Alaska Radiology Associates

Premera Blue Cross Plus HSA Qualified Silver 3200

1040097

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.

WELCOME

Thank you for choosing Premera Blue Cross Blue Shield of Alaska for your healthcare coverage.

This benefit booklet tells you about this plan's benefits and how to make the most of them. Please read this benefit booklet to find out how your healthcare plan works.

Some words have special meanings under this plan. See ***Definitions*** at the end of this booklet.

In this booklet, the words "we," "us," and "our" mean Premera Blue Cross Blue Shield of Alaska. The words "you," and "your" mean any member enrolled in the plan. The word "plan" means your healthcare plan with us.

Please contact customer service if you have any questions about this booklet or your healthcare plan. We are happy to answer any questions and listen to any of your comments.

On our website at premera.com you can:

- Learn more about this plan
- Find a healthcare provider near you
- Look for information about many health topics

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

We look forward to serving you and your family. Thank you again for choosing Premera.

Group Name:	Alaska Radiology Associates
Effective Date:	January 1, 2024
Group Number:	1040097
Plan:	Premera Blue Cross Plus HSA Qualified Silver 3200
Certificate Form Number:	PBCBSAK SCER (01-2024)

INTRODUCTION

This benefit booklet is for members enrolled in this plan. This benefit booklet describes the benefits and other terms of this plan. It replaces any other benefit booklet you may have received.

The benefits and provisions described in this plan are subject to the terms of the master group contract (contract) issued to the employer. The employer is the firm, corporation or partnership that contracts with us. This benefit booklet is a part of the contract on file at the employer's office.

If any provision of this Plan is superseded by state or federal law, the Plan will comply with the applicable law as it relates to those provisions.

HOW TO USE THIS CONTRACT

Every section in this contract has important information, but you may find that the sections below are especially useful.

How to Contact Us: Our website, phone numbers, mailing addresses, and other contact information.

Summary of Your Costs: A list of your costs for covered services.

Important Plan Information: Describes the applicable cost-shares, out-of-pocket maximums and allowed amount.

How Providers Affect Your Costs: How your choice of a provider affects your benefits and your out-of-pocket costs.

Care Management: Describes prior authorization, clinical review provisions and personal health support programs.

Covered Services: A detailed description of what is covered under this plan.

Exclusions: Services that are limited or not covered under this plan.

Other Coverage: Describes how benefits are paid when you have other coverage or what you must do when a third party is responsible for an injury or illness.

Sending Us A Claim: Instructions on how to send in a claim.

Complaints and Appeals: What to do if you want to share ideas, ask questions, file a complaint, or send in an appeal.

Eligibility and Enrollment: Information on who is eligible for the plan and how to enroll.

Termination of Coverage: When coverage ends under this plan.

Other Plan Information: Lists the general information about how this plan is administered and required state and federal notices.

Definitions: Specific meanings of words and terms used in this plan.

TABLE OF CONTENTS

HOW TO CONTACT US

CUSTOMER SERVICE

Mailing Address:

Premera Blue Cross Blue Shield of Alaska

Physical Address:

3800 Centerpoint Dr, Suite 940
Anchorage, AK 99503-5825

Phone Numbers:

Local and toll-free number:

1-800-508-4722

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

1-800-842-5357

WHERE TO SEND CLAIMS

Mail Your Claims To

Premera Blue Cross Blue Shield of Alaska
P.O. Box 910599
Seattle, WA 98111-9159

PRESCRIPTION DRUG CLAIMS

Mail Your Prescription Drug Claims To

Express Scripts
P.O.Box 747000
Cincinnati, OH 45274-7000

Contact the Pharmacy Benefit Administrator At

1-800-391-9701
www.express-scripts.com

COMPLAINTS AND APPEALS

Premera Blue Cross
Attn: Appeals Coordinator
P.O. Box 91102
Seattle, WA 98111-9202

Local and toll-free number:
1-800-722-1471
Fax: 1-425-918-5592

CARE MANAGEMENT

Prior Authorization
Premera Blue Cross
P.O. Box 91059
Seattle, WA 98111-9159

Local and toll-free number:
1-800-722-1471
Fax: 1-800-843-1114

DENTAL ESTIMATE OF BENEFITS

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

Fax: 1-425-918-5956

BLUECARD

1-800-810-BLUE(2583)

WEBSITE

Visit our website at premera.com for information and secure online access to claims information

SUMMARY OF YOUR COSTS

This is a summary of your costs for covered services.

- 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 allowable charge except for emergency services, covered air ambulance services, or as prohibited by law.
- The **coinsurance**. This is a defined percentage of allowable charges 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".
- The **deductible**. The below amount you pay each calendar year before this plan covers healthcare costs. The amount credited toward the calendar year deductible doesn't include any copays required by this plan and won't exceed the "allowable charge" for any covered service or supply.

	Preferred and Participating INN Providers	**Non-Participating Providers**
Individual Medical Deductible:	$3,200	$6,400

There is a family deductible for services received from out-of-network providers.

Family Medical Deductible:	$6,400	$12,800

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

	Preferred and Participating INN Providers	**Non-Participating Providers**
Individual Out-of-Pocket Maximum:	$7,000	$45,000
Family Out-of-Pocket Maximum:	$14,000	$90,000

- **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.

COVERED SERVICES	YOUR COSTS OF THE ALLOWED AMOUNT		
	PREFERRED INN PROVIDERS	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Acupuncture Limited to 12 visits per calendar year You may have additional costs for hospital facility services. See those covered services for details.	Deductible, then 25% coinsurance		Deductible, then 60% coinsurance
Allergy Testing and Treatment	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Ambulance			
• Emergency ground, water or air ambulance transport	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	In-network deductible, then 25% coinsurance
• Non-emergency ground or water transport			
• Non-emergent air ambulance services, including transfer from one facility to another facility	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Blood Products and Services	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Cellular Immunotherapy and Gene Therapy	Covered as any other service	Covered as any other service	Covered as any other service
Chemotherapy and Radiation Therapy You may have additional costs for hospital facility services. See those covered services for details.	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Clinical Trials and Cancer Clinical Trials			
• Professional and facility services	Covered as any other service	Covered as any other service	Covered as any other service
• Transportation for cancer clinical trials only	Deductible, then 25% coinsurance	In-network deductible, then 25% coinsurance	In-network deductible, then 25% coinsurance
Dental Injury and Facility Anesthesia			
• Dental Anesthesia, when medically necessary	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Dental Injury Limited to services you get within 12 months of the accident.	Covered as any other service	Covered as any other service	Covered as any other service
Diagnostic X-Ray, Lab and Imaging			
• Preventive care screening tests	No Charge	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Basic diagnostic x-ray, lab and imaging	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Major diagnostic x-ray, lab and imaging	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance

COVERED SERVICES	YOUR COSTS OF THE ALLOWED AMOUNT		
	PREFERRED INN PROVIDERS	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Dialysis			
• End-Stage Renal Disease (ESRD) - During Medicare's waiting period	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• End-Stage Renal Disease (ESRD) - After Medicare's waiting period	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Emergency Room			
• Facility services	Deductible, then 25% coinsurance	In-network deductible, then 25% coinsurance	In-network deductible, then 25% coinsurance
• Professional services	Deductible, then 25% coinsurance	In-network deductible, then 25% coinsurance	In-network deductible, then 25% coinsurance
Foot Care			
When medically necessary	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Habilitation Therapy			
Neuropsychological testing to diagnose is not subject to any maximum. See ***Mental Health Care*** for therapies provided for mental health conditions such as autism.			
• Outpatient services to treat non-chronic conditions limited to 45 visits per calendar year.	Deductible, then 25% coinsurance		Deductible, then 60% coinsurance
• Outpatient services to treat chronic conditions unlimited.	Deductible, then 25% coinsurance		Deductible, then 60% coinsurance
• Inpatient services limited to 30 days per calendar year	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Hearing Care			
For hearing loss, often due to age or noise exposure. See ***Office and Clinic Visits*** for hearing loss from disease or injury.			
• Hearing Exam Limited to 1 exam every 2 calendar years	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	In-network deductible, then 20% coinsurance
• Hearing Test Limited to 1 test every 2 calendar years	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	In-network deductible, then 20% coinsurance
• Hearing Hardware Limited to $3,000 every 3 calendar years	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	In-network deductible, then 20% coinsurance
Your cost shares for hearing services do not accrue to the out-of-pocket maximum.			

COVERED SERVICES	YOUR COSTS OF THE ALLOWED AMOUNT		
	PREFERRED INN PROVIDERS	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Home Health Care Limited to 130 visits per calendar year.	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Hospice Care Limited to a lifetime maximum of 6 months. All hospice services are subject to the lifetime maximum. • Unlimited hospice home visits • 10 days of inpatient care • 240 hours of respite care	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Hospital			
• Inpatient Care			
• Facility	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Professional	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Outpatient Care			
• Facility	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Professional	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Infusion Therapy	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Mastectomy and Breast Reconstruction	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Maternity Care Prenatal, postnatal, delivery and inpatient care. See ***Diagnostic X-ray, Lab and Imaging***. For specialty care, see ***Office and Clinic Visits.***	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Medical Foods Metabolic Formula and Low Protein food for Inborn Errors of Metabolism	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Medical Transportation Benefits This plan includes 3 types of Medical Transportation benefits that provide reimbursement as described below. **Medical Transportation – State-Restricted Care** Benefits are limited to members residing in			

COVERED SERVICES	YOUR COSTS OF THE ALLOWED AMOUNT		
	PREFERRED INN PROVIDERS	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
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	Deductible then 0% coinsurance	In-Network Deductible then 0% coinsurance	In-Network Deductible then 0% coinsurance
• To/from provider for medically necessary sexual reassignment surgery	Deductible then 0% coinsurance	Deductible then 0% coinsurance	Deductible then 0% coinsurance
• Calendar year limit: $4,000			
Special criteria are required for travel benefits to be provided. Please see the benefit for coverage details.			
Elective Procedure Travel Cellular Immunotherapy and Gene Therapy travel and lodging benefits are limited to $7,500 per episode of care	Deductible, then 0% coinsurance	In-Network deductible, then 0% coinsurance	In-Network deductible, then 0% coinsurance
Limited to:			
• 1 coach class round trip for the member and medically necessary companion per episode (additional medical travel services may be approved based on medical necessity)			
• Surface transportation and parking limited up to $35 per day. Mileage expenses are reimbursed at 17 cents per mile per trip.			
• Ferry transportation limited up to $50 per person each way			
• Lodging expenses limited up to $50 per day per person			
Reimbursement amounts may be subject to change due to IRS regulations			
Medical Access Transportation	Deductible, then 25% coinsurance	In-network deductible, then 25% coinsurance	In-network deductible, then 25% coinsurance
Limited to:			
• The member needing the transportation			
• For a child under the age 19, this benefit will also cover a parent or guardian to accompany the child			
• 3 round trip coach air or surface transports per medical occurrence per calendar year			

COVERED SERVICES	YOUR COSTS OF THE ALLOWED AMOUNT		
	PREFERRED INN PROVIDERS	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Mental Health Care This benefit covers treatment of mental conditions including services such as physical, speech or occupational therapy. See ***Substance Use Disorder*** for treatment of alcoholism and other substance use disorders.			
• Office or home visits (including virtual care)	Deductible, then 25% coinsurance		Deductible, then 60% coinsurance
• Other professional services	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Outpatient facility services	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Inpatient and residential services	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Newborn Care	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Office and Clinic Visits (including Virtual Care) Includes office, clinic, e-visit and home 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. You may have additional costs for things such as x-rays, lab, therapeutic injections and facility services. See those covered services for details.	Deductible, then 25% coinsurance		Deductible, then 60% coinsurance
Pediatric Care Limited to members under age 19			
Pediatric Dental			
• Class I Services	No Charge	Not Applicable	10% coinsurance, deductible waived
• Class II Services	Deductible, then 30% coinsurance	Not Applicable	Deductible, then 50% coinsurance
• Class III Services (including medically necessary orthodontia for cleft lip and cleft palate)	Deductible, then 50% coinsurance	Not Applicable	Deductible, then 50% coinsurance
Pediatric Vision			
• Exams • Routine exams limited to 1 per calendar year	$25 copay, deductible waived	$25 copay, deductible waived	$25 copay, deductible waived

COVERED SERVICES	YOUR COSTS OF THE ALLOWED AMOUNT		
	PREFERRED INN PROVIDERS	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
• 1 comprehensive low vision evaluation every 5 years; and 4 follow up visits in any 5-calendar year period • Hardware • 1 pair of lenses for glasses or hard contact lenses, or 12-month supply of disposable contact lenses per calendar year • 1 pair of frames per calendar year • Low vision devices, high powered spectacles, magnifiers and telescopes when medically necessary	No Charge	No Charge	No Charge
Premera-Designated Centers of Excellence Program Special criteria are required for coverage. Please see benefit for coverage details. For providers other than Premera-Designated Centers of Excellence, see ***Hospital*** and ***Surgery***.	Deductible, then 0% coinsurance	Covered as any other service	Covered as any other service
Preventive Care Limited to how often you can get services based on your age and gender			
• Routine care, such as exams, screenings, immunizations, contraceptive management and nutritional therapy	No Charge	No Charge	Deductible, then 60% coinsurance
• Seasonal immunizations you get at a pharmacy or other mass immunizer, health education and tobacco cessation programs	No Charge	No Charge	No Charge
Psychological and Neuropsychological Testing	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Rehabilitation Therapy			
• Outpatient services to treat non-chronic conditions limited to 45 visits per calendar year	Deductible, then 25% coinsurance		Deductible, then 60% coinsurance
• Outpatient services to treat chronic conditions, unlimited	Deductible, then 25% coinsurance		Deductible, then 60% coinsurance
• Inpatient services limited to 30 days per calendar year	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Skilled Nursing Facility Care Limited to 60 days per calendar year	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Spinal and Other Manipulations	Deductible, then 25% coinsurance		Deductible, then 60%

COVERED SERVICES	YOUR COSTS OF THE ALLOWED AMOUNT		
	PREFERRED INN PROVIDERS	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Limited to 12 visits per calendar year You may have additional costs for hospital facility services. See those covered services for details.			coinsurance
Substance Use Disorder This benefit covers treatment of alcoholism and other substance use disorders. See ***Mental Health Care*** for coverage of mental health treatment.			
• Office or home visits (including virtual care)	Deductible, then 25% coinsurance		Deductible, then 60% coinsurance
• Other professional services	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Outpatient facility services	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Inpatient and residential services	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Surgery Includes the surgeon, assistant surgeon, and anesthesiology services. You may have additional costs for hospital facility services. See those covered services for details.	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Surgical Center Care - Outpatient	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Therapeutic Injections	Deductible, then 25% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Transplants Donor covered services are limited to $75,000 per transplant.			
• Office Visit	See ***Office and Clinic Visits***	See ***Office and Clinic Visits***	Not covered*
• Other outpatient care services and inpatient services	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance	Not covered*
• $7,500 travel and lodging expenses per transplant	Deductible then 0% coinsurance	In-Network deductible then 0% coinsurance	In-Network deductible then 0% coinsurance
• Mileage expenses are reimbursed at 17 cents per mile per trip			
• Ferry transportation limited up to $50 per person each way			
• Lodging expenses are limited up to $50 per day per person			
Reimbursement amounts may be subject to change due to IRS regulations			

