Premera Blue Cross Preferred Gold 1500

$1,500 deductible (individual),

$3,000 deductible (family)

Contract for Individual and Families Residing in Alaska

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

Language Assistance

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-809-9361 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-809-9361 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-809-9361 (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 800-809-9361 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-809-9361 (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 800-809-9361 (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: 800-809-9361 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ ນພ ້ ອມໃຫ ້ ທ ່ ານ. ໂທຣ 800-809-9361 (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。800-809-9361 （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 800-809-9361 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-809-9361 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-809-9361 (телетайп: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-809-9361 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-809-9361 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-809-9361 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-809-9361 (رقم هاتف الصم والبكم: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-809-9361 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-809-9361 (ATS: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-809-9361 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-809-9361 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-809-9361 (TTY: 711) تماس بگیرید.

PREMERA BLUE CROSS BLUE SHIELD OF ALASKA

Premera Blue Cross Preferred Gold 1500

FOR INDIVIDUALS AND FAMILIES WHO LIVE IN ALASKA

Premera Blue Cross Blue Shield of Alaska is a nonprofit hospital and medical service plan licensed in the state of Alaska. Your contract with us consists of this document, your application form(s), and any related endorsements.

This contract describes the benefits of this plan. When you enroll and pay for coverage, we agree to provide the benefits of this plan to you and your enrolled dependents. We provide benefits for services that are medically necessary, as defined by this plan. Your benefits are subject to all the terms and conditions of this contract.

Preferred INN and Non-Preferred providers will not make you pay a cash deposit. You pay only copays (if any), deductibles, coinsurance amounts, and for items not covered by this contract.

This contract is renewable unless the terms to terminate the contract apply. Premera may change the contract and/or subscription charges with prior approval of the Alaska Division of Insurance. Written notice is sent to the subscriber at least 60 days prior to the change. Payment of subscription charges after notice to the subscriber will be considered acceptance by the subscriber. Failure to pay subscription charges will terminate this contract.

YOUR RIGHT TO RETURN THIS CONTRACT WITHIN TEN DAYS

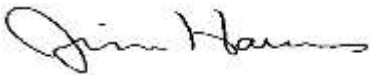
If you are not satisfied with this contract after you read it, for any reason, you may return it. You have 10 days after the delivery date to return it to us for a full refund. Delivery date means 5 days after the postmark date. We will refund your payment no more than 30 days after we receive the returned contract. If your refund takes longer than 30 days, we will add 10 percent to the refund amount.

If you return this contract within the 10-day period, we will treat it as if it was never in effect. However, we have the right to recover any benefits we paid before you returned the contract. We may deduct that amount from your refund.

AFFORDABLE CARE ACT NOTICE

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

PREMERA BLUE CROSS BLUE SHIELD OF ALASKA



Jim Havens

Senior Vice President
Individual and Senior Markets

WELCOME

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

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

Some words have special meanings under this plan. Please see ***Definitions*** at the end of this contract.

In this contract, 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 contract or your healthcare plan. We are happy to answer your questions and listen to any of your comments.

On our website at **premera.com** you can also:

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

Please also go to **premera.com/ak/sbc** for the 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.

HOW TO CONTACT US

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

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

Premera Blue Cross Blue Shield of Alaska
3800 Centerpoint Dr., Suite 940
Anchorage, AK 99503

CUSTOMER SERVICE

Mailing Address:

Premera Blue Cross Blue Shield of Alaska

P.O. Box 21762
Eagan, MN 55121

Telephone Numbers:

Local and toll-free number: 1-800-809-9361

WEBSITE

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

WHERE TO SEND CLAIMS

Mail Your Claims To:

Premera Blue Cross Blue Shield of Alaska
P. O. Box 21762
Eagan, MN 55121

Mail Your Prescription Drug Claims To:

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

Contact the Pharmacy Benefit Administrator at:

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

COMPLAINTS AND APPEALS

Premera Blue Cross
Attn: Appeals Department
P.O. Box 21762
Eagan, MN 55121

Local and toll-free number: 1-800-809-9361

PEDIATRIC DENTAL ESTIMATE OF BENEFITS

Premera Blue Cross
Attn: Dental Review
P.O. Box 21762
Eagan, MN 55121

Local and toll-free number: 1-800-809-9361

BLUECARD

1-800-810-BLUE(2583)

INTRODUCTION

This contract is for members of Premera Blue Cross Blue Shield of Alaska. It describes the benefits and other terms of this plan. This contract replaces any other contract you may have received.

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.

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SUMMARY OF YOUR COSTS

Premera Blue Cross Preferred Gold 1500

The service area for this plan is Alaska and Washington (except Clark county).

Below is a summary of your costs for covered services effective January 1, 2021. Your costs are subject to the all of the following:

- The allowed amount. This is the most this plan allows for a covered service.
- The copays (if applicable). These are set dollar amounts you pay at the time you get services.
- The coinsurance amounts (if applicable). This is the amount you pay after your deductible is met.
- The deductibles (if applicable). These are the amounts you pay before this plan pays for most of your eligible healthcare costs. Sometimes the deductibles are waived. These are shown below. When covered services are subject to the Preferred INN provider cost share, the Preferred INN provider deductible applies.

	Preferred INN Providers *(also applies to Accepted Rural Providers)*	**Non-Preferred Providers** **Non-Participating Providers** **Providers Outside The Service Area** *(except emergencies)*
Individual Deductible:	$1,500	$3,000
Family Deductible:	$3,000	Not applicable

- The out-of-pocket maximum. This is the most you pay each calendar year for the covered services of Preferred INN providers.

	Preferred INN Providers *(also applies to Accepted Rural Providers)*	**Non-Preferred Providers** **Non-Participating Providers** **Providers Outside The Service Area** *(except emergencies)*
Individual Out-of-Pocket Maximum:	$6,000	Not applicable
Family Out-of-Pocket Maximum:	$12,000	Not applicable

- The out-of-pocket maximum does not apply for services you get from Non-Preferred providers, Non-Participating providers, and providers outside the service area. You always pay your applicable cost shares when you see these providers. In addition to your cost shares, you will be responsible for any charges above the allowed amount from these providers.
- Services received for medical emergencies outside the service area are covered at the Preferred INN level.
- Some services must be authorized by us in writing before you get them. See the ***Prior Authorization*** section for details.
- The conditions, time limits and maximum limits are described in detail in the ***Covered Services*** section of this contract. Some services have special rules.

	YOUR COSTS OF THE ALLOWED AMOUNT		
	Preferred INN Providers *(also applies to Accepted Rural Providers)*	**Non-Preferred Providers**	**Non-Participating Providers** **Providers Outside The Service Area** *(except emergencies)*
Covered Services			
Acupuncture Limited to 12 visits per calendar year. You may have additional charges for hospital facility services. See those covered services for details.	$30 copay, deductible waived	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Allergy Testing and Treatment	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Ambulance			
• Emergency ground, water or air ambulance transport	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance
• Non-emergency ground or water transport			
• Non-emergency air ambulance, including transfer from one facility to another facility	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Blood Products and Services	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Chemotherapy and Radiation Therapy You may have additional costs for hospital facility charges. See those covered services for details.	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Clinical Trials and Cancer Clinical Trials Transportation expenses are limited to 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 30% coinsurance	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance
Dental Care			

• **Adult Dental Services**
  • Class 1 specified routine dental services are limited to members age 19 and older.
  • $750 maximum per calendar year. Cost-shares for adult dental services do not accrue to the medical out-of-pocket maximum.
	10% coinsurance, deductible waived	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance

• **Dental Anesthesia** When medically necessary	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• **Dental Injury** Limited to services provided 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 screenings and tests	No charge	Deductible, then 40%	Deductible, then 60%

	YOUR COSTS OF THE ALLOWED AMOUNT		
	Preferred INN Providers *(also applies to Accepted Rural Providers)*	**Non-Preferred Providers**	**Non-Participating Providers** **Providers Outside The Service Area** *(except emergencies)*
Covered Services			
		coinsurance	coinsurance
• Basic diagnostic X-ray, lab, and imaging	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Major diagnostic X-ray, lab, and imaging	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Dialysis	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Emergency Room	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance
Foot Care When medically necessary	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Habilitation Therapy 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 $60 copay	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Outpatient services to treat chronic conditions, unlimited	Deductible, then $60 copay	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Inpatient, limited to 30 days per calendar year	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Home Health Care Limited to 130 visits per calendar year.	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies Orthopedic shoes and shoe inserts for conditions other than diabetes are limited to $300 per calendar year.	Deductible, then 30% 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 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Hospital			
• Inpatient care			
◦ Facility	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
◦ Professional	Deductible, then 30%	Deductible, then 40%	Deductible, then 60%

	YOUR COSTS OF THE ALLOWED AMOUNT		
	Preferred INN Providers *(also applies to Accepted Rural Providers)*	**Non-Preferred Providers**	**Non-Participating Providers** **Providers Outside The Service Area** *(except emergencies)*
Covered Services			
• Outpatient Care	coinsurance	coinsurance	coinsurance
• Facility	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Professional	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Infusion Therapy	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Mastectomy and Breast Reconstruction	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Maternity Care Prenatal, postnatal, delivery and inpatient care, hospitals, birthing centers or short-stay facilities, diagnostic tests during pregnancy and professional services.	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Medical Foods Metabolic formula and low protein food for inborn errors of metabolism	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Medical Transportation Benefits This plan includes 2 types of medical transportation benefits that provide reimbursement as described below: **Elective Procedure Travel** Limited to the member and one companion. • 1 coach class round trip to Washington State per episode • Surface transportation and parking are limited up to $35 per day. Mileage expenses are reimbursed at 17 cents per mile per trip. • Ferry transportation expenses are 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.**	No charge	No charge	No charge
Medical Access Transportation One round-trip coach air or surface transport per medical condition per calendar year. Except for children under 19, limited to the member needing the transportation.	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance
Mental Health Care			

