Alaska Public Broadcasting Health Trust

Alaska Plus HSA

4003399

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

HOW TO CONTACT US

Please call or write our Customer Service staff for help with the following:

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

CUSTOMER SERVICE

Mailing Address:
Premera Blue Cross Blue Shield of Alaska

For Claims Only
P.O. Box 91059
Seattle, WA 98111-9159

Physical Address
3800 Centerpoint Dr., Suite 940
Anchorage, AK 99503

Telephone Numbers:

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

BLUECARD

1-800-810-BLUE(2583)

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

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

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

Please go to **www.premera.com/ak/sbc** for your Notice of Protection provided by the Alaska Life and Health Insurance Guaranty Association.

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

Group Name:	Alaska Public Broadcasting Health Trust
Effective Date:	January 1, 2023
Group Number:	4003399
Plan:	Alaska Plus HSA (Non-Grandfathered)
Certificate Form Number:	40033990122A

INTRODUCTION TO YOUR QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN

This plan meets the requirements of a qualified high deductible health plan for use in conjunction with a health savings account. Participation in a health savings account isn't a requirement for enrollment or continued eligibility on this plan. No feature of this plan is intended to, or should be assumed to, override health savings account requirements. Please contact your health savings account administrator if you have questions about requirements for health savings accounts. If the requirements for high deductible health plans are changed by law or regulation, this plan will be administered according to those changes even though they're not yet specified in this booklet.

Premera Blue Cross Blue Shield of Alaska isn't an administrator, trustee or fiduciary of any health savings account which may be used in conjunction with this health plan.

This plan will comply with the 2010 federal health care reform law, called the Affordable Care Act (see *Definitions*). If Congress, federal or state regulators, or the courts make further changes or clarifications regarding the Affordable Care Act and its implementing regulations, including changes which become effective on the beginning of the calendar year, this plan will comply with them even if they are not stated in this booklet or if they conflict with statements made in this booklet.

This benefit booklet is for members of Premera Blue Cross Blue Shield of Alaska, an independent licensee of the Blue Cross Blue Shield Association. This booklet describes the benefits of this plan and replaces any other benefit booklet you may have received.

The benefits, limitations, exclusions and other coverage provisions described on the following pages are subject to the terms and conditions of the contract we've issued to the Group. The “Group” is the firm, corporation, partnership or association of employers that contracts with us. This booklet is a part of the complete contract, which is on file in the Group's office and at the headquarters of Premera Blue Cross Blue Shield of Alaska.

HOW TO USE THIS BOOKLET

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

- **HOW TO CONTACT US** – our website address, phone numbers, mailing addresses and other contact information are conveniently located inside the front cover
- **SUMMARY OF YOUR COSTS** – A quick overview of what the plan covers and your costs
- **HOW DOES SELECTING A PROVIDER AFFECT MY BENEFITS?** – how using network providers will affect this plan's benefits and reduce your out-of-pocket costs
- **WHAT DO I NEED TO KNOW BEFORE I GET CARE?** – the types of expenses you must pay for covered services
- **COVERED SERVICES** – what's covered under this plan
- **CARE MANAGEMENT** – describes prior authorization, personal health support programs and clinical review provisions
- **EXCLUSIONS** – services that are either limited or not covered under this plan
- **WHO IS ELIGIBLE FOR COVERAGE?** – eligibility requirements for this plan
- **HOW DO I FILE A CLAIM?** – step-by-step instructions for claims submissions
- **COMPLAINTS AND APPEALS** – processes to follow to file a complaint or submit an appeal
- **DEFINITIONS** – many terms that have specific meanings under this plan. Example: The terms “you” and “your” refer to members under this plan. The terms “we,” “us” and “our” refer to Premera Blue Cross Blue Shield of Alaska in the state of Alaska and Premera Blue Cross in the state of Washington.

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SUMMARY OF YOUR COSTS

This is a summary of your costs for covered services. Your costs are subject to all of the following:

- The **allowed amount**. This is the most this plan allows for a covered service. For providers that do not have agreements with us, you are responsible for any amounts over the allowed amount, except for emergency, covered air ambulance services, or as prohibited by law.
- The **coinsurance**. This is a defined percentage of allowed amounts for covered services and supplies you receive. The benefit level provided by this plan and the remaining percentage you are responsible for, not including required copays, are both referred to as "coinsurance."

Coinsurance	**Providers in the Alaska Heritage Preferred Network (including Accepted Rural Providers)**	**Providers in the Alaska Heritage Participating Network**	**Providers Not in the Alaska Heritage Network**
	20% coinsurance	40% coinsurance	60% coinsurance

- The **copay**. This is a fixed up-front dollar amount that you're required to pay for each occurrence of certain covered services. Your provider of care may ask you to pay the copay at the time of service. Unless stated otherwise, benefits subject to a copay aren't subject to your deductible or coinsurance if any.
- The **deductible**. This is the amount you must pay in each calendar year for covered services and supplies before this plan provides certain benefits. The amount credited toward the calendar year deductible won't exceed the "allowed amount" for any covered service or supply.

This deductible is a family aggregate, which means that the deductible can be met by a single enrolled member, or more than one enrolled member in combination. Benefits aren't provided for any family member until the family enrollment deductible has been reached, except where stated otherwise. Once the family enrollment amount is reached, the deductible will be met for all enrolled family members.

	In-Network Providers	**Out-of-Network Providers**
Individual medical deductible	$2,000	Shared with In-Network Deductible
Family medical deductible	$4,000	Shared with In-Network Deductible

- The **out-of-pocket maximum**. This is the amount you could pay toward the calendar year deductible and coinsurance, if any, for services listed under the ***Medical Benefits*** section.

	In-Network Providers	**Out-of-Network Providers**
Individual out-of-pocket maximum	$3,500	$7,000

	In-Network Providers	**Out-of-Network Providers**
Family out-of-pocket maximum	$7,000	$14,000

- **Prior authorization.** Some services must be prior authorized before you get them to be eligible for benefits. See ***Prior Authorization*** for details.
- **Conditions, time limits and maximum limits.** This plan has certain conditions, time limits and maximum limits that are described in this booklet. Some services have special rules. See ***Covered Services*** for details.

The benefits listed in the ***Summary of Your Costs*** table below are for outpatient professional services, unless otherwise indicated. You may have additional out-of-pocket expenses for hospital facility services, if incurred. See ***Hospital Inpatient Care***, ***Hospital Outpatient Care*** and freestanding ***Surgical Center Care – Outpatient*** for details.

	Providers in the Alaska Heritage Preferred Network (including Accepted Rural Providers)	Providers in the Alaska Heritage Participating Network	Providers Not in the Alaska Heritage Network
MEDICAL SERVICES			
Acupuncture Benefits are provided for up to 12 visits per member per calendar year.	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Allergy Testing and Injections – Outpatient Professional	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Ambulance Benefits are provided for licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat your condition. Benefits for ambulance transport depend on whether the medical condition is a medical emergency: • Emergency surface transport • Emergency air transport • Non-emergent surface transport	In-network deductible, then 20% coinsurance In-network deductible, then 20% coinsurance In-network deductible, then 20% coinsurance		
• Non-emergent air transport	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
App-Based Care App-based care select providers			
General Medical Services	In-network deductible, then 20% coinsurance	Not applicable	Not applicable
Mental Health	In-network deductible, then 20% coinsurance	Not applicable	Not applicable
Substance Use Disorder	In-network deductible, then 20% coinsurance	Not applicable	Not applicable

	Providers in the Alaska Heritage Preferred Network (including Accepted Rural Providers)	Providers in the Alaska Heritage Participating Network	Providers Not in the Alaska Heritage Network
App-based care select providers can be found at **https://www.premera.com/visitor/virtual-care** or contact Customer Service for assistance. See the ***Professional Visits and Services, Mental Health Care and Substance Abuse Treatment*** benefits for virtual care benefits.			
Blood Products and Services Benefits are provided for the cost of blood and blood derivatives.	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Cellular Immunotherapy and Gene Therapy	Covered as any other service depending where the service is performed		
Chemotherapy and Radiation Therapy See the ***Hospital Inpatient Care, Hospital Outpatient Care and Surgical Center Care – Outpatient*** for facility charges.	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Clinical Trials Medically necessary care of a qualified clinical trial.	Covered as any other service depending where the service is performed. You may have additional costs for other services such as x-rays, lab, and hospital facility charges. See those covered services for details.		
Transportation for ***Cancer Clinical Trials only***	In-network deductible, then 20% coinsurance		
Contraception Management and Sterilization You may have additional costs for inpatient hospital services, if incurred			
• Male sterilization	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Other covered contraceptive management services	Covered in full		Deductible, then 60% coinsurance
• Prescription contraceptives dispensed in a pharmacy	Prescription contraceptives including emergency contraception and prescription barrier devices or supplies that are dispensed by a licensed pharmacy are covered under the ***Prescription Drugs*** benefit.		
Dental Care • **Dental Anesthesia** Benefits for hospital or ambulatory surgical center care for dental procedures are provided for general anesthesia and related facility services that are medically necessary	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance

	Providers in the Alaska Heritage Preferred Network (including Accepted Rural Providers)	Providers in the Alaska Heritage Participating Network	Providers Not in the Alaska Heritage Network
• **Dental Injuries** When services are related to an accidental injury, benefits are provided when such repair is performed within 12 months of the accidental injury.	Covered as any other service depending where the service is performed. You may have additional costs for other services such as x-rays, lab, and hospital facility charges. See those covered services for details.		
Diagnostic and Preventive Mammography Services			
• Preventive mammography services	Covered in full		Deductible, then 60% coinsurance
• Non-preventive mammography services	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Diagnostic Lab, X-ray, and Imaging **Please note:** For preventive diagnostic services see the ***Preventive Care*** benefit	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Dialysis	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Emergency Room	In-network deductible, then 20% coinsurance		
Foot Care Routine medically necessary foot care	Covered as any other service depending where the service is performed		
Habilitation Therapy			
• Professional outpatient therapy	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Outpatient facility services Benefits for outpatient care will be provided for physical, speech, and occupational therapy services, up to a combined maximum benefit of 45 visits per member each calendar year.	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Inpatient professional services	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Inpatient facility services Benefits for inpatient facility and professional care are provided up to 30 days per member each calendar year.	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Health Management • Health Education • Nicotine Dependency Programs	No cost share, however you must pay for the cost of the class or program and send us proof of payment along with a reimbursement form.		

	Providers in the Alaska Heritage Preferred Network (including Accepted Rural Providers)	Providers in the Alaska Heritage Participating Network	Providers Not in the Alaska Heritage Network
Home Health Care **Professional Home Health** Intermittent home health visits limited to 130 visits per member each calendar year	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Home Medical Equipment (HME), Orthotics, Prosthetics, and Supplies Benefits are provided for foot orthotics (shoe inserts) and therapeutic shoes (orthopedic), including fitting expenses, up to a maximum of $300 per member each calendar year. Items prescribed for the treatment of diabetes are not subject to this benefit limit.	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Hospice Care Benefits for a terminally ill member shall not exceed 6 months of covered hospice care			
• Inpatient hospice care up to a maximum of 10 days	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• In-home intermittent hospice visits (not subject to Home Health Care visit limit)	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Respite care up to a maximum of 240 hours	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Hospital Inpatient Care			
• Inpatient facility	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• All other hospital services and supplies For inpatient hospital maternity care and newborn care, see the ***Maternity Care*** and ***Newborn Care*** benefits.	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Hospital Outpatient Care	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Infusion Therapy – Outpatient Professional	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Mastectomy and Breast Reconstruction Mastectomy necessary due to disease, illness or accidental injury and for breast reconstruction needed in connection with a mastectomy.	Covered as any other service depending where the service is performed		

	Providers in the Alaska Heritage Preferred Network (including Accepted Rural Providers)	Providers in the Alaska Heritage Participating Network	Providers Not in the Alaska Heritage Network
Maternity Care Benefits for the hospital stay and related inpatient medical care following childbirth are provided up to: • 48 hours after a normal vaginal birth; or • 96 hours after a normal cesarean birth.	Covered as any other service depending where the service is performed		
Medical Foods	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Medical Transportation Benefits **State-Restricted Care** Benefits are limited to members residing in states where laws restrict access to care. Travel and lodging are covered up to the IRS limitations. Prior approval required. • To/from provider for elective abortion services • To/from provider for medically necessary gender affirming care services • Calendar year limit: $4,000	In-network deductible, then no cost share		
Elective Procedure Travel Cellular Immunotherapy and Gene Therapy travel and lodging benefits are limited to $7,500 per episode of care. Benefits are provided for: • One round trip airfare by a licensed commercial carrier for the member and one companion per episode Reimbursement rates: • Ferry transportation limited up to $50 per person each way • Lodging expenses are limited up to $50 per day per person. • Mileage expenses are reimbursed at 20 cents per mile per trip • Surface transportation and parking limited up to $35 per day **Please note:** Reimbursement rates are based on IRS guidelines and are subject to change due to IRS regulations.	In-network deductible, then no cost share		

	Providers in the Alaska Heritage Preferred Network (including Accepted Rural Providers)	Providers in the Alaska Heritage Participating Network	Providers Not in the Alaska Heritage Network
Medical Access Transportation Benefits are limited to 3 round trip coach air or surface transports per calendar year only for the ill or injured member. When transportation is for a child under the age of 19, this benefit will also cover a parent or guardian to accompany the child.	In-network deductible, then 20% coinsurance		
Mental Health Care			
• Professional outpatient therapeutic visits (including virtual care)	In-network deductible, then 20% coinsurance		Deductible, then 60% coinsurance
• Outpatient facility services	In-network deductible, then 20% coinsurance		Deductible, then 60% coinsurance
• Inpatient professional	In-network deductible, then 20% coinsurance		Deductible, then 60% coinsurance
• Inpatient facility	In-network deductible, then 20% coinsurance		Deductible, then 60% coinsurance
Newborn Care Benefits for routine hospital nursery charges and related inpatient well-baby care for an eligible newborn are provided up to: • 48 hours after a normal vaginal birth; or • 96 hours after a normal cesarean birth.	Covered as any other service depending where the service is performed		
Newborn Hearing Exams and Testing This benefit provides for one screening hearing exam for covered newborns up to 30 days after birth. Benefits are also provided for diagnostic hearing tests, including administration and interpretation, for covered children up to age 24 months if the newborn hearing screening exam indicates a hearing impairment.	Covered as any other service depending where the service is performed		
Premera Designated Centers of Excellence Program • Knee and Hip Total Joint Replacement • Spinal Surgery • Gynecology Surgery Special criteria are required for coverage. See the ***Premera Designated Centers of Excellence Program*** benefit for details.	**Premera Designated Centers of Excellence:** Deductible, then Covered in full **For all other providers:** Covered as any other surgery depending on whether the services are provided by a preferred, participating, or out-of-network provider and where the services are performed.		

	Providers in the Alaska Heritage Preferred Network (including Accepted Rural Providers)	Providers in the Alaska Heritage Participating Network	Providers Not in the Alaska Heritage Network
Preventive Care • Preventive exams, screenings and immunizations (including seasonal immunizations in a provider's office) are limited in how often you can get them based on your age and gender	Covered in full		Deductible, then 60% coinsurance
• Preventive diagnostic services	Covered in full		Deductible, then 60% coinsurance
• Seasonal and travel immunizations provided by a pharmacy or other mass immunizer	No cost share		
Professional Visits and Services (including virtual care) • Professional office visit and electronic visits *Coverage for office visits throughout this plan includes real-time visits using online and telephonic methods with your doctor or other provider (telemedicine) when appropriate*	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Inpatient and other outpatient professional visits You may have additional costs for things such as x-rays, lab, therapeutic injections and facility charges. See those covered services for details.	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Psychological and Neuropsychological Testing	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Rehabilitation Therapy and Chronic Pain • Outpatient professional services	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Outpatient facility services Physical, speech, occupational, and massage therapy services, including cardiac and pulmonary rehabilitation, up to a combined maximum benefit of 45 visits per member each calendar year.	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Inpatient professional services	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance

	Providers in the Alaska Heritage Preferred Network (including Accepted Rural Providers)	Providers in the Alaska Heritage Participating Network	Providers Not in the Alaska Heritage Network
• Inpatient facility Benefits for inpatient facility and professional care are available up to 30 days per member each calendar year. This benefit covers Inpatient care you receive within 24 months from the onset of the injury or illness or from the date of the surgery that made rehabilitation necessary. This limitation does not apply to chronic pain care. See ***Mental Health*** and ***Substance Abuse*** for therapies provided for mental health conditions such as autism.	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Skilled Nursing Facility Care Benefits are provided up to 60 days per member each calendar year.	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Spinal and Other Manipulations You may have additional costs for hospital charges if incurred Benefits for spinal and other manipulations are provided up to a combined maximum benefit of 12 visits per member each calendar year.	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Substance Abuse Treatment			
• Outpatient professional services (including virtual care)	In-network deductible, then 20% coinsurance		Deductible, then 60% coinsurance
• Outpatient facility services	In-network deductible, then 20% coinsurance		Deductible, then 60% coinsurance
• Inpatient professional	In-network deductible, then 20% coinsurance		Deductible, then 60% coinsurance
• Inpatient facility	In-network deductible, then 20% coinsurance		Deductible, then 60% coinsurance
Surgery This benefit covers surgical services that are not covered under other benefits when performed on an inpatient or outpatient basis, in such locations as a hospital, ambulatory surgical facility, surgical suite or provider's office.	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance

	Providers in the Alaska Heritage Preferred Network (including Accepted Rural Providers)	Providers in the Alaska Heritage Participating Network	Providers Not in the Alaska Heritage Network
See the ***Hospital Inpatient Care, Hospital Outpatient Care and Surgical Center Care – Outpatient*** for facility charges. For organ, bone marrow or stem cell transplant procedure benefit information, please see the ***Transplants*** benefit.			
Surgical Center Care - Outpatient	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Therapeutic Injections – Outpatient Professional	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Transplants This benefit covers medical services only if provided by "Approved Transplant Centers."			
• Outpatient professional visits	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Not covered
• Outpatient facility services	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Not covered
• Inpatient professional	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Not covered
• Inpatient facility	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Not covered
Donor Costs: • Procurement expenses are limited to $75,000 per transplant. All covered donor costs accrue towards the $75,000 maximum, no matter when the donor receives them.			
Travel and Lodging Covered transportation and lodging incurred by the transplant recipient and companions are limited to $7,500 per transplant	In-network deductible, then no cost share		

	Providers in the Alaska Heritage Preferred Network (including Accepted Rural Providers)	Providers in the Alaska Heritage Participating Network	Providers Not in the Alaska Heritage Network

Reimbursement rates:
• **Travel:** Travel is reimbursed between the patient's home and the approved transplant center for round trip (air, train, or bus) coach class transportation costs.
  • Mileage expenses are reimbursed at 20 cents per mile per trip
  • Surface transportation and parking are limited up to $35 per day
  • Ferry transportation expenses are limited up to $50 per person each way
• **Lodging:** Expenses incurred by a transplant patient and companion for hotel lodging away from home. Lodging expenses are limited up to $50 per day per person
Please note: Reimbursement rates are based on IRS guidelines and are subject to change due to IRS regulations.			

Urgent Care You may have additional costs for other services like x-rays, lab, and hospital facility charges, if incurred. • Freestanding urgent care center	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Urgent care (Hospital facility)	See ***Emergency Room*** for cost shares		

	In-Network Pharmacy	Out-of-Network Pharmacy
Prescription Drugs		
Prescription Drugs – Retail Pharmacy • Preferred Generic Drugs • Preferred Brand Name Drugs • Preferred Specialty Drugs • All Non-Preferred Drugs Benefits are provided for up to a 90-day supply of covered medication unless the drug maker's packaging limits the supply in some other way. Dispensing of a greater than 90-day supply is permitted when the drug maker's packaging doesn't allow for a lesser amount.	In-network deductible, then $15 copay In-network deductible, then $30 copay In-network deductible, then $50 copay In-network deductible, then 30% coinsurance	
Prescription Drugs – Mail-Order You must use a participating pharmacy. Benefits are provided for up to a 90-day supply of a covered medication. • Preferred Generic Drugs • Preferred Brand Name Drugs • Preferred Specialty Drugs • All Non-Preferred Drugs You must use a participating pharmacy. Benefits are provided for up to a 90-day supply of a covered medication. Benefits for specialty drugs dispensed through a specialty pharmacy program via mail-order are limited to a 30-day supply.	Deductible, then $37.50 copay Deductible, then $75 copay Deductible, then $50 copay Deductible, then 30% coinsurance	Not covered Not covered Not covered Not covered
Prescription Drugs – Anti-Cancer Medication This benefit covers self-administered anti-cancer drugs when the medication is dispensed by a pharmacy	In-network deductible, then 20% coinsurance	
Per Internal Revenue Service requirements, drug manufacturer coupons and other forms of cost-share assistance cannot be used to satisfy this plan's deductible.		

	In-Network Provider	Out-of-Network Provider
Vision		
Adult Vision Benefits Vision services are provided for covered members 19 years of age or older. For vision benefits provided for members under age 19, see the ***Pediatric Vision*** benefit. **Vision exams** This benefit provides one routine vision exam per member each calendar year. **Vision hardware** The plan pays allowed amounts including any applicable sales tax, shipping and handling costs up to a maximum benefit of $200 per member each calendar year.	Covered in full Covered in full	
Pediatric Vision Benefit This benefit covers vision services for covered children under the age of 19. **Vision Exam** Benefits are provided for one routine eye exam per calendar year.	In-network deductible, then 20% coinsurance	
Vision Hardware Benefits are provided for: • 1 pair of frames and lenses per calendar year, ***or*** • 1 pair of hard contact lenses per calendar year, ***or*** • 12-month supply of disposable contact lenses per calendar year	Covered in full	

HOW DOES SELECTING A PROVIDER AFFECT MY BENEFITS?

The benefits of this plan are based on allowed amounts for covered services and supplies. See ***Definitions*** for a definition of "allowed amount."

This plan does not require use or selection of a primary care provider or require referrals for specialty care. Members may self-refer to providers, including obstetricians, gynecologists and pediatricians, to receive care, and may do so without prior authorization.

If your plan requires you to pay a higher deductible and/or more coinsurance, if any, for services of out-of-network providers, emergency care will always be the exception. You pay the same deductible and/or coinsurance, if any, no matter whether the emergency care is provided by in-network or out-of-network providers. If you see an out-of-network provider, you are always responsible for any charges over the allowed amount except for emergency services, covered air ambulance services, or as prohibited by law.

You may receive covered services from any provider licensed to provide the service. However, within Alaska, in order to receive the higher level of benefits available under this plan for non-emergent provider or hospital services you must use a provider or a hospital in the **preferred** or **participating** network. For this purpose, a "physician" means a provider who is licensed by the state as a Doctor of Medicine and Surgery (M.D.), Doctor of Osteopathy and Surgery (D.O.) or Podiatrist (D.P.M.).

When you get services from a **preferred physician or hospital**, you will have the lowest out-of-pocket expenses and you are not responsible for amounts above the allowed amount. Therefore, receiving services from a preferred physician or hospital may substantially reduce your healthcare costs.

When you get services from a **participating physician or hospital**, your out-of-pocket expenses will generally be higher than if you receive services from a preferred provider or hospital. You are not responsible for amounts above the allowed amount for these providers.

When you get services from an **out-of-network (or non-participating) physician or hospital**, your out-of-pocket expenses will be higher than if you receive services from a network physician or hospital. You are also responsible for amounts above the allowed amount for these providers except for emergency services, covered air ambulance services, or as prohibited by law.

Preferred and participating physicians and hospitals in the network have agreed to accept the allowed amount as payment in full. They have also agreed to bill us directly for the covered portion of the services you receive, and we make payment directly to them. These commitments are also true of other types of providers that have network agreements with us.