COVERED SERVICES	YOUR COSTS OF THE ALLOWED AMOUNT		
	PREFERRED INN PROVIDERS	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
*All approved transplant centers covered at Preferred INN benefit level.			
Urgent Care Centers			
• Non-hospital urgent care centers	Deductible, then 25% coinsurance		Deductible, then 60% coinsurance
• Urgent care centers attached to or part of a hospital	Deductible, then 25% coinsurance	In-network deductible, then 25% coinsurance	In-network deductible, then 25% coinsurance
Virtual Care Virtual care select providers • General Medical Services • Mental Health • Substance Use Disorder Virtual care select providers can be found at https://www.premera.com/visitor/virtual-care or contact Customer Service for assistance. See the ***Office and Clinic Visits, Mental Health Care*** and ***Substance Use Disorder*** benefits for virtual care benefits.	Deductible, then 25% coinsurance	Not Covered	Not Covered

COVERED PRESCRIPTION DRUGS	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PHARMACIES	OUT-OF-NETWORK PHARMACIES
Prescription Drugs– Retail Pharmacy Limited up to a 90-day supply. Applicable cost-shares apply to each 30-day supply. Per Internal Revenue Service requirements, drug manufacturer coupons and other forms of cost-share assistance cannot be used to satisfy this plan's deductible.		
• Preventive drugs required by health care reform and certain generic drugs to prevent or treat specific conditions.	No Charge	No Charge
• Tobacco cessation drugs, oral generic and single-source brand-name female contraceptive drugs and devices	No Charge	No Charge
• Formulary preferred generic drugs	Deductible, then 25% coinsurance	In-network deductible, then 25% coinsurance
• Formulary preferred brand drugs	Deductible, then 25% coinsurance	In-network deductible, then 25% coinsurance
• Formulary non-preferred drugs	Deductible, then 25% coinsurance	In-network deductible, then 25% coinsurance
• Anti-cancer drugs	Deductible, then 25% coinsurance	In-network deductible, then 25% coinsurance
Prescription Drugs– Mail Order Pharmacy Limited up to a 90-day supply. Applicable cost-shares apply to each 90-day supply. Per Internal Revenue Service requirements, drug manufacturer coupons and other forms of cost-share assistance cannot be used to satisfy this plan's deductible.		
• Preventive drugs required by health care reform and certain generic drugs to prevent or treat specific conditions.	No Charge	Not Covered
• Tobacco cessation drugs, oral generic and single-source brand name female contraceptive drugs and devices	No Charge	Not Covered
• Formulary preferred generic drugs	Deductible, then 25% coinsurance	Not Covered
• Formulary preferred brand drugs	Deductible, then 25% coinsurance	Not Covered
• Formulary non-preferred drugs	Deductible, then 25% coinsurance	Not Covered
• Anti-cancer drugs	Deductible, then 25% coinsurance	Not covered
Prescriptions – Specialty Pharmacy Limited up to a 30-day supply		
• Specialty drugs (specialty or retail pharmacy)	Deductible, then 25% coinsurance	In-network deductible, then 25% coinsurance

COVERED PRESCRIPTION DRUGS	YOUR COSTS OF THE ALLOWED AMOUNT	
	IN-NETWORK PHARMACIES	OUT-OF-NETWORK PHARMACIES
• Specialty drugs requiring special handling, provider coordination, and patient education (available from in-network specialty pharmacy only) Please refer to our website formulary display or contact Customer Service for additional information.	Deductible, then 25% coinsurance	Not applicable

IMPORTANT PLAN INFORMATION

This plan is a Preferred Provider Plan (PPO) and provides you benefits for covered services from providers within the Heritage and Dental Choice network in Alaska.

You have access to:

- Emergency rooms
- Equipment vendors
- Facilities
- One of the many providers included in our network of providers for covered services included in this plan without referral. See ***How Providers Affect Your Costs*** for more information.
- Pharmacies providing covered services throughout the United States and wherever you may travel.
- Surgical centers

ALLOWED AMOUNT

This plan provides benefits based on the allowed amount for covered services. The allowed amount is described below.

- **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 will be responsible only for any applicable cost-sharing, including:

  - Deductibles
  - Copays
  - Coinsurance
  - Charges in excess of the stated benefit maximums
  - 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 amount is determined as stated in ***BlueCard® Program***.

- **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 receive 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.

  Using this methodology, the allowed amount will be the least of the following:

  - In circumstances where the Centers for Medicare and Medicaid Services (Medicare) does not have a rating schedule, we will use an amount that is no less than the lowest amount we allow for the same or similar service from a comparable provider that has a contracting agreement with us.
  - For providers located within our service area, 185% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), if available.
  - For providers located outside our service area, 125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), if available.
  - The provider's billed charges. Ground ambulance providers are always paid based on billed charges.

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

For these services, the allowed amount is calculated consistent with the requirements of federal law.

- **Emergency Services**

The allowed amount for non-participating providers will be calculated consistent with the requirements of the federal law.

You do not have to pay amounts over the allowed amount for emergency services delivered by non-participating providers or facilities.

Note: Non-participating ground ambulances are always paid based on billed charges.

- **Air Ambulance**

The allowed amount for non-participating air ambulance providers will be calculated consistent with the requirements of federal law.

COINSURANCE

Coinsurance is a percentage of healthcare costs you're responsible for. You start paying coinsurance after you pay your deductible. Your plan's coinsurance is shown on the ***Summary of Your Costs***.

COPAY

Copay is fixed amount that you pay at the time of service for each healthcare visit. If this plan includes copays, your provider may ask you to pay the copay at the time of service. See ***Summary of Your Costs*** for any copays required by your plan.

DEDUCTIBLE (CALENDAR YEAR)

The calendar year deductible is the amount you pay each year before this plan starts to pay for covered services. Copays, if any, do not count toward meeting your deductible. Your calendar year deductible amount for this plan is shown on the ***Summary of Your Costs***.

If you and one or more of your dependents are enrolled in this plan, the family deductible applies. If you add or drop dependents from coverage during the calendar year, your calendar year deductible will change to the individual or family calendar year deductible, as appropriate.

Individual Deductible

This plan includes an individual deductible for covered services received from the following providers:

- Preferred INN (In-Network) and Participating providers
- Non-Participating providers

After you have met the individual deductible, this plan will begin paying for your covered services from these providers for the remainder of the calendar year.

Family Deductible

This plan includes a family embedded deductible. Family embedded deductible is the combined individual and family amount your family must pay before this plan will begin paying for your family's covered services received from the following providers:

- Preferred INN and Participating Providers
- Non-Participating Providers

Family deductible is met when the following are true:

- Two enrolled family members meet their individual deductibles
- A combination of several family members meet their deductibles

Once your family meets this deductible, we will consider the family deductible to have been met for the year and this plan will begin paying for covered services for all enrolled family members for the remainder of the calendar year.

The individual and family deductibles are subject to the following:

- Deductibles add up during a calendar year, and renew each year on January 1
- There is no carry over provision. Amounts credited to your deductible during the current year will not carry forward to the next year's deductible.
- Amounts credited to the deductible will not exceed the allowed amount
- Copays (if any) do not apply to the deductible

- Prior authorization penalties do not apply to the deductible
- Amounts credited toward the deductible do not add to benefits with an annual dollar maximum
- Amounts credited toward the deductible accrue to benefits with visit limits and other annual durational maximums
- Per Internal Revenue Service requirements, drug manufacturer coupons and other forms of cost-share assistance cannot be used to satisfy the deductible

BALANCE BILLING PROTECTION

EMERGENCY SERVICES

Emergency services from a Non-Participating hospital or facility or from a non-participating 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

If a non-emergency service from a Non-Participating 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 non-participating 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.

OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is the most you or your family will pay each calendar year for covered services received from any provider before this plan begins to pay 100%. The out-of-pocket maximum is the total amount of deductible, coinsurance and copays (if any) you must pay each year. See the ***Summary of Your Costs*** for your out-of-pocket maximum.

If you add or drop dependents from coverage during the year, your out-of-pocket maximum will change to the family or individual out-of-pocket maximum as required by the change in family status.

Individual Out-of-Pocket Maximum

This plan includes an individual out-of-pocket maximum for covered services received from the following providers:

- Preferred INN and Participating providers
- Non-Participating providers

Once you meet this maximum, the benefits of this plan that are subject to the out-of-pocket maximum will be provided to you at 100% of the allowed amount for covered services for the remainder of the calendar year.

Family Out-of-Pocket Maximum

This plan includes a family out-of-pocket maximum for covered services received by you and one or more of your enrolled family members from the following providers:

- Preferred INN and Participating providers
- Non-Participating providers

Family out-of-pocket maximum is met when the following are true:

- If two enrolled family members meet their individual out-of-pocket maximums
- A combination of several family members meet the out-of-pocket maximums

Once your family meets this maximum, we will consider the family out-of-pocket maximum of all of your enrolled family members to be met for that calendar year. Benefits will then be paid at 100% of the allowed amount for covered services for all of your enrolled family members for the remainder of the calendar year.

Expenses that do not apply to the Individual and Family out-of-pocket maximums include:

- Charges above the allowed amount
- Services above any benefit maximum limit or durational limit
- Services not covered by this plan
- Prior authorization penalties
- Any benefit shown on the ***Summary of Your Costs*** as not applying to the out-of-pocket maximum
- Per Internal Revenue Service requirements, drug manufacturer coupons and other forms of cost-share assistance

Pediatric Dental Services

- **Providers Who Have Signed A Contracting Agreement With Us**
  The allowed amount is the fee that we have negotiated with contracting dental providers.
- **Providers Who Have Not Signed A Contracting Agreement With Us**
  The allowed amount will be the maximum allowed amount in the geographical area where the services were provided. In no case will the allowed amount be higher than the 90th percentile of provider fees in that area where the services are received.

HOW PROVIDERS AFFECT YOUR COSTS

MEDICAL SERVICES

This plan is a Preferred Provider Plan (PPO). That means that this plan provides you benefits for covered services from providers of your choice. Throughout this section you will find information on how to control your out-of-pocket costs and how the providers you see for covered services can affect your plan benefits.

To help you manage the cost of healthcare, we have a network of healthcare providers. You have access to one of the many providers included in our Heritage and Dental Choice network. In Alaska your network includes any provider that has signed a contract with Blue Cross Blue Shield of Alaska. You also have access to qualified practitioners, facilities, emergency rooms, surgical centers, equipment vendors or pharmacies providing covered services throughout the United States and wherever you may travel. See ***BlueCard® Program*** below. Hospitals, doctors and other providers in these networks are called "in-network providers."

A list of network providers is available in our provider directory. These providers are listed by geographical area, specialty and in alphabetical order to help you select a provider that is right for you. We update this directory regularly but it is subject to change. We suggest that you call us for current information and to verify that your provider, their office location or provider group is included in our network before you receive services.

The Heritage and Dental Choice provider directory is available any time on our website at premera.com. You may also request a copy of this directory by calling customer service at the number listed in this benefit booklet or on your Premera ID card. See ***How To Contact Us*** for additional information.

Preferred INN Providers

The Preferred INN providers are part of our Heritage and Dental Choice network, or providers who are a part of a Host Blue's provider network. Preferred INN providers provide medical services at a negotiated fee. This fee is the allowed amount. You also have access to qualified practitioners, facilities, emergency rooms, surgical centers, equipment vendors or pharmacies providing covered services throughout the United States and wherever you may travel. See ***BlueCard® Program*** below.

If a covered service is not available from a Preferred INN provider, you may receive benefits for services provided by a Participating or Non-Participating provider at the Preferred INN provider benefit level. See ***Prior Authorization*** for details.

You do not need a referral from Premera or from any other person for access to specialty care.

In order to receive the highest level of benefits available under this plan for non-emergent services, you must use a Preferred INN provider. Preferred INN providers 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 payments directly to them. Your portion of the charges for covered services you get from Preferred INN providers will be the lowest.

Services you receive in a Preferred INN hospital may be provided by doctors, anesthesiologists, radiologists or other professionals who are not part of our network. When you receive non-emergent services from these providers, the Participating or Non-Participating provider cost-share will apply. You will be responsible for amounts over the allowed amount for services received from Non-Participating providers except for emergency services, covered air ambulance services, or as prohibited by law. Amounts in excess of the allowed amount do not count toward your deductible, coinsurance or out-of-pocket maximum, if any.

Participating Providers

Participating providers are not included in our network, but do have a contract with Premera. Your medical bills will be reimbursed at a lower percentage when you use a Participating provider. This means that your out-of-pocket costs will be higher because your benefit level is lower. You are not responsible for any charges over the allowed amount. These providers also bill us directly for your care.

Non-Participating Providers

Non-Participating providers are not in our provider network and do not have a contract with Premera. This means that your out-of-pocket costs will be the highest because your benefit level is the lowest and you are responsible for any charges over the allowed amount except for emergency services, covered air ambulance services, or as prohibited by law. Amounts in excess of the allowed amount also do not count toward your deductible or coinsurance. You may have to pay for services and send us a claim for reimbursement.

Accepted Rural Providers

Accepted rural providers are providers practicing in a medically under-served area of Alaska. They do not contract with us and are not in our network. Your cost-shares for services you get from these providers are the same as the cost-shares for Preferred INN providers. Because accepted rural providers are not in our network, you must also pay for any charges over the allowed amount except for emergency services, covered air ambulance services, or as prohibited by law. You may also have to pay the provider for services and send us a claim for reimbursement.

Finding a Network Provider

A list of network providers is available in our Heritage and Dental Choice provider directory. These providers are listed by geographical area, specialty and in alphabetical order to help you select a provider that is right for you.

We update this directory regularly and it is subject to change. We suggest that you call us for current information and to verify that your provider, their office location or provider group is included in the Heritage and Dental Choice network before you get services.

The Heritage and Dental Choice provider directory is available any time on our website at premera.com. You may also request a copy of this directory by calling customer service at the number located in this benefit booklet or on your Premera ID card. See ***How To Contact Us*** for additional information.

Special Circumstances

The following services and/or providers will always be covered at the Preferred INN provider benefit level based on the allowed amount:

- Care received from Participating or Non-Participating providers for covered stays at Preferred INN hospitals when you have no choice as to who performs the services
- Certain categories of providers that we do not have contracting agreements
- Emergency services. You may get care in the emergency room from non-participating providers. You will not be balance billed for emergency services provided by a non-participating provider under federal law. See the definition of “Allowed Amount” for more information about allowable amount for emergency services.
- Non-emergency care services received from a Participating or a Non-Participating provider in Alaska when the nearest Preferred INN provider is more than 50 miles from your home. We suggest that you contact us before you receive non-emergency care covered services from a Participating or Non-Participating provider. See ***Prior Authorization*** for additional information.

You must pay your deductibles, copays (if any), coinsurance and any charges over the allowed amount except as prohibited by law.

See ***Prior Authorization*** for more information about requesting the Preferred INN provider benefit level when you receive other covered services from Non-Participating providers.

WHEN YOU RECEIVE CARE IN WASHINGTON

You have access to the Heritage and Dental Choice network of providers when you receive care in Washington. Like Preferred 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.

PROVIDER STATUS

A provider's agreement with us is subject to change at any time. Therefore, it is important to verify a provider's status before you receive services. This will help you avoid additional out-of-pocket costs. You can call our customer service department at the number listed in this booklet to verify a provider's status. See ***How To Contact Us*** for additional information. If you are outside Alaska, Washington or Clark County Washington, call 1-800-810-BLUE (2583) to locate or verify the status of a provider.