	YOUR COSTS OF THE ALLOWED AMOUNT		
	Preferred INN Providers *(also applies to Accepted Rural Providers)*	**Non-Preferred Providers**	**Non-Participating Providers** **Providers Outside The Service Area** *(except emergencies)*
Covered Services			
This benefit covers treatment of mental conditions, including physical, speech or occupational therapy. See ***Substance Use Disorders*** for treatment of alcoholism and other substance use disorders.			
• Office visits	$60 copay, deductible waived	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Other professional services	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Outpatient facility services	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Inpatient, partial hospital, and residential facilities	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Newborn Care	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Office and Clinic Visits			
• The first two office, clinic, telehealth or home visits combined per calendar year with your designated PCP	No charge	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Subsequent office, clinic or home visits per calendar year with your designated PCP	$30 copay, deductible waived	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• E-visits	$30 copay, deductible waived	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Office, clinic or home visits with your OB/GYN (if not your designated PCP)	$30 copay, deductible waived	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• All other provider office, clinic or home visits, including specialist office visits	$60 copay, deductible waived	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
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 other services such as x-rays, lab, therapeutic injections and hospital facility charges. See those covered services for details.			
Pediatric Care Limited to members up to age 19.			
Pediatric Vision Care			
• Routine exams limited to 1 per calendar year	$30 copay, deductible waived	$30 copay, deductible waived	$30 copay, deductible waived

	YOUR COSTS OF THE ALLOWED AMOUNT		
	Preferred INN Providers *(also applies to Accepted Rural Providers)*	**Non-Preferred Providers**	**Non-Participating Providers** **Providers Outside The Service Area** *(except emergencies)*
Covered Services			
• 1 comprehensive low vision evaluation and 4 follow up visits in a 5-calendar year period	$30 copay, deductible waived	$30 copay, deductible waived	$30 copay, deductible waived
• 1 pair of glasses (frames and lenses) or a 12-month supply of contact lenses per calendar year, in lieu of glasses (frames and lenses). Lens features limited to polycarbonate lenses and scratch resistant coating.	No charge	No charge	No charge
• Low vision devices, high powered spectacles, magnifiers and telescopes when medically necessary	No charge	No charge	No charge
Pediatric Dental Care			
• Class I Services	No charge	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance
• Class II Services	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance
• Class III Services	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance
• Orthodontic Services When medically necessary for conditions such as cleft lip or cleft palate	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance
Preventive Care Limited to how often you can get services based on your age and gender.			
• Routine care such as exams, screening, immunizations, contraceptive management and nutritional therapy	No charge	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Seasonal and travel immunizations you get at a pharmacy or mass immunizer	No charge	No charge	No charge
• Health education and tobacco cessation programs	No charge	No charge	No charge
Psychological and Neuropsychological Testing	Deductible, then 30% 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 $60 copay	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Outpatient services to treat chronic conditions, unlimited	Deductible, then $60 copay	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Inpatient, limited to 30 days per calendar year	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance

	YOUR COSTS OF THE ALLOWED AMOUNT		
	Preferred INN Providers *(also applies to Accepted Rural Providers)*	**Non-Preferred Providers**	**Non-Participating Providers** **Providers Outside The Service Area** *(except emergencies)*
Covered Services			
Skilled Nursing Facility Care Limited to 60 days per calendar year.	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Spinal and Other Manipulations Limited to 12 visits per calendar year. You may have additional charges for hospital facility services. See those ***Covered Services*** for details.	$30 copay, deductible waived	Deductible, then 40% coinsurance	Deductible, then 60% 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 visits	$60 copay, deductible waived	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Other professional services	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Outpatient facility services	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
• Inpatient, partial hospital, and residential facilities	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Surgery Includes the surgeon, assistant surgeon and anesthesia, office surgeries, ambulatory surgical centers, and inpatient and outpatient hospital services.	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Surgical Center Care - Outpatient	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Therapeutic Injections	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
Transplants Donor covered services are limited to $75,000 per transplant.			
• Office visits	See Office and Clinic Visits	Not covered*	Not covered*
• Other inpatient and outpatient care services	Deductible, then 30% coinsurance	Not covered*	Not covered*
**All approved transplant centers covered at the Preferred INN benefit level*			
• Travel and lodging expenses, limited to $7,500 per transplant. • Mileage expenses are reimbursed at 17 cents per mile per trip	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance

	YOUR COSTS OF THE ALLOWED AMOUNT		
	Preferred INN Providers *(also applies to Accepted Rural Providers)*	**Non-Preferred Providers**	**Non-Participating Providers** **Providers Outside The Service Area** *(except emergencies)*
Covered Services			
• Surface transportation and parking are limited up to $35 per day • Ferry transportation expenses are limited up to $50 per person each way • Lodging expenses are limited up to $50 per day per person **Reimbursement amounts may be subject to change due to IRS regulations.**			
Urgent Care • Non-hospital urgent care centers • Urgent care centers attached to or part of a hospital You may have additional costs for other services such as x-rays. See those covered services for details.	$60 copay, deductible waived Deductible, then 30% coinsurance	Deductible, then 40% coinsurance Deductible, then 30% coinsurance	Deductible, then 60% coinsurance Deductible, then 30% coinsurance
Virtual Care – On Demand Access to medical care for low level conditions using virtual methods like secure chat, text, voice or video chat. See the ***Office and Clinic Visits***, ***Mental Health Care*** and ***Substance Use Disorder*** benefits for real time visits with you and your doctor using online and telephonic methods (telemedicine).	$5 copay, deductible waived	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance

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. Copays and coinsurance apply to each 30-day supply.		
• Preventive drugs required by federal health care reform. See ***Covered Services*** for details.	No charge	No charge
• Nicotine cessation drugs, oral generic and single-source brand-name female contraceptive drugs and devices	No charge	No charge
• Formulary Preferred generic drugs	$10 copay, deductible waived	$10 copay, deductible waived
• Formulary Preferred brand-name drugs	$45 copay, deductible wavied	$45 copay, deductible wavied
• Formulary Non-Preferred drugs	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance
• Anti-cancer drugs	Deductible, then 30% coinsurance	Deductible, then 30% coinsurance
Prescription Drugs – Mail Order Pharmacy Limited up to a 90-day supply. Copays and coinsurance apply to each 90-day supply.		
• Preventive drugs required by federal health care reform. See those covered services for details.	No charge	Not covered
• Nicotine cessation drugs, oral generic and single-source brand-name female contraceptive drugs and devices	No charge	Not covered
• Formulary Preferred generic drugs	$30 copay, deductible wavied	Not covered
• Formulary Preferred brand-name drugs	$135 copay, deductible waived	Not covered
• Formulary Non-Preferred drugs	Deductible, then 50% coinsurance	Not covered
• Anti-cancer drugs	Deductible, then 30% coinsurance	Not covered
Specialty Pharmacy Drugs – Retail Limited up to a 30-day supply		
• Specialty drugs (specialty or retail pharmacy)	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance
• Specialty drugs requiring special handling, provider coordination, and patient education (available from in-network specialty pharmacy only)	Deductible, then 40% coinsurance	Not applicable

IMPORTANT PLAN INFORMATION

This section includes important information about this plan, such as your deductibles, out-of-pockets limits and the allowed amount.

CALENDAR YEAR DEDUCTIBLE

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 will apply. This plan's deductibles are shown on the ***Summary of Your Costs***.

Individual Deductible

This plan includes an individual deductible for covered services received from Preferred INN providers, and a separate individual deductible for covered services received from Non-Preferred providers, Non-Participating providers, and providers outside the service area.

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

After you have met the individual deductible for services received from Non-Preferred providers, Non-Participating providers, and providers outside the service area combined, 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 deductible for covered services received from Preferred INN providers. 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.

If two enrolled family members meet their individual deductibles for services from Preferred INN providers, 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.

There is no family deductible for Non-Preferred providers, Non-Participating providers and providers outside the service area. Each enrolled family member must satisfy the individual deductible for Non-Preferred, Non-Participating and providers outside the service area.

The individual and family deductibles are subject to all of 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 a dollar maximum
- Amounts credited toward the deductible accrue to benefits with visit limits and other annual durational maximums

COPAY

A copay is the 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 the ***Summary of Your Costs*** for any copays required by this plan.

COINSURANCE

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

OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is the most you or your family will pay each calendar year for covered services from Preferred INN providers before this plan begins to pay 100%. The out-of-pocket maximum for this plan is shown on the ***Summary of Your Costs***.

Individual Out-of-Pocket Maximum

This plan includes an individual out-of-pocket maximum for covered services received from Preferred INN providers. The out-of-pocket maximum is the total amount of deductible, coinsurance and copays (if any) you must pay each year.

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 from Preferred INN providers for the remainder of the calendar year.

There is no individual out-of-pocket maximum for Non-Preferred providers, Non-Participating providers, and providers outside the service area. You must always pay your cost-shares when covered services are received from these providers.

Family Out-of-Pocket Maximum

This plan includes a family out-of-pocket maximum for covered services received by you or one or more of your enrolled family members from Preferred INN providers. The family out-of-pocket maximum is the total amount of deductible, coinsurance and copays (if any) your family must pay each calendar year.