If you use a physician or hospital that isn't in the network, as stated above, except for emergency services, you'll be responsible for amounts above the allowed amount. This is also true of any other provider that doesn't have a network agreement with us. Amounts in excess of the allowed amount also don't count toward the calendar year deductible or as coinsurance.

The following services and/or providers will always be covered at the highest in-network benefit level for covered services and supplies, based on the allowed amount:

- Emergency services. You may get care in the emergency room from out-of-network or out-of-network providers. You will not be balance billed for emergency services provided by a out-of-network provider under federal law. See **Definitions** for a definition of "Allowed Amount" for more information about allowed amounts for emergency services.
- Non-emergency care services received from out-of-network providers in Alaska when there isn't a network provider located within 50 miles of your home. We suggest that you contact us before you receive non-emergency care covered services from an out-of-network provider.
- Care received from out-of-network providers for covered stays at in-network hospitals when you have no choice as to who performs the services
- Categories of providers with whom we do not have a contract, including accepted rural providers. See ***Definitions*** for a definition of "accepted rural providers."

Benefits are provided at the highest benefit level, but you will be required to pay any amounts that exceed the allowed amount except as prohibited by law.

WHEN YOU GET CARE IN WASHINGTON

You have access to a network of providers when you get care in Washington. Like in-network providers in Alaska, you will receive the highest benefit level and lowest out-of-pocket costs when you see these providers. All the requirements of your plan described in this booklet apply to services received in Washington.

To find an in-network provider in Washington, see our provider directory at **premera.com**, or call Customer Service.

WHEN YOU GET CARE OUTSIDE ALASKA AND WASHINGTON

If you're outside Alaska and Washington, you may receive covered services from any provider licensed to provide the service. For non-emergent physician and hospital services in Washington (except Clark County, Washington), you'll receive the higher level of benefits available under this plan when you use network physicians and hospitals.

Except as stated below, for the same services outside of Alaska and Washington or in Clark County, Washington, you'll receive the higher level of benefits available by using physicians and hospitals with PPO agreements with the Blue Cross or Blue Shield Licensee in the area where you're receiving services. For more information about receiving care outside Alaska and Washington or in Clark County, Washington, see ***What Do I Do If I'm Outside Alaska and Washington?*** for details.

Covered emergency services received from providers located outside the United States, Puerto Rico and the U.S. Virgin Islands are provided at the highest level of benefits available under the plan.

For the purpose of care you receive in Alaska, references to “network” in this booklet refer to the Heritage network. For the purpose of care you receive outside Alaska, references to “network” refer to the networks stated in ***When You Get Care Outside Alaska and Washington***. This booklet uses “out-of-network” to refer to physicians and hospitals that aren't in the applicable network for the area in which you receive care.

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

For the most current information on preferred or participating network hospitals, and network physicians, please refer to our website at **premera.com** or contact Customer Service. If you're outside Alaska and Washington or in Clark County, Washington, call 1-800-810-BLUE (2583).

PROVIDER STATUS

Since a provider's agreement with us is subject to change at any time, it's important to verify a provider's status. This may help you avoid additional out-of-pocket expenses. Please call our Customer Service Department at the number listed inside the front cover of this booklet to verify a provider's status. If you're outside Alaska and Washington or in Clark County, Washington, call 1-800-810-BLUE (2583) to locate or verify the status of a provider.

CONTINUITY OF CARE

How Continuity of Care Works You may qualify for Continuity of Care (COC) under certain circumstances when a provider leaves your health plan’s network or your employer transitions to a new carrier. This will depend on your medical condition at the time the change occurs. COC is a process that provides you with short-term, temporary coverage at in-network levels for care received by a non-participating provider.

COC applies in these situations:

- The contract with your provider ends
- The benefits covered for your provider change in a way that results in a loss of coverage
- The contract between your company and us ends and that results in a loss of benefits for your provider

How you qualify for Continuity of Care You may qualify if you are in an “active relationship” or treatment with your provider. This means that you have had three or more visits with the provider within the past 12 months and you meet one or more of these conditions with respect to a terminated provider or facility:

- Undergoing a course of treatment for a serious and complex condition
- Undergoing a course of institutional or inpatient care
- Are scheduled for a non-elective surgery, including receipt of postoperative care
- Are pregnant and undergoing a course of treatment for the pregnancy

- Are receiving treatment for a terminal illness

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

Duration of Continuity of Care

If you qualify for continuity of care, you will get continuing care from the terminating provider until the longer of the following:

- For pregnant members, the completion of postpartum care
- For terminally ill members, the end of medically necessary treatment for the terminal illness. ("Terminal" means a life expectancy of less than one year.)
- The end of the current plan year
- Up to 90 days after the provider's contract termination date, if the member is continuing ongoing treatment

Continuity of care does not apply if your provider:

- No longer holds an active license
- Relocates out of the service area
- Goes on leave of absence
- Is unable to provide continuity of care because of other reasons
- Does not meet standards of quality of care

When continuity of care terminates, you may continue to receive services from this same provider, however, we will pay benefits at the out-of-network benefit level subject to the allowed amount. See ***How Providers Affect Your Costs*** for an illustration about benefit payments. If you disagree with the continuity of care qualifications, you may request an appeal of the denial. Please see ***Complaints and Appeal***s.

BALANCE BILLING PROTECTION

Out-of-network providers have the right to charge you more than the allowed amount for a covered services. This is called "surprise billing" or "balance billing." However, federal law protects you from balance billing for:

Emergency Services

Emergency services from an out-of-network hospital or facility or from an out-of-network provider at the hospital or facility.

Emergency services includes certain post-stabilization services you may get after you are in stable condition. These include covered services provided as part of outpatient observation or during an inpatient or outpatient stay related to the emergency visit, regardless of which department of the hospital you are in.

Non-Emergency Services from an out-of-network provider at an in-network hospital or outpatient surgery center

If a non-emergency service from an out-of-network provider is not covered under the in-network benefits and terms of coverage under your health plan, then the federal law regarding balance billing do not apply for these services.

Air Ambulance

Your cost-sharing for out-of-network air ambulance services shall be no more than if the services were provided by an in-network provider. The cost sharing amount shall be counted towards the in-network deductible and the in-network out of pocket maximum amount. Cost-sharing shall be based upon the lesser of the qualifying payment amount (as defined under federal law) or the billed amount.

WHAT DO I NEED TO KNOW BEFORE I GET CARE?

This section of your booklet explains the amounts you must pay for covered services before the benefits of this plan are provided. To prevent unexpected out-of-pocket expenses, it's important for you to understand the amounts you're responsible for. Please see the ***Summary of Your Costs*** for your deductible, copays (if any), coinsurance and benefit limits.

COINSURANCE

“Coinsurance” is a defined percentage of allowed amounts for covered services and supplies you receive. The benefit level provided by this plan and the remaining percentage you're responsible for are both referred to as “coinsurance.” Your coinsurance amount for this plan is shown on the ***Summary of Your Costs***.

Please note: When this booklet refers to coinsurance, it means that either the in-network or out-of-network coinsurance shown on the ***Summary of Your Costs*** applies, depending on the provider.

CALENDAR YEAR DEDUCTIBLE

A deductible is an amount you must pay in each calendar year for covered services and supplies before this plan provides certain benefits. The amount credited toward the calendar year deductible won't exceed the “allowed amount” for any covered service or supply.

The calendar year deductible is dependent upon whether you're enrolled as an individual (subscriber only) or as a family (subscriber and one or more dependents).

This deductible is a family aggregate, which means that the deductible can be met by a single enrolled member, or more than one enrolled member in combination. Benefits aren't provided for any family member until the family enrollment deductible has been reached, except where stated otherwise. Once the family enrollment amount is reached, the deductible will be met for all enrolled family members.

Your calendar year deductible amount for this plan is shown on the ***Summary of Your Costs***.

Please note: If a subscriber adds or drops dependents from coverage during the calendar year, the subscriber's calendar year deductible will change to the single enrollment or family enrollment deductible, as appropriate.

While some benefits have dollar maximums, others have different kinds of maximums, such as a maximum number of visits or days of care that can be covered. We don't count allowed amounts that apply to the calendar year deductible toward dollar benefit maximums. But if a member receives services or supplies covered by a benefit that has any other kind of maximum, and those services or supplies apply toward the calendar year deductible, those services or supplies will count toward the benefit maximum of the member who received them.

This plan's calendar year deductible applies to all covered providers, including out-of-network providers. See ***What Doesn't Apply To The Calendar Year Deductible?*** to find out what doesn't apply to the calendar year deductible.

What Doesn't Apply To The Calendar Year Deductible?

The calendar year deductible needn't be met before some benefits of this plan can be provided. These exceptions are stated in the specific benefits shown on the ***Summary of Your Costs***.

Other amounts that don't accrue toward this plan's calendar year deductible are:

- Amounts that exceed the allowed amount
- Charges for excluded services
- Prior authorization penalties
- Per Internal Revenue Service requirements, drug manufacturer coupons and other forms of cost-share assistance cannot be used to satisfy the deductible

OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is the most you or your family will pay each calendar year for deductible, coinsurance, and copay amounts (if any) for covered services before this plan begins to pay 100%. Your out-of-pocket maximum amount for this plan is shown on the ***Summary of Your Costs***.

Individual out-of-pocket maximum

For each member, there is an out-of-pocket maximum. Once this maximum has been satisfied, the benefits of this plan that are subject to the out-of-pocket maximum will be provided at 100% of allowed amounts for the remainder of that calendar year for covered services.

Family out-of-pocket maximum

We also keep track of the total deductible, coinsurance, and copay amounts (if any) applied to individual out-of-pocket maximums that are incurred by all enrolled family members combined. When this total equals the family out-of-pocket maximum, we'll consider the individual out-of-pocket maximum of every enrolled family member to be met for that calendar year.

This table outlines what services apply to the out-of-pocket maximum of this plan.

Service Type	**Providers In The Alaska Heritage Preferred Network (including Accepted Rural Providers):**	**Providers In The Alaska Heritage Participating Network**	**Providers Not In The Alaska Heritage Network**
Physician Office Visits (MD, DO, DPM)	Yes, out-of-pocket maximum applies	Yes, out-of-pocket maximum applies	Yes, out-of-pocket maximum applies
Other Physician Services (MD, DO, DPM)	Yes, out-of-pocket maximum applies	Yes, out-of-pocket maximum applies	Yes, out-of-pocket maximum applies
Hospital-Based Services	Yes, out-of-pocket maximum applies	Yes, out-of-pocket maximum applies	Yes, out-of-pocket maximum applies
Other covered services paid at the highest in-network benefit such as ***Emergency Services***. See ***Emergency Services*** for details.	Yes, out-of-pocket maximum applies	Yes, out-of-pocket maximum applies	Yes, out-of-pocket maximum applies

What Doesn't Apply To The Out-Of-Pocket Maximum?

The amounts below don't apply to the out-of-pocket maximum. You must continue to pay these amounts after the out-of-pocket maximum is met in each calendar year.

- Amounts that exceed the allowed amount
- Services and supplies not covered under this plan
- Per Internal Revenue Service requirements, drug manufacturer coupons and other forms of cost-share assistance cannot be used to satisfy the deductible
- Prior authorization penalties

COVERED SERVICES

This section explains the medical services covered by this plan. Benefits are available for covered services and supplies when they meet all the following requirements.

- It must be furnished in connection with either the prevention or diagnosis and treatment of a covered illness, disease or accidental injury
- It must be medically necessary and must be furnished in a medically necessary setting
- It mustn't be excluded from coverage under this plan
- The expense for it must be incurred while you're covered under this plan and after any applicable waiting period required under this benefit plan is satisfied
- It must be furnished by a provider who is performing services within the scope of his or her license or certification. See ***Definitions*** for a definition of "provider."
- Prior authorization. Some services or supplies must be approved in writing by us before you receive them. See ***Prior Authorization*** for details.
- Medical and Payment policies are used to administer the terms of the plan. Medical policies are generally used to further define medical necessity or investigational status for specific procedures, drugs, biologic agents, devices, level of care or services. Payment policies define our provider billing and payment rules. Our policies are based on accepted clinical practice guidelines and industry standards accepted by organizations like the American Medical Association (AMA), other professional societies and the Center for Medicare and Medicaid Services (CMS). Our policies are available to you and your provider at **premera.com** or by calling customer service.

Benefits for some types of services and supplies may be limited or excluded under this plan. Please refer to the actual benefit provisions below and the ***Exclusions*** section for a complete description of covered services and supplies, limitations and exclusions.

The services listed in this section are covered as shown on the ***Summary of Your Costs***. See ***Summary of Your Costs*** for deductible, coinsurance, copays (if any), and benefit limits.

Acupuncture

The technique of inserting thin needles through the skin at specific points on body to help control pain and other symptoms. Services must be provided by a certified or licensed acupuncturist.

This benefit covers acupuncture to:

- Relieve pain
- Provide anesthesia for surgery
- Treat a covered illness, injury, or condition

Allergy Testing and Treatment

Skin and blood tests used to diagnose what substances a person is allergic to, and treatment for allergies. Services must be provided by a certified or licensed allergy specialist.

This benefit covers:

- Testing
- Allergy shots
- Serums

Ambulance

This benefit covers:

- Transport to the nearest facility that can treat your condition
- Medical care you get during the trip
- Transport from one medical facility to another as needed for your condition
- Transport to your home when medically necessary

These services are only covered when:

- Any other type of transport would put your health or safety at risk
- The service is from a licensed ambulance
- It is for the member who needs transport

Air or sea emergency medical ambulance transportation is covered when:

- Transport takes you to the nearest available facility that can treat your condition
- The above requirements for ambulance services are met
- Geographic restraints prevent ground transport
- Ground emergency transportation would put your health or safety at risk

Ambulance services that are not for an emergency need to be prior authorized. See ***Prior Authorization*** for details.

This benefit does not cover:

- Services from an unlicensed ambulance

App-Based Care

Providers covered under this benefit offer their services exclusively by methods like secure chat, text, voice or audio message, and video chat. They do not maintain a physical location that you can visit. This benefit does not cover real-time office visits using online and telephonic methods between you and your doctor or other provider who also maintains a physical location. These visits are covered under the ***Professional Visits and Services*** and other benefits of this plan.

App-based care select providers can be found at **www.premera.com/visitor/virtual-care** or contact Premera Customer Service for assistance.

Blood Products and Services

- Blood components and services, like blood transfusions, which are provided by a certified or licensed healthcare provider
- Blood products and services that either help with prevention or diagnosis and treatment of an illness, disease or injury

Cellular Immunotherapy and Gene Therapy

Treatment which uses your body's own immune system or genes to treat disease.

These therapies are fairly new, and their use is evolving. They must meet three criteria in order to be covered:

- Prescribed by a doctor
- Meet Premera's medical policy (See **premera.com** or call customer service) and
- Approved by Premera before they can happen (See ***Prior Authorization)***

This benefit covers:

- Medically necessary cellular immunotherapy and gene therapy like CAR-T

If you travel more than 50 miles for these therapies, keep all receipts. You can be reimbursed for some expenses up to $7,500 per episode of care. See ***Medical Transportation Benefits***.

See ***Prior Authorization*** for more information on getting prior approval for services.

See the ***Summary of Your Costs*** under ***Medical Transportation Benefits*** for travel benefit limits.

Chemotherapy and Radiation Therapy

Treatment which uses powerful chemicals (chemotherapy) or high-energy beams (radiation) to shrink or kill cancer cells.

Chemotherapy and radiation must be prescribed by a doctor and approved by Premera to be covered. See ***Prior Authorization***.

This benefit covers:

- Outpatient chemotherapy and radiation therapy
- Supplies, solutions and drugs used during chemotherapy or radiation visit
- Tooth extractions to prepare your jaw for radiation therapy

For drugs you get from a pharmacy, see ***Prescription Drugs***. Some services need to be prior authorized before you get them. See ***Prior Authorization*** for details.

Clinical Trials

A qualified clinical trial (see Definitions) is a scientific study that tests and improves treatments of cancer and other life-threatening conditions.

This benefit covers qualified clinical trial medical services that are already covered under this plan. The clinical trial has to be suitable for your health condition. You also have to be enrolled in the trial at the time of the treatment.

Benefits are based on the type of service you get. For example, if you have an office visit, it's covered under ***Professional Visits and Services***, and if you have a lab test it's covered under ***Diagnostic Lab, X-ray and Imaging***.

You may also be assigned a nurse case manager to work with you and your provider. See ***Personal Health Support Programs*** for details.

Cancer Clinical Trials

In addition to routine medical care described above, benefits for a cancer clinical trial also include:

- Palliative care, diagnosis and treatment of the symptoms of cancer, any complications and the FDA approved drug or device used in the clinical trial.
- Costs for reasonable and necessary travel for the person enrolled in the clinical trial and one companion. These services are limited to the following:
  - Travel to the place of the clinical trial
  - Commercial coach (economy) fare for air transportation
  - Travel for follow-up care that cannot be provided near your home

You must complete a Travel Claim Form for these services. A separate claim form is needed for each patient and each commercial carrier or transportation service used. You can get a Travel Claim Form on our website at **premera.com**. You can also call us for a copy of the form.

This benefit doesn't cover:

- Costs for treatment that aren't primarily for your care (such as lab tests performed just to collect information for the clinical trial)
- The drug, device or services being tested
- Travel costs, except as described under Cancer Clinical Trials
- Housing, meals, or other nonclinical expenses
- A service that isn't part of an approved clinical trial. See ***Definitions*** for a definition of "clinical trials."
- Services, supplies or drugs that would not be charged to you if there were no coverage
- Services provided to you in a clinical trial that are fully paid for by another source
- Services that are not routine costs normally covered under this plan

Contraceptive Management and Sterilization

Benefits include the following services and supplies:

- Sterilization procedures. When sterilization is performed as the secondary procedure, associated services such as anesthesia, facility expenses will be subject to your calendar year deductible and coinsurance, if any, and will not be reimbursed under this benefit.
- Office visits and consultations related to contraception

- Injectable contraceptives and related services
- Implantable contraceptives (including hormonal implants) and related services
- Emergency contraception methods (oral or injectable)

Prescription Contraceptives Dispensed by a Pharmacy

Prescription contraceptives (including emergency contraception) and prescription barrier devices or supplies that are dispensed by a licensed pharmacy are covered under the ***Prescription Drugs*** benefit. Your normal cost-share is waived for these devices and for generic and single-source brand name birth control drugs when you get them from a participating pharmacy. Examples of covered devices are diaphragms and cervical caps.

This benefit doesn't cover:

- Non-prescription contraceptive drugs, supplies or devices (not including emergency contraceptive methods) except as required by law
- Prescription contraceptive take-home drugs dispensed and billed by a facility or provider's office
- Hysterectomy (Covered on the same basis as other surgeries, see ***Surgery*** for details)
- Sterilization reversal
- Assisted reproduction services, procedures, supplies and drugs

Dental Injury and Facility Anesthesia

Dental Anesthesia

Anesthesia and facility care done outside of the dentist’s office for medically necessary dental care

This benefit covers:

- Hospital or other facility care
- General anesthesia provided by an anesthesia professional other than the dentist or the physician performing the dental care

This benefit is covered for any one of the following reasons:

- The member is under age 19 and failed patient management in the dental office
- The member has a disability, medical or mental health condition making it unsafe to have care in a dental office
- The severity and extent of the dental care prevents care in a dental office

Dental Injury

Treatment of dental injuries to teeth, gum and jaw.

This benefit covers:

- Exams
- Consultations
- Dental treatment
- Oral surgery

This benefit is covered on sound and natural teeth that:

- Do not have decay
- Do not have a large number of restorations such as crowns or bridge work
- Do not have gum disease or any condition that would make them weak

Care is covered within 12 months of the injury. If more time is needed, please ask your doctor to contact Customer Service.

This benefit does not cover injuries from biting or chewing, including injuries from a foreign object in food.

Benefits are based on the type of service you get. For example, if you have an office visit, it’s covered under ***Professional Visits and Services***, and if you have a lab test it’s covered under ***Diagnostic Lab, X-ray and Imaging***.

Diagnostic and Preventive Mammography

Preventive mammography services include a baseline mammogram and annual mammogram screenings thereafter, regardless of age. Benefits are also provided for mammography for a member with symptoms, a history of breast cancer, or whose parent or sibling has a history of breast cancer, or as recommended by a physician.

Diagnostic Lab, X-ray and Imaging

Diagnostic lab, x-ray, and imaging services are basic and major medical tests that help find or identify diseases. For more information about what services are covered as preventive see ***Preventive*** Care. A typical test can result in multiple charges for things like an office visit, test, and anesthesia. You may receive separate bills for each charge. Some tests need to be approved before you receive them. See ***Prior Authorization*** for details.

This benefit covers:

- Bone density screening for osteoporosis
- Cardiac testing
- Pulmonary function testing
- Diagnostic imaging and scans such as x-rays
- Lab services
- Mammograms (including 3-D mammograms) for a medical condition
- Neurological and neuromuscular tests
- Pathology tests
- Echocardiograms
- Ultrasounds
- Diagnosis and treatment of the underlying medical conditions that may cause infertility
- Computed Tomography (CT) scan
- Nuclear cardiology
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Positron Emission Tomography (PET) scan

For additional details see the following benefits:

- ***Emergency Room***
- ***Hospital***
- ***Maternity Care***
- ***Preventive Care***
- Genetic testing may be covered in some cases. Call customer service before seeking testing since it may require Prior Authorization

This benefit does not cover non-diagnostic testing required for employment, schooling, screening or public health reasons that is not for the purpose of treatment.

Dialysis

When you have end-stage renal disease (ESRD) you may be eligible to enroll in Medicare. If eligible, it is important to enroll in Medicare as soon as possible. When you enroll in Medicare, this plan and Medicare will coordinate benefits. In most cases, this means that you will have little or no out-of-pocket expenses.

If the dialysis services are provided by an out-of-network provider and you do not enroll in Medicare then you will owe the difference between the out-of-network provider's billed charges and the payment the plan will make for the covered services. See ***Definitions*** for a definition of “Allowed Amount.”

Emergency Room

This benefit covers:

- Emergency room and doctor services
- Equipment, supplies and drugs used in the emergency room
- Services and exams used for stabilizing an emergency medical condition, including mental health or substance use disorder. This includes emergency services arising from complications from a service that was not covered by the plan.
- Diagnostic tests performed with other emergency services
- Emergency detoxification

You need to let us know if you are admitted to the hospital from the emergency room as soon as possible. See ***Prior Authorization*** for details.

You may get care in the emergency room from out-of-network providers. You will not be balance billed for emergency services provided by an out-of-network provider or hospital emergency room under federal law.

Foot Care

This benefit covers the following medically necessary foot care services that require care from a doctor:

- Foot care for members with impaired blood flow to the legs and feet when the problems from the condition puts the member at risk
- Treatment of corns, calluses, and toenails

This benefit does not cover routine foot care such as trimming nails or removing corns and calluses that does not need care from a doctor.

Habilitation Therapy

The following inpatient and outpatient habilitation therapy services must be medically necessary to restore and improve function, or to maintain function where significant physical deterioration would occur without the therapy.

Inpatient Care Inpatient facility services must be furnished and billed by a hospital or by a rehabilitation facility and will only be covered when services can't be done in a less intensive setting.

Outpatient Care Benefits for outpatient care are subject to the following provisions:

- The member mustn't be confined in a hospital or other medical facility
- The therapy must be part of a formal written treatment plan prescribed by a physician
- Services must be furnished and billed by a hospital, rehabilitation facility, physician, physical, occupational, or speech therapist.

When the above criteria are met, benefits will be provided for physical, speech, and occupational therapy services. This benefit includes physical, speech, and occupational therapy assessments and evaluations related to treatment of covered habilitation therapy.

A “visit” is a session of treatment for each type of therapy. Each type of therapy combined accrues toward the above visit maximum. Multiple therapy sessions on the same day will be counted as one visit, unless provided by different health care providers.