If you are seeing a provider and their written agreement with us is terminated while you are receiving pregnancy care or other active treatment, we will consider the provider to still have an agreement with us for the purpose of that care until one of the following occurs:

- The provider's status will change on the date the provider's medically necessary treatment of a terminal condition ends. "Terminal" means that the patient is expected to live less than one year from the date the provider's agreement is terminated.
- This plan is terminated

In all other cases, the provider's status will change on the last of 3 dates to occur:

- The 90th day after the date the provider's agreement is terminated
- The date postpartum care is completed
- The date the current plan year ends

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 are approved 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. Please refer to the ***How Providers Affect Your Costs*** for an illustration about benefit payments. If we deny your request for continuity of care, you may request an appeal of the denial. See ***Complaints and Appeals***.

WHEN YOU ARE OUTSIDE OF ALASKA AND WASHINGTON

If you are outside Alaska and Washington, you may receive covered services from any provider licensed to provide the service. For non-emergent doctor and hospital services in Washington (except Clark County, Washington), you will receive the higher level of benefits available under this plan when you use network doctors and hospitals. Except as stated below, for the same services outside of Alaska and Washington or in Clark County, Washington, you will receive the higher level of benefits available by using doctors and hospitals with PPO agreements with the Blue Cross or Blue Shield Licensee in the area where you are receiving services.

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 (non-contracted providers). This Out-Of-Area Care section explains how the plan pays both types of providers.

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

You're getting services through these Inter-Plan Arrangements does not change what the plan covers, benefit levels, or any stated eligibility requirements. Please call us if your care needs prior authorization.

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.

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.

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.

Non-Contracted 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 the definition of "Allowed Amount" in "Definitions" in this booklet for details on allowed amounts.

In these situations, you may owe the difference between the amounts that the non-contracted provider bills and the payment the plan makes for the covered services as set forth above.

Blue Cross Blue Shield Global® Core
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 Claims Section for more information. However, if you need hospital inpatient care, the Blue Cross Blue Shield Global Core 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.

More 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, go to www.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.

PEDIATRIC DENTAL

An enrolled member under the age of 19 is eligible for pediatric dental. A member is eligible for these services up to the last day of the month following their 19th birthday, as long as all other eligibility requirements are met.

In-Network Dental Providers

This plan is designed to provide the lowest out-of-pocket costs when you receive services from in-network providers. Your claims will be submitted directly to us and available benefits will be paid directly to the pediatric dental care provider. Our in-network dental providers agree to accept our allowed amount as payment in full. When you are outside of the service area, you also have access to a nationwide network of contracted pediatric dental providers who can provide covered pediatric dental.

You are only responsible for your in-network dental cost-shares, and charges for non-covered services. See ***Summary of Your Costs*** for cost-share amounts. For the most current information on dental network providers, see our website at premera.com or contact customer service.

Out-of-Network Dental Providers

Out-of-network dental providers are not in your provider network and do not have a contract with us. These providers can bill you for charges above the allowed amount. If you receive services from out-of-network dental care providers, you'll get the highest out-of-pocket costs under this plan for covered services. You may also have to pay for services and send us a claim for reimbursement. See ***Sending Us a Claim*** for details.

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 program.

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.

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 Preferred INN Cost-Shares For Participating Or Non-Participating Providers** You must get prior authorization in order for the plan to:
   - Cover a Participating or Non-Participating provider in Alaska at the Preferred INN benefit level.

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

How Prior Authorization Works

We will make a decision 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. A prior authorization may not be retroactively denied unless it was based on materially incomplete or inaccurate information provided to us by you or your provider.

1. **Prior Authorization for Benefit Coverage**

   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. See **Medical Prior Authorization List** below. Please contact your in-network provider or Premera customer service before you receive a service to confirm that your service requires prior authorization.

   You can find our medical policies at premera.com.

   - **Preferred INN and Participating providers or facilities** are required to request prior authorization for the service.
   - **Non-Participating and out-of-area 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.

Medical Prior Authorization List The following services and items require prior authorization, including but not limited to:

- **Elective (non-emergent) Air or Ground Ambulance Transport**
- **Experimental or investigational**
- **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, 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
- Surgical treatments for the temporomandibular joint (joint that connects the jaw to the rest of the skull)
- 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)
- 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)
- Vagus nerve blocking therapy (obesity treatment that blocks signals going to the nerve that goes to the stomach)
- 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)
  - 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)

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 and renin inhibitor
- Anorexiants
- Antiandrogens
- Anticholinergics and antispasmodics
- Anticonvulsants
- Antidiarrheals
- Antimalarials
- Antimetabolites
- Antiplatelet drugs
- Antipsoriatic/Antiseborrheic

- Antivertigo and antiemetic agents
- Beta agonists inhalers
- Beta blockers
- Blood derivatives
- Blood glucose monitoring devices and supplies
- Botulinum toxins
- Bowel evacuants
- Combination narcotic/analgesics
- Compounds
- Direct acting miotics
- Drugs with significant changes in product labeling
- Erythroid stimulants
- Estrogen combinations
- Estrogens
- Fluoroquinolones
- Gene therapies and cellular immunotherapies such as CAR-T
- Glucose elevating agents
- Gonadotropin and related agents
- Gout therapy
- Growth hormones (excluding idiopathic short stature without growth hormone deficiency)
- Headache therapy
- Hemostatics
- HIV/AIDS therapy
- Hypnotic agents
- Immunosuppressant drugs
- 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 antineoplastic drugs
- 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
- Myasthenia gravis
- Myeloid stimulants
- Narcotic antagonists
- Narcotics
- Newly FDA-approved drugs
- Non-insulin hypoglycemic agents
- NSAIDS
- NSAIDS-specific Cox II inhibitors
- Osteoporosis therapy
- Other glaucoma drugs
- Proton pump inhibitors
- Radiopharmaceuticals
- 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
- Vasodilators

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 Participating, Non-Participating and Out-Of-Area Provider Coverage**

   Generally, non-emergent care by Participating and Non-Participating providers and providers outside the service area is covered at lower benefit levels. However, you may ask for a prior authorization to cover one of these providers at the Preferred INN level if the services are medically necessary and are available from a Preferred INN provider within 50 miles of your home. You or the Participating, Non-Participating 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 care covered services from a Participating or Non-Participating provider so that we can apply your benefits correctly.

   Note: It is your responsibility to get prior authorization for any services that require it when you see a Participating, Non-Participating or out-of-area provider. If you do not get a prior authorization, the services will not be covered at the Preferred INN benefit level.

   The prior authorization request for a Participating, Non-Participating or out-of-network provider 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 Preferred INN provider, and
   - Medical records needed to support the request.

   If the Participating, Non-Participating, or out-of-area provider's services are authorized, the plan will cover the service at the Preferred INN 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 Preferred or Participating 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 Participating, Non-Participating And Out-Of-Area Providers

   Out-of-network providers can be covered at the Preferred INN 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 a Participating, Non-Participating or out-of-area hospital due to an emergency condition, those services are always covered at the Preferred INN benefit level. We will continue to cover those services until you are medically stable and can safely transfer to a Preferred INN hospital.

   If you choose to stay in the Participating, Non-Participating or out-of-area hospital after you are medically stable and can safely transfer to a Preferred INN 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
- Center for Medicare and Medicaid Services (CMS)
- Industry standards accepted by organizations like the American Medical Association (AMA)
- Other professional societies

You can find our medical policies at premera.com.

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.

COVERED SERVICES

This section describes the services this plan covers. Covered service means medically necessary services (see ***Definitions***) and specified preventive care services you get when you are covered for that benefit. This plan provides benefits for covered services only if all of the following are true when you get the services:

- The provider is working within the scope of their license or certification
- The reason for the service is to prevent, diagnose or treat a covered illness, disease or injury
- The service is not excluded
- The service takes place in a medically necessary setting. This plan covers inpatient care only when you cannot get the services in a less intensive setting.

This plan may exclude or limit benefits for some services. See the specific benefits in this section and ***Exclusions*** for details.

Benefits for covered services are subject to the following:

- Benefit limits
- Coinsurance
- Copays (if any)
- Deductibles
- Prior authorization. Some services must be authorized in writing by us before you get them. For more information, see Prior Authorization.
- Medical and payment policies. These policies are used to administer the terms of this plan. Medical policies are generally used to further define medical necessity or investigational status for specific procedures, drugs, biological 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 on our website at premera.com or by calling customer service.

If you have any questions regarding your benefits and how to use them, call customer service at the number listed in this benefit booklet or on the back of your Premera ID card.

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

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

This benefit does not cover:

Services from an unlicensed ambulance.

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

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

Clinical Trials and Cancer Clinical Trials

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 ***Office and Clinic Visits***, and if you have a lab test it's covered under ***Diagnostic X-ray, Lab and Imaging***.

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 consistent with established standards of care for a certain condition
- 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

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.

Diagnostic X-Ray, Lab and Imaging

The same test can be either Preventive or Diagnostic. If the test was ordered to evaluate a sign, symptom or health concern, it is Diagnostic. 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.

Basic services include:

- 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
- Standard ultrasounds
- Diagnosis and treatment of the underlying medical conditions that may cause infertility

Major services include:

- Computerized Tomography (CT) scan
- High technology ultrasounds
- 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.

Some tests need to be approved before you receive them. See ***Prior Authorization*** for details.

The ***Diagnostic X-ray, Lab and Imaging*** benefit does not cover:

- Preventive screenings and tests. See ***Preventive Care*** for those covered services.
- Diagnostic services from an inpatient facility, an outpatient facility, or emergency room that are billed with other hospital or emergency room services
- Diagnostic surgeries, biopsies and scope insertion procedures. These are covered under ***Surgery*** and

Hospital.

- Testing required for employment, schooling, screening or public health reasons that is not for the purpose of treatment.
- Allergy tests. These services are covered under ***Allergy Testing and Treatment***.

Dialysis

When you have end stage renal disease (ESRD) you may be eligible to enroll in Medicare. If eligible, it is recommended 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.

As soon as you are enrolled in Medicare Part B, Premera will pay your Medicare Part B premiums. Premera will continue to pay these premiums for as long as you are enrolled in this plan and eligible for Medicare due to ESRD.

For non-participating providers during Medicare's waiting period, the allowed amount is 300% of the fee schedule determined by the Center for Medicare and Medicaid Services (Medicare). After Medicare's waiting period, the allowed amount for non-participating providers inside our service area is 185% of the fee schedule determined by the Center for Medicare and Medicaid Services. The allowed amount for non-participating providers outside of our service area after Medicare's waiting period is 125% of the fee schedule determined by the Center for Medicare and Medicaid Services. If the dialysis services are provided by a non-participating provider and you do not enroll in Medicare, you will owe the difference between any billed charges and the payment the plan will make for the covered services.

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. This includes emergency services arising from complications from a service that was not covered by the plan.
- Diagnostic tests performed with other emergency services
- Medically necessary 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 non-participating providers. You will not be balance billed for emergency services provided by a non-participating 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 it puts the member at risk
- Treatment of corns, calluses and toenails

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

Habilitation Therapy

This plan covers medically necessary and appropriate services and devices 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 member.

Habilitative services include:

- Habilitative devices that have been approved by FDA and prescribed by a qualified provider.
- Massage therapy. If provided by massage therapist who is not licensed by the state, the services must be billed by a supervising doctor to be covered.
- Occupational therapy
- Physical therapy

- Speech language therapy

The outpatient visit limit listed in the ***Summary of Your Costs*** applies to non-chronic conditions. It does not apply to chronic conditions such as cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions or diseases.

This benefit does not cover:

- Chore services to assist with basic needs
- Custodial care
- Day habilitation services designed to provide training, structured activities and specialized assistance
- Educational, vocational and recreational services
- Respite care
- Treatment for mental health care or substance use disorders. See ***Mental Health Care*** or ***Substance Use Disorder*** for those covered services.

Hearing Care

This plan covers hearing exams and hardware.

Hearing Exams

Hearing exam services include:

- Examination of the inner and exterior of the ear
- Observation and evaluation of hearing, such as whispered voice and tuning fork
- Case history and recommendations
- Hearing testing services including the use of calibrated equipment

Hearing Hardware

Before you receive your hearing hardware benefit:

- You must be examined by a licensed doctor before obtaining hearing aids, and
- You must purchase a hearing aid device

Covered services include:

- A follow-up consultation within 30 days following delivery of the hearing aids with either the prescribing doctor or audiologist
- A warranty
- Ear molds
- Hearing aid instruments
- Hearing aids (monaural or binaural) prescribed as a result of the examinations
- Hearing aid rental while the primary unit is being repaired
- Initial batteries, cords, and other necessary ancillary equipment
- One audiologic (hearing) examination and hearing evaluation by a certified or licensed audiologist, including a follow-up consultation.
- One otologic (ear) examination by a doctor
- Repairs, servicing, and alteration of hearing aid equipment

This benefit does not cover:

- Batteries or other ancillary equipment other than that obtained upon purchase of the hearing aids
- Expenses incurred after your coverage ends under this plan unless hearing aids were ordered prior to that date and were delivered within 90 days after the day your coverage ended
- Hearing aid charges in excess of this benefit are not eligible under this plan's other benefits
- Hearing aids purchased prior to your effective date of coverage on this plan
- Hearing aids which exceed the specifications prescribed for correction of hearing loss
- Replacement of a hearing aid for any reason more often than once in a three consecutive calendar year period

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.

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 for members age 19 and older 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

Medical vision hardware for members under age 19 is covered under pediatric vision in ***Pediatric Care***.

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, lancets, test strips, testing agents and alcohol swabs. These services are covered under the ***Prescription Drugs***.
- 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

This plan covers hospice care. The benefit limit shown on the ***Summary of Your Costs*** may be extended for an extra 6 months when medically necessary for your condition.

All inpatient hospice care requires prior authorization from us before you receive treatment. See ***Prior Authorization*** for details.

Covered services include:

- Continuous home care during a period of crisis in which you require skilled intervention to achieve palliation or management of acute medical symptoms
- Home health aide services for personal care, maintenance of a safe and healthy environment and general support to the goals of the plan of care
- Home medical equipment, medical supplies and devices, including medications used primarily for the relief of pain and control of symptoms related to the terminal illness
- Medical social services provided by a medical social worker who is working under the direction of a doctor; this may include counseling for the purpose of helping you and your caregivers to adjust to the approaching death
- Nursing care provided by or under the supervision of a registered nurse
- Palliative care for members facing serious, life-threatening conditions, including expanded access to home based care and care coordination. Participation in palliative care is usually approved for 12 months at a time and may be extended based on the member's specific condition.
- Rehabilitation therapies provided for purposes of symptom control or to enable you to maintain activities of daily living and basic functional skills
- Services provided by a qualified provider associated with the hospice program
- Short term inpatient care provided in a hospice inpatient unit or other designated hospice bed in a hospital or skilled nursing facility. This care may be for the purpose of occasional respite for your caregivers, or for pain control and symptom management.

This benefit does not cover:

- Custodial care
- Nonmedical services, such as housekeeping, dietary assistance or spiritual bereavement, legal or financial counseling
- Over the counter (OTC) drugs, solutions and nutritional supplements
- Services provided to someone other than the ill or injured member
- Services provided by family members or volunteers
- Services, supplies or providers not in the written plan of care or not named as covered in this benefit
- Services that provide food, such as Meals on Wheels or advice about food

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

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 You may not be balance billed for certain services by a non-participating provider as prohibited by federal 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

This benefit covers doctors and facility charges for prenatal care, delivery and postnatal care. The hospital stay for the mother is covered up to 48 hours for a vaginal delivery or up to 96 hours following a cesarean section. A length of stay that will be longer than these limits must be prior authorized. See ***Prior Authorization*** for details.

