drugs
The "home delivery pharmacy" program has been changed to "mail-order pharmacy" program. Our participating mail-order pharmacy has changed its name from "Home Delivery Pharmacy" to "Medco-By-Mail."

What If I Have A Question Or Appeal?
- We have removed an erroneous reference to phone numbers listed "below" under the When You Have Ideas heading. This revision now refers members to inside the front cover of the booklet for the plan phone numbers.
- Under the Urgent Appeals heading, we have clarified the language to direct members to the inside front cover of the booklet for plan phone numbers.

What If I Have Other Coverage?
We have added a note under the Coordinating Benefits With Other Health Care Plans heading advising that participation in other health care coverage may affect the tax deductibility of health savings account contributions.

Employer Contract Changes

COBRA

We have revised the language throughout the COBRA section to comply with the new regulations published by the Department of Labor in the federal register on May 26, 2004. Among the changes for groups in the regulations are the responsibility to issue two new COBRA notices, a notice when COBRA coverage is unavailable and a notice when COBRA coverage is terminated before the end of the maximum COBRA period. Another change is that, in order to enforce the 60-day time limit for members to notify the group of qualifying events such as divorce, a child's loss of eligibility, or a disability determination, the groups must first notify members of their procedures for sending these notices.

Employer Associations

We have added a new section to the Group Employer Agreement that outlines employer association responsibilities, delegation and rights.

Funding Arrangement Changes

- We will now charge one-time fees for setting up new benefits in your plan that we have not determined to be standard for the plan type. "Benefits" for this purpose include eligibility, termination, continuation and benefit payment provisions, benefit terms, limitations, and exclusions, funding arrangement changes, and any other standard provisions of your plan. We compute the fee based on current administrative costs to implement and administer the nonstandard benefit.
- We will now charge one-time fees for making off-anniversary benefit changes. Fees will apply even if the requested benefit is standard for the plan type.

Notification of Plan Changes

Please indicate below any other changes to the existing benefit plan at renewal, including a change in the Group's legal name or address, any affiliate or subsidiary additions or deletions, and revised eligibility requirements or IRS Section 125 Cafeteria Plan revisions. *Attach additional pages as necessary.*

Questions

If you have any questions about this renewal, please contact your Marketing Representative for assistance.

State-Mandated Benefit Offerings

Vision, Hearing and Dental

In compliance with the Alaska Insurance laws, the following minimum levels of coverage for dental, vision, and hearing benefits are being offered as an option to all new or renewing Alaska groups.

The following is a description of the dental, vision and hearing benefits that meet the required minimum levels.

Please contact your Marketing Representative if you would like to add any of these options or need further information.

Vision Care Benefit

- **Examinations** Up to 80% of Allowable Charges; one examination per enrollee each calendar year
- **Lenses** Up to 80% of Allowable Charges; maximum of two eyeglass lenses (single vision, bifocal, trifocal, lenticular) or two cosmetic contact lenses per enrollee per calendar year. Contact lenses are limited to a lifetime benefit maximum of $400
- **Frames** Up to 80% of Allowable Charges; one pair of frames in any two consecutive calendar years

Hearing Aid Benefit

- **Hearing Examination** 80% of Allowable Charges; one exam every three consecutive calendar years
- **Hearing Aid** 80% of Allowable Charges
- **Maximum Benefit** $800 in a period of three consecutive years.

DENTAL CARE BENEFITS

- **Calendar Year Deductible** $50 per enrollee; $150 per family
- **Diagnostic, Preventive, and Basic Services** 80% of Allowable Charges
- **Major Services** 50% of Allowable Charges
- **Dental Benefit Maximum** $1,500 per enrollee in a calendar year

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Alaska Political Subdivision
Rates Effective July 1, 2005 - June 30, 2006