This benefit is not provided with the ***Rehabilitation Therapy and Chronic Pain Care*** benefit for the same condition. Once a calendar year maximum has been exhausted under one of these benefits, no further coverage is available for the same condition under the other.

This benefit does not cover:

- Treatment of a psychiatric condition. Please see the ***Mental Health Care*** benefit for those covered services.
- Recreational, vocational or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Treatment that isn't actively engaged in by the ill, injured or impaired member
- Gym or swim therapy

- Custodial care

Health Management

Health Education

Benefits are provided for outpatient health education services to manage pain or cope with a covered condition, like heart disease, diabetes, or asthma.

Nicotine Dependency Programs

Benefits are provided for outpatient nicotine dependency programs. You pay for the cost of the program and send us proof of payment along with a reimbursement form. Please contact our Customer Service department for a reimbursement form or for help finding covered providers.

This benefit doesn't cover drugs for the treatment of nicotine dependency. See ***Prescription Drugs*** for details.

Home Health Care

General Home Health Care

General Home Health Care is short-term care performed at your home. These occasional visits are done by a medical professional that's employed through a home health agency that is state-licensed or Medicare-certified. Care is covered when a doctor states in writing that care is needed in your home.

The following are covered under the Home Health Care benefit:

- Home visits and short-term nursing care
- Home medical equipment, supplies and devices
- Prescription drugs given by the home health care agency
- Therapy, such as physical, occupational or speech therapy to help regain function

Only the following employees of a home health agency are covered:

- A registered nurse
- A licensed practical nurse
- A licensed physical or occupational therapist
- A certified speech therapist
- A certified respiratory therapist
- A home health aide directly supervised by one of the above listed providers
- A social worker

This benefit does not cover:

- Over-the-counter drugs, solutions and nutritional supplements
- Private Duty Nursing that is not General Home Health Care
- Non-medical services, such as housekeeping
- Services that bring you food, such as Meals on Wheels, or advice about food

Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies

This benefit covers:

Home medical equipment (HME), fitting expenses and sales tax. This plan also covers rental of HME, not to exceed the purchase price.

In cases where an alternative type of equipment is less costly and serves the same medical purpose, the plan will provide benefits only up to the lesser amount.

Repair or replacement of medical and respiratory equipment medically necessary due to normal use or growth of a child is covered.

Covered items include:

- Wheelchairs
- Hospital beds
- Traction equipment
- Ventilators
- Diabetic equipment, such as an insulin pump

Medical Supplies such as:

- Dressings
- Braces
- Splints
- Rib belts
- Crutches
- Blood glucose monitor and supplies
- Supplies for an insulin pump

Medical Vision Hardware to correct vision due to the following medical eye conditions:

- Corneal ulcer
- Bullous keratopathy
- Recurrent erosion of cornea
- Tear film insufficiency
- Aphakia
- Sjogren's disease
- Congenital cataract
- Corneal abrasion
- Keratoconus
- Aniridia
- Aniseikonia
- Anisometropia
- Corneal disorders
- Irregular Astigmatism
- Pathological Myopia
- Post traumatic disorders
- Progressive high (degenerative) myopia

External Prosthetics and Orthotic Devices used to:

- Replace absent body limb and/or
- Replace broken or failing body organ

Orthopedic Shoes and Shoe Inserts

Orthopedic shoes for the treatment of complications from diabetes or other medical disorders that cause foot problems.

You must have a written order for the items. Your doctor must state your condition and estimate the period of its need. Not all equipment or supplies are covered. Some items need prior authorization from us (see ***Prior Authorization***).

This benefit does not cover:

- Hypodermic needles, syringes, lancets, test strips, testing agents and alcohol swabs. These services are covered under the Prescription Drugs benefit.

- Supplies or equipment not primarily intended for medical use
- Special or extra-cost convenience features
- Items such as exercise equipment and weights
- Over bed tables, elevators, vision aids and telephone alert systems
- Over the counter orthotic braces and or cranial banding
- Non-wearable defibrillator, trusses and ultrasonic nebulizers
- Blood pressure cuff/monitor (even if prescribed by a physician)
- Enuresis alarm
- Compression stockings which do not require a prescription
- Physical changes to your house and/or personal vehicle
- Orthopedic shoes used for sport, recreation or similar activity
- Penile prostheses
- Routine eye care
- Prosthetics, intraocular lenses, equipment or devices which require surgery. These items are covered under the ***Surgery*** benefit.

Hospice Care

To be covered, hospice care must be part of a written plan of care prescribed, periodically reviewed and approved by a physician. In the plan of care, the physician must certify that confinement in a hospital or skilled nursing facility would be required without hospice services.

This plan provides benefits for covered services furnished and billed by a hospice that is Medicare-certified or is licensed or certified by the state it operates in.

Covered employees of a hospice are a registered nurse; a licensed practical nurse; a licensed physical therapist or occupational therapist; a certified respiratory therapist; a speech therapist certified by the American Speech, Language, and Hearing Association; a home health aide directly supervised by one of the above providers (performing services prescribed in the plan of care to achieve the desired medical results); and a person with a social worker.

This benefit covers:

- **In-home intermittent hospice visits** by one or more of the hospice employees above.
- **Inpatient hospice care** this benefit provides for inpatient services and supplies used while you're a hospice inpatient, such as solutions, medications or dressings, when ordered by the attending physician.
- **Respite care** to relieve anyone who lives with and cares for the terminally ill member.
- **Palliative care** in cases where the member has a serious or life-threatening condition that is not terminal. Coverage of palliative care can be extended based on the member's specific condition. Coverage includes expanded access to home-based care and care coordination.
- **Insulin and Other Hospice Provider Prescribed Drugs** Benefits are provided for prescription drugs and insulin when furnished and billed by a home health care provider, home health agency or hospice.

This benefit does not cover:

- Over-the-counter drugs, solutions and nutritional supplements
- Services provided to someone other than the ill or injured member
- Services of family members or volunteers
- Services, supplies or providers not in the written plan of care or not named as covered in this benefit
- Non-medical services, such as spiritual, bereavement, legal or financial counseling
- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care; and transportation services

Hospital

This benefit covers:

- Inpatient room and board
- Doctor and nurse services
- Intensive care or special care units
- Operating rooms, procedure rooms and recovery rooms
- Surgical supplies and anesthesia
- Drugs, blood, medical equipment and oxygen for use in the hospital
- X-ray, lab and testing billed by the hospital

For inpatient hospital maternity care and newborn care, see ***Maternity Care*** and ***Newborn Care*** for details.

Even though you stay at an in-network hospital, you may get care from doctors or other providers who do not have a network contract at all. In that case, you will have to pay any amounts over the allowed amount except for emergency services, covered air ambulance services, or as prohibited by law.

You pay out-of-network cost shares if you get care from a provider not in your network. See ***How Providers Affect Your Costs*** for details.

We must approve all planned inpatient stays before you enter the hospital. See ***Prior Authorization*** for details.

This benefit does not cover:

- Hospital stays that are only for testing, unless the tests cannot be done without inpatient hospital facilities, or your condition makes inpatient care medically necessary
- Any days of inpatient care beyond what is medically necessary to treat the condition

Infusion Therapy

Fluids infused into the vein through a needle or catheter as part of your course of treatment.

Infusion examples include:

- Drug therapy
- Pain management
- Total or partial parenteral nutrition (TPN or PPN)

This benefit covers:

- Outpatient facility and professional services
- Professional services provided in an office or home
- Prescription drugs, supplies and solutions used during infusion therapy

This benefit does not cover over-the-counter:

- Drugs and solutions
- Nutritional supplements

Mastectomy and Breast Reconstruction

Benefits are provided for mastectomy necessary due to disease, illness or injury.

This benefit covers:

- Reconstruction of the breast on which mastectomy was performed
- Surgery and reconstruction of the other breast to produce a similar appearance
- Physical complications of all stages of mastectomy, including lymphedema treatment and supplies
- Inpatient care

Planned hospital admissions require prior authorization, see ***Prior Authorization*** for details.

Maternity Care

Certain preventive diagnostic maternity care services that meet the preventive federal guidelines as defined for women's health are covered as stated in the ***Preventive Care*** benefit when you see a network provider. A full list of preventive services is available on our website or by calling Customer Service.

Please note: Attending provider as used in this benefit means a physician, a physician's assistant, a certified nurse midwife (C.N.M.), a licensed midwife or an advanced registered nurse practitioner (A.R.N.P.). If the attending provider bills a single fee that includes prenatal, delivery and/or postpartum services received on multiple dates of service, this plan will cover those services as it would any other surgery. See ***Surgery*** for details on surgery coverage.

Benefits for pregnancy, childbirth and elective abortion are provided on the same basis as any other condition.

Maternity care benefits cover the following.

Benefits for the hospital stay and related inpatient medical care following childbirth are provided up to:

- 48 hours after a normal vaginal birth; or
- 96 hours after a normal cesarean birth.

If it's determined that the length of stay will exceed the above limitations, we recommend that the hospital contact us for discharge planning and potential personal health support programs.

For members residing in states where laws prohibit access to abortion services, travel to a provider in another state may be covered. Please see ***Medical Transportation – State-Restricted Care*** for details.

Plan benefits are also provided for medically necessary services and supplies related to home births.

This benefit does not cover donor breast milk.

Medical Foods

Medical foods are foods that are specially prepared to be consumed or given directly into the stomach under strict supervision of a doctor. They provide most of a person's nutrition. They are designed to treat a specific problem that can be detected using medical tests.

This benefit covers:

- Dietary replacement to treat inborn errors of metabolism (example phenylketonuria (PKU))
- Dietary replacement when you have a severe allergy to most foods based on white blood cells in the stomach and intestine that cause inflammation (eosinophilic gastrointestinal associated disorder)
- Other severe conditions when your body cannot take in nutrient from food in the small intestine (malabsorption) disorder
- Disorders where you cannot swallow due to a blockage or a muscular problem and need to be fed through a tube

Medical foods must be prescribed and supervised by doctors or other health care providers.

This benefit does not cover:

- Oral nutrition or supplements not used to treat inborn errors of metabolism or any of the above listed conditions
- Specialized infant formulas
- Lactose-free foods

Medical Transportation Benefits

This plan includes Medical Transportation Benefits that provide reimbursement as described below. For ambulance benefits see ***Ambulance***.

Medical Transportation – State Restricted Care

This plan provides benefits for travel and lodging for abortion and medically necessary sexual reassignment when the member resides in a state where laws restrict access to these covered services. Prior approval is required. Please call Customer Service to verify if you are eligible for this benefit and to obtain prior approval.

See the ***Summary of Your Costs*** for any travel benefit limitations.

Benefits are provided for:

- Air transportation expenses between the member's home and the location where services will be provided. Air travel expenses cover unrestricted coach class, flexible, and fully refundable round-trip airfare from a licensed commercial carrier.
- Ferry transportation from the member's home community
- Lodging expenses at commercial establishments, including hotels and motels, between home and the medical facility where the service will be provided
- Mileage expenses for the member's personal automobile
- Ground transportation, car rental, taxicab fares and parking fees, for the member and a companion (when covered) between the hotel and the location where services will be provided.

Travel and lodging costs are subject to the IRS limits in place on the date of the expense. The mileage limits and requirements can change if IRS regulations change. Please go to the IRS website, **www.irs.gov**, for details. This summary is not and should not be considered to be tax advice.

Companion Travel

One companion needed for the member's health and safety is covered only if medically necessary.

Reimbursement of Travel Claims

You must pay for all travel expenses yourself and submit an Elective Procedure Travel Claim Form.

A separate Elective Procedure Travel Claim Form is needed for each patient and each commercial carrier or transportation service used. You can get Elective Procedure Travel Claim Forms on our website at **www.premera.com.** You can also call us for a copy of the form.

You must attach the following documents to the Elective Procedure Travel Claim Form:

- A copy of the detailed itinerary as issued by the transportation carrier, travel agency or online travel website. The itinerary must identify the names of the passengers, the dates of travel and total cost of travel, and the origination and final destination points.
- Receipts for all covered travel expenses

Credit card statements or other payment receipts are not acceptable forms of documentation.

This benefit does not cover:

- Charges and fees for booking changes
- Cancellation fees
- First class airline fees
- International travel
- Lodging at any establishment that is not commercial
- Meals
- Personal care items
- Pet care, other than for service animals
- Phone service and long-distance calls
- Reimbursement for mileage rewards or frequent flier coupons
- Reimbursement for travel before contacting us and receiving prior approval
- Travel for medical procedures not listed above
- Travel in a mobile home, RV, or travel trailer
- Travel insurance
- Reimbursement for companion travel and lodging, except for medical necessity or safety of the patient

Elective Procedure Travel

Reimbursement for certain travel expenses when traveling outside Alaska for approved elective (non-emergency) surgeries. The plan will also reimburse certain travel expenses when traveling within Alaska if the member lives more than 50 miles from a Premera Designated Centers of Excellence. Prior authorization required.

This benefit provides reimbursement of certain travel costs up to IRS guidelines for members who reside in Alaska and travel outside of Alaska only for specified non-emergent medical procedures performed at certain in-network providers. Please contact Customer Service for a list of eligible procedures and providers. Before you travel, you must get prior authorization. Approval is based on the member's medical condition, and the provider who will be performing the services. Please contact Customer Service for assistance with the process.

Benefits are provided for:

- Air transportation expenses for the member and a companion from the member's home in Alaska to and from the medical facility where services will be provided. Air travel expenses cover unrestricted, flexible and fully refundable round-trip coach airfare from a licensed commercial carrier.
- Ferry transportation expenses for the member and a companion from the member's home community based on current IRS guidelines
- Lodging expenses at commercial establishments (hotels and motels) for the member and a companion while traveling between home and the medical facility where services will be provided based on current IRS guidelines
- Mileage expenses for the members personal automobile are covered based on current IRS guidelines
- One round-trip coach airfare by a licensed commercial carrier for the member and one companion per episode
- Surface transportation, car rental, taxicab fares and parking fees for the member and a companion between the hotel and the medical facility where the services will be provided based on current IRS guidelines

If the member using the Elective Procedure Travel benefit is a child under age 19, one companion is automatically permitted, however a second companion will only be permitted if medically necessary.

Some reimbursement rates are based on IRS guidelines for the date(s) the expenses were incurred. These reimbursement amounts are subject to change due to IRS regulations. Please refer to the IRS website, **www.irs.gov**, for additional information. The information in this benefit should not be assumed as tax advice.

Air travel and lodging arrangements can be made by Premera's travel partner or by the member. Expenses must be incurred while the member is covered under the plan.

Please note: Companion travel and lodging expenses are only covered if they must, as a matter of medical necessity or safety, to accompany the member. A second companion or if a companion is required to travel separately will only be permitted if medically necessary.

You may choose to pay for travel and lodging services up front and submit a claim for reimbursement. Please see ***How To File an Elective Procedure Travel Claim*** section for more information. If you would like assistance from Premera in booking and prepaying for some travel accommodations, please contact Customer Service to discuss these options.

This benefit does not cover:

- Airline charges and fees for booking changes
- First class airline fees
- International travel
- Lodging at any establishment that is not a hotel or motel
- Meals
- Personal care items
- Pet care, except for service animals
- Phone service and long-distance calls
- Reimbursement for mileage rewards or frequent flier coupons

- Reimbursement for travel to an in-network facility not on the list of eligible facilities before contacting us and receiving prior authorization. If a procedure is performed at a facility that is not on the list, travel expenses will not be reimbursed if the total cost of the procedure plus travel expenses, exceeds the cost of having that procedure performed at a facility in Alaska.
- Reimbursement for travel before contacting us and receiving approval
- Travel for ineligible medical procedures
- Travel in a mobile home, RV, or travel trailer
- Travel to providers outside the network

How To File an Elective Procedure Travel Claim:

Travel services may be arranged through Premera. Contact Customer Service if you wish to take advantage of this service.

To make a claim for travel expenses covered under this benefit, please complete an Elective Procedure Travel Claim Form. A separate Elective Procedure Travel Claim Form is necessary for each patient and each carrier or transportation service used.

You must include a statement or letter from your doctor attesting to the medical necessity of extending your stay past the approved travel duration guidelines.

You must also attach the following documents:

- A Utilization Management Authorization number for travel to providers not on the list
- The boarding pass and a copy of the ticket from the airline or other transportation carrier. The ticket(s) must indicate the name(s) of the passenger(s), the dates of travel and total cost of the travel, and the origination and final destination points.
- Receipts for all covered travel expenses

Please note: Credit card statements or other payment receipts are not acceptable forms of documentation.

Medical Access Transportation

Round-trip coach air or ground transportation to the closest in-network provider for a serious medical condition that can't be treated locally. Transportation outside of Alaska will be limited to Seattle, Washington, when the closest in-network provider is located in Seattle, Washington. Prior authorization not required.

This benefit covers transportation via commercial carrier when you have a serious medical condition that cannot be treated locally. Round-trip coach air or surface transportation by a licensed commercial carrier is provided only for the ill or injured member. The trip must begin in Alaska where you became ill or injured and end at the closest in-network provider equipped to provide treatment not available in a local facility. Transportation outside Alaska will be limited to Seattle, Washington.

Benefits are limited to 3 round-trip transports per calendar year.

When transportation is for a child under the age of 19, this benefit will also cover a parent or guardian to accompany the child.

To submit a claim for these services:

- Complete a Travel Claim Form. A separate Travel Claim Form is needed for each patient and each commercial carrier or transportation service used. You can get a Travel Claim Form on our website at **premera.com**. You can also call us for a copy of the form.
- A statement or letter from your physician attesting to the medical necessity of the services you received that required the air or service travel.

Attach one of the following forms of documentation:

- A copy of the ticket from the airline or other transportation carrier. The tickets must indicate the names of the passenger(s), dates and total cost of travel, and the origination and final destination points.
- A copy of the detailed itinerary as issued by the airline, transportation carrier, travel agency or on-line travel website. The itinerary must identify the name of the passenger(s), the dates of travel and total cost of travel, and the origination and final destination points.

Please note: Credit card statements or other payment receipts are not acceptable forms of documentation.

This benefit does not cover:

- Meals and lodging
- First class airline fees
- Transport by taxi, bus, private car or rental car
- Transportation for routine dental, vision and hearing services

Mental Health Care

This benefit covers treatment of mental conditions. A mental health condition is any condition listed in the current **Diagnostic and Statistical Manual (DSM)**, published by the American Psychiatric Association, excluding diagnosis and treatments for substance abuse.

Covered services include all the following:

- Inpatient, residential and outpatient facility treatment, and outpatient therapeutic visits (including virtual care) to manage or reduce the effects of a mental health condition, including treatment of eating disorders (such as anorexia nervosa, bulimia or any similar condition)
- Individual, family or group therapy
- Lab and testing
- Take-home drugs you get in a facility
- Biofeedback
- Physical, speech and occupational therapy provided to treat mental health conditions, such as autism spectrum disorders
- Applied behavior analysis (ABA) for the treatment of autism spectrum disorders, including services provided by an autism service provider. See ***Definitions*** for a definition of "autism service provider."

“Outpatient therapeutic visit” (outpatient visit including virtual care) means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards as defined in the Physician’s Current Procedural Terminology, published by the American Medical Association. Outpatient therapeutic visits can include real-time visits with your doctor or other provider via telephone, online chat or text, or other electronic methods.

This benefit does not cover:

- Psychological treatment of sexual dysfunctions, including impotence and frigidity
- EEG biofeedback or neurofeedback services
- Psychological and neuropsychological testing and evaluations. These services are covered under the ***Psychological and Neuropsychological Testing*** benefit.
- Substance abuse treatment. These services are covered under the ***Substance Abuse Treatment*** benefit.
- Mental health evaluations for purposes other than evaluating the presence of or planning treatment for covered mental health disorders, including, but not limited to, custody evaluations, competency evaluations, forensic evaluations, vocational, educational or academic placement evaluations

Newborn Care

Newborn children and grandchildren are covered from the moment of birth. Please see the dependent eligibility and enrollment guidelines outlined under ***Who Is Eligible For Coverage?*** and ***When Does Coverage Begin?*** sections in this booklet.

Benefits for routine hospital nursery charges and related inpatient well-baby care for a newborn dependent child or newborn dependent grandchild are provided up to:

- 48 hours after a normal vaginal birth; or
- 96 hours after a normal cesarean birth.

If it's determined that the length of stay will exceed the above limitations, we recommend that the hospital contact us for discharge planning and potential personal health support programs.

Benefits are also provided for routine circumcision.

This benefit does not cover immunizations. See ***Preventive Care*** for coverage of immunization and outpatient well-baby care.

Newborn Hearing Exams and Testing

This benefit provides for one screening hearing exam for covered newborns up to 30 days after birth. Benefits are also provided for diagnostic hearing tests, including administration and interpretation, for covered children up to age 24 months if the newborn hearing screening exam indicates a hearing impairment.

Premera Designated Centers of Excellence Program

Premera is working on your behalf to deliver better service excellence and better quality outcomes for services. To accomplish this, Premera has partnered with providers that have agreed to be held accountable for care quality, experience and cost. Premera calls these providers Designated Centers of Excellence. These providers can give you high quality care for complex medical situations.

You will have lower out-of-pocket costs when you receive Knee and Hip Total Joint Replacement, Spinal Surgery or Gynecological Surgery services from a Designated Center of Excellence.

Services other than a Knee and Hip Total Joint Replacement, Spinal Surgery or Gynecological Surgery are not covered under this benefit, even if provided by a Designated Center of Excellence. However, they may be covered under other benefits in your plan.

Members work with Premera and the Designated Centers of Excellence to ensure that their treatment is coordinated and consistent with established standards of medical care. Contact Customer Service for the latest lists of Designated Centers of Excellence and to be connected with a Premera Personal Health Support Clinician to begin the process.

Like many elective procedures those listed below may require prior authorization from Premera to ensure the procedure is a medically appropriate option for you. If you do not receive prior authorization, this plan may not cover the services, and you will have to pay the total cost for the services. See ***Prior Authorization***.

Once you are given approval for the services that require prior authorization, Premera will refer you to the Designated Centers of Excellence closest to your place of residence.

Knee and Hip Total Joint Replacement. Services provided by the Designated Center of Excellence and covered under this benefit include, pre-operative services and supplies before the procedure (professional visits, x-ray, PT evaluation, basic labs, and preoperative EKG, if needed), and surgery and associated facility care. Post-surgery care includes professional visits, post-operative x-ray, and limited durable medical equipment (walker or cane only) that occur prior to patient being cleared to travel.

Post-surgical rehabilitation (physical and occupational therapy), skilled nursing facility, or rehabilitation services are subject to your standard cost shares, and not covered under this benefit. See the ***Summary of Your Costs*** and ***Rehabilitation Therapy*** for benefits for those services.

Spinal Surgery. Services provided by the Designated Center of Excellence and covered under this benefit include the pre-operative services and supplies before the procedure (professional visits, x-ray, PT evaluation, basic labs, and preoperative EKG, if needed), and surgery and associated facility care. Post-surgery care includes professional visits, post-operative x-ray, and limited durable medical equipment (walker or cane only) that occur prior to patient being cleared to travel.

Post-surgical rehabilitation (physical and occupational therapy), skilled nursing facility, or rehabilitation services are subject to your standard cost shares, and not covered under this benefit. See the ***Summary of Your Costs*** and ***Rehabilitation Therapy*** for benefits for those services.

Gynecological Surgery. Services provided by the Designated Center of Excellence and covered under this benefit include pre-operative services and supplies before the procedure (professional visits, x-ray, ECHO, EKG, Urinary Muscle Study, Cystometrogram, anesthesiologist clinic, CT, Tissue exam), and surgery and associated facility care. Post-surgery care includes professional visits, post-operative x-ray, and limited durable medical equipment (walker or cane only) that occur prior to patient being cleared to travel.

Travel. Benefits are provided for certain travel expenses related to services provided by Designated Centers of Excellence that are arranged by Premera's travel partner.

Benefits for travel expenses related to covered services in this benefit are provided under the ***Medical Transportations*** benefit. See ***Medical Access Transportation*** or ***Elective Procedure Travel***.