If you reside in states where laws prohibit access to abortion services, travel to a provider in another state may be covered. See ***Medical Transportation*** Benefits for details.

Home birth and birthing center services are also covered. The services must be provided by a licensed women's health care provider who is working within their license and scope of practice.

This benefit does not cover:

- Complications of pregnancy. These services are covered as other medical conditions and benefits are based on the type of services you get. For example, office visits are covered as shown under Office and Clinic Visits.
- Home birth services provided by family members or volunteers
- Donor breast milk
- Outpatient x-ray, lab and imaging. These services are covered under ***Diagnostic X-Ray, Lab and Imaging***.

Medical Foods

Medical foods are foods that are specially prepared to be consumed or given directly into the stomach by feeding tube 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 three types of 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 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 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 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 is required.

This benefit provides reimbursement of certain travel costs up to IRS guidelines for members who reside in Alaska and travel outside of the state 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 airfare from a licensed commercial carrier.
- Ferry transportation expenses for the member and a companion from the member's home community
- 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 member's personal automobile are covered based on IRS guidelines
- One roundtrip 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 services will be provided

If the member using the Medical Travel Support benefit is a child (under age 19), one companion is automatically permitted. However, a second companion will only be permitted if medically necessary.

See the ***Summary of Your Costs*** for the current reimbursement rates.

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 and current reimbursement amounts.

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.

Note: Companion travel and lodging expenses are only covered if they must, as a matter of medical necessity or safety, accompany the member.

You may choose to pay for travel and lodging services up front and submit a claim for reimbursement. See ***How To File an Elective Travel Claim Form*** below 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 before contacting us and receiving prior authorization.
- Travel for ineligible medical procedures
- Travel in a mobile home, RV, or travel trailer
- Travel to providers outside the network

How To File An ElectiveTravel Claim Form:

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 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 copy of the detailed itinerary as issued by the airline, transportation carrier, travel agency or online travel website. The itinerary must identify the name(s) of the passenger(s), the dates of travel and total cost of travel, and the origination and final destination points.
- A reference number for travel, you can find this on the approval letter we sent to you
- Receipts for all covered travel expenses
- The boarding pass and a copy of the ticket from the airline or other transportation carrier. The tickets must indicate the name(s) of the passenger(s), dates and total cost of travel, and the origination and final destination points

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, only when the closest in-network provider is located in Seattle, Washington. Prior authorization is 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.

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:

- A statement or letter from your doctor attesting to the medical necessity of the services you received that required the air or surface travel.
- Complete a Medical Access Transportation Claim Form. A separate Medical Access Transportation Claim Form is needed for each patient and each commercial carrier or transportation service used. You can get a Medical Access Transportation Claim Form on our website at premera.com. You can also call us for a copy of the form.
- Attach one of the following forms of documentation:
  - A copy of the detailed itinerary as issued by the airline, transportation carrier, travel agency or online 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.
  - A copy of the ticket from the airline or other transportation carrier. The ticket must show the name of the passenger(s), dates and total cost of travel, and the origination and final destination points.

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

In addition to "What's Not Covered?" this Medical Access Transportation benefit doesn't cover:

- First-class airline fees
- Meals and lodging
- 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.

Benefits are limited to the least costly treatment setting that is medically necessary for your condition. This plan complies with federal mental health parity requirements.

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

This benefit covers all of the following services:

- Applied behavior analysis (ABA) for the treatment of autism
- Biofeedback
- Individual, family or group therapy
- Inpatient, residential treatment, partial hospitalization and outpatient therapeutic visits to manage or reduce the effects of the mental health condition
- Lab and testing
- Physical, speech and occupational therapy provided to treat a mental health condition, including autism spectrum disorders
- Services received from individuals supervised by an autism service provider treating autism spectrum disorders. See ***Definitions*** for description of autism service providers.
- Take-home drugs you get in a facility

For this benefit, "outpatient therapeutic visit" means a clinical treatment session with a mental health provider including virtual care. Outpatient therapeutic visits can include real-time visits with your doctor or other provider via telephone, online chat or text, or other electronic methods (telemedicine).

Applied Behavioral Analysis (ABA) Therapy

This plan covers Applied Behavioral Analysis (ABA) Therapy. The member must be diagnosed with one of the following disorders:

- Asperger's disorder
- Autistic disorder
- Autism spectrum disorder
- Childhood disintegrative disorder

- Pervasive developmental disorder
- Rett's disorder

Benefits must be provided by:

- A physician (MD or DO) who is a psychiatrist, developmental pediatrician, or pediatric neurologist
- A state-licensed psychiatric nurse practitioner (NP), advanced nurse practitioner (ANP) or advanced registered nurse practitioner (ARNP)
- A state-licensed mental health clinician (e.g., licensed clinical social worker, licensed marriage and family counselor, licensed mental health counselor)
- A state-licensed occupational or speech therapist when providing ABA services
- A state-licensed psychologist
- Any other provider with appropriate training in behavioral analysis, or whose scope of licensure includes behavioral analysis
- Board Certified Behavior Analyst (BCBA), licensed in states with behavior analyst licensure, otherwise, certified by the Behavior Analyst Certification Board
- Licensed Community Mental Health or Behavioral Health agency that is also state certified for ABA
- Other providers, including therapy assistants/behavioral technicians/ paraprofessionals; when supervised and billed by a licensed provider or Board-Certified Behavioral Analyst (BCBA)

Covered services include:

- Direct treatment or direct therapy services for identified patients and/or family members when provided by a licensed provider, Board Certified Behavioral Analyst (BCBA), or therapy assistants who are supervised by a licensed provider or BCBA.
- Also covered when performed by a licensed provider or BCBA:
  - Communication/coordination with other providers or school personnel
  - Initial evaluation/assessment
  - Supervision of therapy assistants
  - Treatment review and planning

Note: Delivery of all ABA services for an individual may be managed by a BCBA or licensed provider who is called a Program Manager.

See the ***Substance Use Disorder*** benefit for coverage of treatment for alcoholism and other substance use conditions.

See the ***App-based Care*** benefit for coverage of telephonic, electronic, or on-line services (virtual care).

Newborn Care

This plan covers newborn hospital nursery care and includes pediatrician services. Benefits for the newborn services are subject to the newborn's cost-shares. The hospital stay for the newborn is covered up to 48 hours for a vaginal delivery or up to 96 hours following a cesarean section. Prior authorization is not required. However, we suggest that you let us know of the newborn's admission as soon as reasonably possible.

Newborn children of a covered member are covered from the moment of birth. See the dependent eligibility and enrollment guidelines under ***Eligibility and Enrollment*** for details.

Covered newborn care services include the following:

- Circumcision
- Hospital nursery care
- Newborn hearing screening exams. Your costs for these services depend on where the services are received. If the newborn is tested in the hospital, you pay your cost-share for hospital services. For office visits, you pay the ***Office and Clinic Visits*** cost-share. For diagnostic services, you pay the cost-share for ***Diagnostic X-Ray, Lab and Imaging***.
  - One screening within 30 days of the date of birth
  - A diagnostic hearing evaluation for children up to age 24 months if the newborn screening shows an impairment

This benefit does not cover:

- Outpatient x-ray, lab and imaging. These services are covered under ***Diagnostic X-Ray, Lab and Imaging***.
- Routine outpatient well baby care. See ***Preventive Care*** for those covered services

Office and Clinic Visits

This plan covers professional office, home visits, including virtual care and real-time visits online or telephonic methods (telemedicine) as shown in the ***Summary of Your Costs***. The visits can be for examination, consultation and diagnosis of an illness or injury. Please call customer service for help in finding a physician approved to provide these services. You may have to pay a separate copay (if any), or coinsurance for other services you get during a visit. This includes services such as x-rays, lab work, therapeutic injections and office surgeries. Some outpatient services you get must have prior authorization. See ***Prior Authorization*** for details.

This benefit covers all of the following:

- Primary care provider visits
- 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 only when provided by an approved provider and all of the following are true:
  - The doctor has been approved for e-visits by us
  - You have been treated by the doctor before and have established a patient-physician relationship with that specific doctor
  - The e-visit is medically necessary

    You can call us at the number listed on the back of your Premera ID card for help finding a doctor approved to provide e-visits.
- Prostate, colorectal and cervical cancer exams, unless they meet the guidelines for preventive care
- Biofeedback for migraines and other conditions that are not considered experimental and investigational
- Second opinions for covered medical conditions or treatment plans

This benefit does not cover:

- EEG biofeedback or neurofeedback services
- Facility charges. When you get care at a hospital-based clinic or hospital-based doctor's office, you must pay your deductible and coinsurance for the facility charges. See ***Hospital*** for those costs.
- Home health or hospice care visits. See ***Home Health Care*** and ***Hospice Care*** for those covered services.
- Mental health services including biofeedback services. See ***Mental Health Care*** for those covered services.
- Surgical services. See ***Surgery*** for those covered services.

Pediatric Care

This plan covers vision and dental services for covered children up to age 19. A child is eligible for these services up to the end of the month following the child's 19th birthday, when all eligibility requirements are met.

Pediatric Dental

This plan covers pediatric dental services until the end of the month of a member's 19th birthday, when all eligibility requirements are met.

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

This plan covers dental services if all of the following are true:

- They must be dentally or are medically necessary (see ***Definitions***)
- They must be named in this plan as covered
- They must be provided by a licensed dentist (DMD or DDS) or denturist. Services may also be provided by a dental hygienist under the supervision of a licensed dentist, or other individual, performing within the scope of his or her license or certification, as allowed by law.

- They must not be excluded from coverage under this benefit.

At times we may need to review diagnostic materials such as dental x-rays to determine your available benefits. We will request these materials directly from your dental provider. If we are not able to obtain the necessary materials, we will provide benefits only for those dental services we can verify as covered.

Alternative Benefits

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

Dental Estimate of Benefits

You can ask for a ***Dental Estimate of Benefits*** before you receive dental services. A ***Dental Estimate of Benefits*** verifies your eligibility and benefits for you and your provider. It may also clarify what is covered or not covered. This can protect you from unexpected out-of-pocket expenses.

A ***Dental Estimate of Benefits*** is not required for you to receive your dental benefits. However, we suggest that your dental care provider submit an estimate to us for any proposed dental services in which you are concerned about your out-of-pocket expenses.

Our ***Dental Estimate of Benefits*** is not a guarantee of payment. Payment of any service will be based on your eligibility and benefits available at the time you received services. See ***How to Contact Us*** for the address and fax for an estimate of benefits, or call customer service.

Dental care coverage includes the following:

Class I – Diagnostic and Preventive Services

- Collection and preparation of genetic sample for laboratory analysis is limited to once per lifetime
- Genetic test and analysis for susceptibility to diseases is limited to once per lifetime
- Routine comprehensive, periodic and non-routine oral evaluations, including problem focused oral evaluations are limited to 2 per calendar year
- Covered x-rays or images include:
  - 2D or 3D oral/facial photographic images
  - Bitewing x-rays are limited to 2 per calendar year
  - Either a complete series (full-mouth series) x-ray or panoramic films once every 60 months but not both
  - Periapical, occlusal, and cephalometric x-rays
- Diagnostic casts (study models)
- Fixed and removable space maintainers
- Re-cement or re-bond space maintainers
- Interim caries medicament on permanent teeth is limited to once per tooth every 36 months
- Interpretation of diagnostic image by a provider that is not associated with capture of the image including report
- Prophylaxis (cleanings) are limited to 2 per calendar year
- Sealants on permanent molars, preventive resin restorations on permanent teeth, and sealant repair on permanent teeth are limited to once per tooth every 36 months
- Topical application of fluoride (including fluoride varnish) is limited to 2 treatments per calendar year

Class II – Basic Services

- Adjustment to complete and partial dentures when performed 6 or more months after the initial installation of the denture
- Cleaning and inspection of removable complete and partial dentures once every 6 months
- Collection and application of autologous blood concentrate product is limited to once every 36 months
- Diagnostic professional consultation provided by a dentist or physician other than the requesting dentist or physician

- Emergency palliative treatment. We require a written description and/or office records of services provided
- Endodontic services include:
  - Partial pulpotomy for apexogenesis on permanent teeth
  - Therapeutic pulpotomy
  - Pulpal therapy (resorbable filling) is covered for members up to age 11 and is limited to once per tooth in a lifetime
- Fillings, consisting of amalgam and resin-based composite, on any tooth surface
- Non-surgical periodontal services include:
  - Full mouth debridement is limited to once per lifetime
  - Periodontal maintenance following periodontal therapy is limited to 4 visits every 12 months
  - Periodontal scaling and root planing are limited to once per quadrant every 24 months
- Oral surgery includes:
  - Alveoloplasty
  - Bone replacement grafts for ridge preservation
  - Excision of pericoronal gingiva
  - Incision and drainage of abscess (intra oral soft tissue)
  - Removal of exostosis
  - Simple and surgical extractions (includes local anesthesia and routine postoperative care)
  - Surgical access of an unerupted tooth
  - Suture of wound up to 5 cm
  - Tooth reimplantation/stabilization of accidentally evulsed or displaced tooth
  - Treatment of post-surgical complications due to unusual circumstances
- Pin retention in addition to restoration
- Prefabricated stainless steel crowns and prefabricated porcelain crowns are covered for members under age 15 and limited to once per tooth every 60 months
- Protective restoration (sedative filling)
- Re-cement or re-bond crowns, inlays, onlays, veneers, indirectly fabricated or prefabricated post and cores
- Reline and rebase of dentures are limited to once every 36 months when performed 6 or more months after the initial installation of the denture
- Repair and re-cement fixed partial dentures (bridges)
- Repair to complete and partial dentures
- Therapeutic drug injections provided in the dental office
- Tissue conditioning

Class III – Major Services

- Crowns, onlays, and labial veneers when there is significant loss of clinical crown and no other dentally appropriate restoration will restore function is limited to once per tooth every 60 months
  - Crown core buildup when done in conjunction with a covered crown when there is significant loss of clinical crown and no other dentally appropriate restoration will restore function is limited to once per tooth every 60 months
  - Crown, inlay, onlay, and veneer repair
  - Inlays will be reduced to the corresponding amalgam filling allowance
  - Prefabricated post and core in addition to crown
- Dentures and fixed partial dentures (bridges) are limited to once every 60 months
- Endodontic services include:
  - Apexification/recalcification
  - Apicoectomy/periradicular surgery

  - Endodontic therapy (root canal)
  - Hemisection
  - Pulpal regeneration
  - Retreatment of previous endodontic therapy (root canal)
  - Root amputation
- General anesthesia or intravenous conscious sedation
- Implants, implant services, and implant supported prosthetics including abutments are subject to dental necessity and limited to once every 60 months
- Occlusal guard (nightguard) designed to minimize the effects of bruxism or other occlusal factors for members age 13 and older and is limited to once every 12 months
- Occlusal guard adjustments for members age 13 and older is limited to once every 24 months
- Periodontal surgery includes:
  - Bone replacement graft and soft tissue allograft is limited to once every 36 months
  - Osseous surgery, gingivectomy or gingivoplasty, and gingival flap procedures are limited to once every 36 months
  - Clinical crown lengthening
  - Pedical, subepithelial and free soft tissue grafts
- Resin infiltration of incipient smooth surface lesions is limited to once every 36 months

Orthodontia Services

Orthodontia services are covered only for medically necessary conditions, such as cleft palate or cleft lip. We recommend that you get a Dental Estimate of Benefits. This benefit does not cover cosmetic orthodontia services.