City of Wasilla

roup Name

Option	Plan Design	E	ES	ESC	EC	Check Option
HeritageSelect $100	HeritageSelect $100/20%/$2100 RX: Retail $10/$20/$40; Mail $20/$40/$80 Dental Vision 1 exam per calendar year Hearing – 1 exam every 3CY, $400 hardware every 3CY	$493.67	$1,128.60	$1,570.62	$926.66	☐
HeritageSelect $250	HeritageSelect $250/20%/$2250 Office Visit co-pay $25 RX: Retail $10/$20/$40; Mail $20/$40/$80 Dental Vision 1 exam per calendar year Hearing – 1 exam every 3CY, $400 hardware every 3CY	$399.09	$912.71	$1,270.14	$756.51	☐
HeritageSelect $500	HeritageSelect $500/20%/$2500 Office Visit co-pay $25 RX: Retail $10/$20/$40; Mail $20/$40/$80 Dental Vision 1 exam per calendar year Hearing – 1 exam every 3CY, $400 hardware every 3CY	$361.78	$827.36	$1,151.38	$685.80	☐
HeritageSelect $1000	HeritageSelect $1000/20%/$4000 Office Visit co-pay $25 RX: Retail $10/$20/$40; Mail $20/$40/$80 Dental Vision 1 exam per calendar year Hearing – 1 exam every 3CY, $400 hardware every 3CY	$308.52	$704.17	$980.00	$584.35	☒

[redacted]

epted by:

Dianne M. Keller
ature

6/14/05
Date

DIANNE M. Keller, MAYOR
Name

2550 Denali Street
Suite 1404
Anchorage, AK 99503

tel 907.258.5065
fax 907.258.1619

www.premera.com

An Independent Licensee of the Blue Cross Blue Shield Association

ALASKA POLITICAL SUBDIVISION

GROUP NAME: City of Wasilla
GROUP NUMBER: 9000 117
EFFECTIVE DATE: JULY 1, 2005

LIFEWISE ASSURANCE COMPANY
Life | Disability | Stop Loss

Basic Life and AD&D Options:

	Basic Life	Rate	Basic AD&D	Rate	Check option
Option I	$ 2,000	$ .19/$1,000	$ 5,000	$ .06/$1,000	☒
Option II	$ 10,000	$ .16/$1,000	$ 10,000	$ .06/$1,000	☐
Option III					
Superintendents	$ 10,000	$ .19/$1,000	$ 25,000	$ .06/$1,000	☐
All other employees	$ 2,000	$ .19/$1,000	$ 5,000	$ .06/$1,000	
Option IV					
Superintendents	$ 50,000	$ .16/$1,000	$ 50,000	$ .06/$1,000	☐
All other employees	$ 10,000	$ .16/$1,000	$ 10,000	$ .06/$1,000	

- Basic Life and AD&D benefits reduce to 65% at age 65, to 50% of original amount at age 70, to 30% of original amount at age 75, to 20% of original amount at age 80, and terminate at retirement.
- Only one option per group, based on employer selection. All segments of an employer must elect the same option.
- Only groups of 10 or more employees qualify for coverage as part of the Alaska Political Subdivision (APS).

Options for basic benefits are selected for contract year beginning July 1st, and remain for that contract year ending the next June 30th.

CHANGE NOTIFICATION MUST BE RECEIVED BY LWAC NO LATER THAN 6/1/2005.

UPPLEMENTAL LIFE AND SUPPLEMENTAL AD&D:

second Supplemental benefit option originally offered 7/1/2001 – employer can choose only one plan design. Employer option, Supplemental plan design cannot be changed each year.

Check option

ENEFIT: A - one times annual salary rounded up to the next $1,000 to a maximum of $60,000. ☐
B – increments of $20,000 to a maximum of $300,000, G.I. $60,000. ☐

Benefit can not exceed 5 times salary

AGE	RATES SUPPLEMENTAL LIFE	AD&D
Under 30	$ .11	$ .06
30 - 34	$ .13	$ .06
35 - 39	$ .18	$ .06
40 - 44	$ .28	$ .06
45 - 49	$ .42	$ .06
50 - 54	$ .64	$ .06
55 - 59	$ 1.00	$ .06
60 - 64	$ 1.51	$ .06
65 - 69	$ 2.18	$ .06
70 - 74	$ 3.65	$ .06
75 - 79	$ 5.33	$ .06
80+	$ 7.78	$ .06

pplemental Life and AD&D benefits reduce to 65% at age 65, to 50% of original amount at age 70, to 30% of original amount at age 75, to 20% riginal amount at age 80 and terminate at retirement.

PENDENT LIFE:

NEFIT: Spouse: $1,000 Child: graded benefit from 14 days to 23 years - maximum $500
ST:

Family Unit (Spouse & Children)	$ .40
Spouse Only	$ .27
Children Only	$ .13

[redacted]

NATURE: Diane M. Keller DATE: 6/14/05

7001 220th St. SW, Building 2
Mountlake Terrace, WA 98043-2124
P.O. Box 2272
Seattle, WA 98111-2272

tel 425.918.4575
fax 425.918.4485

www.lifewiseac.com