Prescription Drugs

This benefit provides coverage for medically necessary prescription drugs, prescriptive oral agents for controlling blood sugar levels, glucagon emergency kits, allergy emergency kits and insulin when prescribed for your use outside of a medical facility and dispensed by a licensed pharmacist in a pharmacy licensed by the state in which the pharmacy is located. For the purposes of this plan, a prescription drug is any medical substance that, under federal law, must be labeled as follows: "Caution: Federal law prohibits dispensing without a prescription." In no case will the member's out-of-pocket expense exceed the cost of the drug or supply. This plan covers FDA-approved drugs only if they are medically necessary.

Some prescription drugs require prior authorization. See ***Prior Authorization*** for details.

PV Core Preventive Drugs The plan also covers some other preventive drugs. These drugs are on our PV Core list. Preventive care prescription drugs are drugs taken regularly by a member for disease prevention or to prevent the reoccurrence of specific diseases. These preventive care drugs include only generic drugs, utilizing the American Hospital Formulary Service (AHFS) as a reference. For example, treatment of high cholesterol with cholesterol-lowering medications or medication taken to prevent heart disease or medications to treat a recovered heart attack or stroke victim constitute preventive care prescription drugs.

Please call Customer Service or go to the member portal on our website at premera.com to find out whether a drug is on the plan's preventive care list.

You can lower your out-of-pocket cost by using participating pharmacies. By showing your Premera Blue Cross Blue Shield of Alaska ID card at a participating pharmacy, you won't be charged more than our allowed amount for covered drugs. If you don't show your card, or use a non-participating pharmacy, you'll be required to pay the pharmacy's full retail price for the drug. Your reimbursement, however, will be based on the allowed amount. If you use a non-participating pharmacy, you'll also have to submit the claim yourself.

If the pharmacy does not submit your claim for you, you will have to pay the full cost for new prescriptions and refills purchased at these pharmacies. You will also need to fill out a prescription drug claim form, attach your prescription drug receipts and submit the information to the address shown on the claim form. See the prescription drug claim instructions in the ***How Do I File A Claim?*** for details.

If you need a list of participating pharmacies, please call us at the number listed. You can also call the toll-free Pharmacy Locator Line; this number is located on the back of your Premera Blue Cross Blue Shield of Alaska ID card.

Mail-Order Pharmacy Program

You can often save time and money by filling your prescriptions through the Mail-Order Pharmacy program. Ask your physician to prescribe needed medications for up to a 90-day supply, plus refills. If you're presently taking medication, ask your physician for a new prescription. Make sure that you have at least a 14- to 21-day supply on hand for each drug at the time you submit a refill prescription to the mail-order pharmacy. See ***How Do I File A Claim?*** for more information on submitting claims.

To obtain additional details about the mail-order pharmacy program, or to obtain order forms, you may call our Customer Service department at the number listed inside the front cover of this booklet. You may also call the pharmacy's benefit manager's Customer Service department or visit their website at:

1-800-391-9701

www.express-scripts.com

You can mail your prescription drug claims to:

Express Scripts
Attn: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

What's Covered?

This benefit provides for the following items when dispensed by a licensed pharmacy for use outside of a medical facility:

- Prescription drugs and vitamins (federal legend and state restricted drugs as prescribed by a licensed provider). This benefit covers off-label use of FDA-approved drugs as provided under this plan's definition of "Prescription Drug." See Definitions for details.
- Prescriptive oral agents for controlling blood sugar levels
- Prescribed injectable medications for self-administration (such as insulin)
- Glucagon and allergy emergency kits
- Compounded medications of which at least one ingredient is a covered prescription drug
- Hypodermic needles, syringes and alcohol swabs used for self-administered injectable prescription medications. Also covered are the following disposable diabetic testing supplies: test strips, testing agents and lancets.
- Inhalation spacer devices and peak flow meters
- Drugs for the treatment of nicotine dependency, including over the counter (OTC) nicotine patches, gum or lozenges purchased through a participating retail pharmacy
- Prescription contraceptive drugs and devices (e.g. oral drugs, diaphragms and cervical caps)
- Prescription drugs for the treatment of autism

For benefit information on therapeutic devices, appliances, medical equipment, medical supplies, diabetic equipment and accessories (except for those specifically stated as covered in this benefit), please see ***Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies*** for details.

For benefit information about immunization agents and vaccines, including the professional services to administer them, see the ***Preventive Care*** benefit.

Additional Information About Your Prescription Drug Benefit

Generic Drugs

This plan requires the use of appropriate "generic drugs". When available and indicated by the prescriber, a generic drug will be dispensed in place of a brand name drug. Once your deductible is satisfied, if you or the prescriber request a brand name drug when a generic equivalent is available, in addition to your coinsurance, you will be required to pay the difference in cost between the brand name drug and the generic equivalent. Your cost for brand name drugs will never exceed the cost of the drug at the time you receive services. Please consult with your pharmacist on the higher costs you'll pay if you select a brand name drug.

A "generic drug" is a prescription drug product manufactured and distributed after the brand name drug patent of the innovator company has expired. Generic drugs have obtained an AB rating from the U.S. Food and Drug Administration and are considered by the FDA to be therapeutically equivalent to the brand name product. For the purposes of this plan, classification of a particular drug as a generic is based on generic product availability and cost as compared to the reference brand name drug.

Refills

Benefits for refills will be provided only when you have used three-fourths (75%) of a single medication. The seventy-five percent (75%) is calculated based on the number of units and days' supply dispensed in the 180 days immediately preceding the last refill.

You may request an early refill for topical eye medication when prescribed for a chronic eye condition. Your request must be made no earlier than all the following:

- 23 days after a prescription for a 30-day supply is dispensed
- 45 days after a prescription for a 60-day supply is dispensed
- 68 days after a prescription for a 90-day supply is dispensed

An early refill will be allowed if it does not exceed the number of refills prescribed by your doctor and only once during the approved dosage period.

Prescription Drug Formulary

This benefit uses our Essentials drug list, sometimes referred to as a "formulary." Our Pharmacy and Therapeutics Committee, which includes medical practitioners and pharmacists from the community, frequently reviews current medical studies and pharmaceutical information. The Committee then makes recommendations on which drugs are included on our drug lists. The drug lists are updated quarterly based on the Committee's recommendations.

The Essentials drug list includes preferred generic drugs, preferred brand name drugs, preferred specialty drugs, and non-preferred generic, brand name and specialty drugs. Preferred brand name drugs are brand-name drugs that are only made by one drug company. Consult the RX Search tool on our website or contact Customer Service for a complete list of covered prescription drugs.

It's important to note that this plan provides benefits for non-preferred generic, brand name, and specialty drugs, but at a higher cost to you

Generic Substitution This plan requires the use of appropriate "generic drugs" (as defined below). When available, a generic drug will be dispensed in place of a brand name drug. You or the prescriber may request a brand name drug instead of a generic, but if a generic equivalent is available, you'll have to pay the difference in price between the brand name drug and the generic equivalent, in addition to paying the applicable brand name drug cost-share. Please consult with your pharmacist on the higher costs you'll pay if you select a brand name drug.

A "generic drug" is a prescription drug manufactured and distributed after the brand name drug patent of the innovator company has expired. Generic drugs have an AB rating from the U.S. Food and Drug Administration (FDA). The FDA considers them to be therapeutically equivalent to the brand name product. For the purposes of this plan, classification of a particular drug as a generic is based on generic product availability and cost as compared to the reference brand name drug.

Right to a Review

- If you cannot tolerate the generic equivalent drug or the prescriber determines that it is not effective in treating your condition, the prescriber can request a medical necessity review. If approved, you'll only have to pay the applicable brand-name cost-share.
- Your prescriber can also ask for a medical necessity review of a drug not on the Essentials drug list if you cannot tolerate the drugs or dosages included on the list. If approved, the drug or dosage will be covered. You will pay the cost-share above for the non-preferred drug.

Specialty Pharmacy Program

Benefits for specialty drugs dispensed through a specialty pharmacy program via mail-order are limited to a 30-day supply.

"Specialty drugs" are drugs used to treat complex or rare conditions that require special handling, storage, administration or patient monitoring. They are high cost, often self-administered injectable drugs for the treatment of conditions such as rheumatoid arthritis, hepatitis or multiple sclerosis.

Please note: There may be times when a specialty drug is not available through your specialty pharmacy. When the specialty drug is not available the pharmacies will contact you or your provider and notify them which pharmacy can fill the medication. In some instances, the specialty pharmacy will assist with the transfer of the prescription to the pharmacy that carries the drug.

Specialty pharmacies are pharmacies that focus on the delivery and clinical management of specialty drugs. You and your health care provider must work with a network specialty pharmacy to arrange ordering and delivery of these drugs. See ***How Does Selecting A Provider Affect My Benefits?*** for details about the provider networks.

Please note: This plan will only cover specialty drugs that are dispensed by a network specialty pharmacy. Contact Customer Service for details on which drugs are included in the specialty pharmacy program or visit our website at **premera.com**.

Pharmacy Management

Sometimes benefits for prescription drugs may be limited to one or more of the following:

- A set quantity limit or a specific drug or drug dosage appropriate for a usual course of treatment

- Certain drugs for a specific diagnosis
- Step therapy, meaning you must try a generic drug or a specified brand name drug first

These limitations are based on medical standards, the drug maker's recommendations, and the circumstances of the individual case. They are also based on U.S. Food and Drug Administration guidelines, published medical literature and standard medical references.

Anti-Cancer Medication

This benefit covers self-administered anti-cancer drugs when the medication is dispensed by a pharmacy. Anti-cancer medication means a drug or biologic used to kill cancerous cells, to slow or prevent the growth of cancerous cells, or to treat related side effects. These drugs are covered as shown in the ***Summary of Your Costs***.

Drug Discount Programs

Premera Blue Cross Blue Shield of Alaska may receive rebates from its pharmacy benefit manager or other vendors. These rebates are retained by Premera Blue Cross Blue Shield of Alaska and may be taken into account in setting subscription charges or may be credited to administrative charges and are not reflected in your allowed amount. The allowed amount is not adjusted to reflect rebates received as part of Drug Discount Programs.

In addition, the allowed amount that your payment for drugs is based on may be higher than the price Premera Blue Cross Blue Shield of Alaska pays its pharmacy benefit manager or other vendors for those drugs. The difference constitutes Premera Blue Cross Blue Shield of Alaska property. Premera Blue Cross Blue Shield of Alaska is entitled to retain and shall retain the difference and may apply it to the cost of Premera Blue Cross Blue Shield of Alaska's operations. If your drug benefit includes a copay, coinsurance calculated on a percentage basis, or a deductible, the amount you pay, and your account calculations are based on the allowed amount. The allowed amount is not adjusted to reflect discounts received as part of Drug Discount Programs.

Per Internal Revenue Service requirements, drug manufacturer coupons and other forms of cost-share assistance cannot be used to satisfy this plan's deductible.

This Prescription Drug benefit doesn't cover:

- Over the counter (OTC) drugs and medicines unless prescribed by a practitioner, or as required by law. Even when prescribed by a practitioner, OTC drugs and supplies are not covered unless otherwise stated in this plan. Examples of such excluded items include, but aren't limited to, non-prescription drugs and vitamins, food and dietary supplements, herbal or naturopathic medicines and nutritional and dietary supplements (e.g. infant formulas or protein supplements).
- Over the counter (OTC) contraceptives (e.g. jellies, creams, foams or devices) unless prescribed by a practitioner or as required by law
- Drugs for the purpose of cosmetic use, or to promote or stimulate hair growth (e.g. wrinkles or hair loss)
- Drugs for experimental or investigational use
- Biologicals, blood or blood derivatives
- Any prescription refilled in excess of the number of refills specified by the prescribing provider, or any refill dispensed after one year from the prescribing provider's original order
- Drugs dispensed for use or administration in a health care facility or provider's office, or take-home drugs dispensed and billed by a medical facility
- Replacement of lost or stolen medication
- Infusion therapy drugs or solutions and drugs requiring parenteral administration or use, and injectable medications. (The exception is injectable drugs for self-administration, such as insulin and glucagon). See Infusion Therapy for details.
- Drugs to enhance fertility, including assisted reproduction medications
- Drugs to treat sexual dysfunction of organic origin
- Weight management drugs

- The plan does not cover some of the drugs in certain drug classes. An example is proton pump inhibitors. However, at least 1 drug in every drug class is covered. (A drug class is a group of drugs that may work in the same way, have a similar chemical structure, or may be used to treat the same conditions or group of conditions.) Please call Customer Service or visit our website for more information or to find out if a certain drug is covered. If your drug is not covered, please work with your provider to find an alternative drug in that drug class that the plan does cover.

Preventive Care

Preventive services are a specific set of evidence-based services expected to prevent future illness. These services are based on guidelines established by government agencies and professional medical societies.

Please go to this government website for more information:

https://www.healthcare.gov/coverage/preventive-care-benefits/

Preventive services provided by in-network providers are covered in full. But they have limits on how often you should get them. These limits are often based on your age and gender. After a limit has been exceeded, these services are not covered in full and may require you to pay more out-of-pocket costs.

Some of the services your doctor does during a routine exam may not meet preventive guidelines. These services are then covered the same as any medical service and are not covered in full and you may be responsible for part of the costs.

For example:

During your preventive exam, your doctor may find an issue or problem that requires further testing or screening for a proper diagnosis to be made. Also, if you have a chronic disease, your doctor may check your condition with tests. These types of screenings and tests help to diagnose or monitor your illness and would not be covered under your preventive benefits. They would require you to pay a greater share of the costs.

You can also get a complete list of the preventive care services with the limits on our website at **premera.com** or call us for a list. The list will include website addresses where you can see current federal preventive guidelines.

Preventive services under this plan are those services with an “A” or “B” rating by the United States Preventive Services Task Force (USPSTF), immunizations recommended by the Centers for Disease Control (CDC) and Prevention and as required by state law. When federal or state preventive requirements change, this plan will administer preventive care consistent with those changes, as of their effective date, even if they are not specifically referenced in this document.

Covered preventive services include and are unlimited unless otherwise specified.

Preventive Exams

- Routine physical exams
- Well-baby exams from birth to three years and well-child exams, including those provided by a qualified health aide from four to eighteen years
- Physical exams related to school, sports, and employment
- Depression screening, including screening for adults and pregnant/postpartum members

Immunizations

- Preventive immunizations
- Seasonal and certain other immunizations provided by a pharmacy or other mass immunizer location. Covered services include flu shots, flu mist, pneumonia immunizations, whooping cough, adult shingles immunizations and travel immunizations.

Screening Tests and Imaging

- Routine lab tests and imaging
- Mammograms (including 3D)
- Pap smears
- BRCA genetic testing for women at risk for certain breast cancers

- Cervical cancer annual pap smear for women 18 years of age and older, or as recommended by a physician
- Diabetes screening
- Prostate cancer screening. Includes digital rectal exams and prostate-specific antigen (PSA) tests. Annual tests for prostate cancer for high-risk men under 40, all men over 40 years of age, or as recommended by a physician.

Colon Cancer Screenings (for high-risk individuals under 45 years of age, or all individuals 45 years of age or older as recommended by the American Cancer Society)

- Pre-colonoscopy consultation and exam
- Barium enema
- Colonoscopy, sigmoidoscopy, and fecal occult blood tests
- If polyps are found during the screening, their removal and lab tests are covered as preventive.
- Medically necessary anesthesia
- Colonoscopies as follow-up to positive non-invasive stool-based screening tests

Routine Maternity Care

- Routine prenatal exams and tests
- Breastfeeding support and counseling
- Standard breast pump (bought from approved suppliers). Call Premera customer service for a list of approved suppliers
- Rental of hospital-grade breast pumps
- Maternity diagnostic screening
- Screening for gestational diabetes

Counseling

- Contraceptive counseling. See ***Contraceptive Management and Sterilization*** for additional information.
- Counseling for sexually transmitted infections

Health Education and Training

- Outpatient programs and classes to help you manage pain or cope with covered conditions like heart disease, diabetes, or asthma
- The program or class must take place in an approved setting, like a hospital

Nutritional Counseling and Therapy

- Healthy diet and eating habits for members at risk for health conditions that are affected by diet and nutrition
- Obesity screening and counseling for weight loss

Pre-exposure (PrEP) for members at high-risk for HIV infection

Tobacco Cessation Programs

Fall Prevention

- Professional services to prevent falling for members who are 65 or older and have a history of falling or mobility issues.

This Preventive Care benefit does not cover:

- Gym memberships or exercise classes and programs
- Inpatient routine newborn exams while the child is in the hospital following birth. These services are covered under the ***Newborn Care*** benefit.
- Physical exams for basic life or disability insurance
- Prescription contraceptives, including over the counter (OTC) items, dispensed, and billed by your provider or a hospital. See ***Prescription Drugs*** for prescribed contraceptives.
- Work-related disability evaluations or medical disability evaluations

Professional Visits and Services

Benefits are provided for the examination, diagnosis and treatment of an illness or injury when such services are performed on an inpatient or outpatient basis, including your home and virtual care. Benefits are also provided for the following professional services when provided by a qualified provider:

- Biofeedback for migraines and other conditions for which biofeedback is not deemed experimental or investigational when provided by a qualified provider. See ***Definitions*** for a definition of "experimental/ investigational."
- Consultations and treatment for nicotine dependency
- Electronic Visits. This benefit includes electronic visits (e-visits). E-visits are structured, secure online messaging protocol (email) consultations between an approved doctor and you. They are not real-time visits. Your approved doctor will determine which conditions and circumstances are appropriate for e-visits in their practice. E-visits are covered when provided by an approved provider and all the following are true:
  - Premera Blue Cross Blue Shield of Alaska has approved the physician for e-visits. Not all doctors have agreed to or have the software capabilities to provide e-visits.
  - The member has previously been treated in the approved doctor's office and has established a patient-physician relationship with that doctor
  - The e-visit is medically necessary for a covered illness or injury

  Please call Customer Service at the number listed inside the front cover of this booklet for help in finding a physician approved to provide e-visits.
- Real time visits via online and telephonic methods with your doctor or other provider
- Prostate, colorectal, and cervical cancer screening exams, unless they meet the guidelines for preventive medical services described in the ***Preventive Care*** benefit
- Second opinions for any covered medical diagnosis or treatment plan when provided by a qualified provider

This benefit does not cover:

- Surgical procedures performed in a provider's office, surgical suite or other facility. These services are covered under the ***Surgery*** benefit, unless they meet the guidelines for preventive medical services described in the ***Preventive Care*** benefit.
- Professional diagnostic imaging and laboratory services. These services are covered under the ***Diagnostic Lab, X-ray and Imaging*** benefit and the ***Diagnostic and Preventive Mammography*** benefit, unless they meet the guidelines for preventive medical services described in the ***Preventive Care*** benefit.
- Home health or hospice care visits. These services are covered under the ***Home Health Care*** and ***Hospice Care*** benefits.
- Hair analysis or non-legend drugs or medicines, such as herbal, naturopathic or homeopathic medicines or devices
- EEG biofeedback or neurofeedback services
- Services related to the diagnosis or treatment of psychiatric conditions, including biofeedback services. These services are covered under the ***Mental Health Care*** benefit.
- Services related to the diagnosis and treatment of temporomandibular joint disorder
- Injectable or implantable contraceptives and related services. These drugs and services are covered under the ***Contraceptive Management and Sterilization*** benefit.

Psychological and Neuropsychological Testing

Covered services are psychological and neuropsychological testing, including interpretation and report preparation, necessary to prescribe an appropriate treatment plan. This includes later re-testing to make sure the treatment is achieving the desired medical results. Physical, speech or occupational therapy assessments and evaluations for rehabilitation of a psychiatric condition are provided under the ***Mental Health Care*** benefit. For conditions other than a psychiatric condition, see ***Rehabilitation Therapy and Chronic Pain Care***.

Rehabilitation Therapy and Chronic Pain Care

Rehabilitation Therapy

Benefits for the following inpatient and outpatient rehabilitation therapy services are provided when such services are medically necessary to either:

- Restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an accidental injury, illness or surgery; or
- Treat disorders caused by physical congenital anomalies. See ***Habilitation Therapy*** for coverage of disorders caused by neurological congenital anomalies.

Covered services include all the following:

- Physical, speech, and occupational therapies
- Chronic pain care. Chronic pain is pain that is hard to control or that will not stop. Treatment for chronic pain is not subject to the 24-month limit for inpatient care.
- Cardiac and pulmonary rehabilitation
- Massage therapy. If provided by a massage therapist, the massage therapist must be licensed by the state to be covered.
- Assessments and evaluation related to rehabilitative therapy
- Rehabilitative devices that have been approved by the FDA and prescribed by a qualified provider

Inpatient Care Inpatient facility services must be furnished in a specialized rehabilitative unit of a hospital and billed by the hospital or be furnished and billed by another rehabilitation facility and will only be covered when services can't be done in a less intensive setting. When rehabilitation follows acute care in a continuous inpatient stay, this benefit starts on the day that the care becomes primarily rehabilitative. This benefit only covers care you receive within 24 months from the onset of the injury or illness or from the date of the surgery that made rehabilitation necessary. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physician specializing in physical medicine and rehabilitation.

Outpatient Care Benefits for outpatient care are subject to the following provisions:

- You mustn't be confined in a hospital or other medical facility
- The therapy must be part of a formal written treatment plan prescribed by a physician
- Services must be furnished and billed by a hospital, rehabilitation facility, physician, physical, occupational, or speech therapist

When the above criteria are met, benefits will be provided for physical, speech and occupational therapy services, including cardiac and pulmonary rehabilitation. Benefits are also included for physical, speech, and occupational assessments and evaluations related to rehabilitation.

A “visit” is a session of treatment for each type of therapy. Each type of therapy combined accrues toward the above visit maximum. Multiple therapy sessions on the same day will be counted as one visit, unless provided by different health care providers.

Chronic Pain Care

These services must also be medically necessary to treat intractable or chronic pain. Benefits for inpatient and outpatient chronic pain care are subject to the above rehabilitation therapy benefit limits. All benefit maximums apply. However, inpatient services for chronic pain care aren't subject to the 24-month limit.

This benefit won't be provided in addition to the ***Habilitation Therapy*** benefit for the same condition. Once a calendar year maximum has been exhausted under one of these benefits, no further coverage is available for the same condition under the other.

This benefit does not cover:

- Recreational, vocational or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Treatment that isn't actively engaged in by the ill, injured or impaired member
- Gym or swim therapy

- Custodial care
- Inpatient rehabilitation received more than 24 months from the date of onset of the member's accidental injury or illness or from the date of the member's surgery that made rehabilitation necessary
- Services to treat a psychiatric condition, see the ***Mental Health Care*** benefit
- Therapy for flat feet except to help you recover from surgery to correct flat feet

Skilled Nursing Facility Care

This benefit includes:

- Room and board
- Skilled nursing services
- Supplies and drugs
- Skilled nursing care during some stages of recovery
- Skilled rehabilitation provided by physical, occupational or speech therapists while in a skilled nursing facility
- Short or long term stay immediately following a hospitalization
- Active supervision by your doctor while in the skilled nursing facility

We must approve all planned skilled nursing facility stays before you enter a skilled nursing facility. See ***Prior Authorization*** for details.

This benefit does not cover:

- Acute nursing care
- Skilled nursing facility stay not immediately following hospitalization or inpatient stay
- Skilled nursing care outside of a hospital or skilled nursing facility
- Care or stay provided at a facility that is not qualified per our standards

Spinal and Other Manipulations

This benefit covers manipulations to treat a covered illness, injury or condition.

Rehabilitation therapy, such as massage or physical therapy, provided with manipulations is covered under the ***Rehabilitation Therapy*** and ***Habilitation Therapy*** benefits.

Substance Abuse Treatment

This benefit covers treatment of substance abuse including virtual care (see ***Definitions***). Benefits are limited to the least costly treatment setting that is medically necessary for your condition. This plan complies with federal parity requirements.