This benefit does not cover:

- Analgesia, anxiolysis, inhalation of nitrous oxide
- Analysis of saliva
- Anatomical crown exposure
- Appliance removal
- Behavior management
- Biopsy of hard and soft oral tissue
- Bone grafts when done in connection with extractions or apicoectomies
- Caries test
- Case presentation
- Cleaning of appliances
- Cone beam, MRI or ultrasounds
- Connector bar
- Coping
- Direct and indirect pulp caps
- Duplicate appliances
- Enamel microabrasion, odontoplasty internal and external bleaching
- Endodontic implant
- Evaluation for deep sedation or general anesthesia
- Gold foils
- Harvest of bone for use in grafting procedures
- House, extended care facility and hospital calls
- Intentional re-implantation
- Intraoral placement of a fixation device not in conjunction with a fracture

- Local, regional block, trigeminal division block anesthesia, and non-intravenous conscious sedation
- Maxillofacial prosthetics, including fluoride gel carrier
- Nutritional and tobacco counseling
- Occlusal orthotic devices
- Occlusal orthotic device adjustment
- Occlusion analysis and limited and complete occlusal adjustments
- Oral pathology laboratory
- Oral tests and examinations except those listed in the “Covered Section” of this contract
- Oral hygiene instructions for control of dental disease
- Periodontal splinting and/or crown and bridgework in conjunction with periodontal splinting
- Precision attachments, personalization, precious metal bases and other specialized techniques
- Plaque control programs including home fluoride kits
- Post removal
- Pulp vitality tests
- Radical resection of maxilla or mandible
- Re-evaluations
- Removal of foreign body and removal of reaction producing foreign bodies
- Removal of space maintainer
- Services received or ordered when this plan is not in effect, or when you are not covered under this plan (including services and supplies started before your coverage effective date or after the date coverage ends
- Sialography
- Sialolithotomy, excision of salivary gland, sialodochoplasty and closure of salivary fistula
- Sinus augmentation
- Stress breakers and athletic mouth guards
- Surgical excision of soft tissue lesions
- Surgical placement of temporary anchorage devices
- Surgical procedure for isolation of tooth with rubber dam, canal preparation and fitting of preformed dowel or post
- Temporary, interim or provisional services for crowns, bridges or dentures
- Temporomandibular Joint (TMJ) services
- Tomographic survey

Pediatric Vision

This plan covers routine eye exams and glasses as follows:

- Contact lenses in lieu of lenses for glasses, including those required for medical reasons
- Glasses, frames and lenses
- Low vision devices, high powered spectacles, magnifiers and telescopes when medically necessary
- Low vision evaluation and follow up visits by an ophthalmologist or an optometrist
- Sales tax, shipping and handling charges for vision hardware
- Vision exams by an ophthalmologist or an optometrist. A vision exam may consist of external and ophthalmoscopic examination, determination of the best corrected visual acuity, determination of the refractive state, gross visual fields, basic sensorimotor examination and glaucoma screening.

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 one day 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 one day 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 one day 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.

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.

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 Transportation benefits: Medical Access Transportation or Elective Procedure Travel.

Prescription Drugs

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

This plan also covers prescription drugs 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:

- One of the following standard reference compendia:
  - Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services or the Insurance Commissioner
  - The American Hospital Formulary Service-Drug Information
  - The American Medical Association Drug Evaluation
  - The United States Pharmacopoeia-Drug Information
- 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)
- The Federal Secretary of Health and Human Services

"Off-label use" means the prescribed use of a drug that is other than that stated in its FDA-approved labeling.

Benefits are not 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.

Pharmacy Management

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

- A specific number of days' supply 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 criteria, 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.

Prescription Drug Formulary

This benefit uses a specific list of covered prescription drugs, 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 in our drug lists. The drug lists are updated quarterly based on the committee's recommendations.

The formulary includes preferred generic drugs, preferred name drugs and non-preferred drugs. Consult the Pharmacy Benefit Guide or RX search tool listed on our website at premera.com. You can also call customer service for a complete list of this plan's covered prescription drugs.

Drugs not included in the formulary are not covered by this plan.

You or your provider may request that you get a non-formulary drug or a dose that is not on the drug list either in writing, electronically, or by telephone. Under some circumstances, such as the ones listed below, a non-formulary drug may be covered if one of the following is true:

- The formulary drug or dose is not safe or effective for your condition
- There is no formulary drug or alternative available
- You cannot tolerate the formulary drug

Your provider must give us a written or oral statement providing a justification in support of the need for the non-formulary drug to treat your condition, including a statement that all covered formulary drugs on any tier will be (or have been) ineffective, would not be as effective as the non-formulary drug, or would have adverse side effects. We will review your request and let you know in writing if it is approved. An expedited review will be completed within 24 hours, and a standard review will be completed within 72 hours. During this review process, the drug will be covered. If approved, your cost will be as shown on the ***Summary of Your Costs*** for formulary preferred generic and formulary non-preferred brand name drugs, and will be covered for the duration of the prescription. If your request is not approved, the drug will not be covered.

Expedited Exceptions Request for Non-Formulary Drugs

If exigent circumstances exist, you or your provider may request that you get a non-formulary drug or a dose that is not on the drug list. Exigent circumstances include when you are suffering from a health condition that may seriously jeopardize your life, health or ability to regain maximum body function or when you are undergoing a current course of treatment using a non-formulary drug. In addition to your provider's justification for the non-formulary drug as described above, your provider will need to give us an oral or written statement that confirms that an exigency exists, including the basis for the exigency (the harm that could reasonably come to you if the requested non-formulary drug was not provided within the timeframes of the standard Exceptions Request).

External Review for Non-Formulary Drugs

If you disagree with our decision, you may ask for an additional review by an independent review organization (IRO). We will let you and your provider know the decision within 72 hours (24 hours in the case of an expedited exception) of the IRO's receipt of the request. See ***Complaints and Appeals***.

If your provider determines that a generic FDA drug approved for female contraception is medically inappropriate for you based upon the provider's determination of medical necessity, your cost for a preferred brand name or non-preferred name drug prescribed in its place will be covered the same as formulary preferred generic drugs.

If you disagree with our decision you may ask for an appeal. See ***Complaints and Appeals*** for details.

Covered Prescription Drugs

- Anti-cancer drugs
- Compound drugs when the main drug ingredient is a covered prescription drug
- Drugs associated with an emergency medical condition (including drugs from a foreign country)
- Drugs for nicotine dependency
- Drugs for shots that you give yourself
- FDA approved formulary prescription drugs. Federal law requires a prescription for these drugs. They are known as "legend drugs."
- FDA approved oral contraceptive drugs and devices such as diaphragms and cervical caps
- Glucagon emergency kits
- Human growth hormone drugs when medically necessary
- Inhalers, supplies and peak flow meters
- Needles, syringes and alcohol swabs you use for shots
- Oral drugs for controlling blood sugar levels, insulin and insulin pens
- Throw-away diabetic test supplies such as test strips, testing agents and lancets

Anti-Cancer Medications

This benefit covers medications that are injected or intravenously administered by your doctor and 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***.

Diabetic Injectable Supplies

Whether injectable diabetic drug needles and syringes are purchased along with injectable diabetic drugs or separately, the deductible and applicable cost-share applies to all items. The deductible and applicable cost-share also applies to purchases of alcohol swabs, test strips, testing agents and lancets.

Dispensing Limits

Benefits are limited to a certain number of days' supply as shown in the ***Summary of Your Costs***. Sometimes a drug maker's packaging may affect the supply in some other way. We will cover a supply greater than normally allowed under this plan if the packaging does not allow a lesser amount. You must pay your applicable cost-share for each limited days' supply.

Preventive Drugs

Certain outpatient generic drugs are included in the prescription drug benefit and are covered as shown on the ***Summary of Your Costs***. These include drugs required by federal health care reform and certain preferred

generic drugs that are taken regularly by a member for disease prevention or to prevent the reoccurrence of a specific disease or condition.

You can get a list of covered preventive generic drugs by calling customer service at the number shown on the ***How To Contact Us*** or by:

- Logging into your secure website at premera.com and visiting ***My Plan Information*** for a list of preventive drugs required by federal health care reform. This list includes drugs such as aspirin, folic acid and certain supplements. These drugs require a prescription and may be limited to a certain age, condition, dosage or type.
- Logging into your secure website at premera.com and go to the pharmacy section for the HSA Preventive Drug list. This list includes generic medications used to lower cholesterol; prevent heart disease; treat a recovered heart attack or stroke victim; and treat diabetes.

Using In-Network Pharmacies

When you use a network pharmacy, always show your Premera ID Card. As a member, you will not be charged more than the allowed amount for each prescription or refill. The pharmacy will also submit your claims to us. You only have to pay the deductible, copay (if any) or coinsurance as shown in the ***Summary of Your Costs***.

If you do not show your Premera ID Card, you will be charged the full retail cost. Then you must send us your claim for reimbursement. Reimbursement is based on the allowed amount. See ***Sending Us a Claim*** for instructions.

Specialty Pharmacy Programs

The Specialty Pharmacy Program includes drugs that are used to treat complex or rare conditions.

Specialty drugs are high-cost often self-administered injectable drugs. We contract with a specialty pharmacy that specializes in these drugs.

Some of these drugs need special handling, storage, administration, or patient monitoring and therefore must be filled at our in-network specialty pharmacy. Drugs that may only be filled at our in-network specialty pharmacy are identified on our website formulary display.

Visit the pharmacy section of our website at premera.com or call customer service for more information.

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.

Drug Discount Programs

Premera may receive drug rebates or discounts.

- Your benefit programs include per-claim rebates that Premera receives from its pharmacy benefit manager or other vendors. We consider these rebates when we set the subscription charges, or we credit them to administrative charges that we would otherwise pay. These rebates are not reflected in your allowed amount.
- We also may receive discounts from our pharmacy benefit manager or other vendors. These discounts are reflected in your allowed amount. If the allowed amount for prescription drugs is higher than the price we pay after our discount, then Premera does one of two things with this difference:
  - We keep the difference and apply it to the cost of our operations and the prescription drug benefit program.
  - We credit the difference to premium rates for the next benefit year

If your benefit includes a copay, coinsurance calculated as a percentage, or a deductible, the amount you pay and your account calculations are based on the allowed amount.

Refills

Benefits for refills will be provided when the member has used 75% of a supply of a single medication. The 75% is based on all of the following:

- The number of units and days' supply dispensed on the last refill.
- The total units or days' supply dispensed for the same medication 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 of 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.

This benefit does not cover:

- Any prescription refill beyond the number of refills shown on the prescription or any refill after one year from the original prescription
- Drugs and medicines that you can legally buy over the counter (OTC) without a prescription. OTC drugs are not covered even if you have a prescription. Examples include, but are not limited to, nonprescription drugs and vitamins, herbal or naturopathic medicines, and nutritional and dietary supplements such as infant formulas or protein supplements. This exclusion does not apply to OTC drugs that are required to be covered by state or federal law.
- Biological, blood or blood derivatives
- Drugs dispensed for use in a healthcare facility or provider's office or take-home medications. Exceptions to this exclusion are injectable drugs for self-administration such as insulin and glucagon and growth hormones drugs when medically necessary.
- Drugs for cosmetic use such as for wrinkles
- Drugs from out-of-network specialty pharmacies
- Drugs to promote or stimulate hair growth
- Drugs to enhance fertility or to treat sexual dysfunction of organic origin
- Growth hormones to stimulate growth, except when it meets medical standards, or for treatment of idiopathic short stature without growth-hormone deficiency
- Immunizations. See ***Preventive Care***.
- Infusion therapy drugs or solutions, drugs requiring parenteral administration or use, and injectable medications. Exceptions to this exclusion are injectable drugs for self-administration such as insulin and glucagon and growth hormones drugs when medically necessary. See ***Infusion Therapy*** for covered infusion therapy services.
- Lost or stolen medication
- Non-formulary generic and brand name drugs
- Therapeutic devices or appliances. See ***Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies***
- Weight management drugs

Preventive Care

Preventive care is 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 provider 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 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:

- Approved tobacco habit breaking programs recommended by your doctor. After you have completed the program, please provide us with proof of payment and a completed reimbursement form. You can get a reimbursement form on our website at premera.com. See Prescription Drugs for covered drug benefits.
- Colon cancer screening for those who are considered high risk individuals under 45 years of age, or individuals 45 years of age or older, as recommended by the American Cancer Society. Includes pre-colonoscopy consultations, exams, colonoscopy, sigmoidoscopy and fecal occult blood tests. Removal and pathology (biopsy) related to polyps found during a screening procedure are covered as part of the preventive screening. Includes anesthesia your doctor considers medically appropriate for you.
- Colonoscopies as follow-up to a positive non-invasive stool-based screening test.
- Contraceptive management. Includes exams, treatment you get at your provider's office, prescribed generic emergency contraceptives, and prescribed contraceptive supplies and devices. Tubal ligation and implanted devices (including removal) are also covered. See ***Prescription Drugs*** for prescribed oral contraceptives and devices.
- Depression screening, including screening for adults and pregnant/postpartum women
- Diabetes screening
- Electric breast pumps and supplies. Includes the purchase of a non-hospital grade breast pump or rental of a hospital grade breast pump. The cost of the rental cannot be more than the purchase price. For electric breast pumps and supplies purchased at a retail location you will need to pay out of pocket and submit a claim for reimbursement. See ***Sending Us a Claim*** for instructions.
- Health education and training for covered conditions such as diabetes, high cholesterol and obesity. Includes outpatient self-management programs, training, classes and instruction.
- Nutritional therapy. Includes outpatient visits with a doctor, nurse, pharmacist or registered dietitians. The purpose of the therapy must be to manage a chronic disease or condition such as diabetes, high cholesterol and obesity. The number of therapy visits that are covered as preventive depends on your medical needs.
- Obesity screening and counseling for weight loss
- Outpatient lab and radiology for preventive screening and tests
- Pregnant women's services such as diabetic supplies, breast feeding counseling before and after delivery and maternity diagnostic screening
- Pre-exposure (PrEP) for members at risk for HIV infection
- Preventive drugs required by federal law. See ***Prescription Drugs***.
- Professional services to prevent falling for members who are 65 years and older and have a history of falling or mobility issues
- Prostate cancer screening. Includes digital rectal exams and prostate-specific antigen (PSA) tests. Annual tests for prostate cancer for those who are considered high risk men under 40 years of age, or men 40 years of age and older, or as recommended by a doctor.
- Removal of contraceptive devices approved by the U.S. Food and Drug Administration (FDA)
- Routine exams, also included are exams for school, sports and employment
- Cervical cancer screenings: Annual pap smear cancer screening test for a person who is 18 or more years of age.
- Routine immunizations and vaccinations as recommended by your doctor. These include seasonal, travel, and certain other immunization provided by a pharmacy or other mass immunizer location. You can also get flu shots, flu mist, and immunizations for shingles, pneumonia and pertussis (whooping cough) at a pharmacy or

other seasonal immunization center. If you use an out-of-network provider for seasonal and travel immunizations you may need to pay out of pocket and submit a claim for reimbursement. See ***Sending Us a Claim*** for instructions.

- Screening mammograms, including 3-D mammograms. See ***Diagnostic X-ray, Lab and Imaging*** for mammograms needed because of a medical condition.
- Well-baby care, including those provided by a qualified health aide from birth to three years
- Well child care, including care provided by a qualified health aide, from four to eighteen years.