If two family members meet their individual out-of-pocket maximums, we will consider the individual 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 from Preferred INN providers for all of your enrolled family members for the remainder of the calendar year.

There is no family out-of-pocket maximum for Non-Preferred providers, Non-Participating providers and providers outside the service area. You and your enrolled family members must always pay your cost-shares when covered services are received from these providers.

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
- Covered services provided by Non-Preferred providers, Non-Participating providers and providers outside the service area. You must always pay your cost-share when you see these providers for care.
- Prior authorization penalties
- Any benefit shown on the ***Summary of Your Costs*** as not applying to the out-of-pocket maximum

ALLOWED AMOUNT

This plan provides benefits based upon 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'll be responsible only for any applicable cost sharing, including deductibles, copays, coinsurance, charges in excess of the stated benefit maximums and charges for services and supplies not covered under this plan.

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

  For covered services and supplies received outside Alaska and Washington or in Clark County, Washington, allowed 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.

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

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

  - An amount that is no less than the lowest amount we pay for the same or similar service from a comparable provider that has a contracting agreement with us
  - 250% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), if available
  - The provider's billed charges. Ambulance providers that don't have agreements with us or another Blue Cross Blue Shield Licensee are always paid based on billed charges.

  In no case will the allowed amount be less than the 80th percentile of charges in geographical area where services are received, or as otherwise required by law.

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 less than the 80th percentile or no higher than the 90th percentile of provider fees in that area where services are received.

Emergency Care

Consistent with the requirements of the Affordable Care Act the allowed amount will be the greater of the following:

- The median amount providers who contract with us have agreed to accept for the same services
- The amount Medicare would allow for the same services
- The amount calculated by the same method the plan uses to determine payment to providers who don't have contracting agreements with us

In addition to your applicable cost sharing, you will be responsible for charges above the allowed amount when services are received from providers who do not have contracting agreements with us.

Note: Ambulance providers that don't have agreements us or another Blue Cross Blue Shield Licensee are always paid based on billed charges.

HOW PROVIDERS AFFECT YOUR COSTS

This plan is a Preferred Provider Plan (PPO). This means that this plan provides benefits to you for covered services from covered 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 this plan's 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 Legacy and Dental Select network and network providers throughout the United States as described under the ***BlueCard® Program***.

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 Legacy and Dental Select 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 on the front cover or on your Premera ID card.

YOU CAN BENEFIT BY DESIGNATING A PRIMARY CARE PROVIDER

We believe wellness and overall health is enhanced by working closely with one provider. Although this plan does not require the use of a primary care provider (PCP) or require a referral for specialty care, we encourage you to designate a PCP at the time you enroll in this plan and notify us of your selection. Selecting a PCP gives you a partner to help you manage your care. If you have difficulty locating an available PCP, contact us and we will help you in selecting one.

If you do not select a PCP, we may assign a provider you have previously seen as your PCP. You may request to change this PCP selection by contacting us.

How you Pay the Lowest Copay

When you use your designated PCP for office visits, you will have a lower cost-share than if you use other providers or specialists in our network. Preferred INN OB/GYN providers are always covered at the lower cost-share no matter if you designated a PCP or not.

Here is an example: When you designate a PCP and see that PCP for a cut that needs stitches, you will pay the lower copay amount for that office visit. For the stitching procedure, you will pay the plan's deductible and coinsurance. If you do not designate a PCP, your office visit copay will be the higher copay amount shown on the ***Summary of Your Costs***.

Only one copay, per provider, per day will apply. If you receive multiple services from the same provider in the same visit and the copay amounts are different, then the highest copay will apply.

Who you May select As your Designated PCP

A PCP must be a Preferred INN provider. You can choose one of the following providers:

- General practitioners
- Family practitioners
- Internal medicine practitioners
- Pediatricians
- Nurse practitioners
- OB/GYN practitioners
- Physician assistant practitioners
- Naturopathic practitioners
- Geriatric practitioners

If your designated PCP is part of a group practice, you can see any provider type listed above in that practice and receive the PCP office visit copay.

Obstetrical/Gynecologist (OB/GYN) Visits

Obstetrical/Gynecologist (OB/GYN) office visits are covered as shown on the ***Summary of Your Costs***. Preferred INN obstetricians and gynecologists are always covered at the lower cost-share no matter if you have designated one as a PCP or not.

Specialist Visits

Specialist office visits are covered as shown on the ***Summary of Your Costs***. Specialists include providers such as psychologists, psychiatrists, and optometrists. This also applies if you see these providers at an urgent care center.

How to Designate a PCP

You can designate any Preferred INN provider listed above who is available to accept you or your family members. Each enrolled family member may select a different PCP. To designate a PCP, please select one from our provider directory at **premera.com** or contact Customer Service by calling the phone number listed on your Premera ID card. Once you have selected a PCP, call us and we will update your information.

If your PCP is Not Available

If you need to see your PCP and your PCP is not available, you may see any PCP within the same clinic. You will pay the lower copay.

If your PCP is the only provider in a clinic, you may see a PCP that your provider has asked to cover in their absence. You will still pay the lower copay.

If you Want to Change your PCP

You have the option to change your designated PCP. You may change your PCP at any time by contacting us. To change your PCP, please select one from our provider directory at **premera.com** or contact Customer Service by calling the phone number listed on your Premera ID card. Once you have chosen a PCP, call us and we will update your selection.

WHEN YOU RECEIVE CARE IN ALASKA OR WASHINGTON (THE SERVICE AREA)

The service area is the state of Alaska and the state of Washington (except Clark County, Washington).

Preferred In-Network Providers (Preferred INN)

Preferred INN providers have contracted with us and are included in our network. You benefit in 2 ways when you get services from a Preferred INN provider. Your out-of-pocket costs will be the lowest and these providers accept our allowed amount as payment in full. They bill us directly for your care.

Non-Preferred Providers

Non-Preferred providers are not included in our network. However, they have contracted with us and will accept our allowed amount as payment in full. Your out-of-pocket costs will be higher because your cost-share is more for these providers. They will also bill us directly for your care.

Non-Participating Providers

Non-Participating providers are providers that do not contract with us and are not in our network. Your out-of-pocket cost for these providers is the highest. In addition to your cost-share, you must also pay for charges over the allowed amount. You may have to pay the provider 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 receive from these providers is 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. You may also have to pay the provider for services and send us a claim for reimbursement.

Dental Providers

In-Network Dental Providers

This plan is designed to provide the lowest out-of-pocket costs when you receive services from Preferred INN dental 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.

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, please 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.

When You receive Care in Washington

You have access to the Legacy and Dental Select network of providers when you receive care in Washington.

Like Preferred INN 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 this plan described in this contract apply to services received in Washington.

To find a Legacy and Dental Select network provider in Washington, see our provider directory at **premera.com**, or call Customer Service.

Special Circumstances

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

- Emergency care (inside and outside the service area)
- Non-emergency care services received from a Non-Preferred 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 Non-Preferred or Non-Participating providers in Alaska.
- Care received from Non-Preferred 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 to whom we do not offer contracting agreements

You must pay your deductibles, copays (if any), coinsurance and any charges over the allowed amount.

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

Continuity Of Care

You may be able to continue to receive covered services from a provider for a limited period of time at the in-network benefit level after the provider ends his/her contract with Premera. To be eligible for continuity of care you must be covered under this plan, in an active treatment plan and receiving covered services from an in-network provider at the time the provider ends his/her contract with Premera. The treatment must be medically necessary, and you and this provider agree that it is necessary for you to maintain continuity of care.

We will not provide continuity of care if your provider:

- Will not accept the reimbursement rate applicable at the time the provider contract terminates
- Retired
- Died
- No longer holds an active license
- Relocates out of the service area
- Goes on sabbatical
- Is prevented from continuing to care for patients because of other circumstances
- Terminates the contractual relationship in accordance with provisions of the contract relating to quality of care and exhausts his/her contractual appeal rights

We will not provide continuity of care if you are no longer covered under this plan.

We will notify you no later than 10 days after your provider's Premera contract ends if we reasonably know that you are under an active treatment plan. If we learn that you are under an active treatment plan after your provider's contract termination date, we will notify you no later than the 10th day after we become aware of this fact.

You can call or send your request to receive continuity of care to Care Management at the address or fax number shown on the front cover.

Duration of Continuity of Care

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

- 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

- 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.)

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. Please refer to ***Complaints and Appeals*** for information on how to submit a complaint review request.

WHEN YOU ARE OUTSIDE ALASKA OR WASHINGTON

Except for emergency care, you pay the Non-Participating/Outside the Service Area cost-share for services you get from any state-licensed or certified provider outside the service area of Alaska or Washington.

Emergency care received outside the service area is covered at the Preferred INN level.

Your out-of-pocket costs will be lower if the provider has a contract with the local Blue Cross and/or Blue Shield Licensee (“Host Blues”), as these providers accept our allowed amount as payment in full.

Out-of-Area Care

As a member of the Blue Cross Blue Shield Association (“BCBSA”), Premera 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 section explains how the plan pays both types of providers.

Your 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.

We process claims for the ***Prescription Drugs*** benefit, ***Pediatric Dental Services*** benefit and ***Adult Routine Dental Services*** benefit directly, not through an Inter-Plan Arrangement.

BlueCard Program

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

- The provider's billed charges for your covered services; or
- The allowed amount that the Host Blue made available to us.

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. Please see the definition of "Allowed Amount" in the ***Definitions*** section in this contract for details on allowed amounts.