Some services require prior authorization before you receive treatment. See ***Prior Authorization*** for details.

This plan covers all of the following services:

- Individual, family or group therapy
- Inpatient, residential treatment, partial hospitalization and outpatient visits (including virtual care) to manage or reduce the effects of the alcohol or drug dependence
- Lab and testing
- Take-home drugs you get in a facility

For this benefit, “outpatient visit” means a clinical treatment session with a substance use provider. Outpatient visits can include real-time visits with your doctor or other provider via telephone, online chat or text, or other electronic methods.

Medically necessary detoxification is covered in any medically necessary setting. Detoxification in the hospital is covered under the ***Emergency Room*** and ***Hospital*** benefits.

In determining whether services for substance abuse treatment are medically necessary, Premera Blue Cross Blue Shield of Alaska will use the current edition of the Patient Placement Criteria for the Treatment of Substance-Related Disorders as published by the American Society of Addiction Medicine.

This benefit does not cover:

- Alcohol or drug use or abuse that does not meet the definition of substance abuse as stated in ***Definitions***.
- Halfway houses, quarterway houses, recovery houses, and other sober living residences

Surgery

This benefit covers surgical services, including injections that are not covered under other benefits when performed on an inpatient or outpatient basis, in such locations as a hospital, ambulatory surgical facility, surgical suite or provider's office. Also covered under this benefit are:

- Anesthesia or sedation and postoperative care as medically necessary. Benefits include anesthesia performed in connection with the preventive colonoscopy that your provider determines would be medically appropriate for you.
- Cornea transplantation, skin grafts, and the transfusion of blood or blood derivatives
- Sexual reassignment surgery if medically necessary and not for cosmetic purposes
- Colonoscopy and other scope insertion procedures are also covered under this benefit unless they qualify as preventive services described in the ***Preventive Care*** benefit
- Surgical services that are considered medically necessary to correct the cause of infertility
- The repair of a dependent child's congenital anomaly

This benefit also covers services of an assistant surgeon only when medically necessary. Assistant surgeons are not involved in the pre-operative or post-operative care and only assist during a surgical procedure at the direction of the primary surgeon. Benefits allowed for an assistant surgeon are based on their participation in this one element of your care and will be their billed charges or 20% of the primary surgeon's allowed amount, whichever is less.

When multiple or bilateral procedures are performed during the same operative session, the plan will provide benefits based on the allowed amount for the first or major procedure and one-half of the allowed amount for eligible secondary procedures.

For organ, bone marrow or stem cell transplant procedure benefit information, see the ***Transplants*** benefit for details.

For members residing in states where laws prohibit access to medically necessary sexual reassignment surgery, travel to a provider in another state may be covered. Please see ***Medical Transportation – State-Restricted Care*** for details.

Surgical Center – Outpatient

Benefits are provided for services and supplies furnished by a licensed ambulatory surgical center.

Therapeutic Injections

This benefit covers:

- Shots given in the doctor's office
- Supplies used during visit, such as serums, needles and syringes
- Three teaching doses for self-injectable specialty drugs

This benefit does not cover:

- Immunizations (see ***Preventive Care***)
- Self-injectable drugs (see ***Prescription Drugs***)
- Infusion therapy (see ***Infusion Therapy***)
- Allergy shots (see ***Allergy Testing and Treatment***)

Transplants

This benefit covers medical services only if provided by "Approved Transplant Centers." Please see the transplant benefit requirements later in this benefit for more information about approved transplant centers.

Covered Transplants

Solid organ transplants and bone marrow/stem cell reinfusion procedures mustn't be considered experimental or investigational for the treatment of your condition. See ***Definitions*** for a definition of “experimental/ investigational.”

The plan reserves the right to base coverage on all the following:

- Solid organ transplants and bone marrow/stem cell reinfusion procedures must be medically necessary and meet the plan's criteria for coverage. The medical indications for the transplant, documented effectiveness of the procedure to treat the condition and failure of medical alternatives are all reviewed.
- The types of solid organ transplants and bone marrow/stem cell reinfusion procedures that currently meet the plan's criteria for coverage are:
  - Heart
  - Heart/double lung
  - Single lung
  - Double lung
  - Liver
  - Kidney
  - Pancreas
  - Pancreas with kidney
  - Bone marrow (autologous and allogeneic)
  - Stem cell (autologous and allogeneic)

Please note: For the purposes of this plan, the term “transplant” doesn't include cornea transplantation, skin grafts or the transplant of blood or blood derivatives (except for bone marrow or stem cells). Benefits for such services are provided under other benefits of this plan.

- Your medical condition must meet the plan's written standards, which are found by referring to our website at **premera.com** or by contacting Customer Service.
- The transplant or reinfusion must be furnished in an approved transplant center. (“Approved Transplant Center” is a hospital or other provider that's developed expertise in performing solid organ transplants, or bone marrow or stem cell reinfusion.) Premera Blue Cross Blue Shield of Alaska has agreements with approved transplant centers in Alaska and Washington, and Premera Blue Cross Blue Shield of Alaska has access to a special network of approved transplant centers around the country. Whenever medically possible, you'll be directed to an approved, contracted transplant center for transplant services.

Of course, if none of our centers or the network centers can provide the type of transplant you need, this benefit will provide benefits for your transplant furnished by another transplant center.

Recipient Costs

This benefit covers transplant and reinfusion-related expenses, including the preparation regiment for a bone marrow or stem cell reinfusion. Also covered are anti-rejection drugs administered by the transplant center during the inpatient or outpatient stay in which the transplant was performed.

Donor Costs

This plan covers donor or procurement expenses for a covered transplant as shown in the ***Summary of Your Costs***. Covered services include:

- Selection, removal (harvesting) and evaluation of the donor organ, bone marrow or stem cell
- Transportation of donor organ, bone marrow and stem cells, including the surgical and harvesting teams
- Donor acquisition costs such as testing and typing expenses
- Storage costs for bone marrow and stem cells for a period of up to 12 months

Travel and Lodging

The transplant recipient must reside more than 50 miles from the approved transplant center, unless medically necessary treatment protocols require the member to remain closer to the transplant center. Travel and lodging

expenses will be based on current IRS guidelines on the date(s) the expenses were incurred. Please see the ***Summary of Your Costs*** to find out what the reimbursement rates are.

- **Travel:** Travel is reimbursed between the patient's home and the approved transplant center for round-trip (air, train, or bus) coach class transportation costs. If traveling by car, mileage, parking and toll costs are reimbursed.
- **Lodging:** Expenses incurred by a transplant patient and companion for hotel lodging away from home.

Companion travel and lodging expenses are covered if the companion must, as a matter of medical necessity, accompany the member. If the member receiving the transplant is a child under age 19, one companion is automatically permitted. A second companion will only be permitted if medically necessary.

Reimbursement amounts are subject to change due to IRS regulations. Please refer to the IRS website, **www.irs.gov**, for additional information. The information in this benefit should not be assumed as tax advice.

This benefit does not cover:

- Services and supplies that are payable by any government, foundation or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers.
- Donor costs for a solid organ transplant or bone marrow or stem cell reinfusion that isn't covered under this benefit, or for a recipient who isn't a member
- Donor costs for which benefits are available under other group or individual coverage
- Non-human or mechanical organs, unless they aren't experimental or investigational services. See ***Definitions*** for a definition of "experimental/ investigational."
- Anti-rejection drugs, except those administered by the transplant center during the inpatient or outpatient stay in which the transplant was performed
- Planned storage of blood for more than 12 months against the possibility it might be used at some point in the future
- Meals
- Alcohol or tobacco
- Car rentals
- Personal care items, such as shampoo or a toothbrush
- Souvenirs or other tourist items such as T-shirts, sweatshirts, or toys
- Entertainment such as movies, visits to museums or mileage for sightseeing
- Phone calls
- Costs for people other than you and your covered companion(s)
- Take-home prescription drugs dispensed by a licensed pharmacy. See ***Prescription Drugs*** for benefit information.

Urgent Care

This benefit covers:

Exams and treatment of:

- Minor sprains
- Cuts
- Ear, nose and throat infections
- Fever

Some services done during the urgent care visit may be covered under other benefits of this plan with different or additional cost shares, such as:

- X-rays and lab work
- Shots or therapeutic injections
- Office surgeries

This benefit does not cover emergency room or an urgent care facility attached to or part of a hospital, see ***Emergency Room*** for benefit details.

Vision Benefits

Vision services are provided for covered members 19 years of age or older. For vision benefits provided for members under age 19, see ***Pediatric Vision***.

Vision Exams

Covered routine exam services include:

- Examination of the outer and inner parts of the eye
- Evaluation of vision sharpness (refraction)
- Binocular balance testing
- Routine tests of color vision, peripheral vision and intraocular pressure
- Case history and recommendations

Vision Hardware

Benefits for vision hardware listed below are provided when they meet all these requirements:

- They must be prescribed and furnished by a licensed or certified vision care provider;
- They must be named in this benefit as covered; and
- They mustn't be excluded from coverage under this plan.

The following types of vision hardware are covered under this benefit.

- Prescription eyeglass lenses (single vision, bifocal, trifocal, quadrafocal or lenticular)
- Frames for eyeglasses
- Prescription contact lenses (soft, hard or disposable)
- Prescription safety glasses
- Prescription sunglasses
- Special features, such as tinting or coating
- Fitting of eyeglass lenses to frames
- Fitting of contact lenses to the eyes

Important note: Prescribed vision hardware necessitated by surgery, injury or disease is covered under ***Medical Vision Hardware***.

Vision hardware benefits are based on allowed amounts for covered services and supplies. Please see the ***Definitions*** section for a definition of “allowed amount.” Charges for vision services or supplies that exceed what's covered under this benefit aren't covered under other benefits of this plan.

This benefit does not cover:

- Services or supplies that aren't named above as covered, or that are covered under other provisions of this plan
- Non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments) or light-sensitive lenses, even if prescribed
- Vision therapy, eye exercise or any sort of training to correct muscular imbalance of the eye (orthoptics), or pleoptics
- Supplies used for the maintenance of contact lenses
- Services and supplies (including hardware) received after your coverage under this benefit has ended, except when all the following requirements are met:
  - You ordered covered contact lenses, eyeglass lenses and/or frames before the date your coverage under this benefit or plan ended; and

- You received the contact lenses; eyeglass lenses and/or frames within 30 days of the date your coverage under this benefit or plan ended.

Pediatric Vision Benefit

This benefit covers vision services for covered children under the age of 19.

Vision Exam

Covered routine exam services include:

- Examination of the outer and inner parts of the eye
- Evaluation of vision sharpness (refraction)
- Binocular balance testing
- Routine tests of color vision, peripheral vision and intraocular pressure
- Case history and recommendations

The Vision Exam benefit for members under 19 will provide coverage until the end of the month in which the member turns 19.

Vision Hardware

This benefit covers vision services for covered children under the age of 19.

The Vision Hardware benefit for members under 19 will provide coverage until the end of the month in which the member turns 19.

WHAT DO I DO IF I'M OUTSIDE ALASKA AND WASHINGTON?

OUT-OF-AREA CARE

As a member of the Blue Cross Blue Shield Association ("BCBSA"), Premera Blue Cross Blue Shield of Alaska has arrangements with other Blue Cross and Blue Shield Licensees ("Host Blues") for care outside Alaska and Washington and in Clark County, Washington. These arrangements are called "Inter-Plan Arrangements." Our Inter-Plan Arrangements help you get covered services from providers within the geographic area of a Host Blue.

The BlueCard® Program is the Inter-Plan Arrangement that applies to most claims from Host Blues' network providers. The Host Blue is responsible for its network providers and handles all interactions with them. Other Inter-Plan Arrangements apply to providers that are not in the Host Blues' networks (out-of-network providers). This Out-Of-Area Care section explains how the plan pays both types of providers.

Getting services through these Inter-Plan Arrangements does not change covered benefit levels, or any stated eligibility requirements. Please call us if your care needs prior authorization. See ***Prior Authorization*** for details.

We process claims for the Prescription Drugs benefit directly, not through an Inter-Plan Arrangement.

BlueCard Program

Except for copays, we will base the amount you must pay for claims from Host Blues' network providers on the lower of:

- The provider's billed charges for your covered services; or
- The allowed amount that the Host Blue made available to us. See ***Definitions*** for a definition of "allowed amount."

Often, the allowed amount is a discount that reflects an actual price that the Host Blue pays to the provider. Sometimes it is an estimated price that takes into account a special arrangement with a single provider or a group of providers. In other cases, it may be an average price, based on a discount that results in expected average savings for services from similar types of providers.

Host Blues may use a number of factors to set estimated or average prices. These may include settlements, incentive payments, and other credits or charges. Host Blues may also need to adjust their prices to correct their estimates of past prices. However, we will not apply any further adjustments to the price of a claim that has already been paid.

Clark County Providers Services in Clark County, Washington are processed through the BlueCard Program. Some providers in Clark County do have contracts with us. These providers will submit claims directly to us, and benefits will be based on our allowed amount for the covered service or supply.

Value-Based Programs

You might access covered services from providers that participate in a Host Blue's value-based program (VBP). Value-based programs focus on meeting standards for treatment outcomes, cost and quality, and for coordinating care when you are seeing more than one provider. The Host Blue may pay VBP providers for meeting the above standards. Your subscription charges for this plan may also include an amount for VBP payments. If the Host Blue includes charges for these payments in the allowed amount on a claim, you would pay a part of these charges if a deductible, coinsurance, or copay applies to the claim. If the VBP pays the provider for coordinating your care with other providers, you will not be billed for it.

Taxes, Surcharges and Fees

A law or regulation may require a surcharge, tax or other fee be added to the price of a covered service. If that happens, we will add that surcharge, tax or fee to the allowed amount for the claim.

Out-of-Network Providers

It could happen that you receive covered services from providers outside Alaska and Washington and in Clark County, Washington that do not have a contract with the Host Blue. In most cases, we will base the amount you pay for such services on either our allowed amount for these providers or the pricing requirements under applicable law. See ***Definitions*** for a definition of "allowed amount."

In these situations, you may owe the difference between the amount that the out-of-network provider bills and the payment the plan makes for the covered services as set forth above.

Blue Cross Blue Shield Global® Core Program

If you are outside the United States, Puerto Rico, and the U.S. Virgin Islands (the "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core. Blue Cross Blue Shield Global Core is unlike the BlueCard Program in the BlueCard service area in some ways. For instance, although Blue Cross Blue Shield Global Core helps you access a provider network, you will most likely have to pay the provider and send us the claim yourself in order for the plan to reimburse you. See ***How Do I File A Claim?*** for more information on submitting claims. However, if you need hospital inpatient care, the Service Center can often direct you to hospitals that will not require you to pay in full at the time of service. In such cases, these hospitals also send in the claim for you.

If you need to find a doctor or hospital outside the BlueCard service area, need help submitting claims or have other questions, please call the service center at 1-800-810-BLUE (2583). The center is open 24 hours a day, seven days a week. You can also call collect at 1-804-673-1177.

Further Questions?

If you have questions or need to find out more about the BlueCard Program, please call our Customer Service Department. To find a provider outside our service area, go to **premera.com** or call 1-800-810-BLUE (2583). You can also get Blue Cross Blue Shield Global Core information by calling the toll-free phone number.

CARE MANAGEMENT

Care Management services work to help ensure that you receive appropriate and cost-effective medical care. Your role in the Care Management process is simple, but important, as explained below.

You must be eligible on the dates of service and services must be medically necessary. We encourage you to call Customer Service to verify that you meet the required criteria for claims payment and to help us identify admissions that might benefit from personal health support programs.

PRIOR AUTHORIZATION

You must get Premera's approval for some services before the service is performed, or you may pay a penalty. This process is called prior authorization. You can find our medical policies at **premera.com**.

There are two different types of prior authorization required:

1. **Prior Authorization for Benefit Coverage** You must get prior authorization for certain types of medical services, equipment, and for most inpatient facility stays, as listed below. This is so that Premera can confirm that these services are medically necessary and covered by the plan.
2. **Prior Authorization for In-Network Cost Shares for Out-of-Network Providers** Except for emergency services. (Please see ***Exceptions to Prior Authorization for Out-of-Network and Out-Of-Area Providers*** below for more information) you must get prior authorization in order for the plan to:
   - Cover an out-of-network provider in Alaska at the in-network benefit level.

     Note: If there are no in-network providers within 50 miles of your home, out-of-network providers will be covered at the in-network level in Alaska without prior authorization. Please notify us by calling Customer Service when you receive non-emergency care covered services from an out-of-network provider so that we can apply your benefits correctly.
   - Cover a provider who is outside the service area at the in-network benefit level.

How Prior Authorization Works

We will decide on a request for services that require prior authorization in writing within 5 work days of receipt of all information necessary to make the decision. The response will let you know whether the services are authorized or not, including the reasons why. If you disagree with the decision, you can ask for an appeal. See ***Complaints and Appeals***.

If your life or health would be in serious jeopardy if you did not receive treatment right away, you may ask for an expedited review. We will respond in writing as soon as possible, but no more than 24 hours after we get all the information we need to make a decision.

Our prior authorization will be valid for 90 calendar days. This 90-day period depends on your continued coverage under the plan. If you do not receive the services within that time, you will have to ask us for another prior authorization.

1. Prior Authorization for Benefit Coverage

Prior Authorization for Medical Services, Supplies or Equipment

The plan has a list of services, equipment, and facility types that must have prior authorization before you receive the service or are admitted as an inpatient at the facility. Please contact your in-network provider or Premera Customer Service before you receive a service to confirm that your service requires prior authorization.

- **In-network providers or facilities** are required to request prior authorization for the service.
- **Out-of-network providers and facilities and all providers and facilities outside Alaska and Washington** will not request prior authorization for the service. You have to ask Premera to prior authorize the service.

  If you do not ask for prior authorization, you will pay a penalty. The penalty is 50 percent of the allowed amount for the covered service, supply or device. The maximum penalty is $1,500 per occurrence. Penalty amounts do not count toward your plan deductible or out-of-pocket maximum.

The following services require prior authorization:

- **Elective (non-emergent) Air or Ground Ambulance Transport**
- **Home Medical Equipment (HME) and Prosthetic Devices**

  HME rental for home use do not require prior authorization. However, **rental** beyond 3 months may be reviewed for ongoing medical necessity.
  - Bone growth stimulators – electronic and ultrasonic
  - Chest compression vests and devices
  - Cochlear devices
  - Custom-made knee braces
  - Electrical stimulation devices – includes bone growth stimulators
  - Electronic, mechanical or microprocessor-controlled artificial limb or joint

- Equipment and supplies to treat obstructive sleep apnea: CPAP, BiPAP and APAP machines and related supplies
- Hospital beds and accessories (no prior authorization needed for rental of standard beds for hospital to home transitions for less than 3 months)
- Lymphedema pumps (pumps to reduce swelling)
- Medical foods
- Myoelectric upper limb prosthetic (externally powered artificial arm or hand)
- Oral devices, appliances, surgical splints and impressions – includes preparation
- Power-operated lifting devices
- Standing frames
- Vagal nerve stimulators other than TENS (implanted devices to stimulate a specific nerve)
- Wheelchairs, power-operated vehicles and scooters (no prior authorization is needed for standard manual wheelchairs rented for less than 3 months)

- **Inpatient Facility Admissions**
  - All planned (elective) inpatient hospital care (surgical, non-surgical, behavioral health and/or substance abuse)
  - Elective admissions must have prior authorization before admission

    For facilities only, if the service for which the member is admitted is not included in the list below, notification from the facility is required within 24 hours of the admission
  - Admission to skilled nursing facility, a long-term acute care hospital (LTACH) or a rehabilitation facility
  - Admission to all residential treatment program
- **Outpatient imaging tests**
  - Contrast enhanced computed tomography (CT) angiography of the heart
  - Computed tomography (CT) scans
  - Echocardiograms (ultrasound test of the heart)
  - Magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA)
  - Magnetic resonance spectroscopy (special imaging to look at the brain)
  - Nuclear cardiology (using special dyes to look at heart function)
  - Positron emission tomography (PET and PET/CT)
- **Surgical, Medical, Therapeutic, Diagnostic and Reconstructive procedures (inpatient or outpatient)**
  - Ablation therapy (destruction of abnormal tissue)
  - Artificial intervertebral disc, any level (artificial disc between vertebrae in the spine)
  - Bioengineered skin substitutes
  - Blepharoplasty (eyelid surgery)
  - Bone anchored and implantable hearing aids
  - Breast surgeries – selected: implant removal, mastectomy for gynecomastia (removal of breast tissue in males), prophylactic mastectomy (removal of breasts to prevent breast cancer), reduction mammoplasty (breast reduction)
  - Cardiac devices; including related services for implantation if applicable: ventricular assist devices for outpatient (a certain kind of device to help the heart pump), implanted and wearable defibrillators (a device to shock the heart into a normal rhythm); closure devices for septal defects (a hole in a specific part of the heart); transcatheter aortic valve replacement known as TAVR/TAVI (a specific procedure that replaces the heart's aortic valve)
  - Chelation therapy
  - Chemotherapy administration and radiation oncology
  - Cochlear implantation (stimulates the nerve in the inner ear)

- Corneal remodeling/keratoprosthesis (reshaping the clear front layer of the eyeball/implanting an artificial cornea)
- Cosmetic or reconstructive surgeries (usually done to change appearance) that are covered under this plan
- Cryosurgical ablation/ablation of tumors (using extreme cold to destroy tumors)
- Deep brain stimulation (electrical stimulation of the brain through implanted wires)
- Electrophysiologic studies
- Esophageal sphincter procedures (anti-reflux surgery)
- Extracorporeal photopheresis (collecting cells, treating them with special light, and then returning specific cells to the body)
- Facet arthroscopy (replacing a specific part of a joint in the spine with an artificial support)
- Facility based polysomnography (sleep studies done in a lab)
- Foot surgery (some specific surgeries)
- Fundus photography
- Genetic testing and analysis
- Hernia repair
- Home-based polysomnography (sleep studies done at home)
- Hyaluronan or derivative for intra-articular injection
- Hyperbaric oxygen therapy (pressurized oxygen to treat certain kinds of wounds and illnesses
- Hysterectomy
- Implantation or application of electric stimulator devices – selected: gastric (stomach), spinal cord, sacral nerve (a specific nerve that affects bladder and bowel function), pelvic floor (muscles at the bottom of the pelvis), implanted bone stimulators, posterior tibial nerve (a nerve running down the back of the lower leg)
- Interspinous distraction devices (spacers between the bone of the spine)
- Intraoperative neurophysiology monitoring, continuous
- Joint surgeries, arthroscopy: ankle, elbow, foot, and wrist
- Lab services
- Major joint surgeries, arthroplasty/arthroscopy: knee, hip and shoulder
- Mitral valve repair (repair of a specific heart valve)
- Myringotomy
- Nasal/sinus surgery
- Panniculectomy (removing an apron of fat and tissue that hangs far below the waist)
- Radiation therapy – selected: stereotactic radiosurgery, gamma knife, proton beam, intensity modulated radiation therapy (IMRT), high dose rate electronic brachytherapy, and brachytherapy
- Radiofrequency ablation of tumors and treatment of facet joints (using heat to destroy tumors and treat nerves at specific joints of the spine)
- Septoplasty
- Skilled home health care services
- Spine surgeries and treatments
- Surgeries related to gender reassignment
- Surgery to treat sleep apnea
- Therapeutic apheresis (removing certain components of the blood)
- Therapy (physical/occupational/speech) after first visit
- Total ankle replacement
- Transcatheter occlusion or embolization for tumor destruction (closing off the blood supply to tumors)

- Transcranial magnetic stimulation, TMS (magnetic pulses to the brain)
- Tympanoplasty without mastoidectomy (including canalplasty, atticotomy and/or middle ear surgery)
- Upper gastrointestinal endoscopy (a viewing scope inserted through the mouth to examine the esophagus, stomach, and first part of the small intestine)
- Vagus nerve blocking therapy (obesity treatment that blocks signals going to the nerve that goes to the stomach)
- Vascular embolization or occlusion for tumors, organ ischemia or infarction (closing off a blood vessel to treat a tumor or other tissue)
- Vertebroplasty, kyphoplasty, or sacroplasty (specific treatments for stabilizing compression fractures in the spine)
- Varicose veins and perforator veins – all procedures

- **Transplant (inpatient or outpatient)**
  - Autologous progenitor cell therapy (stem cell transplants)
  - Complex organ transplants (small bowel, lung, heart, liver, multi-organ, face, limb)
  - Transplant donor procedures and services (for all types of transplants)
- **Dental Services**
  - Anesthesia for dental services and related facility charges
  - Medically necessary orthodontia (medically necessary braces for teeth)
  - Orthognathic surgery (jaw enlargement or reduction)
  - Pediatric orthodontia, non-routine (non-routine braces for children)
  - Sleep apnea intraoral appliances (devices worn in the mouth to treat sleep apnea)
  - Temporomandibular (TMJ) treatments (MRIs, oral splints, mouth guards, TMJ surgery)

Prior Authorization For Prescription Drugs

Certain prescription drugs must have prior authorization before you get them at a pharmacy. The list is on our website at **premera.com**. Your provider can ask for a prior authorization by faxing an accurately completed prior authorization form to us. This form is also on the pharmacy section of our website.