This Preventive Care benefit does not cover:

- Gym memberships or exercise classes and programs
- Inpatient newborn exams while the child is in the hospital following birth. See the ***Newborn Care*** for those covered services.
- 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

Psychological and Neuropsychological Testing

Covered services include interpretation and report preparation needed to prescribe an appropriate treatment plan. This includes later re-testing to make sure the treatment is achieving the desired medical results.

Coverage for autism spectrum disorders includes services received from individuals supervised by an autism service provider (see ***Definitions***).

This benefit does not cover:

- Physical, speech or occupational assessments and evaluations for rehabilitation. See ***Rehabilitation Therapy*** or ***Mental Health Care*** for those covered services.
- Physical, speech or occupational therapy assessments related to neurodevelopmental disabilities. See ***Habilitation Therapy***.

Rehabilitation Therapy

This plan covers medically necessary inpatient and outpatient rehabilitation therapies. Rehabilitative therapy services or devices are provided when medically necessary for the restoration of bodily or cognitive functions lost due to a medical condition. These services must be provided by a state-licensed or state-certified provider acting within the scope of their license or certification.

Covered services include all of the following:

- Assessments and evaluation related to rehabilitative therapy
- Massage therapy
- Physical, speech, and occupational therapies
- Rehabilitative devices that have been approved by the FDA and prescribed by a qualified provider

Note: Cardiac rehabilitation, pulmonary rehabilitation and chronic pain care are covered as any other medical condition and do not accrue to rehabilitation therapy limits.

Inpatient Care

You must get inpatient care in a specialized rehabilitative unit of a hospital or in a separate rehabilitation facility. If you are already in inpatient care, this benefit will start when your care becomes mainly rehabilitative.

You must get prior authorization from us before you get inpatient treatment. See ***Prior Authorization*** for details.

This plan covers inpatient rehabilitative therapy only when all of the following are true:

- You cannot get the services in a less intensive setting
- You get the services within 24 months after the injury occurred, the date the illness started, or the date of the surgery that made you need rehabilitation
- The care is part of a written plan of treatment to be provided by several specialists. A doctor specializing in rehabilitative medicine prescribed this treatment plan and reviews it regularly.

Outpatient Care

This plan covers these services only when all of the following are true:

- Services are provided and billed by a hospital, a rehabilitation facility approved by us, or another licensed provider
- The therapy is a part of a formal written treatment plan prescribed by a doctor
- You are not staying in a hospital or other medical facility.

A "visit" is one session of treatment for each type of therapy. Each type of therapy counts toward the combined benefit maximum limit listed in the ***Summary of Your Costs***. If you have two or more therapy sessions in one day with the same provider, it counts as one visit.

The outpatient visit limit listed in the ***Summary of Your Costs*** applies to non-chronic conditions. It does not apply to chronic conditions such as cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions or diseases.

This benefit does not cover:

- Custodial care
- Exercise programs
- Gym or swim therapy
- Inpatient rehabilitative therapy received more than 24 months after the accidental injury, the start of the illness, or the date of surgery
- Maintenance therapy, therapy performed to maintain a current level of functioning without documentation of significant improvement
- Neurodevelopmental therapy or treatment of developmental or neurodevelopmental disabilities. See ***Habilitation Therapy*** for details.
- Recreational, vocational, or educational therapy
- Social or cultural therapy
- Treatment for mental health conditions or substance use disorders. See ***Mental Health Care*** and ***Substance Use Disorder*** for those covered services.
- Treatment that the ill, injured, or impaired member does not actively take part in
- Outpatient rehabilitation therapy virtual care is not covered by this plan.

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 Use Disorder

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 (including virtual care) and outpatient visits 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 (telemedicine).

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

This benefit does not cover:

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

Surgery

This plan covers inpatient and outpatient surgical services at a hospital or ambulatory surgical facility, surgical suite or provider's office. Some inpatient and outpatient surgeries must be prior authorized before you have them. See ***Prior Authorization*** for details.

Services of an assistant surgeon are covered as stated in the ***Summary of Your Costs*** 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.

Sometimes more than one procedure is done during the same surgery. These may be two separate procedures or the same procedure on both sides of the body. In these cases, benefits for the main procedures will be based on the allowed amount for the first or main procedure. Benefits for the secondary procedure will be one half of the allowed amount for the main procedure.

Covered services include, but not limited to:

- Abortions, elective and medically necessary
- Anesthesia or sedation and postoperative care, as medically necessary
- Biopsies and scope insertion procedures such as endoscopies
- Blood transfusion, including blood derivatives
- Cochlear implants, including bilateral implants
- Colonoscopy and sigmoidoscopy services when needed because of a medical condition and that do not meet the preventive guidelines
- Cornea transplants and skin grafts
- Reconstructive surgery that is needed because of an injury, infection or other illness
- Sexual reassignment surgery if medically necessary and not for cosmetic purposes
- The repair of a dependent child's congenital anomaly

- Vasectomy

This benefit does not cover:

- Breast reconstruction. See ***Mastectomy and Breast Reconstruction*** for those covered services.
- Routine colonoscopy, sigmoidoscopy and barium enema screening. See ***Preventive Care*** for details.
- The use of an anesthesiologist for monitoring and administering general anesthesia for endoscopies, colonoscopies and sigmoidoscopies unless medically necessary when specific medical conditions and risk factors are present
- Transplant services. See ***Transplants*** for details.

Note: If you reside in states where laws prohibit access to abortion services or medically necessary sexual reassignment surgery, travel to a provider in another state may be covered. See Medical Transportation Benefits for details.

Surgical Center Care - Outpatient

Benefits are provided for services and supplies furnished by an outpatient surgical center or ambulatory surgical facility.

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 plan covers transplant services. These services are covered only when they are provided at an approved transplant center. An approved transplant center is a hospital or other provider that Premera Blue Cross Blue Shield of Alaska has approved for solid organ transplants or bone marrow or stem cell reinfusion. Please call us as soon as you learn you need a transplant. Some services require prior authorization from us before you get treatment. See ***Prior Authorization*** for details.

Covered Transplants

This plan covers only transplant procedures that are not considered experimental or investigational for your condition. Solid organ transplants and bone marrow/stem cell reinfusion procedures must meet coverage criteria. We review the medical reasons for the transplant, how effective the procedure is and possible medical alternatives. This plan covers the following types of transplants:

- Bone marrow (autologous and allogeneic)
- Double lung
- Heart
- Heart/double lung
- Kidney
- Liver
- Pancreas
- Pancreas with kidney
- Single lung
- Stem cell (autologous and allogeneic)

This benefit does not include cornea transplants or skin grafts. It also does not include transplants of blood or

blood derivatives (except bone marrow or stem cells). These procedures are covered the same way as other covered surgical procedures; see ***Surgery***.

Recipient Costs

This plan covers services from an approved transplant center and related professional services. This benefit also provides coverage for anti-rejection drugs given by the transplant center.

Covered services consist of all phases of treatment:

- Evaluation
- Follow up treatment
- Pre-transplant care
- Transplant

Donor Costs

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

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

Transportation and Lodging

This plan covers costs for transportation and lodging for the member getting the transplant (while not confined) and one companion. The member getting the transplant must live more than 50 miles from the facility, unless treatment protocols require them to remain closer to the transplant center.

Travel Allowances: Travel is reimbursed between the patient's home and the facility for round trip (air, train, or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking and toll costs are reimbursed. Mileage expenses will be based on the current IRS medical mileage reimbursement on the date(s) the expenses were incurred. See the ***Summary of Your Costs*** to find out what the reimbursement rates are.

Lodging Allowances: Expenses incurred by a transplant patient and companion for hotel lodging away from home is reimbursed based on current IRS guidelines on the date(s) the expenses were incurred. See the ***Summary of Your Costs*** to find out what the reimbursement rates are.

Companions:

Companion travel and lodging expenses are only covered if the companion must, as a matter of medical necessity, accompany the member. If the member receiving the transplant is a child (up to age 19), one companion is automatically permitted, however 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, or contact customer service for additional information and the current reimbursement amounts.

This benefit does not cover the following:

- Alcohol/tobacco
- Car rental
- Donor costs for a transplant that is not covered under this benefit or when the recipient is not a member
- Donor costs that may be covered by other group or individual coverage
- Entertainment (such as movies, visits to museums, additional mileage for sightseeing, etc.)
- Expenses for persons other than the patient and his/her covered companion
- Meals
- Nonhuman or mechanical organs that are experimental or investigative
- Personal care items (such as: shampoo, deodorant, etc.)
- Planned blood storage for more than 12 months for possible future use
- Services that will be paid by any government, foundation, or charitable grant. This includes services performed on potential or actual living donors or recipients and on cadavers.

- Souvenirs (such as t-shirts, sweatshirts, toys, etc.)
- Telephone calls
- Transplants or related services from a provider not approved by us

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

Urgent care centers can be part of a hospital or not. See the ***Summary of Your Costs*** for information about each type of center you may visit.

Virtual 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 ***Office and Clinic Visits*** 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.

EXCLUSIONS AND LIMITATIONS

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 a Non-Participating provider.

Assisted Reproduction

Assisted reproduction technologies, including but not limited to:

- Drugs to treat infertility or that are required as part of assisted reproduction procedures
- Artificial insemination or assisted reproduction methods, such as in-vitro fertilization. It does not matter why you need the procedure.
- Services to make you more fertile or for multiple births
- Reversing sterilization surgery

Benefits from other sources

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

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

Benefits that have been exhausted

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

Broken or missed appointments

Caffeine Dependency

Charges for records or reports

Charges from providers for supplying records or reports that aren't requested by Premera for utilization review.

Complications of a non-covered service

Includes follow-up services or effects of those services.

Cosmetic Services

Drugs, services or supplies for cosmetic services not medically necessary.

Counseling, Education or Training

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

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

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

Custodial services that are not covered hospice care services.

Dental Care

Dental care or supplies, that are not covered under any dental benefits.

EEG biofeedback or neurofeedback services

Environmental Therapy

Therapy designed to provide a change or controlled environment.

Experimental or Investigational Services

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

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

Family Members or Volunteers

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

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

Government Facilities

Services provided by a state or federal facility that are not emergency services or 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

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, including any related civilian forces or units

Non-Covered Services

Services or supplies:

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

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

Non-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 conditions. Examples are prisons, nursing homes, and juvenile detention facilities.

Orthodontia

Orthodontic services including casts, models, x-rays, photographs, examinations, appliances, braces and retainers.

Orthognathic Surgery

Procedures to lengthen or shorten the jaw. Orthognathic surgery is not covered other than for treatment of the following:

- Temporomandibular joint disorder due to illness or injury which meet the criteria of our medical policy
- Sleep apnea, or
- Congenital anomaly

Personal comfort or convenience items

This plan does not cover:

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

Provider's License or Certification

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

Recreational, Camp and Activity Programs

Recreational, camp and activity-based programs. These programs are not medically necessary and include:

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

Serious Adverse Events and Never Events

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

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

Members and this plan are not responsible for payment of services provided by in-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. In-network providers may not bill members for these services and members are held harmless.

Not all medical errors are defined as serious adverse events or never events. You can obtain a list of serious

adverse events by contacting us or on the Centers for Medicare and Medicaid Services (CMS) website.

Services or Supplies Not Medically Necessary

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

Sexual Dysfunctions

Diagnosis and treatment of sexual dysfunctions, regardless of origin or cause, surgical, medical or psychological treatment of impotence or hypoactive sexual desire disorder, 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)

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 Exams

Routine vision exams to test visual acuity and/or to prescribe any type of vision hardware for members 19 and older.

Vision Hardware

Vision hardware (and their fittings) used to improve visual sharpness, including eyeglasses and contact lenses and related supplies for members 19 and older. This plan never covers eyeglasses or contact lenses or other special purpose vision aids (such as magnifying attachments), sunglasses or light-sensitive lenses, even if prescribed.

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 results of these treatments.

Voluntary Support Groups

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

Weight Loss Surgery or Drugs

Surgery, drugs or supplements for weight loss or weight control.

Work-Related Illness or Injury

Any illness or injury for which you can get benefits under:

- Separate coverage for injuries on the job, even if you did not have to buy it
- Worker's compensation laws
- Any other law that will repay you for an illness or injury you get from your job

OTHER COVERAGE

Note: If you participate in a Health Savings Account (HSA) and have other healthcare coverage that is not a high deductible health plan as defined by IRS regulations, the tax deductibility of the Health Savings Account contributions may not be allowed. Contact your tax advisor or HSA plan administrator for more information.

Coordinating Benefits With Other Plans

If you have other health plan coverage, this plan will work with other group or individual plans so that both plans

may share a part of the costs.

All of the benefits of this plan are subject to coordination of benefits.

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

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

Coordination of Prescription Claims

If this plan is the secondary plan as described below, you must submit your pharmacy receipts attached to a completed claim form for reimbursement. Please send the information to the address listed under Secondary Prescription Claims included on the prescription drug claim form.

If you need a supply of envelopes or prescription drug claim forms, contact customer service at the number located on the back of your ID card.

Definitions Applicable To Coordination Of Benefits

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

- **Allowable Medical Expense** means the usual, customary and reasonable charge for any medically necessary health care service or supply provided by a licensed medical professional when the service or supply is covered at least in part under this plan. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense.
- **Allowable Dental Expense** means the usual, customary and reasonable charge for any dentally necessary service or supply provided by a licensed dental professional when the service or supply is covered at least in part under this plan. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense.
- **Medical Plan** means all of the following health care coverages, even if they do not 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 does not include workers' compensation.
  - Group student coverage that's sponsored by a school or other educational institution and includes medical benefits for illness or disease
- **Dental Plan** means all of the following dental care coverages, even if they do not 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 is also important to note that for the purpose of this plan, we will coordinate benefits for allowable medical expenses separately from allowable dental expenses, as separate plans.

Effect On Benefits

An important part of coordinating benefits is determining the order in which the plans provide benefits. One plan

is responsible for providing benefits first. This is called the “primary” plan. The primary plan provides its full benefits as if there were no other plans involved. The other plans then become “secondary.” When this plan is secondary, it will reduce its benefits for each claim so that the benefits from all medical plans aren’t more than the allowable medical expense for that claim and the benefits from all dental plans aren’t more than the allowable dental expense for that claim. Coordination of benefits applies only on a per-claim basis, and is not cumulative.

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

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

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

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

Right of Recovery/Facility of Payment

Sometimes we pay more than we should under COB. When that happens, we have the right to recover any amount we overpaid. We may recover these amounts from your provider, other insurance companies, service plans, or other organizations. Also, if another plan makes a payment that we should have made, we have the right to pay the other plan directly. Our payment will be considered a benefit under this plan.

We will provide a minimum of 30 calendar days’ notice of the recovery. You have the right to challenge the recovery.

We will not initiate any recovery more than 365 days after the original claim is settled, unless we have a clear and documented reason to believe that fraud was committed or there was other intentional misconduct.

Coordinating Benefits With Medicare

If you are 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 is not primary, we will 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 is a party other than you or us. This party includes a UIM carrier because it stands in the shoes of a third-party tort feasor and because we exclude coverage for such benefits.

Definitions: The following terms have specific meanings in this contract:

- **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 this plan. Because we have paid for your illness or injuries, we are entitled to recover those expenses.
- **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.

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 of your damages in the recoveries that you receive. Our right of recovery is not subject to reduction for 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. Exceptions will be allowed when required by law or regulation. 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.

Uninsured and Underinsured Motorist/Personal Injury Protection Coverage

We have the right to be reimbursed for benefits provided, but only to the extent that benefits are also paid for such services and supplies under the terms of a motor vehicle uninsured motorist and/or underinsured motorist (UIM) policy, personal injury protection (PIP) or similar type of insurance or contract.