In these situations, you may owe the difference between the amount 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 the ***Sending Us A Claim*** section for more information. However, if you need hospital inpatient care, the service center can often direct you to hospitals that will not require you to pay in full at the time of service. In such cases, these hospitals also send in the claim for you.

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

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 **premera.com** or call 1-800-810-BLUE (2583). You can also get Blue Cross Blue Shield Global Core information by calling the toll-free phone number.

CARE MANAGEMENT

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

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

PRIOR AUTHORIZATION

You must get Premera's approval for some services before the service is performed, or you may pay a penalty. This process is called prior authorization.

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 Non-Preferred Or Non-Participating Providers** You must get prior authorization in order for the plan to:
   - Cover a Non-Preferred 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, Non-Preferred 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 Non-Preferred 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.

- **Preferred INN and Non-Preferred 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**
- **Home Medical Equipment (HME) and Prosthetic Devices**

  HME rentals or purchases over $750 regardless of place of service. Rental beyond 3 months may be reviewed for ongoing medical necessity.
  - Bone growth stimulators – electronic and ultrasonic
  - Chest compression vests and devices
  - Cochlear devices
  - Compression units
  - Continuous glucose monitors
  - Custom-made knee braces
  - DME corrective appliances
  - 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
  - External insulin pumps
  - Hearing aids
  - Hospital beds and accessories (no prior authorization needed for rental of standard beds for hospital to home transitions for less than 3 months)
  - Infusion pumps
  - Lymphedema pumps (pumps to reduce swelling)
  - Medical foods
  - Myoelectric upper limb prosthetic (externally powered artificial arm or hand)

- Negative pressure wound care
- Oral devices, appliances, surgical splints and impressions – includes preparation
- Power-operated lifting devices
- Spinal orthosis
- Standing frames
- Traction and orthopedic devices
- 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 a skilled nursing facility, a long-term acute care hospital (LTACH) or a rehabilitation facility
  - Admission to all residential treatment programs
- **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)
  - Applied behavioral analysis (ABA)
  - Artificial intervertebral disc, any level (artificial disc between vertebrae in the spine)
  - Blepharoplasty (eyelid surgery)
  - Bioengineered skin substitutes
  - 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)
  - Certain injections for pain management, including but not limited to therapeutic agents and anesthesia
  - Chelation therapy
  - Chemotherapy administration and radiation oncology
  - Cochlear implantation (stimulates the nerve in the inner ear)
  - Cognitive testing
  - Corneal cross-linking

- 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)
- Electroconvulsive therapy
- 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
- Home-based polysomnography (sleep studies done at home)
- Home health
- Home infusion
- 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)
- Intensive outpatient hospitalization
- Intensive cardiac and pulmonary rehabilitation services
- Interspinous distraction devices (spacers between the bone of the spine)
- Intraoperative neurophysiology monitoring, continuous
- Intravitreal implants
- Major joint surgeries, arthroplasty/arthroscopy: knee, hip and shoulder
- Mitral valve repair (repair of a specific heart valve)
- Nasal/sinus surgery
- Negative pressure wound therapy
- Nerve block, paravertebral, facet joint and SI injections
- Nerve conduction and monitoring
- Neurobehavioral status exam
- Neuropsychological testing
- More than 2 ultrasounds per pregnancy
- Panniculectomy (removing an apron of fat and tissue that hangs far below the waist)
- Parental nutrition
- Partial hospitalization
- Psychological testing
- 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)
- Radiosurgery
- Services and drugs reported with unlisted/non-specific CPT or HCPCS codes
- Skilled home health care services
- Skilled hourly nursing care
- Spine surgeries and treatments
- Surgical procedures in an outpatient setting
- 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)
- Transient elastography
- Trigger point injections
- Upper gastrointestinal endoscopy (a viewing scope inserted through the mouth to examine the esophagus, stomach, and first part of the small intestine)
- Vagus nerve blocking therapy (obesity treatment that blocks signals going to the nerve that goes to the stomach)
- Vascular embolization or occlusion for tumors, organ ischemia or infarction (closing off a blood vessel to treat a tumor or other tissue)
- Vertebroplasty, kyphoplasty, or sacroplasty (specific treatments for stabilizing compression fractures in the spine)
- Varicose veins and perforator veins – all procedures
- Wireless capsule endoscopy

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

Prescription Drugs

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

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

You can still buy the drug before it is prior authorized, but you must pay the full cost. If the drug is authorized

after you bought it, you can send us a claim for reimbursement. Reimbursement will be based on the allowed amount. See ***How Do I File A Claim?*** for details.

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

- Adrenal hormones
- Adrenergics
- Androgens
- Angiotensin II receptor blockers & renin inhibitor
- Antiandrogens
- Anticholinergics and antispasmodics
- Anticonvulsants
- Antidiarrheals
- Antimalarials
- Antiplatelet drugs
- Antipsoriatic/Antiseborrheic
- Antivertigo and antiemetic agents
- Beta agonists inhalers
- Beta blockers
- Blood glucose monitoring devices & supplies
- Bowel evacuants
- Combination narcotic/analgesics
- Compounds
- Direct acting miotics
- Drugs with significant changes in product labeling
- Estrogen combinations
- Estrogens
- Fluoroquinolones
- Gene therapies and cellular immunotherapies such as CAR-T
- Glucose elevating agents
- Gonadotropin & related agents
- Growth hormones (excluding idiopathic short stature without growth hormone deficiency)
- Headache therapy
- Hemostatics
- HIV/AIDS therapy
- Hypnotic agents
- Inhaled corticosteroids
- Insulin therapy
- Interferons
- Interleukins
- Intranasal steroids
- Keratolytics
- Kits
- Lipid/Cholesterol lowering agents
- Long acting nitrates
- MAO Inhibitors

- Miscellaneous agents
- Miscellaneous analgesics
- Miscellaneous antidepressants
- Miscellaneous 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
- Myeloid stimulants
- Narcotic antagonists
- Narcotics
- Newly FDA-approved drugs
- Non-insulin hypoglycemic agents
- NSAIDS
- NSAIDS-specific Cox II inhibitors
- Other glaucoma drugs
- Proton pump inhibitors
- Selective serotonin reuptake inhibitors
- Smoking deterrents
- Specialty drugs
- Steroids
- Tetracyclines
- Therapy for acne
- Thiazide and related diuretics
- Topical anesthetics
- Topical antibacterials
- Topical antifungals
- Topical corticosteroids

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

- A quantity limit or a specific drug or drug dosage appropriate for a usual course of treatment.
- Certain drugs for a specific diagnosis
- Step therapy, meaning you must try a generic drug or a specified brand name drug first

These 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 Non-Preferred, Non-Participating and Out-Of-Area Provider Coverage

Generally, non-emergent care by Non-Preferred 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 from your home. You or the Non-Preferred, 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 Non-Preferred or Non-Participating provider so that we can apply your benefits correctly.

Please Note: It is your responsibility to get prior authorization for any services that require it when you see a Non-Preferred, 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 Non-Preferred, 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 Non-Preferred, 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 Non-Preferred, Non-Participating And Out-Of-Area Providers

Out-of-network providers can be covered 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 Non-Preferred, 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. **In addition to the plan's cost shares, you will be required to pay any amounts over the allowed amount if the provider does not have a contract with us or the local Blue Cross and/or Blue Shield Licensee. Any amounts you pay over the allowed amount do not count toward your plan deductible and out-of-pocket maximum.**

If you choose to stay in the Non-Preferred, 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
- Industry standards accepted by organizations like the American Medical Association (AMA)
- Other professional societies
- Center for Medicare and Medicaid Services (CMS).

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

PERSONAL HEALTH SUPPORT PROGRAMS

Premera offers participation in our Personal Health Support Services 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 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 that this plan covers. Covered services means a medically necessary service (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 service:

- The reason for the service is to prevent, diagnose, or treat a covered illness, disease, or injury.
- 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.
- The service is not excluded.
- The provider is working within the scope of their license or certification.

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

Benefits for covered services are subject to all of the following:

- Copays (if any)
- Deductibles
- Coinsurance
- Benefit limits
- Prior Authorization. Some services must be approved in writing by us before you get them. These services are identified in this section. See ***Prior Authorization*** for more information.
- 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 Medicare 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 about your benefits and how to use them, call us at the number listed on the back of your Premera ID card.

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

Acupuncture

This benefit covers acupuncture to:

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

Allergy Testing and Treatment

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 prior authorization. See ***Prior Authorization*** for details.

Blood Products and Services

Benefits are provided for blood, blood derivatives and blood services (storage and procurement, including blood banks) when medically necessary.

Chemotherapy and Radiation Therapy

This benefit covers:

- Outpatient chemotherapy and radiation therapy
- Supplies, solutions and drugs

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

Clinical Trials and Cancer 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 above in this benefit
- Services required only for the provision or monitoring the drug
- 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 Care

Adult Routine Dental Services

This plan covers specified adult routine dental services for members age 19 and older, and when all eligibility requirements are met. A member is eligible for these services the first day of the month following their 19th birthday, as long as all other eligibility requirements are met.

Specified adult routine dental services are covered as stated on the ***Summary of Your Costs***. This benefit does not accrue to the medical out-of-pocket maximum.

The covered services under this plan are classified as Class I –Routine 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.