If your provider does not get prior authorization, when you go to the pharmacy to get your prescription, the pharmacy will tell you that you need it. You or your pharmacy should inform your provider of the need for prior authorization. Your provider can fax us an accurately completed prior authorization form for review.

You can still buy the drug before it is prior authorized, but you must pay the full cost. If the drug is authorized after you bought it, you can send us a claim for reimbursement. Reimbursement will be based on the allowed amount. See ***How Do I File A Claim?*** for details.

The list below includes examples of drug categories that require prior authorization. This list does not include specific drugs, and it may be changed from time to time.

- Adrenal hormones
- Adrenergics
- Androgens
- Angiotensin II receptor blockers & renin inhibitors
- Antiandrogens
- Anticholinergics and antispasmodics
- Anticonvulsants
- Antidiarrheals
- Antimalarials
- Antiplatelet drugs
- Antipsoriatic/Antiseborrheic
- Antivertigo and antiemetic agents

- Beta agonists inhalers
- Beta blockers
- Blood glucose monitoring devices & supplies
- Botulinum toxins
- Bowel evacuants
- Combination narcotic/analgesics
- Compounds
- Direct acting miotics
- Drugs with significant changes in product labeling
- Estrogen combinations
- Estrogens
- Fluoroquinolones
- Gene therapies and cellular immunotherapies such as CAR-T
- Glucose elevating agents
- Gonadotropin & related agents
- Growth hormones
- Headache therapy
- Hemostatics
- HIV/AIDS therapy
- Hypnotic agents
- Inhaled corticosteroids
- Insulin therapy
- Interferons
- Interleukins
- Intranasal steroids
- Keratolytics
- Kits
- Lipid/Cholesterol lowering agents
- Long acting nitrates
- MAO Inhibitors
- Miscellaneous agents
- Miscellaneous analgesics
- Miscellaneous antidepressants
- Miscellaneous antiinfectives
- Miscellaneous antineoplastic drugs
- Miscellaneous antipsychotics
- Miscellaneous antivirals
- Miscellaneous cardiovascular agents
- Miscellaneous coagulation agents
- Miscellaneous dermatologicals
- Miscellaneous gastrointestinal agents
- Miscellaneous neurological therapy drugs
- Miscellaneous ophthalmologics

- Miscellaneous psychotherapeutic agents
- Miscellaneous pulmonary agents
- Miscellaneous rheumatological agents
- Miscellaneous urologicals
- Muscle relaxants and antispasmodic agents
- Myeloid stimulants
- Narcotics
- Narcotics antagonists
- Newly FDA-approved drugs
- Non-insulin hypoglycemic agents
- NSAIDS/Cox II inhibitors
- Other glaucoma drugs
- Proton pump inhibitors
- Selective serotonin reuptake inhibitors
- Smoking deterrents
- Specialty drugs
- Steroids
- Tetracyclines
- Therapy for acne
- Thiazide and related diuretics
- Topical anesthetics
- Topical antibacterials
- Topical antifungals
- Topical corticosteroids

Sometimes, benefits for some prescription drugs may be limited to one or more of the following:

- A set quantity limit or a specific drug or drug dosage appropriate for a usual course of treatment.
- Certain drugs for a specific diagnosis (examples include age limits and testing requirements)
- Step therapy, meaning you must try a generic drug or a specified brand name drug first

These limits are based on medical standards, the drug maker's advice, and your specific case. They are also based on FDA guidelines and medical articles and papers.

Exceptions to Prior Authorization for Benefit Coverage

The following services do not require prior authorization for benefit coverage, but they have separate requirements:

- Emergency care and emergency hospital admissions, including emergency drug or alcohol detox in a hospital.
- Childbirth admission to a hospital, or admissions for newborns who need emergency medical care at birth.

Emergency and childbirth hospital admissions do not require prior authorization, but you must notify us as soon as reasonably possible.

2. Prior Authorization for In-Network Cost Shares for Out-of-Network Providers

Generally, non-emergent care by out-of-network providers in Alaska and providers outside the service area are covered at lower benefit levels. However, you may ask for a prior authorization to cover one of these providers at the in-network level if the services are medically necessary and are available from a in-network provider within 50 miles of your home. You or the out-of-network or out-of-area provider must ask for prior authorization before you receive the services.

Please notify us by calling Customer Service when you receive non-emergency covered services from an out-of-network provider so that we can apply your benefits correctly.

Please note: It is your responsibility to get prior authorization for any services that require it when you see a out-of-network provider. If you do not get a prior authorization, the services will not be covered at the in-network benefit level.

The prior authorization request for an out-of-network provider or provider outside of the service area must include the following:

- A statement explaining how the provider has unique skills or provides unique services that are medically necessary for your care, and that are not reasonably available from a in-network provider, and
- Medical records needed to support the request.

If the out-of-network or out-of-area provider's services are authorized, the plan will cover the service at the in-network benefit level. **However, in addition to the cost shares, you must pay any amounts over the allowed amount if the provider does not have a in-network contract with us or the local Blue Cross and/or Blue Shield Licensee. Amounts over the allowed amount do not count toward your plan deductible and out-of-pocket maximum.**

Exceptions to Prior Authorization for Out-of-Network and Out-Of-Area Providers

Out-of-network providers can be covered at the in-network level without prior authorization for emergency care and hospital admissions for a medical emergency. This includes hospital admissions for emergency drug or alcohol detox or for childbirth.

If you are admitted to an out-of-network or out-of-area hospital due to an emergency condition, those services are always covered at the in-network benefit level. We will continue to cover those services until you are medically stable and can safely transfer to an in-network hospital.

If you choose to stay in the out-of-network or out-of-area hospital after you are medically stable and can safely transfer to a in-network hospital, you may be subject to additional charges which may not be covered by your plan.

CLINICAL REVIEW

Clinical review is a summary of medical and payment policies. These are used to make sure that you get appropriate and cost-effective care. Our policies include:

- Accepted clinical practice guidelines
- Industry standards accepted by organizations like the American Medical Association (AMA)
- Other professional societies
- Center for Medicare and Medicaid Services (CMS)

You can find our medical policies at **premera.com**.

You or your provider may request a copy of the criteria used to make a medical necessity decision. Please send your request to Care Management at the address or fax number located on the inside front cover of this benefit booklet.

Premera may deny payment for services that are not medically necessary or that are considered experimental or investigational. A decision by Premera may be appealed, please see the ***Complaints and Appeals*** section. When there is more than one alternative available, coverage will be provided for the least costly among medically appropriate alternatives.

PERSONAL HEALTH SUPPORT PROGRAMS

Premera offers participation in our personal health support programs to help members with such things as managing complex medical conditions, a recent surgery, or admission to a hospital. Our services include:

- Helping to overcome barriers to health improvement or following providers' treatment plan
- Coordinating care services including access
- Helping to understand the health plan's coverage
- Finding community resources

Participation is voluntary. To learn more about our personal health support programs, contact Customer Service at the phone number listed on the back of your Premera ID card.

EXCLUSIONS

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

Amounts Over the Allowed Amount

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

Assisted Reproduction

Assisted reproduction technologies such as:

- Artificial insemination or in-vitro fertilization
- Services to make you more fertile or for multiple births
- Reversing sterilization surgery

Benefits from Other Sources

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

- Motor vehicle medical or motor vehicle no-fault
- Any type of no-fault coverage, such as Personal injury protection (PIP) coverage, Medical Payment coverage or Medical Premises coverage
- Any type of liability insurance, such as home owners' coverage or commercial liability coverage
- Any type of excess coverage
- Boat coverage
- School or athletic coverage

Benefits That Have Been Exhausted

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

Broken or Missed Appointments

Charges for Records or Reports

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

Clinical Trials

This plan does not cover:

- Clinical trials that are not an approved clinical trial as described in ***Clinical Trials***
- Travel costs, except as described for cancer clinical trials in ***Clinical Trials***
- A drug or device associated with the approved clinical trial that has not been approved by the FDA
- Housing, meals, or other nonclinical expenses
- Items or services provided to satisfy data collection and analysis and not used in the clinical management of the patient
- An item or service excluded from coverage under this plan
- An item or service paid for or customarily paid for through grants or other funding

Comfort or Convenience

- Personal services or items like meals for guests while hospitalized, long-distance phone, radio or TV, personal grooming, and babysitting.
- Normal living needs, such as food, clothes, housekeeping and transport.
- Meal or dietary assistance, including “Meals on Wheels”

Community Wellness and Safety Programs

This plan does not cover community wellness classes or safety programs.

Complications

This plan does not cover complications of a non-covered service, including follow-up services or effects of those services, but see ***Emergency Room*** benefits.

Cosmetic Services

Drugs, services or supplies for cosmetic services, including any direct or indirect complications and aftereffects. Examples of what is not covered are:

- Reshaping normal structures of the body in order to improve or change your appearance and self-esteem and not primarily to restore an impaired function of the body

  The only exceptions to this exclusion are:

  - Repair of a defect that's the direct result of an accidental injury, providing such repair is started within 12 months of the date of the accident
  - Repair of a dependent child's congenital anomaly
  - Reconstructive breast surgery in connection with a mastectomy as provided under the ***Mastectomy and Breast Reconstruction*** benefit
  - Correction of functional disorders (not including removal of excess skin and/or fat related to weight loss surgery or the use of weight management drugs) upon our review and approval
  - Genital or breast surgery that meets medical necessity criteria, or is medically necessary for the treatment of gender dysphoria diagnoses

Counseling, Educational and Training

Counseling, education and training in the absence of illness including:

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

Court-Ordered Services

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

Custodial Care

This plan does not cover custodial services, that are not covered hospice care services.

Dental Care

This plan does not cover dental care or supplies, that are not covered under ***Dental Injury and Facility Anesthesia*** services.

EEG biofeedback or neurofeedback services

Environmental Therapy

Therapy to provide a changed or controlled environment.

Experimental and Investigational Services

Experimental or investigative services or supplies. This plan also does not cover any complications or effects of such services.

Please note: This exclusion does not apply to certain experimental or investigational services provided as part of a qualified clinical trial.

Family Members or Volunteers

Services that you provide to yourself. It also does not cover a provider who is:

- Your spouse, mother, father, child, brother or sister
- Your mother, father, child, brother or sister by marriage
- Your stepmother, stepfather, stepchild, stepbrother or stepsister
- Your grandmother, grandfather, grandchild or the spouse of one of these people
- A volunteer

Governmental Facilities

This plan does not cover services provided by a non-participating state or federal hospital not required by law or regulation.

Hair Analysis

Hair Loss

- Drugs, supplies, equipment, or procedures to replace hair, slow hair loss, or stimulate hair growth
- Hair prostheses, such as wigs or hair weaves, transplants, and implants

Hearing Exams

This plan does not cover routine hearing exams and testing used to prescribe or fit hearing aids and any associated service or supply.

Hearing Hardware

This plan does not cover hearing aids and devices used to improve hearing sharpness and any associated service or supply.

Illegal Acts, Illegal Services and Terrorism

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

Laser Therapy

Low-level laser therapy.

Military Service and War

Illness or injury that is caused by or arises from:

- Acts of war, such as armed invasion, no matter if war has been declared or not
- Services in the armed forces of any country. This includes the air force, army, coast guard, marines, National Guard or navy. It also includes any related civilian forces or units. However, this exclusion does not apply to members of the U.S. military (active or retired) or their dependents enrolled in the TRICARE program. This plan will be primary to TRICARE for these members when required by federal law.

Non-Covered Services

Services or supplies:

- Ordered when this plan is not in effect or when the person is not covered under this plan, except as stated under specific benefits and under ***Extended Benefits*** section
- Provided to someone other than the ill or injured member, other than outpatient health education services covered under the ***Preventive Care*** benefit. This includes health care provider training or educational services.
- You are not required to pay or would not have been charged for if this plan were not in force
- That are not listed as covered under this plan

Non-Treatment Charges

- Charges for provider travel time

- Transporting a member in place of a parent or other family member or accompanying the member to appointments or other activities outside the home, such as medical appointments or shopping.
- Doing housework or chores for the member or helping the member do housework or chores.
- Arrangements in which the provider lives with the member

Non-Treatment Facilities, Institutions or Programs

- Institutional care
- Housing
- Incarceration
- Programs from facilities that are not licensed to provide medical or behavioral health treatment for covered services. Examples are prisons, nursing homes and juvenile detention facilities. Benefits are provided for medically necessary treatment received in these locations. See ***Covered Services*** for specific benefit information.

Orthodontia

Orthodontia, regardless of condition, including casts, models, x-rays, photographs, examinations, appliances, braces, and retainers.

Orthognathic Surgery

Procedures to lengthen or shorten the jaw, except when required for temporomandibular joint disorder, injury, sleep apnea or congenital anomaly.

Provider's Licensing or Certification

This plan does not cover services that the provider's license or certification does not allow him or her to perform. It also does not cover a provider that does not have the license or certification that the state requires.

Recreational, Camp and Activity Programs

Recreational, camp and activity-based programs. These programs include:

- Gym, swim and other sports programs, camps and training
- Creative art, play and sensory movement and dance therapy
- Recreational programs and camps
- Hiking, tall ship and other adventure programs and camps
- Boot camp programs and outward bound programs
- Equine programs and other animal-assisted programs and camps
- Exercise and maintenance-level programs

Serious Adverse Events and Never Events

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

Serious Adverse Event means a hospital injury caused by medical management (rather than an underlying disease) that prolonged the hospitalization, and/or produces a disability at the time of discharge.

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

Not all medical errors are defined as serious adverse events or never events. You can obtain a list of serious adverse events and never events by contacting us at the number listed in the front of this booklet or on the Centers for Medicare and Medicaid Services (CMS) website at www.cms.hhs.gov.

Services or Supplies for which You Do Not Legally Have to Pay

Services and supplies for which no charge is made, for which none would have been made if this plan were not in effect, or for which you are not legally required to pay.

Services or Supplies Not Medically Necessary

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

Sexual Dysfunction

Diagnosis and treatment of sexual dysfunctions, regardless of origin or cause; surgical, medical or psychological treatment including drugs, medications, or penile or other implants.

Skilled Hourly Nursing

Medically intensive care provided by a licensed nurse at home

Temporomandibular Joint Disorders (TMJ)

This plan does not cover treatment of TMJ disorders. TMJ disorders are problems with the lower jaw joint that have one or more of the features below:

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

Vision Hardware

- Non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments) or light-sensitive lenses, even if prescribed
- Services and supplies (including hardware) received after your coverage under this plan has ended, except when all the following requirements are met:
  - You ordered covered contact lenses, eyeglass lenses and/or frames before the date your coverage under this plan ended; and
  - You received the contact lenses, eyeglass lenses and/or frames within 30 days of the date your coverage under this plan ended.

Vision Therapy

Vision therapy, eye exercise or any sort of training to correct muscular imbalance of the eye (orthoptics), and pleoptics, treatment or surgeries to improve the refractive character of the cornea or any results of such treatments.

Voluntary Support Groups

Patient support, consumer or affinity groups such as diabetic support groups or Alcoholics Anonymous.

Weight Loss (Surgery or Drugs)

This plan does not cover surgery, drugs or supplements for weight loss or weight control.

Work-Related Illness or Injury

This plan does not cover any illness, condition or injury you get benefits under:

- Occupational coverage required of, or voluntarily obtained by, the employer
- State or federal workers' compensation acts
- Any legislative act providing compensation for work-related illness or injury

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

WHAT IF I HAVE OTHER COVERAGE?

COORDINATING BENEFITS WITH OTHER HEALTH CARE PLANS

Please Note: If you participate in a health savings account and have other health care coverage in addition to this high deductible health plan, the tax deductibility of the health savings account contributions may not be allowed. Please contact your tax advisor or HSA plan administrator for more information.

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

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

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

Definitions Applicable To Coordination Of Benefits

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

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

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

Effect On Benefits

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

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

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

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

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

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

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

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

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

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

Right Of Recovery/Facility Of Payment

The plan has the right to recover any payments that are greater than those required by the coordination of benefits provisions from one or more of the following: the persons the plan paid or for whom the plan has paid, providers of service, insurance companies, service plans or other organizations. If a payment that should have been made under this plan was made by another plan, the plan may also have the right to pay directly to another plan any amount that the plan should have paid. Such payment will be considered a benefit under this plan and will meet the plan's obligations to the extent of that payment.

This plan has the right to appoint a third party to act on its behalf in recovery efforts.

COORDINATING BENEFITS WITH MEDICARE

If you're also covered under Medicare, federal law determines how we provide the benefits of this plan. Those laws may require this plan to be primary over Medicare.

When this plan isn't primary, we'll coordinate benefits with Medicare. Benefits will be coordinated up to Medicare's allowed amount, as required by federal regulations. If the provider does not accept Medicare assignment, this allowed amount is the Medicare Limiting Charge.

SUBROGATION AND REIMBURSEMENT

If we make claims payment on your behalf for injury or illness for which another party is liable, or for which uninsured/underinsured motorist (UIM) or personal injury protection (PIP) insurance exists, we are entitled to be

repaid for those payments out of any recovery from that liable party. The liable party is also known as the "third party" because it's a party other than you or us. This party includes a UIM carrier because it stands in the shoes of a third-party tortfeasor and because we exclude coverage for such benefits.

Definitions The following terms have specific meanings in this contract:

- **Subrogation** means we may collect directly from third parties to the extent we have paid on your behalf for illnesses or injury caused by the third party.
- **Reimbursement** means that you are obligated under the contract to repay any monies advanced by us from amounts received on your claim.
- **Restitution** means all equitable rights of recovery that we have to the monies advanced under your plan. Because we have paid for your illness or injuries, we are entitled to recover those expenses.

To the fullest extent permitted by law, we're entitled to the proceeds of any settlement or judgment that results in a recovery from a third party, up to the amount of benefits paid by us for the condition. Our right to recover exists regardless of whether it is based on subrogation, reimbursement or restitution. We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not “made whole” for all your damages in the recoveries that you received. Our right of recovery is not subject to reduction for reasonable attorney's fees and costs under the “common fund” or any other doctrine. Such recoveries will not be sought more than 365 days after we receive notice of the settlement or judgment. In recovering benefits provided, we may at our election hire our own attorney or be represented by your attorney. We will not pay for any legal costs incurred by you or on your behalf, and you will not be required to pay any portion of the costs incurred by us or on our behalf.

Before accepting any settlement on your claim against a third party, you must notify us in writing of any terms or conditions offered in a settlement, and you must notify the third party of our interest in the settlement established by this provision. You also must cooperate with us in recovering amounts paid by us on your behalf. If you retain an attorney or other agent to represent you in the matter, you must require your attorney or agent to reimburse us directly from the settlement or recovery. If you fail to cooperate fully with us in the recovery of benefits we have paid as described above, you are responsible for reimbursing us for such benefits.

To the extent that you recover from any available third-party source, you agree to hold any recovered fund in trust or in a segregated account until our subrogation and reimbursement rights are fully determined.

WHO IS ELIGIBLE FOR COVERAGE?

This section of your booklet describes who is eligible for coverage.

Please note that you do not have to be a citizen of or live in the United States if you are otherwise eligible for coverage.

SUBSCRIBER ELIGIBILITY

Under this large employer health benefit plan, to be an “eligible employee,” an employee must be one of the following:

- The employee must be a regular and active employee, owner, partner, or corporate officer of the Group who is paid on a regular basis through the Group's payroll system and reported by the Group for Social Security purposes. The employee must also:
- Regularly work a minimum of 30 hours per week
- Complete a 30-day probationary period

Employees Performing Employment Services in Hawaii

For employers other than political subdivisions, such as state and local governments, and public schools and universities, the State of Hawaii requires that benefits for employees living and working in Hawaii (regardless of where the Group is located) be administered according to Hawaii law. If the Group is not a governmental employer as described in this paragraph, employees who reside and perform any employment services for the Group in Hawaii are not eligible for coverage. When an employee moves to Hawaii and begins performing employment services for the Group there, he or she will no longer be eligible for coverage.

DEPENDENT ELIGIBILITY

An "eligible dependent" is defined as one of the following.

- The lawful spouse of the subscriber, unless legally separated. However, if the spouse is an employee, owner, partner or corporate officer of the Group who meets the requirements in **Employee Eligibility** earlier in this section, the spouse can enroll only as a subscriber.
- The domestic partner of the subscriber. All rights and benefits afforded to a “spouse” under this plan will also be afforded to an eligible domestic partner. In determining benefits for domestic partners and their children under this plan, the term "establishment of the domestic partnership" shall be used in place of “marriage”, and the term “termination of the domestic partnership” shall be used in place of “legal separation” and "divorce”.
- An eligible child under 26 years of age, except as provided for in the ***How Do I Continue Coverage? Continued Coverage For a Disabled Child*** provision. An eligible child is one of the following:
- A natural offspring of either or both the subscriber or spouse;
- A legally adopted child of either or both the subscriber or spouse;
- A child “placed” with the subscriber for the purpose of legal adoption in accordance with state law. “Placed” for adoption means assumption and retention by the subscriber of a legal obligation for total or partial support of a child in anticipation of adoption of such child;
- A legal dependent or foster child for whom the subscriber or spouse has a legal guardianship. There must be a court order or other order signed by a judge or state agency, which grants guardianship of the child to the subscriber or spouse as of a specific date. When the court order terminates or expires, the child is no longer an eligible child.
- A newborn grandchild of either or both the subscriber or spouse if the newborn's mother or father is an enrolled dependent and if the grandchild is enrolled as described under the ***Newborn Grandchildren*** section below. The term “Grandchildren” in this provision means the natural offspring of dependent children, including dependent children for whom the subscriber or spouse has a legal guardianship.

WHEN DOES COVERAGE BEGIN?

ENROLLMENT

Enrollment is timely when we receive the completed enrollment application and required subscription charges within 60 days of the date the employee becomes an “eligible employee” as defined earlier in this section. When enrollment is timely, coverage for the employee and enrolled dependents will become effective on the first of the month that falls on or after the **latest** of the applicable dates below:

- The employee's date of hire;
- The date the employee enters a class of employees to which the Group offers coverage under this plan;
- The next day following the date the probationary period ends; or
- Another date as designated in the Group Master Application or Group Contract.

If we don't receive the enrollment application within 60 days of the date you became eligible, none of the dates above will apply. Please see ***Open Enrollment*** and ***Special Enrollment*** below.

Dependents Acquired Through Marriage After The Subscriber's Effective Date

When we receive the completed enrollment application and any required subscription charges within 60 days after the marriage, coverage will become effective on the first of the month following the date of marriage. When the enrollment application isn't received by us within 60 days of marriage, refer to ***Open Enrollment*** later in this section.