SENDING US A CLAIM

A claim is a request to an insurance company for payment of amount due. Many providers will send claims to us directly. When you need to send a claim to us, follow these simple steps:

Step 1

Complete a claim form. You can get claim forms by calling customer service or you can print them from our website at premera.com. You can also call us and we will mail a claim form to you within 10 days.

Be sure to use a separate claim form for each member and each provider.

Step 2

Attach the bill that lists the services you received. Your claim must show all of the following information:

- Name of the subscriber and the member who received the services
- Date of service and charges for each service
- Diagnosis (ICD) code. You must get this from your provider.
- Identification numbers for both the subscriber and the Group (these are shown on your identification card)
- Name, address, and IRS tax identification number of the provider
- Procedure codes (CPT or HCPCS). You must get these from your provider.

Step 3

If you are also covered by Medicare, attach a copy of the Explanation of Medicare Benefits.

Step 4

Check to make sure that all the information from Steps 1, 2, and 3 is complete. Your claim will be returned if all of this information is not included.

Step 5

Sign the claim form.

Step 6

Mail your claims to the address listed in this benefit booklet. See ***How To Contact Us*** for additional information.

Prescription Drug Claims

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

Participating Pharmacies

For participating pharmacy purchases, you do not have to send us a claim. Just show your ID card to the pharmacist, who will submit the claim information directly to us. If you do not show your ID card you will need to fill out a prescription drug claim form, attach your prescription drug receipts and send in the information to the address shown on the claim form.

For mail-order pharmacy purchases, you do not have to send us a claim, but you will need to follow the instructions on the mail-order envelope and send it to the address printed on the envelope. Please allow up to 14 days for delivery.

Non-Participating Pharmacies

For non-participating pharmacy purchases, you will have to send us a claim. You will need to fill out a prescription drug claim form, attach your prescription drug receipts and send the information to the address shown on the claim form.

Timely Payment of Claim

You should submit all claims within 365 days of the date you received services. No payments will be made by us for claims received more than 365 days after the date of service. Exceptions will be made if we receive documentation of your legal incapacitation. Payment of all claims will be made within the time limits required.

Notice Required for Reimbursement and Payment of Claims

In accordance with federal and state law, we may pay the benefits of this plan to the eligible member, provider, other carrier, or other party legally entitled to such payment under federal or state medical child support laws, or jointly to any of these. Such payment will discharge our obligation to the extent of the amount paid so that we will not be liable to anyone aggrieved by our choice of payee.

Claim Procedure for Groups Subject to the Employee Retirement Income Security Act of 1974 (ERISA)

We will make every effort to review your claims as quickly as possible. We process claims in the order in which we receive them. We will send a written notice to you no later than 30 days after we receive your claim to let you know if this plan will cover all or part of the claim.

Note: If your provider requires a copay when you receive medical services or supplies, it is not considered a claim for benefits. However, you always have the right to request and obtain from us a paper copy of your explanation of benefits in connection with such a medical service by calling customer service. The phone number is on the ***How To Contact Us*** section 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, see ***Sending Us A Claim*** for more information. If your claim is denied in whole or in part, you may submit a complaint or appeal as outlined under ***Complaints and Appeals*** section.

If your claim is denied, in whole or in part, our written notice (see ***Notices***) will include:

- A description of any additional information needed to reconsider your claim and why the information is needed
- A description of the plan's complaint or appeal processes
- A statement that you have the right to submit a complaint or appeal
- The reasons for the denial and a reference to the plan provisions used to decide your claim

If there were clinical reasons for the denial, you will receive a letter from us stating these reasons.

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.

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 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 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, see ***Sending Us A Claim*** for more information.

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.

If you are dissatisfied with our denial of your claim you may submit a complaint as outlined under ***Complaints and Appeals***.

Some services and supplies covered under this plan require prior authorization. See ***Prior Authorization*** for additional information.

Claims for 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 U.S. dollars for claims processing. We use a national currency converter (available at www.oanda.com) as follows:

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

COMPLAINTS AND APPEALS

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

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

What Is A Complaint?

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?

A request to review a specific decision or 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.

	To help process your appeal, be sure to complete the form and return with any supporting documents.
Step 3. **Send in my appeal**	**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 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 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:

- You are requesting coverage for inpatient or receiving emergency care that you are currently receiving
- 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

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

External appeal

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

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 us 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.

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

If your plan is governed by the Federal Employee Retirement Income Security Act of 1974 (ERISA), you can also contact the Employee Benefits Security Administration of the U.S. Department of Labor.

Employee Benefits Security Administration (EBSA)
1-866-444-EBSA (3272)

ELIGIBILITY AND ENROLLMENT

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

This section shows who is eligible for coverage and who can be covered under this plan. Only members enrolled on this plan can receive its benefits.

WHO IS ELIGIBLE FOR COVERAGE

Employee Eligibility

Under this small employer health benefit plan, an eligible employee is an employee who works on a full-time basis, with a normal work week of the minimum hours stated on the Group's application. Eligible employee means a sole proprietor, a partner of a partnership or an independent contractor, provided the sole proprietor, partner, or contractor is included as an employee under a health benefit plan of a small employer. Eligible employee does not include an employee who works on a part-time, temporary, or substitute basis. The employee must also satisfy any eligibility waiting period, if one is required by the Group.

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, they will no longer be eligible for coverage under this plan.

Dependent Eligibility

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

- The legal 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 only enroll as a subscriber.

- The domestic partner of the subscriber as specifically included as eligible by the Group.

The plan will give a spouse's rights and benefits to the domestic partner. Where this benefit booklet refers to marriage, it also means the start of a domestic partnership. Where this contract refers to divorce or legal separation, it also means the end of a domestic partnership.

- An eligible child under 26 years of age, except as provided for in the ***Eligibility For a Disabled Child*** provision.

  An eligible child is one of the following:

  - A biological child of either or both the subscriber, spouse or domestic partner
  - A child placed with the subscriber, spouse or domestic partner for the purpose of legal adoption in accordance with state law. A child is placed when the subscriber, spouse or domestic partner takes the legal duty to support the child. The child must be less than 18 years old when the child was placed.
  - A legally adopted child of either or both the subscriber, spouse or domestic partner
  - A minor or foster child for whom the subscriber, spouse or domestic partner 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, spouse or domestic partner as of a specific date. When the court order terminates or expires, the child is no longer an eligible child.
  - A newborn child of a covered dependent. The newborn's mother or father must be an enrolled dependent and the newborn 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, spouse or domestic partner has a legal guardianship.

WHEN COVERAGE BEGINS

Enrollment

The employee must enroll on forms provided and/or accepted by us. To obtain coverage, an employee must enroll within 60 days after becoming eligible. When the employee enrolls within 60 days of becoming eligible, 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:

- Another date as designated in the Group Master Application or Group Contract
- The date the employee enters a class of employees to which the Group offers coverage under this plan
- The employee's date of hire
- The next day following the date the eligibility waiting period ends, when one is required by the Group

When we do not receive the enrollment application within 60 days of the date you became eligible, none of the dates above will apply. See ***Open Enrollment*** and ***Special Enrollment*** below.

Dependents Through Marriage or Domestic Partnership After the Subscriber's Effective Date

When we receive the completed enrollment application and any required subscription charges within 60 days after the marriage or domestic partnership, coverage will become effective on the first of the month following the date of marriage or domestic partnership. When the enrollment application is not received by us within 60 days of marriage or domestic partnership, 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 do not 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.

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 is not received by us within 60 days of the date legal guardianship began, refer to ***Open Enrollment*** below.

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 do not 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 do not 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 be covered and remain covered under this 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 do not 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.

SPECIAL ENROLLMENT

Involuntary Loss of Other Coverage

If an employee and/or dependent does not enroll in this plan or another plan sponsored by the Group when first eligible because they are not 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'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 Medicaid or a public program providing health benefits
  - 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 as required by the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) at the time coverage under this plan was previously offered and COBRA coverage has been exhausted.
- 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 was offered

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 become effective on the first of the month following the date the other coverage was lost.

When we do not receive the employee and/or dependent's completed enrollment application within 60 days of the date prior coverage ended, refer to ***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, with some or all eligible dependents or change plans, if applicable.

When we receive the completed enrollment application and any required subscription charges within 60 days of the date of marriage, birth, adoption, or placement for adoption. Coverage under this plan will become effective on the first of the month following the date the other coverage was lost.

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 Coverage Begins*** and:

- You no longer qualify for healthcare coverage under Medicaid or CHIP, or
- You qualify for premium assistance for this plan from 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 do not 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 are 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 healthcare plans and you are enrolled under one of the Group's other healthcare plans, enrollment for coverage under this plan can only be made during the Group's open enrollment period.

Note: Grandchildren are not eligible to be enrolled during Open Enrollment. See ***Newborn Grandchildren*** above.

CHANGES IN COVERAGE

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

ELIGIBILITY FOR A DISABLED CHILD

An eligible child can stay on this plan after they reach age 26 if they are developmentally or physically disabled and are not able to support themselves. The child must be dependent upon the subscriber for support and maintenance. The child will continue to be eligible if all of the following are true:

- The child is disabled before reaching 26 years of age
- The child is not married
- We are notified of the child's disability within 31 days of the date the child reached age 26

Within 31 days after the child turns age 26, the subscriber must send us proof that the child meets these conditions. We also have the right to ask for proof. We cannot ask for such proof more often than once a year. If the subscriber does not send us satisfactory proof when we ask for it, the child's coverage will not continue after the last date of eligibility.

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. 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 is 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
- Deductibles. We will credit expenses applied to your prior plan's 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 deductible for the current year.

TERMINATION OF COVERAGE

EVENTS THAT END COVERAGE

Coverage will end without notice 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 is not paid when due or within the grace period
  - The subscriber dies or is otherwise no longer eligible as a subscriber
  - 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 they become legally separated or divorced from the subscriber
- For a child when they no longer meet the requirements for dependent coverage shown in ***Eligibility And Enrollment***
- 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 ***Eligibility And Enrollment***
- For intentional 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.

CONTINUATION OF COVERAGE

FOR A DISABLED CHILD

Coverage for a dependent child who cannot support themselves may continue beyond the dependent age limit if all of the following are true:

- The child became disabled before reaching the dependent age limit

- The child is not able to earn his or her own living because of a developmental or physical disability
- The child mainly depends on the enrolled employee for support and maintenance.
- The child's subscription charges, if any, continue to be paid
- The enrolled employee continues to be covered under this plan
- The enrolled employee gives us proof of the child's disability and dependent status when we request it. After the child has been covered under this provision for two years, we do not ask for proof more often than once a year.
- Within 31 days of the child reaching the dependent age limit, the enrolled employee gives us a Request for Certification of Disabled Dependent form. We must approve the request for coverage to continue.

Note: This provision does not apply to dependent grandchildren.

FOR GROUPS SUBJECT TO THE FEDERAL CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1986 (COBRA)

There are specific requirements, time frames and conditions which must be followed to be eligible for continuation of coverage and which are generally outlined below. Please contact your employer/group as soon as possible for details if you think you may qualify for continuation of coverage.

If you become ineligible you may continue coverage as required by the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). COBRA is a federal law which requires most employers with 20 or more employees to offer continued coverage. You may be eligible to continue coverage on a self-pay basis for 18 or 36 months through COBRA. How long you may continue coverage on COBRA will depend on the circumstances which caused you to lose coverage under the group plan.

WHO MAY BE ELIGIBLE

The enrolled employee or enrolled dependent may be eligible for COBRA if:

- Coverage ends because domestic partnership ends
- Coverage ends because the employee becomes eligible for Medicare
- Coverage ends because the employee's work hours were reduced
- Coverage ends because the employee's employment was terminated. The termination must not be due to gross misconduct as defined by the group.
- Coverage ends because the enrolled dependent no longer qualifies as a dependent
- Coverage ends because the enrolled employee dies
- Coverage ends because the enrolled employee and spouse legally separate or divorce

If you are eligible, you must apply for COBRA coverage within a certain time period. You may also have to pay the subscription charges for it. Please contact your employer for details.

MEMBER IS INPATIENT WHEN COVERAGE ENDS (EXTENDED INPATIENT COVERAGE)

If coverage ends, the inpatient benefits of this plan will continue if:

- Coverage did not end because of fraud by you or the Group;
- Coverage did not end because of an intentional misrepresentation of material fact under the terms of the coverage by you or the Group;
- Coverage had been in effect for more than 31 days;
- You remained as an inpatient in a medical facility for the same medical condition for which you were admitted
- You were admitted to a medical facility before the date coverage ended; and

Inpatient coverage will end when the first of the following occurs:

- Inpatient care is no longer medically necessary (see ***Definitions***)
- You are covered under another health plan that provides benefits for your confinement; or would provide benefits for your confinement if this plan did not exist;
- You are covered under another health plan that would provide benefits for your confinement if this plan did not exist;
- You are discharged from the facility or from any other facility to which you were transferred in which you are

confined

OTHER PLAN INFORMATION

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.

Benefits Not Transferable

This plan's benefits are not transferable. This means no one except you has the right to receive the benefits of this plan. If you use plan benefits in a false or misleading way, we will cancel your plan. We may also take legal action against you.

Conformity With The Law

The Group Contract is issued and delivered in the state of Alaska. This plan conforms with the 10 essential health benefits and is consistent with the requirements of the Affordable Care Act (federal healthcare reform). It is governed by the laws of Alaska, except to the extent preempted by federal law. If any part of this contract or any endorsement to it is found to be in conflict with applicable state or federal laws or regulations, we will administer this contract with those 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"
- 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. See the ***Definitions*** section to learn how the plan defines medically necessity.

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 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. We are not legally responsible for any harm that comes to a member while in a provider's care. This includes, without limitation, any general damages, pain and suffering.

Intentionally False or Misleading Statements

If this plan's benefits are paid in error due to any intentionally false or misleading statements, we will 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.

Interpretation of Plan

To the extent this plan is governed by the Employee Retirement Income Security Act of 1974 (ERISA), as amended, the employer's responsibilities and our responsibilities include the following:

- The employer and not Premera is the "Plan Administrator" as defined in ERISA.
- The employer delegates to Premera to act as the "Plan Administrator" to administer the terms of the health plan contract.
- The employer is responsible for furnishing summary plan descriptions, annual reports and summary annual reports to Plan participants and to the government as required by ERISA.
- The employer is responsible for providing all notices regarding continuation.

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 legally responsible for any of the following:

- 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
- Harm that comes to a member while in a provider's care
- Providing any type of hospital, medical, dental, vision, or similar care
- 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

Member Cooperation

You must cooperate with us in a timely and appropriate way as we manage and provide benefits. You must also cooperate with us if there is a lawsuit.

Newborns and Mothers Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, group health plans and health insurance issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing length of stay not in excess of the 48 hours (or 96 hours).

Not all plans include coverage for dependents and newborns may not be eligible for coverage. See the ***Eligibility and Enrollment*** section of this booklet for details.

Nonwaiver

No delay or failure when exercising or enforcing any right under this contract shall constitute a waiver or relinquishment of that right and no waiver or any default under this contract shall constitute or operate as a waiver of any subsequent default. No waiver of any provision of this contract shall be deemed to have been made

unless and until such waiver has been reduced to writing and signed by the party waiving the provision.

Notice

Any notice we are 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 will 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.