Class I –Routine Services
- Comprehensive, routine, and periodic and oral evaluations are limited to 2 per calendar year
- Prophylaxis (cleanings) are limited to 2 per calendar year

Covered x-rays include:
- Bitewing x-rays are limited to 1 per calendar year

This plan covers these specified adult routine dental services if all of the following are true:
- They must be dentally or medically necessary (see ***Definitions***)
- They must be named in this plan as covered
- They must be furnished by a licensed dentist (D.M.D. or D.D.S.) 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

The ***Adult Routine Dental*** benefit does not cover:
- Class I Routine dental services other than specified above
- Class II Basic dental services
- Class III Major dental services
- Orthodontia services
- 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)

See ***Pediatric Care*** for dental services for members under age 19.

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 Injuries

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

This plan covers diagnostic medical tests that help find or identify diseases.

Basic diagnostic 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

Major diagnostic x-ray, lab and imaging services include:

- Computed 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:

- ***Preventive Care***
- ***Hospital***
- ***Emergency Room***

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. These services are covered under inpatient, outpatient or emergency room benefits.
- Diagnostic surgeries, biopsies and scope insertion procedures. These are covered under ***Surgery*** and ***Hospital***.
- 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 important to enroll in Medicare as soon as possible. When you enroll in Medicare, this plan and Medicare will coordinate benefits. In most cases, this means that you will have little or no out-of-pocket expenses.

If the dialysis services are provided by a Non-Participating or non-contracted provider, you will owe the difference between any billed charges and the payment the plan will make for the covered services. See Allowed Amount for more information.

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
- 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.

If you get emergency care from a Non-Participating provider or hospital emergency room, or from a non-contracted provider or hospital emergency room outside the service area, you must pay for any charges over the allowed amount. See ***How Providers Affect Your Costs*** for details.

Foot Care

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

- Foot care for members with impaired blood flow to the legs and feet when the 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:

- Massage therapy
- Physical therapy
- Occupational therapy
- Speech language therapy
- Habilitative devices that have been approved by the FDA and prescribed by a qualified provider

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 the following:

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

Home Health Care

Care is covered when a doctor states in writing that care is needed in your home. The care needs to be done by staff who works for a home health agency that is state-licensed or Medicare-certified.

Home health care provided as an alternative to hospitalization must have a written plan of care from your doctor. This type of care is not subject to any visit limit shown in the ***Summary of Your Costs***. Medically intensive care in the home, or skilled hourly care provided as an alternative to facility-based care must have prior authorization by the plan.

This benefit covers:

- Home visits and short-term nursing care
- Home medical equipment, supplies and devices
- Prescription drugs given by the home health agency

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 person with a master's degree in social work

This benefit does not cover:

- Over-the-counter drugs, solutions, and nutritional supplements
- Non-medical services, such as housekeeping
- Services that bring you food, such as Meals on Wheels, or advice about food
- Private duty or 24-hour nursing care. Private duty nursing is the independent hiring of a nurse by a family or member to provide care without oversight by a home health agency. The care may be skilled, supportive or respite in nature.

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 ***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.

Inpatient hospice care must have prior authorization. See ***Prior Authorization*** for details.

Covered services include:

- 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.
- Nursing care provided by or under the supervision of a registered nurse
- Medical social services provided by a medical social worker who is working under the direction of a doctor; this may include counseling to help you and your caregivers to adjust to the approaching death
- 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 occasional respite for your caregivers or for pain control and symptom management.
- Home medical equipment, medical supplies and devices, including medications use primarily for the relief of pain and control of symptoms related to the terminal illness
- 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
- Rehabilitation therapies provided for symptom control or to enable you to maintain activities of daily living and basic functional skills
- Continuous home care during a period of crisis in which you required skilled intervention to achieve palliation or management of acute medical symptoms

This benefit does not cover:

- 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
- Custodial care
- Nonmedical services, such as housekeeping, dietary assistance, or spiritual, bereavement, legal, or financial counseling
- 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, 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 Non-Participating or non-contracted providers. In that case, you will have to pay any amounts over the allowed amount.

See the ***Summary of Your Costs*** for the cost-shares for non-emergency care outside the service area. 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

The plan covers outpatient infusion therapy services, supplies, solutions and drugs. Infusion therapy is using a needle or catheter to administer fluids into a vein. Most often this is done to help:

- Maintain fluid and electrolyte balance
- Correct fluid volume deficiencies after an excessive loss of body fluids
- Members who cannot take sufficient volumes of fluids orally

Some drugs may require prior authorization; see ***Prior Authorization*** for details.

This benefit does not cover the following:

- Over-the-counter (OTC) drugs, solutions and nutritional supplements
- Outpatient prescription drugs. See ***Prescription Drugs*** for those covered services.

Mastectomy and Breast Reconstruction

Mastectomy and breast reconstruction services are covered on the same basis as any other condition.

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 plan covers the doctor 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 have prior authorization. See ***Prior Authorization*** 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. Benefits for these services are based on the type of services you get. For example, office visits are covered as shown under ***Office and Clinic Visits***.
- Outpatient x-ray, lab and imaging. These services are covered under ***Diagnostic X-Ray, Lab and Imaging***.
- Home birth services provided by family members or volunteers

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 two types of medical transportation benefits that provide reimbursement as described below. For ambulance benefits, see ***Ambulance***.

Elective Procedure Travel

Reimbursement for certain travel expenses when traveling outside Alaska for approved elective (non-emergency) surgeries. Prior approval is required.

This benefit provides reimbursement of certain travel costs up to IRS guidelines for members who reside in Alaska and travel to Washington only for specified non-emergent medical procedures performed by certain in-network providers. Please contact Customer Service for a list of eligible procedures and providers. Before you travel you must get prior approval. Prior 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:

- One roundtrip coach airfare by a licensed commercial carrier for the member and one companion per episode
- Air transportation expenses for the member and a companion from the member's home in Alaska to and from the medical facility in Washington where services will be provided. Air travel expenses cover unrestricted, flexible and fully refundable round-trip airfare from a licensed commercial carrier.
- 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
- Mileage expenses for the member's personal automobile
- Ferry transportation expenses for the member and a companion from the member's home community, each way
- Lodging expenses at commercial establishments (hotels and motels) for the member and a companion are covered while traveling between home and the medical facility where services will be provided

If the member using the ***Elective Procedure Travel*** benefit is a child (under the age of 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 IRS 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 the member or by Premera's travel partner.

Expenses must be incurred while the member is covered under the plan.

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

The full price for these expenses must be paid in advance, and a claim for reimbursement must be submitted. Please see ***How To File a Travel Claim Form*** below for more information.

This benefit does not cover:

- Airline charges and fees for booking changes or first class
- Companions traveling separately from the member
- 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 approval.
- Travel for ineligible medical procedures
- Travel in a mobile home, RV, or travel trailer
- Travel to providers outside the network
- Travel to providers outside Washington State

How To File a Travel Claim Form:

To make a claim for travel expenses covered under this benefit, please complete a Travel Claim Form. A separate 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 recommended 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 web site. 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 reference number for approved 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 names 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 approval 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 at the location in Alaska where you became ill or injured and end at the location of the closest in-network provider equipped to provide treatment not available in a local facility. Transportation outside Alaska is limited to Seattle, Washington. Prior approval is not required.

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

To submit a claim for these services:

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

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:

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

Mental Health Care

This plan 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:

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

For this benefit, "outpatient therapeutic visit" means a clinical treatment session with a mental health provider. 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:

- Autistic disorder
- Autism spectrum disorder
- Asperger's disorder
- Childhood disintegrative disorder
- Persuasive 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 masters-level 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
- Licensed Community Mental Health or Behavioral Health agency that is also state certified for ABA
- Board certified Behavior Analyst, licensed in states with behavior analyst licensure, otherwise, certified by the Behavior Analyst Certification Board
- Other providers, including therapy assistants/behavioral technicians/ paraprofessionals when services are supervised and billed by a licensed provider or Board-Certified Behavioral Analyst (BCBA)
- Any other provider with appropriate training in behavioral analysis, and whose scope of licensure includes behavioral analysis.

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:
  - Initial evaluation/assessment
  - Treatment review and planning
  - Supervision of therapy assistants
  - Communication/coordination with other providers or school personnel

Please 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 Disorders*** benefit for coverage of treatment for alcoholism and other substance use conditions.

See the ***Virtual Care – On Demand*** benefit for coverage of telephonic, electronic, or on-line services.

Newborn Care

This plan covers newborn hospital nursery care and includes pediatrician services. Benefits for the newborn services are subject to the newborn's deductible and coinsurance. The hospital stay for the newborn is not limited to less than 48 hours for a vaginal delivery or less than 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:

- Hospital nursery care
- Circumcision
- 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 the ***Hospital*** benefit. 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:

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

Office and Clinic Visits

This plan covers professional office, clinic and home visits for examination, consultation, diagnosis, and treatment of an illness or injury. 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 (PCP visits). See ***How Providers Affect Your Costs*** for details about how to designate a PCP.

  The first 2 visits per calendar year with your designated primary care provider (PCP) are covered as described on the ***Summary of Your Costs***. Urgent care, e-visits, preventive and specialty visits are not included in this limit.
- OB/GYN visits with Preferred INN providers are always covered at the lower cost-share no matter if you have designated a PCP or not
- Specialist office visits
- Second opinions for covered medical conditions or treatment plans
- 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
- Real-time visits via online or telephonic methods with your doctor or other provider
- 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.

This benefit does not cover:

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

PEDIATRIC CARE

This plan covers pediatric vision and pediatric dental services for covered members up to age 19. A covered 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.