Newborn And Adoptive Children

Natural newborn dependent children of the subscriber born on or after the subscriber's effective date will be covered from their date of birth. However, if payment of additional subscription charges is required to provide coverage for a newborn child, and the subscriber desires coverage of the newborn child to extend beyond the 31-day period following the newborn child's date of birth, we must receive a completed enrollment application and the required additional subscription charges within the 60-day period following the date of birth.

Adoptive dependent children of the subscriber who are adopted or placed for adoption on or after the subscriber's effective date will be covered from their date of adoption or placement for adoption. However, if payment of additional subscription charges is required to provide coverage for an adoptive dependent child, and the subscriber desires coverage of the adoptive child to extend beyond the 31-day period following the dependent child's date of adoption or placement for adoption, we must receive a completed enrollment application and the required additional subscription charges within the 60-day period following the date of adoption or placement for adoption.

If we don't receive the completed enrollment application and the required additional subscription charges within the 60-day period, initial coverage will be limited to the 31-day period referenced above. The child may then be enrolled at a later date, subject to the ***Open Enrollment*** provisions described later in this section.

Children Acquired Through Legal Guardianship

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

Children Covered Under Medical Child Support Orders

When we receive the completed enrollment application within 60 days of the date of the medical child support order, coverage for an otherwise eligible child that is required under the order will become effective on the date of the order. Otherwise, coverage will become effective on the date we receive the enrollment application for coverage. The enrollment application may be submitted by the subscriber, the child's custodial parent or a state agency. When subscription charges being paid don't already include coverage for dependent children, such charges will begin from the child's effective date. Please contact your Group for detailed procedures.

Court-Ordered Dependent Coverage

When we receive the completed enrollment application within 60 days of the date of the court order, coverage for a lawful spouse and/or dependent children will become effective on the date of the order. Otherwise, coverage will become effective on the first of the month following the date we receive the enrollment application for coverage. When subscription charges being paid don't already include coverage for a spouse and/or dependent children, such charges will begin from the dependent's effective date.

Newborn Grandchildren

Natural newborn children born on or after the subscriber's effective date to a covered dependent child (referred to as "grandchildren") will be covered from their date of birth. The grandchild's parent must remain covered under the plan in order for the grandchild to be covered.

If payment of additional subscription charges is required to provide coverage for a newborn grandchild, and the subscriber desires coverage of the newborn grandchild to extend beyond the 31-day period following the newborn grandchild's date of birth, we must receive written notice and any required additional subscription charges within the 60-day period following the date of birth.

If we don't receive the written notice and any required additional subscription charges within the 60-day period, initial coverage for the newborn grandchild will be limited to the 31-day period referenced above.

A newborn grandchild who is not properly enrolled as stated above may not be enrolled at a later date, including during Open Enrollment or Special Enrollment periods, even if the grandchild's parent is a covered dependent child under this plan.

Please note: The calendar year deductible and out-of-pocket maximum varies based on whether you have single or family enrollment. If you add dependents during the calendar year, your calendar year deductible and out-of-pocket maximum may change from single enrollment to the aggregate family enrollment, as appropriate.

SPECIAL ENROLLMENT

Involuntary Loss Of Other Coverage

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

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

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

When we receive the employee and/or dependent's completed enrollment application and any required subscription charges within 60 days of the date such other coverage ended, coverage under this plan will be effective on the first day of the month following the date the other coverage was lost.

If we do not receive the employee and/or dependent's completed enrollment application within the required 60 days, you and/or your dependents may not enroll until the next group open enrollment period. Please see ***Open Enrollment*** below.

Subscriber And Dependent Special Enrollment

An eligible employee and otherwise eligible dependents, who previously elected not to enroll in any of the employer's group health plans when such coverage was previously offered, may enroll in this plan at the same time a newly acquired dependent is enrolled under ***Enrollment*** in the case of marriage, birth, adoption, or placement for adoption. The eligible employee may also choose to enroll alone, enroll with some or all eligible dependents or change plans, if applicable.

Please note: If a newborn child is born to a dependent child of the subscriber or spouse, and the dependent child was not covered under the plan prior to the newborn's birth, the newborn is not eligible to be enrolled and no Special Enrollment event has occurred.

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

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

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

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

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

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

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

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

OPEN ENROLLMENT

If you're not enrolled when you first become eligible, or as allowed under ***Special Enrollment*** above, you cannot be enrolled until the Group's next "open enrollment" period. An open enrollment period occurs once a year unless otherwise agreed upon between the Group and us. During this period, eligible employees and their dependents can enroll for coverage under this plan.

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

Please note: Grandchildren are not eligible to be enrolled during Open Enrollment. Please see the ***Newborn Grandchildren*** section above.

CHANGES IN COVERAGE

No rights are vested under this plan. Its terms, benefits, and limitations may be changed by us at any time. Changes to this plan will apply as of the date the change becomes effective to all members and to eligible employees and dependents who become covered under this plan after the date the change becomes effective.

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

PLAN TRANSFERS

Subscribers (with their enrolled dependents) may be allowed to transfer to this plan from another plan offered by the Group. Transfers also occur if the Group replaces another plan with this plan. Also, we may replace the Group's current contract for this plan with an updated one from time to time. All transfers to this plan must occur during open enrollment or on another date agreed upon by us and the Group.

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

- Out-of-pocket maximum, if any
- Calendar year deductible. Please note that we will credit expenses applied to your prior plan's calendar year deductible **only** when they were incurred in the current calendar year. Expenses incurred during October through December of the prior year are not credited toward this plan's calendar year deductible for the current year.

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

This provision doesn't apply to transfers from plans not offered by us.

WHEN WILL MY COVERAGE END?

EVENTS THAT END COVERAGE

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

- For the subscriber and dependents when any of the following occur:
- The Group contract is terminated.
- The next monthly subscription charge isn't paid when due or within the grace period.
- The subscriber dies or is otherwise no longer eligible as a subscriber.
- In the case of an association, the Association Employer's membership in the association ceases.

- In the case of a collectively bargained program, the employer fails to meet the terms of an applicable collective bargaining agreement or to employ employees covered by a collective bargaining agreement.
- For a spouse when his or her marriage to the subscriber is annulled, or when he or she becomes legally separated or divorced from the subscriber
- For a child when he or she no longer meets the requirements for dependent coverage shown in ***Who Is Eligible For Coverage?***
- For a grandchild of the subscriber or spouse when the grandchild's parent is no longer enrolled in the plan or no longer meets the requirements for dependent coverage shown in ***Who Is Eligible For Coverage?***
- For fraud or intentional misrepresentation of material fact under the terms of the coverage by the subscriber or the subscriber's dependents

The subscriber must promptly notify the Group when an enrolled family member is no longer eligible to be enrolled as a dependent under this plan. The Group must give us written notice of a member's termination within 30 days of the date the Group is notified of such event.

CONTRACT TERMINATION

No rights are vested under this plan. Termination of the Group Contract for this plan completely ends all members' coverage and all our obligations, except as provided under ***Extended Benefits*** in the ***How Do I Continue Coverage?*** section.

The Group Contract will automatically be terminated if subscription charges or contributions aren't paid when due; coverage will end on the last day for which payment was made. This plan may also terminate as indicated below.

The Group may terminate the Group Contract:

- Effective on any subscription charge due date with 45 days' advance written notice to us
- 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. The Group Contract will end on the last date for which subscription charges were paid.

We may terminate the Group Contract, **upon 45 days advance written notice to the Group if**:

- The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;
- The Group has failed to comply with a material plan provision relating to minimum participation or employer contribution requirements;
- In the case of a network plan, the Group no longer has any members who reside or work in Alaska or Washington;
- We discontinue offering a particular type of health care plan in the group market on condition that:
- We furnish written notice of the decision to discontinue coverage to all affected groups, members, and to the insurance regulatory official in each state in which an affected member is known to reside. Such notice must be given at least 180 days before we decide to discontinue the health care plan;
- We furnish written notice of the decision to discontinue coverage to the director and to the insurance regulatory official in each state in which we're licensed at least 30 days before notice is given to the affected groups and members as described above;
- We offer each group who is provided the particular type of health care plan the option to purchase another health care plan currently being offered by us to groups in the same market in that state; and
- We act uniformly without regard to the claims experience of those groups, or to any health status factor of a member or a prospective member who may become eligible for coverage;
- We discontinue offering and renewing all health care plans in the group market if:
- We furnish written notice of the decision to discontinue coverage to all affected groups, members, and to the insurance regulatory official in each state in which an affected member is known to reside. Such notice must be given at least 180 days before we decide to discontinue the health care plans;

- We furnish written notice of the decision to discontinue coverage to the director and to the insurance regulatory official in each state in which we're licensed at least 30 days before the notice is given to the affected groups and members as described above; and
- We don't issue a health care plan in the group market in the applicable states for five (5) years from the date the last group health care plan was discontinued.

HOW DO I CONTINUE COVERAGE?

CONTINUED ELIGIBILITY FOR A DISABLED CHILD

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

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

Please note: This provision does not apply to dependent grandchildren.

LEAVE OF ABSENCE

Coverage for a subscriber and enrolled dependents may be continued for up to 90 days, or as otherwise required by law, when the employer grants the subscriber a leave of absence and subscription charges continue to be paid.

The 90-day leave of absence period counts toward the maximum COBRA continuation period, except as prohibited by the Family and Medical Leave Act of 1993.

COBRA

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

At the Group's request, we'll provide qualified members with COBRA coverage under this plan when COBRA's enrollment and payment requirements are met. But, coverage is provided only to the extent that COBRA requires and is subject to the other terms and limitations of this plan. Members' rights to this coverage may be affected by the Group's failure to abide by the terms of its contract with us. The Group, **not us**, is responsible for all notifications and other duties assigned by COBRA to the “plan administrator” within COBRA's time limits.

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

Qualifying Events and Length of Coverage

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

Please note: Covered domestic partners and their children have the same rights to COBRA coverage as covered spouses and their children. Covered grandchildren also have the same rights to COBRA coverage as covered children.

- The Group must offer the subscriber and covered dependents an election to continue coverage for up to 18 consecutive months if their coverage is lost because of 1 of 2 qualifying events:
  - **The subscriber's work hours are reduced**
  - **The subscriber's employment terminates, except for discharge due to actions defined by the Group as gross misconduct.**

  However, if one of the events listed above follows the covered employee's entitlement to Medicare by less than 18 months, the Group must offer the covered spouse and children an election to continue coverage for up to 36 months starting from the date of the Medicare entitlement.
- COBRA coverage can be extended if a member who lost coverage due to a reduction in hours or termination of employment is determined to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act at any time during the first 60 days of COBRA coverage. In such cases, all family members who elected COBRA may continue coverage for up to a total of 29 consecutive months from the date of the reduction in hours or termination.
- The Group must offer the covered spouse or children an election to continue coverage for up to 36 consecutive months if their coverage is lost because of 1 of 4 qualifying events:
  - **The subscriber dies.**
  - **The subscriber and spouse legally separate or divorce.**
  - **The subscriber becomes entitled to Medicare.**
  - **A child loses eligibility for dependent coverage.**

  In addition, the occurrence of one of these events during the 18-month period described above can extend that period for a continuing dependent. This happens only if the event would have caused a similar dependent who was not on COBRA coverage to lose coverage under this plan. The extended period will end no later than 36 months from the date of the first qualifying event.

Conditions of COBRA Coverage

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

You Must Give Notice Of Some Qualifying Events

The plan will offer COBRA coverage only after the Group receives timely notice that a qualifying event has occurred.

The subscriber or affected dependent must notify the Group in the event of a divorce, legal separation, child's loss of eligibility as a dependent, or any second qualifying event which occurs within the 18-month period as described in ***Qualifying Events And Lengths Of Coverage***. The subscriber or affected dependent must also notify the Group if the Social Security Administration determines that the subscriber or dependent was disabled on any of the first 60 days of COBRA coverage. You also have the right to appoint someone to give the Group this notice for you.

If the required notice is not given or is late, the qualified member loses the right to COBRA coverage. Except as described below for disability notices, the subscriber or affected dependent has 60 days in which to give notice to the Group. The notice period starts on the date shown below.

- For determinations of disability, the notice period starts on the **later** of: 1) the date of the subscriber's termination or reduction in hours; 2) the date qualified member would lose coverage as the result of one of these events; or 3) date of the disability determination. **Please Note: Determinations that a qualified member is disabled must be given to the Group before the 18-month continuation period ends. This means that the subscriber or qualified member might not have the full 60 days in which to give the notice.** Please include a copy of the determination with your notice to the Group.

  Note: The subscriber or affected dependent must also notify the Group if a qualified member is deemed by the Social Security Administration to no longer be disabled. See ***When COBRA Coverage Ends*** for details.
- For the other events above, the 60-day notice period starts on the **later** of: 1) the date of the qualifying event, or 2) the date the qualified member would lose coverage as a result of the event.

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

The Group must notify qualified members of their rights under COBRA. If the Group has named a third party as its plan administrator, the plan administrator is responsible to notify members on behalf of the group. In such cases, the Group has 30 days in which to notify its plan administrator of a subscriber's termination of employment, reduction in hours, death or Medicare entitlement. The plan administrator then has 14 days after it receives notice of a qualifying event from the Group (or from a qualified member as stated above) in which to notify qualified members of their COBRA rights.

If the Group itself is the plan administrator, it has more than 14 days in which to give notice for certain qualifying events. The Group must furnish the notice required because of a subscriber's termination of employment, reduction in hours, death or Medicare entitlement no later than 44 days after the **later** of 1) the date of the qualifying event, or 2) the date coverage would end in the absence of COBRA. For all other qualifying events, the 14-day notice time limit applies.

You Must Enroll And Pay On Time

- You must elect COBRA coverage no more than 60 days after the **later** of 1) the date coverage was to end because of the qualifying event, or 2) the date you were notified of your right to elect COBRA coverage. You may be eligible for a second COBRA election period if you qualify under section 201 of the Federal Trade Act of 2002. Please contact the Group or your bargaining representative for more information if you believe this may apply to you.

  Each qualified member will have an independent right to elect COBRA coverage. Subscribers may elect COBRA coverage on behalf of their spouses, and parents may elect COBRA coverage on behalf of their children.

  If you're not notified of your right to elect COBRA coverage within the time limits above, you must elect COBRA coverage no more than 60 days after the date coverage was to end because of the qualifying event in order for COBRA coverage to become effective under this plan. If you're not notified of your right to elect COBRA coverage within the time limit, and you don't elect COBRA coverage within 60 days after the date coverage ends, we won't be obligated to provide COBRA benefits under this plan. The Group will assume full financial responsibility for payment of any COBRA benefits to which you may be entitled.
- You must send your first subscription charge payment to the Group no more than 45 days after the date you elected COBRA coverage
- Subsequent subscription charges must be paid to the Group and submitted to us with the Group's regular monthly billings

Adding Family Members

Eligible family members may be added after the continuation period begins, but only as allowed under ***Special Enrollment*** or ***Open Enrollment*** in the ***When Does Coverage Begin?*** section. With one exception, family members added after COBRA begins aren't eligible for further coverage if they later have a qualifying event or if they are determined to be disabled as described under ***Qualifying Events And Lengths Of Coverage*** earlier in this COBRA section. The exception is that a child born to or placed for adoption with a covered employee while the covered employee is on COBRA has the same COBRA rights as family members on coverage at the time of the original qualifying event. The child will be covered for the duration of the covered employee's initial 18-month COBRA period, unless a second qualifying event occurs which extends the child's coverage. COBRA coverage is subject to all other terms and limitations of this plan.

Keep The Group Informed Of Address Changes

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

When COBRA Coverage Ends

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

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

- When coverage is extended from 18 to 29 months due to disability (Please see ***Qualifying Events And Lengths Of Coverage*** in this section), COBRA coverage beyond 18 months ends if there's a final determination that a qualified member is no longer disabled under the Social Security Act. However, coverage won't end on the date shown above, but on the last day for which subscription charges have been paid in the first month that begins more than 30 days after the date of the determination. The subscriber or affected dependent must provide the Group with a copy of the Social Security Administration's determination within 30 days after the **later** of: 1) the date of the determination, or 2) the date on which the subscriber or affected dependent was informed that this notice should be provided and given procedures to follow.
- You become covered under another group health care plan after the date you elect COBRA coverage. However, if the new plan contains an exclusion or limitation for a pre-existing condition, coverage doesn't end for this reason until the exclusion or limitation no longer applies.
- You become entitled to Medicare after the date you elect COBRA coverage
- The Group ceases to offer group health care coverage to any employee

However, even if one of the events above hasn't occurred, COBRA coverage **under this plan** will end on the date that the contract between the Group and us is terminated.

When COBRA coverage under this plan ends, you may be eligible for benefits as described in ***Extended Benefits*** later in this section.

If You Have Questions

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

Extended Benefits

Under the following circumstances, certain benefits of this plan may be extended after your coverage ends. If the contract between the Group and us is terminated while you're receiving the extended benefits below, your right to those benefits won't be affected.

The inpatient benefits of this plan will continue to be available after coverage ends if:

- Your coverage had been in effect for more than 31 days;
- Your coverage didn't end because of fraud or an intentional misrepresentation of material fact under the terms of the coverage by you or the Group;
- You were admitted to a medical facility prior to the date coverage ended; and
- You remained continuously confined in a medical facility because of the same medical condition for which you were admitted.

Such continued inpatient coverage will end when the first of the following occurs:

- You're covered under a health plan or contract that provides benefits for your confinement or would provide benefits for your confinement if coverage under this plan didn't exist;
- You're discharged from that facility or from any other facility to which you were transferred;
- Inpatient care is no longer medically necessary;
- The maximum benefit for inpatient care in the medical facility has been provided. If the calendar year ends before a calendar year maximum has been reached, the balance is still available for covered inpatient care you receive in the next year. Once it's used up, however, a calendar year maximum benefit won't be renewed.

OTHER CONTINUED COVERAGE OPTIONS

Continuation Under USERRA

The Uniformed Services Employment And Reemployment Rights Act (USERRA) protects the job rights (including enrollment rights on employer-provided health care coverage) of individuals who voluntarily or involuntarily leave

employment positions to undertake military service. If you leave your job to perform military service, you have the right to elect to continue existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are re-employed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

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

Medicare Supplement Coverage

We also offer Medicare supplement coverage for those who are eligible for and enrolled in Parts A and B of Medicare. Also, you may be eligible for guarantee-issued coverage under certain Medicare supplement plans if you apply within 63 days of losing coverage under this plan. For more information, contact your producer or our Customer Service Department.

HOW DO I FILE A CLAIM?

MEDICAL CLAIMS

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

Step 1

Complete a separate Subscriber Claim Form for each patient and each provider. You can get a claim form at **premera.com**. You can also call us and we will mail a claim form to you within 10 days.

Step 2

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

- Names of the subscriber and the member who incurred the expense
- Identification numbers for both the subscriber and the Group (these are shown on the subscriber's identification card)
- Name, address and IRS tax identification number of the provider
- Information about other insurance coverage
- Date of onset of the illness or injury
- Diagnosis (ICD) code
- Procedure codes (CPT-4, HCPCS, ADA, or UB-92) for each service
- Dates of service and itemized charges for each service rendered
- If the services rendered are for treatment of an accidental injury, the date, time, location, and a brief description of the accident

Step 3

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

Step 4

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

Step 5

Sign the Subscriber Claim Form in the space provided.

Step 6

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

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

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

The plan won't provide benefits for claims we receive after the later of these two dates, nor will the plan provide benefits for claims which were denied by Medicare because they were received past Medicare's submission deadline. Exceptions will be allowed when required by law or regulation.

PRESCRIPTION DRUG CLAIMS

To make a claim for covered prescription drugs, please follow these steps:

Participating Pharmacies

For retail pharmacy purchases, you don't have to send us a claim. Just show your Premera Blue Cross Blue Shield of Alaska ID card to the pharmacist, who will bill us directly. If you don't show your ID card you'll have to pay the full cost of the prescription and submit the claim yourself. You'll need to fill out a prescription drug claim form, attach your prescription drug receipts and submit the information to the address shown on the claim form.

For mail-order pharmacy purchases, you don't have to send us a claim, but you'll need to follow the instructions on the mail-order form and submit it to the address printed on the form. Please allow up to 14 days for delivery.

Non-participating Pharmacies

If the pharmacy does not submit your claim for you, you will have to pay the full cost for new prescriptions and refills purchased at these pharmacies. You will also need to fill out a prescription drug claim form, attach your prescription drug receipts and submit the information to the address shown on the claim form.

If you need a supply of envelopes or prescription drug claim forms, contact our Customer Service department at the numbers shown on the inside front cover of this booklet.

CLAIMS PROCEDURE

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

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

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

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

If all you have to pay is a copay for a covered service or supply, your payment of the copay to your provider is not considered a claim for benefits. You can call Customer Service to get a paper copy of an Explanation of Benefits for the service or supply. The phone number is on the front cover of your booklet and on your Premera ID card. Or, you can visit our website, **premera.com**, for information and secure online access to claims information. To file a claim, please see the ***How Do I File A Claim?*** section for more detail. If your claim is denied in whole or in part, you may submit a complaint or appeal as outlined under ***Complaints and Appeals*** in this booklet.

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

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

CARE RECEIVED OUTSIDE THE UNITED STATES

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

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

- For professional outpatient services and other care with single dates of service, we use the exchange rate on the date of service
- For inpatient stays of more than one day, we use the exchange rate on the date of discharge

COMPLAINTS AND APPEALS

If at any time you have questions regarding your healthcare, you may contact customer service for assistance. They are here to serve you and answer questions.

If you disagree with a decision we made or feel dissatisfied, and would like us to formally review your concerns, you can file a complaint or appeal with Premera.

WHAT IS A COMPLAINT?

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

How to file a complaint

Call customer service at 800-722-1471 (TTY: 711)

Send a fax to 425-918-5592

Send the details in writing to:

Premera Blue Cross Blue Shield of Alaska
PO Box 91102
Seattle, WA 98111-9202

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

WHAT IS AN APPEAL?

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

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

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

What you can appeal

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

Appeal Levels

You have the right to two levels of appeals:

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

HOW TO SUBMIT AN APPEAL IN WRITING

Step 1. **Get the form**	• Complete the **Member Appeal Form**, you can find it on **premera.com** or call customer service to request a copy. If you need help submitting an appeal, or would like a copy of the appeals process, call customer service at 800-722-1471 (TTY 711)
Step 2. **Collect supporting documents**	• Collect any supporting documents that may help with your appeal. This may include chart notes, medical records, or a letter from your doctor. Within 3 working days, we will confirm in writing that we have your request. • If you would like someone to appeal on your behalf, including your provider, complete a **Member Appeal Form** with authorization, you can find it on **premera.com**. We can't release your information without this form.
Step 3. **Send in my appeal**	To help process your appeal, be sure to complete the form and return with any supporting documents. **Send your documents to:** Premera Blue Cross Blue Shield of Alaska Attn: Appeals Coordinator PO Box 91102 Seattle, WA 98111-9202 Fax to 425-918-5592

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

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

Premera Blue Cross Blue Shield of Alaska
Attn: Appeals Coordinator
PO Box 91102
Seattle, WA 98111
Fax: 425-918-5592

APPEAL RESPONSE TIME LIMITS

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

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

WHAT HAPPENS IF YOU HAVE ONGOING CARE?

Ongoing care is continuous treatment you are currently receiving, such as residential care, care for a chronic condition, in-patient care and rehabilitation.

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

WHAT HAPPENS IF IT'S URGENT

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

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

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

HOW TO ASK FOR AN EXTERNAL REVIEW

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

Step 1. **Complete the form**	**We will send you an External Review Application Form authorizing the release of your medical records to an IRO with the written decision of your internal appeal.** • External appeals are available only for decisions involving a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the service or treatment you received. • You must include the signed **External Review Application Form** you received from us. You may also include medical records and other information.
Step 2.	• Collect any supporting documents that may help with your external review. This may include medical records and other information. • You must file your request for external review with the Alaska Division of Insurance within 180 days of the date you got our internal appeal letter.