A notice of a material modification to the benefits or provisions in this plan will be provided to the member 60 days in advance of the material modification, including changes in preventive benefits.

Notice of Information Use and Disclosure

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

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

- Determining your eligibility for benefits and paying claims. (Genetic information is not collected or used for enrollment purposes.)
- Coordinating benefits with other healthcare plans
- Conducting care management, ***Personal Health Support Programs***, or quality reviews
- 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 is not 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 customer service and ask a representative to 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
- Any other insurance under which you are or may be entitled to recover compensation
- The name and address of any insurance carrier that provides:
  - Personal injury protection (PIP)
  - Underinsured motorist coverage
  - Uninsured motorist coverage
- The name of any other group or individual insurance plans that cover you

Premera Blue Cross Blue Shield of Alaska ID Card

The Premera Blue Cross Blue Shield of Alaska ID card is issued by Premera Blue Cross Blue Shield of Alaska for member identification purposes only. It does not confer any right to services or other benefits under this contract.

Recovery of Claims Overpayments

We have the right to recover money we overpay in error. We may recover this money from the member or anyone else that was paid, including a provider. We may deduct the money from future benefits of the employee or any of his or her dependents (even if the original payment was not for that member). We can only do this if we would otherwise pay those benefits directly to the subscriber or to a provider that does not have a contract with us. We will provide a minimum of 30 calendar days' notice of the recovery, and you will have the right to challenge the recovery. We will do any recovery no later than 365 days after the original claim is settled.

Rights of Assignment

Notwithstanding any other provision in this contract, and subject to any limitations of state or federal law, in the event that we merge or consolidate with another corporation or entity, or do business with another entity under another name, or transfer this contract to another corporation or entity, this contract shall remain in full force and effect, and bind the subscriber and the successor corporation or other entity.

We agree to guarantee that all transferred obligations will be performed by the successor corporation or entity according to the terms and conditions of this contract. In consideration for this guarantee, the subscriber consents to the transfer of this contract to such corporation or entity.

Right of Recovery

We have the right to recover amounts we paid that exceed the amount for which we are liable. Such amounts may be recovered from the subscriber or any other payee, including a provider. Or, such amounts may be deducted from future benefits of the subscriber or any of his or her dependents (even if the original payment was not made on that member's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a provider that does not have a contract with us.

In addition, if this contract is voided as described in ***Intentionally False or Misleading Statements***, we have the right to recover the amount of any claims we paid under this plan and any administrative costs we incurred to pay those claims.

Right to and Payment of Benefits

The benefits of this plan are available only to enrolled members. Except as required by law, we will not honor any attempted assignment, garnishment, or attachment of any right of this plan.

Payments of benefits of this plan are subject to the following provisions:

- **Non-Participating Providers:** Except as required by law, we will pay benefits for covered services from providers who are not in our network to you.
- **Preferred and Participating Providers:** For covered services from these providers, we pay the providers directly. You only have to pay deductibles, copays, coinsurance, and amounts for services that are not covered.

If we get a request in writing within 30 days of a claim, we will pay the provider directly. You or an individual named in a qualified domestic relations order may make this request. Once you send us this request, it can only be changed by sending another written request to us and the provider of services.

Federal or state laws may require us to pay benefits to certain agencies. These may include a state child support enforcement agency, a public health program, or other agencies.

Payment as stated above satisfies our obligation to pay benefits.

Severability

Invalidation of any term or provision herein by judgment or court order shall not affect any other provisions, which shall remain in full force and effect.

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:

- In the state of Alaska
- Within 3 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

Women's Health and Cancer Rights Act of 1998

This plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas. See ***Covered Services***.

Workers' Compensation Insurance

This contract is not in lieu of, and does not affect, any requirement for coverage by Workers' Compensation

insurance.

DEFINITIONS

Some words we use to describe this plan have special meanings in the benefit booklet. The information here will help you understand what these words mean.

Accepted Rural Provider

A selected provider practicing in a medically under-served area of Alaska. These providers are paid at the highest in-network 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, unexpected event at a certain time and place.

Accidental injury does not mean any of the following:

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

Adverse Benefit Determination

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

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

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).

Ambulatory Surgical Facility

A healthcare 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 mainly for the purpose of performing surgical procedures
- It doesn't provide inpatient services or accommodations

Applied Behavior Analysis (ABA)

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.

Benefit

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

Benefit Booklet

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

Benefit Waiting Period

Means a period during which specified treatment or services are excluded from coverage under this plan. The benefit exclusion periods begins on your effective date of coverage.

Calendar Year (Year)

The period of 12 consecutive months that start each January 1 at 12:01 a.m. and ends on December 31 at midnight.

Claim

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

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 federal standards for protecting human research subjects; and
- The United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers
- The 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 Institutes of Health guidelines

Complication of Pregnancy

A medical condition related to pregnancy or childbirth that falls into one of these three categories:

- A condition of the fetus that needs surgery while still in the womb (in utero)
- A condition the mother has that is caused by the pregnancy. It is more difficult to treat because of the pregnancy. These conditions are limited to:
  - Ectopic pregnancy
  - Hydatidiform mole/molar pregnancy
  - Incompetent cervix that requires treatment
  - Complications of administration of anesthesia or sedation during labor or delivery
  - Obstetrical trauma, such as uterine rupture before onset or during labor
  - Hemorrhage before or after delivery that requires medical or surgical treatment
  - Placental conditions that require surgical intervention
  - Preterm labor and monitoring
  - Toxemia
  - Gestational diabetes
  - Hyperemesis gravidarum
  - Spontaneous miscarriage or missed abortion
- A disease the mother has during pregnancy that is not caused by the pregnancy. The disease is made worse by pregnancy.

A complication of pregnancy needs services that are more than the usual maternity services. This includes care before, during, and after birth (normal or cesarean).

Comprehensive Oral Evaluation

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

Congenital Anomaly

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

Contract

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

Cosmetic Services

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

Cost-Share

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

Covered Service

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

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.

Dental (Pediatric)

An enrolled member under the age of 19 is eligible for pediatric dental. A member is eligible for these services up to the last day of the month following their 19th birthday, as long as all other eligibility requirements are met.

Dental Emergency

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

Dentally Necessary and Dental Necessity

Those covered services which are determined to meet all of the following requirements:

- Appropriate and consistent with authoritative dental or scientific literature
- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of a disease, injury, or condition harmful or threatening to the member’s dental health, unless provided for preventive services when specified as covered under this plan
- Not primarily for the convenience of the member, the member’s family, the member’s dental care provider or another provider

Dependent

The Subscriber’s spouse or domestic partner and any children who are on this plan.

Detoxification

Active medical management of substance intoxication or substance withdrawal. Active medical management means repeated physical examination appropriate to the substance taken, repeated vital sign monitoring, and use of medication to manage intoxification or withdrawal.

Observation without active medical management, or any service that is claimed to be detoxification but does not

include active medical management, is not detoxification.

Effective Date

The date your coverage under this plan begins.

Eligibility Waiting Period

The length of time that must pass before a subscriber or dependent is eligible to be covered under the Group's 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 eligibilty waiting period, unless all or part of the initial eligibility waiting period had not been met.

Emergency Medical Condition (also called "Emergency")

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

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

Emergency Services

- A medical screening examination to evaluate a medical 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 such medical treatment of the medical emergency as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the member from a medical facility.
- Ambulance transport as needed in support of the services above.

Endorsement

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

Essential Health Benefits

Benefits defined by the Secretary of Health and Human Services that shall include at least the following general categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. The designation of benefits as essential shall be consistent with the requirements and limitations set forth under the Affordable Care Act and applicable regulations as determined by the Secretary of Health and Human Services.

Experimental and Investigational Services

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

- A drug or device which cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and does not have approval on the date the service is provided.
- It is subject to oversight by an Institutional Review Board
- There is no reliable evidence showing that the service is effective in clinical diagnosis, evaluation, management or treatment of the condition.
- It is the subject of ongoing clinical trials to determine its maximum tolerated dose toxicity, safety or efficacy.
- Evaluation of reliable evidence shows that more research is necessary before the service can be classified as equally or more effective than conventional therapies.

Reliable evidence means only published reports and articles in authoritative medical and scientific literature and asssesments.

Explanation of Benefits

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

Facility (Medical Facility)

A hospital, skilled nursing facility, approved treatment facility for substance use disorder, state-approved institution for treatment of mental or psychiatric conditions, or hospice. Not all health care facilities are covered under this contract.

Group

A small employer, including a person, firm, corporation, partnership, or political subdivision, that is actively engaged in business and is a party to the Group Contract. The "Group" is responsible for collecting and paying all subscription charges, receiving notice of additions and changes to employee and dependent eligibility and providing such notice to us, and acting on behalf of its employees.

Habilitation Services

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.

Home Health Agency

An organization that provides covered home health services to a member.

Home Medical Equipment (HME)

Equipment ordered by a healthcare provider for everyday or extended use to treat an illness or injury. HME may include: oxygen equipment, wheelchairs or crutches. This is also sometimes known as "Durable Medical Equipment" or "DME".

Hospice

A facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill.

Hospital

A healthcare facility that meets all of these criteria:

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

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

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

Illness

A sickness, disease, or medical condition.

Injury

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

Inpatient

Confined in a medical facility or as an overnight bed patient.

Limited Oral Evaluation – Problem Focused

A limited oral evaluation – problem focused is an evaluation limited to a specific oral health problem or complaint and may include evaluation of a specific dental problem or oral health complaint, dental emergency and referral for other treatment.

Medical Equipment

Mechanical equipment that can stand repeated use and is used in connection with the direct treatment of an illness or injury.

Medically Necessary and Medical Necessity

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

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

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

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

Any person covered under this plan as a subscriber or dependent.

Mental Health Conditions

A condition that is listed in the most recent edition of the **Diagnostic and Statistical Manual of Mental Disorders (DSM)**. This does not include conditions and treatments for substance use disorder.

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

Services from doctors, hospitals, and other healthcare professionals that have not contracted with your plan. Depending on the healthcare professional, the service could cost more or not be covered at all by your plan.

Outpatient

Treatment received in a setting other than as inpatient in a medical facility.

Physician

A state-licensed:

- Doctor of Medicine and Surgery (MD)
- Doctor of Osteopathy and Surgery (DO)
- Podiatrist (DPM)

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 (ANP)
- A Certified Direct-Entry Midwife
- A Chiropractor (DC)
- A Dentist (DDS or DMD)
- A Licensed Clinical Social Worker (LCSW)
- A Licensed Marital and Family Therapist (LMFT)
- A Licensed Marriage and Family Counselor (LMFC)
- A Naturopath (ND)
- A Nurse Midwife
- An Occupational Therapist (OT)
- An Optometrist (OD)
- A Physical Therapist (PT)
- A Physician Assistant supervised by a collaborating MD or DO
- A Psychological Associate
- A psychologist

Plan

The benefits, terms, and limitations stated in this Group contract.

Preferred Provider Plan (PPO)

Means that this plan provides you benefits for covered services from providers of your choice.

Prescription Drug

Any medical substance, including biological products, 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
- 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).

“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.

Primary Care Providers

A doctor (MD – Medical Doctor or DO – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or doctor assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of healthcare services.

Prior Authorization

Prior Authorization is a process that requires you or a provider to follow to determine if a service is a covered service and meets medical necessity, clinical appropriateness, level of care, or effectiveness. You must ask for prior authorization before the service is delivered. See ***Prior Authorization*** for details.

Provider

A doctor or other healthcare 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. Not all services they provide are covered under this plan. See ***Covered Services*** and ***Exclusions*** for additional information.

For providers of medical care within the service area, we use the following terms.

- **Non-Participating Providers** are providers that do not have a contract with us. You receive the lowest benefit coverage for services provided by Non-Participating Providers, and they will bill you for amounts over the allowed amount for a covered service except for emergency services, covered air ambulance services, or as prohibited by law.
- **Participating Providers** are providers that have a contract with us, but they are not in your provider network. You receive lower benefit coverage for services provided by Participating Providers. Participating providers will not bill you the amount above the allowed amount for a covered service.
- **Preferred INN Providers** are contracted providers that are in your provider network. You receive the highest benefit level when you use a Preferred INN Provider. Preferred INN Providers will not bill you for the amount above the allowed amount for a covered service.

For providers of medical care outside the service area, we use the following terms:

- **In-Network Providers** are providers who have contracts with other Blue Cross and/or Blue Shield Licensees outside the service area.
- **Out-of-Network Providers** are providers who do not have contracts with other Blue Cross and/or Blue Shield Licensees outside the service area**.**

See ***BlueCard® Program*** for details.

For providers of dental care within the service area, we use the following terms:

- **In-Network Providers** are contracted providers that are in your provider network. You receive the highest benefit level when you use an in-network provider. In-network providers will not bill you for the amount above the allowed amount for a covered service.
- **Out-of-Network Providers** are providers that are not in your provider network. You receive lower benefit coverage for services provided by out-of-network dental providers. An out-of-network dental provider will bill you the amount over the allowed amount for a covered service.

Psychiatric Condition

A condition that is listed in the most recent edition of the **Diagnostic and Statistical Manual of Mental Disorders (DSM)**. This does not include conditions and treatments for substance use disorder.

Reconstructive Surgery

Is surgery:

- That restores features damaged as a result of injury or illness.
- To correct a congenital deformity or anomaly.

Rehabilitation Therapy

Rehabilitation therapy or devices are medical services or devices provided when medically necessary for restoration of bodily or cognitive functions lost due to a medical condition.

Rehabilitation therapy includes physical therapy, occupational therapy, and speech-language therapy when provided by a state-licensed or state-certified provider acting within the scope or their license. Therapy performed to maintain a current level of functioning without documentation of significant improvement is considered maintenance therapy and is not a rehabilitative service. Rehabilitative devices may be limited to those that have FDA approval and are prescribed by a qualified provider.

Service Area

Service area means the states of Alaska and Washington (except Clark County, Washington).

Services

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

Skilled Nursing Care

Medical care ordered by a physician and requiring the knowledge and training of a licensed registered nurse.

Skilled Nursing Facility

A medical facility licensed by the state to provide nursing services that require the direction of a physician and nursing supervised by a registered nurse, and that is approved by Medicare or would qualify for Medicare approval if so requested.

Small Employer

A small employer is an employer who employed an average of at least 1 but not more than 50 common law employees on business days during the preceding calendar year and who employs at least 1 common law employee on the first day of the current plan year.

In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer 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.

Specialist

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

Spouse

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

Subscriber

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

Subscription Charges

The monthly rates we establish as consideration for the benefits offered under this contract.

Substance Use Disorder Conditions

Substance-related disorders included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Substance use disorder is an addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with an individual's social, psychological, or physical adjustment to common problems. Substance use disorder does not include addiction to or dependency on tobacco, tobacco products, or foods.

Urgent Care

Treatment of unscheduled, drop-in patients who have minor illnesses and injuries. These illnesses or injuries need treatment right away but they are not life-threatening. Examples are high fevers, minor sprains and cuts, and ear, nose and throat infections. Urgent care is provided at a medical facility that is open to the public and has extended hours.

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.

Visit

A visit is one session of consultation, diagnosis, or treatment with a provider. We count multiple visits with the same provider on the same day as one visit. Two or more visits on the same date with different providers count as separate visits.

Visual Oral Screenings or Assessments

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

We, Us and Our

Premera Blue Cross Blue Shield of Alaska (“Premera”) in the state of Alaska and Premera Blue Cross in the state of Washington.

You and Your

Means any member enrolled in this plan.

38344AK0710020 1-KDKCQZ