Pediatric Vision

This plan covers routine eye exams and glasses as follows:

- 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.
- Low vision evaluation and follow up visits by an ophthalmologist or an optometrist
- Glasses, frames and lenses
- Contact lenses in lieu of lenses for glasses, including those required for medical reasons
- Low vision devices, high powered spectacles, magnifiers and telescopes when medically necessary

Note: Vision hardware benefits include sales tax and shipping and handling costs.

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 pediatric dental services if all of the following are true:

- They must be dentally or medically necessary (see ***Definitions***)
- They must be named in this plan as covered
- They must be provided by a licensed dentist (D.M.D. or D.D.S.) 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're unable to obtain the necessary materials, we'll 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 provider are utilized. In all cases where there is an alternative course of treatment that's less costly, we'll only provide benefits for the treatment with the lesser fee. If you and your dental care provider choose a more costly treatment, you are responsible for additional charges beyond those for the less costly alternative treatment.

Estimate of Dental Benefits

You can ask for an ***Estimate of Benefits*** before you receive dental services. An ***Estimate of Benefits*** verifies your eligibility and benefits of this plan 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.

An ***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 ***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:
  - 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 an Estimate of Dental Benefits. This benefit does not cover cosmetic orthodontia services.

The pediatric dental 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 device
- 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

Prescription Drugs

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

This plan also includes benefits for “off-label” prescription drug 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:
  - 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)
- The Federal Secretary of Health and Human Services

“Off-label” use means the prescribed use of a drug that's other than that stated in its FDA-approved labeling.

Benefits aren't available for any drug when the U.S. Food and Drug Administration (FDA) has determined its use to be contra-indicated, or for experimental or investigational drugs not otherwise approved for any indication by the FDA.

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 both preferred generic drugs, preferred brand name drugs, and non-preferred drugs. Consult the Pharmacy Benefit Guide or RX search tool listed on our website. 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:

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

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 drugs, formulary preferred brand name drugs, or formulary non-preferred 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 brand name drug prescribed in its place will be covered the same as formulary generic drugs.

Covered Prescription Drugs

- FDA approved formulary prescription drugs. Federal law requires a prescription for these drugs. They are known as “legend drugs.”
- Compound drugs when all of the ingredients are covered prescription drugs
- Oral drugs for controlling blood sugar levels, insulin and insulin pens
- Throw-away diabetic test supplies such as test strips, testing agents and lancets
- Drugs for shots for you give yourself
- Needles, syringes and alcohol swabs you use for shots
- Glucagon emergency kits
- Inhalers, supplies and peak flow meters
- Drugs for nicotine dependency
- Human growth hormone drugs when medically necessary

- FDA approved oral contraceptive drugs and devices such as diaphragms and cervical caps
- Anti-cancer drugs and drugs to treat related side effects
- Drugs associated with an emergency medical condition (including drugs from a foreign country)

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

Benefits for certain preventive care drugs are covered as shown in the ***Summary of Your Costs*** when prescribed by your provider. These drugs are limited to those required by federal health care reform, 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. You can get a complete list of these drugs by logging into your secure website and visiting "My Plan Information" at **premera.com**. You can also call Customer Service at the number on your ID Card to get a list of these drugs.

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 specific 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.

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.

Anti-Cancer Medication

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

Drug Discount Programs

Premera may receive drug rebates or discounts.

Your prescription drug benefit program includes 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 may also 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 subscription rates for the next benefit year

If your prescription drug 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 80% of a supply of a single medication. The 80% 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 can 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:

- 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.
- Non-formulary generic and brand name drugs
- Drugs from out-of-network specialty pharmacies
- Drugs for cosmetic use such as for wrinkles
- Drugs to promote or stimulate hair growth
- Biological, blood or blood derivatives
- Any prescription refill beyond the number of refills shown on the prescription or any refill after one year from the original prescription
- Lost or stolen medication
- 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.
- 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.
- Immunizations. See ***Preventive Care***.
- Drugs to enhance fertility or to treat sexual dysfunction of organic origin
- Weight management drugs
- Growth hormones to stimulate growth, except when it meets medical standards, or for treatment of idiopathic short stature without growth-hormone deficiency
- Therapeutic devices or appliances. See ***Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies***.

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 Preferred INN providers are covered in full. But, they have limits on how often you should get them. After a limit has been exceeded, services are then covered the same as any other similar medical service and are not covered in full. These limits are often based on your age and gender. After a limit has been reached, 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 other similar medical service and are not covered in full.

For example:

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

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

This plan covers the following as preventive services:

- Covered preventive services include those with 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; and preventive care and screenings recommended by the Health Resources and Services Administration (HRSA). 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.
- Depression screening, including screening for adults and pregnant/postpartum women
- Routine exams, also included are exams for school, sports and employment
- Well baby care, including care provided by a qualified health aide
- Women's preventive exams. Includes pelvic exams, pap smears and clinical breast exams.
- Screening mammograms, including 3-D mammograms. See ***Diagnostic X-ray, Lab and Imaging*** for mammograms needed because of a medical condition.
- Pregnant women's services such as diabetic supplies, breast feeding counseling before and after delivery, and maternity diagnostic 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 must pay for these services and send us a claim for reimbursement. See ***Sending Us a Claim*** for instructions.
- BRCA genetic testing for women at risk for certain breast cancers
- 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.
- Colon cancer screening for high risk individuals under 50 years of age, all individuals 50 years of age or older, or as recommended by a doctor. 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. Also, pre-colonoscopy consultations are considered part of the preventive screening. Includes anesthesia your doctor considers medically appropriate for you.
- Outpatient lab and radiology for preventive screening and tests
- Diabetes screening

- 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 at a pharmacy or other center. If you use a Non-Participating provider you must pay for the services and send us a claim for reimbursement. See ***Sending Us a Claim*** for instructions.
- Obesity screening and counseling for weight loss
- Contraceptive management. Includes exams, treatment you get at your provider's office, and generic emergency contraceptives, supplies and devices. Tubal ligation, vasectomy, and implanted devices are also covered. See ***Prescription Drugs*** for prescribed contraceptives.
- Removal of contraceptive devices approved by the U.S. Food and Drug Administration (FDA)
- 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.
- Preventive drugs required by federal law. See ***Prescription Drugs***.
- Approved tobacco use cessation 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 **premera.com**. See ***Prescription Drugs*** for covered drug benefits.

This Preventive Care benefit does not cover:

- Prescription contraceptives, including over-the-counter items, dispensed and billed by your provider or a hospital. See ***Prescription Drugs*** for prescribed contraceptives.
- Gym memberships or exercise classes and programs
- Inpatient newborn exams while the child is in the hospital following birth. See the ***Newborn Care*** benefit for those covered services.
- Physical exams for basic life or disability insurance
- 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***.
- 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. The 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:

- Physical, speech, and occupational therapies
- Chronic pain care. Chronic pain is pain that is hard to control or that will not stop. Treatment for chronic pain is not subject to the 24-month limit for inpatient care.
- Cardiac and pulmonary rehabilitation
- Massage therapy
- Assessments and evaluation related to rehabilitative therapy

- Rehabilitative devices that have been approved by the FDA and prescribed by a qualified provider

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 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
- You cannot get the services in a less intensive setting
- 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:

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

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 the following:

- Recreational, vocational, or educational therapy
- Exercise programs
- Maintenance therapy, therapy performed to maintain a current level of functioning without documentation of significant improvement
- Social or cultural therapy
- Treatment that the ill, injured, or impaired member does not actively take part in
- Gym or swim therapy
- Custodial care
- Inpatient rehabilitative therapy received more than 24 months after the accidental injury, the start of the illness, or the date of surgery
- Neurodevelopment therapy or treatment of developmental or neurodevelopmental disabilities
- Treatment for mental health. See ***Mental Health Care*** for those covered services.

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 (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 benefit covers all of the following:

- Inpatient, partial hospitalization and residential treatment and outpatient visits to manage or reduce the effects of the substance abuse.
- Individual, family or group therapy
- Lab and testing
- Take-home drugs you get in a facility. See the ***Prescription Drugs*** benefit for coverage of other prescription drugs.

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).

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

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 surgery services. This includes services you get in a hospital, ambulatory surgical center, surgical suite or a provider's office. Some surgeries must have prior authorization 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 in the same surgery. These may be two separate procedures, or the same procedure on both sides of the body. 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 are not limited to:

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

This benefit does not cover:

- 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.
- Routine colonoscopy, sigmoidoscopy; see ***Preventive Care*** for those covered services
- Breast reconstruction; see ***Mastectomy and Breast Reconstruction*** for those covered services
- Transplant services; see ***Transplants*** for those covered services
- Vasectomy; see ***Preventive Care*** for those covered services

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 approved by us for solid organ transplants or bone marrow or stem cell reinfusion. Please call us as soon as you learn you need a transplant.

Transplant services require prior authorization; see ***Prior Authorization*** for details.

Covered Transplants

The plan covers only transplant procedures that are not considered experimental or investigational (see ***Definitions***). Solid organ transplants and bone marrow/stem cell reinfusion procedures must meet medical criteria for coverage. 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:

- Heart

- Heart/double lung
- Single lung
- Double lung
- Liver
- Kidney
- Pancreas
- Pancreas with kidney
- Bone marrow (autologous and allogeneic)
- 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. These procedures are covered the same way as other covered surgical procedures; see ***Surgery***.

Recipient Costs

This plan covers services from the 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
- Pre-transplant care
- Transplant and any donor covered services
- Follow up treatment

Donor Costs

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

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

Transportation and Lodging

The plan covers expenses 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 transplant 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 transportation (air, train, or bus) 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 Internal Revenue Service (IRS) medical mileage reimbursement on the date(s) the expenses were incurred. See the ***Summary of Your Costs*** for the current reimbursement rates.