Collect supporting documents	You can request an extension of the 180-day deadline by sending the Alaska Division of Insurance a written request that includes the reason why you believe an extension should be granted.
Step 3. **Send in my external review request**	• The Alaska Division of Insurance will provide your request to Premera within one working day. Premera will complete a preliminary review within five working days to determine whether the request is eligible for external appeal. • For urgent external appeals, Premera will complete the preliminary review immediately. Premera will notify you, your authorized representative, and the Alaska Division of Insurance in writing of the results of our preliminary review within one day after we have completed it. • If your request is eligible for external appeal, the Alaska Division of Insurance will assign an IRO to review your appeal. We will forward your medical records and other information to the IRO. If you have additional information on your appeal, you may send it to the IRO. • If the request is not complete, Premera will notify you, your authorized representative, and the Alaska Division of Insurance in writing of what information or materials are needed to make the request complete. • If the request is not eligible for external appeal, Premera will notify you or your authorized representative and the Alaska Division of Insurance in writing of the reasons why the request is not eligible for external review. If you do not agree with this decision, you may appeal to the Director of the Alaska Division of Insurance.

External appeals are also available for decisions related to Premera's compliance with protections established by the No Surprises Act (NSA) such as:

- Cost-sharing and surprise billing for emergency services
- Cost-sharing and surprise billing protections related to care you received from non-participating providers at participating facilities
- Your condition to receive notice and provide informed consent to waive NSA protections; and
- If a claim for care received is coded correctly and accurately reflects the treatments received, and the associated NSA protections related to patient cost-sharing and surprise billing.

These reviews will be referred to CMS for the HHS-Administered Federal External Review Process.

ONCE THE IRO DECIDES

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

Premera will accept the IRO decision.

If the IRO:

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

If you have questions about a denial of a claim or your appeal rights, you may call Customer Service at the number listed on your Premera ID card. Contact the Alaska Division of Insurance at any time during this process if you have any concerns or need help filing an appeal.

Alaska Division of Insurance

550 W 7th Ave., Suite 1560

Anchorage, Alaska 99501-3567

1-800-INSURAK (467-8725) (within Alaska)

1-907-269-7900 (outside Alaska)

Email: **insurance@alaska.gov**

Online: **https://www.commerce.alaska.gov/web/ins/**

OTHER INFORMATION ABOUT THIS PLAN

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

Conformity With The Law

The Group Contract is issued and delivered in the State of Alaska and is governed by the laws of the State of Alaska, except to the extent preempted by federal law. If any provision of the Group Contract or any amendment is deemed to be in conflict with applicable state or federal laws or regulations, upon discovery of such conflict the Group Contract will be administered in conformance with the requirements of such laws and regulations as of their effective date.

Entire Contract

The Entire Contract between the Group and us consists of all of the following.

- The contract face page and “Standard Provisions”
- The Funding Arrangement Agreement between the Group and us
- This benefit booklet
- The Group's signed application
- All attachments, endorsements and riders included or issued hereafter

No representative of Premera Blue Cross Blue Shield of Alaska or any other entity is authorized to make any changes, additions or deletions to the Group Contract or to waive any provision of this plan. Changes, alterations, additions or exclusions can only be done with the signature of an officer of Premera Blue Cross Blue Shield of Alaska.

If there is a language conflict in the contract, the benefit booklet (as amended by any attachments, endorsements or riders) will govern.

Evidence Of Medical Necessity

We have the right to require proof of medical necessity for any services or supplies you receive before benefits are provided under this plan. Members or providers must provide evidence of medical necessity when requested. If this evidence is not provided when required, benefits will not be available.

Group As The Agent

Your Group is your agent for all purposes under this plan and not the agent of Premera Blue Cross Blue Shield of Alaska. Any action taken by your Group will be binding on you.

Health Care Providers - Independent Contractors

All health care providers who provide services and supplies to a member do so as independent contractors. None of the provisions of this contract between Premera and the Group are intended to create, nor shall they be deemed or construed to create, any employment or agency relationship between us and the provider of service other than that of independent contractors.

ID Card

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

Intentionally False Or Misleading Statements

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

If you make any intentionally false or misleading statements on any application or enrollment form that affects your acceptability for coverage, we may, at our option:

- Deny your claim;
- Reduce the amount of benefits provided for your claim; or
- Void your coverage under this plan. (Void means to cancel coverage back to its effective date as if it had never existed at all.) Your coverage cannot be voided based on a misrepresentation you made unless you have performed an act or practice that constitutes fraud; or made an intentional misrepresentation of material fact that affects your acceptability for coverage.

Finally, intentionally false or misleading statements on any group form required by us, which affect the acceptability of the Group or the risks to be assumed by us, may cause the voiding of the Group Contract for this plan. Such recoveries will not be sought more than 365 days from the date we discovered, or could have reasonably discovered the intentionally false or misleading statements.

Legal Action

No action at law or in equity shall be brought to recover under this contract before the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this contract. No action shall be brought after the expiration of three years after the written proof of loss is required to be furnished.

Limitations Of Liability

We're not liable for any of the following:

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

Member Cooperation

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

Notice Of Information Use And Disclosure

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

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

- Underwriting and determining your eligibility for benefits and paying claims (we do not use genetic information for underwriting or enrollment purposes);
- Coordinating benefits with other health care plans;
- Conducting care management, personal health support programs or quality reviews; and
- Fulfilling other legal obligations that are specified under the Group Contract

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

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

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

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

Notice Of Other Coverage

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

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

Notices

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

Recovery Of Claims Overpayments

We have the right to recover amounts we have overpaid in error. Such amounts may be recovered from the subscriber or any other payee, including a provider. Or, such amounts may be deducted from future benefits of the subscriber or any of his or her dependents (even if the original payment wasn't made on that member's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a provider who doesn't have a contract with us.

We will give written notice to the subscriber, or any other payee, including a provider at least 30 calendar days before the insurer seeks recovery of an overpayment. The notice will include how to identify the specific claim and the specific reason for the recovery. You have the right to challenge the recovery of overpayment. Such recoveries will not be sought more than 365 days after adjudication of the original claim.

Right To And Payment Of Benefits

Benefits of this plan are available only to members. Except as required by law, we will not honor any attempted assignment, garnishment or attachment of any right of this plan. In addition, members may not assign a payee for claims, payments or any other rights of this plan.

At our option only and in accordance with the law, we may pay the benefits of this plan to:

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

Payment to any of the above satisfies our obligation as to payment of benefits.

Venue

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

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

Workers' Compensation Insurance

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

WHAT ARE MY RIGHTS UNDER ERISA?

The Group has an employee welfare benefit plan that is subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA). This employee welfare benefit plan is called the “ERISA Plan” in this section. The insured Premera Blue Cross Blue Shield of Alaska plan described in this booklet is part of the ERISA Plan.

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

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

ERISA provides that all plan participants shall be entitled to:

- Examine without charge, at the ERISA Plan administrator's office and at other specified locations (such as work sites and union halls), all documents governing the ERISA Plan, including insurance contracts and collective bargaining agreements. (Please note that our contract with the Group by itself does not meet all the requirements for an ERISA plan document.) If the ERISA Plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to examine a copy of its latest annual report (Form 5500 Series) filed and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the ERISA Plan administrator, copies of documents governing the operation of the ERISA Plan, including insurance contracts and collective bargaining agreements and updated summary plan descriptions. (Please note that this booklet by itself does not meet all the requirements for a summary plan description.) If the ERISA Plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to obtain copies of the latest annual report (Form 5500 Series). The administrator may make a reasonable charge for the copies.
- Receive a summary of the ERISA Plan's annual financial report, if ERISA requires the ERISA Plan to file an annual report. The ERISA Plan administrator for such plans is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there's a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your ERISA Plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. Premera Blue Cross Blue Shield of Alaska is a fiduciary only with respect to claims processing and payment. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

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

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

Please note: Under ERISA, the ERISA Plan administrator is responsible for furnishing each participant and beneficiary with a copy of the Summary Plan Description.

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

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

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

DEFINITIONS

The terms listed below have specific meanings under this plan.

Accepted Rural Provider

A selected provider practicing in a medically under-served area of Alaska. These providers are paid at the highest in-network provider benefit level, however, since there is no contract in effect with these providers you are responsible for amounts above the allowed amount.

Accidental Injury

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

Adverse Benefit Determination

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

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

Affordable Care Act

The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Allowed Amount

The allowed amount shall mean one of the following:

- **Providers In Alaska and Washington Who Have Agreements With Us**

  For any given service or supply, the allowed amount is the lesser of the following:

  - The provider's billed charge; or
  - The fee that we have negotiated as a "reasonable allowance" for medically necessary covered services and supplies.

  Contracting providers agree to seek payment from us when they furnish covered services to you. You'll be responsible only for any applicable deductibles, coinsurance, charges in excess of the stated benefit maximums and charges for services and supplies not covered under this plan.

- **Providers Outside Alaska and Washington Who Have Agreements With Other Blue Cross Blue Shield Licensees**

  For covered services and supplies received outside Alaska and Washington or in Clark County, Washington, allowed amounts are determined as stated in the ***What Do I Do If I'm Outside Alaska And Washington?*** section in this booklet.

- **Providers Who Don't Have Agreements With Us Or Another Blue Cross Blue Shield Licensee**

  The allowed amount shall be defined as indicated below. When you get services from a provider who does not have an agreement with us or another Blue Cross Blue Shield Licensee, you are responsible for any amounts not paid by us, including amounts over the allowed amount except for emergency services as described below.

  For Services and Supplies Received Within Our Service Area

  In determining the allowed amount, we establish a profile of billed charges, using statistically creditable data for a period of 12 months by examining the range of charges for the same or similar service from providers within each geographical area for which we receive claims. The allowable will be no less than 80th percentile of billed charges for that service. If we are unable to obtain sufficient data from a given geographical area, we will use a wider geographical area. If inclusion of the wider geographical area still does not provide sufficient data, we will set the allowed amount to no less than the equivalent of the 80th percentile or no lower than 250% of Medicare allowed amounts for the same services or supplies, whichever is greater.

  Services and Supplies from Professional Providers: The allowed amount will be no less than the 80th percentile of billed charges as determined from a profile derived using the methodology described above.

  Services from Ambulatory Surgical Centers: The allowed amount will be no less than the 80th percentile of billed charges as determined from a profile derived using the methodology described above.

  Services from Skilled Nursing Facilities, Extended Care Facilities, Birthing Centers, Kidney Dialysis Centers, Rehabilitation Facilities, and other Sub-Acute Facilities: The allowed amount will be no less than the 80th percentile of billed charges using the methodology described above.

  Services from Hospitals (Acute Facilities): In determining the allowed amount, we establish a profile of billed charges, using statistically creditable data for a period of 12 months by examining the range of charges for the same or similar service from facilities within each geographical area for which we receive claims. The allowable will be no less than 80th percentile of billed charges for that service. If we are unable to obtain sufficient data from a given geographical area, we will use a wider geographical area. If inclusion of the wider geographical area still does not provide sufficient data, we will set the allowed amount to no less than the equivalent of the 80th percentile or no lower than 250% of Medicare allowed amounts for the same services or supplies, whichever is greater.

- **Providers Outside Our Service Area Who Don't Have Agreements With Us or Another Blue Cross Blue Shield Licensee:**

  The allowed amount will be no less than the 80th percentile of billed charges in the geographical area in which a medical service or supply is received.

- **Dialysis Due To End-Stage Renal Disease**

  Providers Who Have Agreements With Us Or Other Blue Cross Blue Shield Licensees

  The allowed amount is the amount explained above in this definition.

Providers In Alaska Who Don’t Have Agreements With Us Or Another Blue Cross Blue Shield Licensee

The allowed amount will be no less than the 80th percentile of billed charges using the methodology described above.

Providers Outside of Alaska Who Don’t Have Agreements With Us or Another Blue Cross Blue Shield Licensee

The amount the plan allows for dialysis will be no less than 125 percent of the amount allowed by Medicare and no more than 90 percent of billed charges.

Please see the ***Dialysis*** benefit for more details.

- **Non-Emergency Services Protected From Balance Billing**

  For these services, the allowed amount is calculated consistent with the requirements of federal law but no lower than the 80th percentile of charges.

- **Emergency Services**

  The allowed amount for non-participating providers will be calculated consistent with the requirements of federal law but no lower than the 80th percentile of charges

- **Air Ambulance**

  The allowed amount for non-participating air ambulance providers will be calculated consistent with the requirements of federal law but no lower than the 80th percentile of charges.

  Please note: Ground ambulance providers that don't have agreements with us or another Blue Cross Blue Shield Licensee are always paid based on billed charges.

  If you have questions about this information, please call us at the number listed on your Premera Blue Cross Blue Shield of Alaska ID card.

Ambulatory Surgical Center

A facility that's licensed or certified as required by the state it operates in and that meets all of the following:

- It has an organized staff of physicians.
- It has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures.
- It doesn't provide inpatient services or accommodations.

Applied Behavior Analysis

The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including direct observation, measurement and functional analysis of the relationship between environment and behavior to produce socially significant improvement in human behavior or to prevent the loss of an attained skill or function.

Autism Spectrum Disorders

Pervasive developmental disorders or a group of conditions having substantially the same characteristics as pervasive developmental disorders, as defined in the current **Diagnostic and Statistical Manual (DSM)** published by the American Psychiatric Association, as amended or reissued from time to time.

Autism Service Provider

An individual who is licensed, certified, or registered by the applicable state licensing board or by a nationally recognized certifying organization, and who provides direct services to an individual with autism spectrum disorder.

Calendar Year

The period of 12 consecutive months that starts each January 1 at 12:01 a.m. and ends on the next December 31 at midnight.

Clinical Trials

An approved clinical trial means a scientific study using human subjects designed to test and improve prevention, diagnosis, treatment, or palliative care of cancer, or the safety and effectiveness of a drug, device, or procedure used in the prevention, diagnosis, treatment, or palliative care, if the study is approved by the following:

- An institutional review board that complies with 45 CFR Part 46 and
- One or more of the following:
  - The United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers
  - The United States Department of Health and Human Services, United States Food and Drug Administration (FDA)
  - The United States Department of Defense
  - The United States Department of Veterans' Affairs
  - A nongovernmental research entity abiding by current National Institute of Health guidelines

Congenital Anomaly

A marked difference, from the normal structure of a body part that's physically evident at birth.

Cost-share

Member's share of the allowed amount for covered services. Deductibles, copays, and coinsurance are all types of cost-shares. Please see the ***Summary of Your Costs*** to find out what your cost-share is.

Custodial Care

Any portion of a service, procedure or supply that is provided primarily:

- For ongoing maintenance of the member's health and not for its therapeutic value in the treatment of an illness or injury
- To assist the member in meeting the activities of daily living. Examples are help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication not requiring constant attention of trained medical personnel.

Detoxification

Detoxification is active medical management of medical conditions due to substance intoxication or withdrawal, which requires repeated physical examination appropriate to the substance ingested, and use of medication. Observation alone is not active medical management.

Effective Date

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

Eligibility Waiting Period

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

Emergency Services

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

deterioration of the condition is likely to result from or occur during the transfer of the member from a medical facility.

- Ambulance transport as needed in support of the services above

Enrollment Date

For the subscriber and eligible dependents who enroll when the subscriber is first eligible, the enrollment date is the subscriber's date of hire. There's one exception to this rule. If the subscriber was hired into a class of employees to which the Group doesn't provide coverage under this plan, but was later transferred to a class of employees to which the group does provide coverage under this plan, the enrollment date is the date the subscriber enters the eligible class of employees. (For example, the enrollment date for a seasonal employee who was made permanent after six months would be the date the employee started work as a permanent employee.). For subscribers who don't enroll when first eligible and for dependents added after the subscriber's coverage starts, the enrollment date is the effective date of coverage.

Experimental/Investigational Services

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

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

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

Group

A large employer is an employer who employed an average of at least 51 common law employees on business days during the preceding calendar year and who employs at least 51 employees on the first day of the current Contract Term.

In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a large employer will be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

Habilitation Therapy

Habilitative services or devices are medical services or devices provided when medically necessary for development of bodily or cognitive functions to perform activities of daily living that never developed or did not develop appropriately based on the chronological age of the insured. Habilitative services include physical therapy, occupational therapy, and speech-language therapy when provided by a state-licensed or state-certified provider acting within the scope or his or her license. Therapy to retain skills necessary for activities of daily living and prevent regression to a previous level of function is a habilitative service, if medically necessary and appropriate. Habilitative devices may be limited to those that have FDA approval and are prescribed by a qualified provider. Habilitative services do not include respite care, day habilitation services designed to provide training, structured activities and specialized assistance for adults, chore services to assist with basic needs, educational, vocational, recreational or custodial services.

Hospital

A facility legally operating as a hospital in the state in which it operates and that meets the following requirements:

- It has facilities for the inpatient diagnosis, treatment and acute care of injured and ill persons by or under the supervision of a staff of physicians
- It continuously provides 24-hour nursing services by or under the supervision of registered nurses

A “hospital” will never be an institution that's run mainly:

- As a rest, nursing or convalescent home; residential treatment center; or health resort
- To provide hospice care for terminally ill patients
- For the care of the elderly
- For the treatment of substance abuse or tuberculosis

Illness

A sickness, disease, medical condition, complications of pregnancy or pregnancy.

Inpatient

Confined in a medical facility as an overnight bed patient.

Maternity Care

Care furnished during pregnancy (antepartum, delivery and postpartum), including elective abortion, or any condition arising from pregnancy, except for complications of pregnancy. This includes the time during pregnancy and within 45 days following delivery.

Medical Equipment

Mechanical equipment that can stand repeated use and is used in connection with the direct treatment of an illness or accidental injury. It's of no use in the absence of illness or accidental injury.

Medical Emergency

The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. (A “prudent layperson” is someone who has an average knowledge of health and medicine.)

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

Medical Facility (also called “Facility”)

A hospital, skilled nursing facility, state-approved substance abuse treatment program or hospice.

Medically Necessary

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

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

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant

medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

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

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

Network Provider

A provider that is in one of the networks stated in the ***How Does Selecting A Provider Affect My Benefits?*** section.

Orthodontia

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

Orthotic

A support or brace applied to an existing portion of the body for weak or ineffective joints or muscles, to aid, restore or improve function.

Out-of-network or Non-participating Provider

A provider that is not in one of the provider networks stated in the ***How Does Selecting A Provider Affect My Benefits?*** section. Out-of-network providers may also be called "non-participating" or "non-contracted".

Outpatient

A patient receiving treatment in a setting other than as an inpatient in a medical facility.

Participating Pharmacy (Participating Retail/Participating Mail-Order Pharmacy)

A licensed pharmacy which contracts with us or the Pharmacy Benefits Administrator, to provide prescription drugs as specified under the ***Prescription Drugs*** benefit section.

Participating Provider

A provider, who at the time services are received, has a participating contract in effect with us.

Pharmacy Benefits Administrator

An entity that contracts with us to administer prescription drug benefits as specified under the ***Prescription Drugs*** benefit section.

Physician

A state-licensed:

- Doctor of Medicine and Surgery (M.D.)
- Doctor of Osteopathy and Surgery (D.O.)
- Podiatrist (D.P.M.)

Professional services provided by one of the following types of providers will be covered under this plan but only when the provider is licensed to practice where the care is provided, is providing a service within the scope of that license, is providing a service or supply for which benefits are specified in this plan, and when benefits would be payable if the services were provided by a "physician" as defined above:

- An Advanced Nurse Practitioner (A.N.P.)
- A Certified Direct-Entry Midwife
- A Chiropractor (D.C.)
- A Dentist (D.D.S. or D.M.D.)
- A Licensed Clinical Social Worker (L.C.S.W.)
- A Licensed Marital and Family Therapist (L.M.F.T.)
- A Licensed Marriage and Family Counselor (L.M.F.C.)

- A Naturopath (N.D.)
- A Nurse Midwife
- An Occupational Therapist (O.T.)
- An Optometrist (O.D.)
- A Physical Therapist (P.T.)
- A Physician Assistant supervised by a collaborating M.D. or D.O.
- A Psychological Associate
- A Psychologist

Plan (also called “This Plan” or “The Plan”)

The benefits, terms and limitations set forth in this booklet.

Preferred Provider

A provider, who at the time services are received, has a preferred contract in effect with us.

Prescription Drug

Any medical substance, including biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication or for the treatment of people with HIV or AIDS, the label of which, under the Federal Food, Drug and Cosmetic Act, as amended, is required to bear the legend: “Caution: Federal law prohibits dispensing without a prescription.”

Benefits available under this plan will be provided for “off-label” use, including administration, of prescription drugs for treatment of a covered condition when use of the drug is recognized as effective for treatment of such condition by:

- One of the following standard reference compendia:
  - **The American Hospital Formulary Service-Drug Information**;
  - **The American Medical Association Drug Evaluation**;
  - **The United States Pharmacopoeia-Drug Information**; or
  - Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services or the Insurance Commissioner.
- If not recognized by one of the standard reference compendia cited above, then recognized by the majority of relevant, peer-reviewed medical literature (original manuscripts of scientific studies published in medical or scientific journals after critical review for scientific accuracy, validity and reliability by independent, unbiased experts); or,
- The Federal Secretary of Health and Human Services.

“Off-label use” means the prescribed use of a drug that's other than that stated in its FDA-approved labeling.

Benefits aren't available for any drug when the U.S. Food and Drug Administration (FDA) has determined its use to be contra-indicated, or for experimental or investigational drugs not otherwise approved for any indication by the FDA.

Provider (also called “Covered Provider”)

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

Psychiatric Condition

A condition listed in the current **Diagnostic and Statistical Manual (DSM)** published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse.

Service Area

The area in which we directly operate provider networks. This area is made up of the state of Alaska and the state of Washington (except for Clark County).

Skilled Care

Care that's ordered by a physician and requires the medical knowledge and technical training of a licensed registered nurse.

Skilled Nursing Facility

A medical facility providing services that require the direction of a physician and nursing supervised by a registered nurse and that's state-licensed, approved by Medicare or would qualify for Medicare approval if so requested.

Subscriber

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

Subscription Charges

The monthly rates set by us as consideration for the benefits offered in this plan.

Substance Abuse

An illness characterized by physiological or psychological dependency, or both, on alcohol or a state-regulated controlled substance. It's further characterized by a frequent or intense pattern of pathological use to the extent:

- The user exhibits a loss of self-control over the amount and circumstances of use
- The user develops symptoms of tolerance, or psychological and/or physiological withdrawal if use is reduced or discontinued
- The user's health is substantially impaired or endangered, or his or her social or economic function is substantially disrupted

Temporomandibular Joint (TMJ) Disorders

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

Virtual Care

Healthcare services provided through the use of online technology, telephonic and secure messaging of member initiated care from a remote location (e.g. home) or an originating site with a provider that is diagnostic and treatment focused.

Originating site: Hospital, rural health clinic, federally qualified health center, physician’s or other health care provider office, community mental health center, skilled nursing facility, home, or renal dialysis center, except an independent renal dialysis center.

We, Us And Our

Means Premera Blue Cross Blue Shield of Alaska in the state of Alaska and Premera Blue Cross in the state of Washington.

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Discrimination is Against the Law

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

Language Assistance

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

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

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

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

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

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

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

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-508-4722 (TTY: 711).

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

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

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

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.

Телефонуйте за номером 800-508-4722 (телетайп: 711).

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

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

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

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

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

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

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

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

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

where to send claims

MAIL YOUR CLAIMS TO:

Premera Blue Cross Blue Shield of Alaska

P.O. Box 91059

Seattle, WA 98111-9159

MAIL PRESCRIPTION DRUG CLAIMS TO:

Express Scripts
ATTN: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

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