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*** for the current reimbursement rates.

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 current reimbursement amounts.

This benefit does not cover the following:

- Transplants or related services from a provider not approved by us
- 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.
- 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
- Nonhuman or mechanical organs that are experimental or investigative
- Planned blood storage for more than 12 months for possible future use
- Alcohol or tobacco
- Car rental
- Entertainment (such as movies, visits to museums, or additional mileage for sightseeing)
- Meals
- Personal care items (such as shampoo or deodorant)
- Souvenirs (such as t-shirts, sweatshirts or toys)
- Telephone calls

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. Please see the ***Summary of Your Costs*** for cost-shares type of center you visit.

Virtual Care – On Demand

On demand virtual care provides ease, convenience and immediate access to medical care for limited low-level acute medical conditions such as a urinary tract infection or strep throat using several technology solutions. This benefit covers on-demand virtual care using secure chat, text, voice or audio messaging, and video chat.

This benefit does not cover real-time visits between you and your doctor via online and telephonic methods (telemedicine). See the ***Office and Clinic Visits***, ***Mental Health Care and Substance Use Disorder*** benefits.

EXCLUSIONS

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

Amounts Over the Allowed Amount

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

Assisted Reproduction

This plan does not cover any assisted reproduction technologies, including but not limited to:

- Artificial insemination or in-vitro fertilization
- Services to make you more fertile or for multiple births
- Reversing sterilization surgery
- Diagnosis and treatment of underlying medical conditions that may cause infertility are covered on the same basis as any other condition.

Benefits from Other Sources

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

- Motor vehicle medical or 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

Charges for Records or Reports

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

Clinical Trials

This plan does not cover:

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

Comfort or Convenience

This plan does not cover:

- Items that are mainly for your convenience or that of your family. For instance, the plan does not cover personal services or items like meals for guests while hospitalized, long-distance phone, radio or TV, personal grooming and babysitting.
- Normal living needs, such as food, clothes, housekeeping and transport. This does not apply to chores done by a home health aide as prescribed in your treatment plan.
- Meal or dietary assistance, including Meals on Wheels.

Complications

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

Cosmetic Services

This plan does not cover drugs, services or supplies for cosmetic services. This includes services performed to reshape normal structures of the body in order to improve or alter your appearance and not primarily to restore an impaired function of the body.

Counseling, Education and Training

This plan does not cover counseling and training in the absence of illness. This includes, but is 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

Court-Ordered Services

This plan does not cover services that you must get to avoid being tried, sentenced or losing the right to drive when they are not medically necessary.

Custodial Care

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

Dental Care

This plan does not cover dental care that are not covered in ***Pediatric Care*** and ***Dental Care*** services.

Donor Breast Milk

EEG biofeedback or neurofeedback services

Environmental Therapy

This plan does not cover therapy to provide a changed or controlled environment.

Experimental and Investigative Services

This plan does not cover any service that is experimental or investigative, see ***Definitions***. This plan also does not cover any complications or effects of such services.

This exclusion does not apply to services that are part of an approved clinical trial. See ***Clinical Trials*** for details.

Family Members or Volunteers

This plan does not cover services that you give to yourself. It also does not cover a provider who is:

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

Government Facilities

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

Hair Analysis

Hair Loss

This plan does not cover:

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

Hearing Exams

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

Hearing Hardware

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

Hospital Admission Limitations

This plan does not cover hospital stays solely for diagnostic studies, physical examinations, checkups, medical evaluations, or observations, unless:

- The services cannot be provided without the use of a hospital
- There is a medical condition that makes hospital care medically necessary

Illegal Acts and Terrorism

This plan does not cover illness or injury you get while committing a felony, an act of terrorism, or an act of riot or revolt.

Laser Therapy

This plan does not cover low-level laser therapy.

Military Service and War

This plan does not cover 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
- Service in the armed forces of any country. This includes the air force, army, coast guard, marines, National Guard, or navy. It also includes any related civilian forces or units. However, this exclusion does not apply to members of the U.S. military (active or retired) or their dependents enrolled in the TRICARE program. This plan will be primary to TRICARE for these members when required by federal law.

Non-Covered Services

This plan does not cover 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, other than outpatient health education services covered under the Preventive Care benefit. This includes health care provider training or educational services.
- You are not required to pay or would not have been charged for if this plan were not in force
- That are not listed as covered under this plan

Non-Treatment Charges

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

Non-Treatment Facilities, Institutions or Programs

Benefits are not provided for institutional care, housing, incarceration or programs from facilities that are not licensed to provide treatment for covered conditions. Examples are prisons, nursing homes, and juvenile detention facilities. Benefits are provided for medically necessary treatment received in these locations. See ***Covered Services*** for specific benefit information.

Not Medically Necessary

Services and places of service that are not medically necessary.

Orthodontia

This plan does not cover orthodontia services in excess of the limits in ***Pediatric Dental*** (see ***Pediatric Care***), including services for members age 19 and older.

Orthognathic Surgery

Procedures to lengthen or shorten the jaw (orthognathic surgery), regardless of the origin of the condition that makes the procedure necessary.

Provider's License or Certification

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

Recreational, Camp and Activity Programs

This plan does not cover recreational, camp and activity-based programs. These programs include:

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

Serious Adverse Events and Never Events

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

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

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

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

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

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

Sexual Dysfunctions

Diagnosis and treatment of sexual dysfunction, regardless of origin or cause, surgical, medical or psychological treatment, including drugs, medications or penial or other implants.

Temporomandibular Joint (TMJ) Disorders

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

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

Vision Exams

This plan does not cover routine vision exams to test visual acuity and/or to prescribe any type of vision hardware, not covered under pediatric vision under ***Pediatric Care***.

Vision Hardware

This plan does not cover vision hardware (and their fittings) used to improve visual sharpness, including eyeglasses and contact lenses and related supplies, not covered under the ***Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies*** and the ***Pediatric Care*** benefit. This plan never covers non-prescription 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. Also not covered are treatment or surgeries to improve the refractive character of the cornea, including treatment of any results of such treatment.

Voluntary Support Groups

Patient support, consumer or affinity groups or Alcoholics Anonymous.

Weight Loss (Surgery or Drugs)

This plan does not cover surgery, drugs or supplements for weight loss or weight control. This is true even if you have an illness or injury that might be helped by weight loss surgery or drugs.

Work-Related Illness or Injury

This plan does not cover any illness or injury that you can get benefits under:

- Separate coverage for illness or injury on the job
- Workers compensation laws
- Any other law that will repay you for an illness or injury you get from your job

OTHER COVERAGE

COORDINATION OF BENEFITS (COB)

If you have other health plan coverage, this plan will work with that other plan so that both plans may share a part of the costs. This means that the total benefits from all plans will not be more than the allowable expense for the covered service. This is called coordination of benefits (COB). Medical expenses and dental expenses are coordinated separately.

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.

Key Terms for COB

The terms listed below will help you understand how COB works.

Allowable Medical Expense

This means the charge allowed for the services that this plan covers or partly covers. When we provide services instead of cash, the cash value is the allowable expense.

Plan

This means any of the healthcare plans listed below

- Plans and policies that cover a company's workers, former workers, and their families
- Plans and policies that cover one person or one family

- Blanket disability policies and plans, such as plans offered to members of clubs or interest groups
- Plans that are offered jointly by businesses and labor unions, or by groups of businesses, or several labor unions or worker organizations.
- Government plans that cover civilian workers or their family
- Group coverage that must be provided by law. This does not include workers' compensation or Medicare.
- Group student plans sponsored by a school or other institution of learning that have health benefits

Primary and Secondary Plans

The first step in COB is to find out which plan is your primary plan. The first rule that fits your situation will tell us which plan is primary. If none of these rules apply to you, the plan that has covered you the longest will be the primary plan.

The order in which plans provide benefits is:

First: A plan that does not have any COB rules.

Next: The plan that covers you as the subscriber.

Next: The plan that covers you as a dependent.

If the dependent is a child, the following rules apply:

When the parents are married or living together

The plan of the parent whose birthday (month and day) comes first in the calendar year is the primary plan. The other parent's plan is the secondary plan. This is called the "birthday rule."

When the parents are legally separated, divorced or not living together

If a court order says one parent must pay for the child's healthcare costs, that parent's plan is the primary plan.

If there is no court order, the plan order is:

- The plan of the parent with custody is the primary plan
- Next, the plan of the spouse of the parent with custody
- Next the plan of the parent who does not have custody

Special Rules

There are times when we do not use the rules listed above. They are:

- The law makes some plans secondary to all other plans, such as Medicaid and TRICARE
- A plan that does not have COB rules that meet state of Alaska standards is primary to this plan. There may be times when the COB rules of both plans agree that this plan is the primary plan.
- A plan that covers you and your dependents as a laid-off employee or as a retired employee is the secondary plan. This rule applies only when all other plans include this rule.
- Medicare is the primary plan when a member is enrolled in Medicare and enrolled in this plan at the same time. This plan will coordinate benefits with Medicare.

How Benefits are Provided

The primary plan provides its benefits in full, as if you have no other coverage.

The secondary plan looks at the benefits provided by the primary plan. It will subtract the primary plan's benefits from the allowable expense and provide benefits on the amount left over. It will not provide more benefits that they would have if they were your only plan. They will also reduce your deductible by the amount that would have applied if it were your only health plan.

Claims should be sent to the primary and secondary plans at the same time. This plan will coordinate benefits with a primary plan even if a claim is not filed with the primary plan. COB is applied to each claim separately.

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.

SUBROGATION AND REIMBURSEMENT

This section is about what happens when we make certain kinds of payments on your behalf. Sometimes we may make payments on your behalf for injury or illness and one of these two things is true:

- Another party is liable, or legally responsible for the illness or injury
- There is uninsured/underinsured motorist (UIM) or personal injury protection (PIP) insurance that covers the illness or injury

When we make such payments, 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 not you or us. The liable party may be an uninsured motorist and/or underinsured motorist (UIM) carrier because we exclude coverage for such benefits.

Definitions

We use three special terms when we talk about these situations. These words have specific meanings related to this process:

- “Subrogation” means we may collect money directly from third parties. We may collect the amount we paid on your behalf for illnesses or injury caused by the third party.
- “Reimbursement” means that you must repay any us from the amounts you received from the third party.
- “Restitution” means the rights we have to recover the amounts we paid under this plan. Because we paid for your illness or injury, we are entitled to recover these amounts.

As far as the law allows, we are entitled to the proceeds of any settlement or judgment that results in a recovery from a third party, up to the amount we paid. We have this right to recover regardless of whether it is based on subrogation, reimbursement or restitution. We will recover these amounts no more than 365 days after we receive notice of the settlement or judgment. Exceptions will be allowed when required by law or regulation. We may choose to either hire our own attorney or be represented by your attorney. We will not pay any of your legal costs, and you do not have to pay any of our legal costs.

Before you accept any settlement, you must tell us in writing about the terms and conditions of the settlement. You must tell the third party of our interest in the settlement. You must also cooperate with us in recovering amounts we paid on your behalf. If you hire an attorney or other agent to represent you, you must have your attorney or agent reimburse us directly from the settlement or recovery. If you do not cooperate fully with us in the recovery, you will be responsible for reimbursing us.

If you recover money from a third party, you agree to hold the money in trust or in a separate account until our subrogation and reimbursement rights are determined.

UNINSURED AND UNDERINSURED MOTORISTS / PERSONAL INJURY PROTECTION COVERAGE

We have the right to be reimbursed for benefits we provided when benefits are also provided under the terms of the following:

- A motor vehicle uninsured motorist and/or underinsured motorist (UIM) policy
- A 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. Use a separate claim form for each patient and each provider. You can get claim forms by calling Customer Service and we will mail a claim form to you within 10 days, or you can print them from our

website at **premera.com**.

Step 2

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

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

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:

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

PRESCRIPTION DRUG CLAIMS

For non-participating pharmacies, you must send a completed prescription drug claim form. Contact Customer Service to get a claim form or print one from our website at **premera.com**. Complete the form, attach the pharmacy receipt, and mail them to the address listed on the claim form.

CLAIMS FOR CARE OUTSIDE THE UNITED STATES

When you send us a claim for care you received outside the United States, please include the following whenever possible:

- A detailed description of the services, drugs, or supplies received (in English)
- The names and credentials of the providers
- Medical records or chart notes

To process your claim, we will convert any foreign currency amounts on the claim into U.S. dollars. We use a national currency converter (available at **www.oanda.com**) as follows:

- We use the exchange rate on the date of service for outpatient services and other care with single dates of service.
- We use the exchange rate on the date of discharge for inpatient stays of more than one day.

WHEN TO SEND US YOUR CLAIMS

Send your claim as soon as you can. It is best if you can send us your claim within 90 days of the start of service, or within 30 days after the service is completed. We must receive claims:

- Within 365 days of the date you received services or were discharged from a hospital
- For members with Medicare, within 90 days of the process date shown on the Explanation of Medicare Benefits, or 365 days from the date you received services, whichever is greater

We will not provide benefits for claims we receive after these time periods. Also, we will not provide benefits for claims that Medicare denied because they were received after Medicare's deadline. We may be able to make an exception if we receive proof of your legal incapacitation.

CLAIMS PROCESS

We process your claims as stated below:

- Claims that have all the necessary information are processed within 30 calendar days of the date we receive them
- If we need more information to process claims, we will let you and/or your provider know within 30 calendar days of the date we receive them. Once we receive the information, claims are processed within 15 calendar days.

If we do not process claims or provide notice as stated above, interest shall accrue at a rate of 15% annually beginning on the date the notice was due. Interest will not be paid if the amount of interest is $1 or less.

You will also get a written notice from us explaining how the claim was processed. If your claim is denied, this notice will also tell you the reason why it was denied and how you can ask for an appeal.

If all you have to pay is a copay for a covered service or supply, your payment of the copay to your provider is not considered a claim for benefits. You can call Customer Service to get a paper copy of an Explanation of Benefits for the service or supply. The phone number is on the back of your Premera ID card. Or, you can visit our website, **premera.com**, for information and secure online access to claims information. To file a claim, please see the steps above 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***.

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.

COMPLAINTS AND APPEALS

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

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

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

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

You may also appeal decisions we make regarding coverage for drugs not on the plan's formulary. See ***Prescription Drugs*** for details.

HOW TO SUBMIT AN APPEAL

The process begins with an internal appeal. If you do not agree with the internal decision, you might qualify for an external appeal.

INTERNAL APPEAL

People who were not part of the initial decision will review your appeal. Medical review denials will be reviewed by a medical specialist. We must receive your internal appeal request within 180 days of the date you were notified of our initial decision. You can request an extension of the 180-day deadline by sending us a written request that includes the reason why you believe an extension should be granted.

WHO CAN APPEAL?

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

HOW TO APPEAL

You can call Customer Service, or you can write to us at the address listed in ***How To Contact Us***. By sending your appeal in writing, you can provide more details about 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 need help filing an appeal, or would like a copy of the appeals process, please call Customer Service. You can also get a description of the appeals process by visiting our website.

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

WHAT HAPPENS WHEN YOU HAVE ONGOING CARE

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

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

WHAT HAPPENS WHEN IT'S URGENT

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

- Your life or health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal
- You are inpatient or receiving emergency care

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

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

WHAT HAPPENS NEXT

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

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

If we stand by our first decision or we do not follow the process above you can request an external appeal. External appeal is 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.

WHEN YOU HAVE AN APPEAL ABOUT ELIGIBILITY

If you enrolled or are enrolling through The Exchange, they are responsible for all decisions and appeals related to eligibility. Your appeal should be filed with The Exchange. Please contact the Exchange at 1-800-318-2596 for information on this process. If we receive an appeal from you, we will forward it to The Exchange.

EXTERNAL APPEAL

External appeals will be done by an Independent Review Organization (IRO). There is no cost to you for an external appeal.

- We will send you an external appeal request form authorizing the release of your medical records to an IRO with the written decision of your internal appeal. You may also write to us directly to request an external appeal.
- 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.

- You must include the signed external appeal form you received from us. You may also include medical records and other information.
- 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 completed, 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.

WHAT HAPPENS NEXT

Once the external appeal is done, the IRO will let you and us know their decision within the time limits below.

- For urgent external appeals no later than 72 hours after receiving the request
- For all other appeals within 45 days from the date the IRO gets your request

ONCE A DECISION IS MADE

For urgent appeals, the IRO will inform you and us immediately. We will follow up with a written decision by mail. For all other appeals, we will send you a written decision by mail.

Premera will accept the IRO decision.

If the IRO:

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

If you have questions about a denial of a claim or your appeal rights, you may call Customer Service at the number listed on your Premera ID card.

Contact the Alaska Division of Insurance at any time during this process if you have any concerns or need help filing an appeal.

Alaska Division of Insurance
550 W 7th Ave., Suite 1560
Anchorage, Alaska 99501-3567

Call: 1-800-INSURAK (467-8725) (within Alaska)
1-907-269-7900 (outside Alaska)
Email: insurance@alaska.gov

ELIGIBILITY AND ENROLLMENT

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

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

To enroll on this plan, individuals must meet the eligibility requirements established by the Federally Facilitated Health Insurance Exchange (Exchange) and complete any enrollment process as required by the Exchange. Enrollment is also subject to payment of any required subscription charges.

Enrollment on this plan is limited to the annual enrollment period, or when an individual experiences a qualifying event for a special enrollment period. See the ***Open and Special Enrollment Periods*** section for details.

To be covered you must meet these conditions.

- You must have completed an Exchange application that includes appropriate signatures and initials.
- The subscriber must be a permanent resident of the state of Alaska. “Resident” means a person who lives in Alaska State and intends to remain in the state permanently or indefinitely. In no event will coverage be extended to a subscriber or dependent who resides in the state for the primary purpose of obtaining health care or health care coverage. The confinement of a person in a nursing home, hospital, or other medical institution shall not by itself be sufficient to qualify such person as a resident. We may require proof of residency from time to time. Examples of proof include, but shall not be limited to, a valid photo ID, current utility bills, tax or financial records. All documents must show the street address of the individual's residence and not a post office box.

If the conditions above are true, the individuals listed below can be covered:

- The subscriber
- The subscriber's legal spouse, unless legally separated
- The subscriber's domestic partner. A domestic partner is someone who:
  - Lives with the subscriber
  - Is at least 18 years old
  - Has a close personal relationship with the subscriber in which they each take care of the other
  - Shares the costs of basic living, such as food and shelter, with the subscriber. The partners do not need to pay these expenses equally or jointly as long as they agree that both are responsible.
  - Is not married to anyone
  - Is not related to the subscriber by blood more closely than Alaska allows a married couple to be
  - Is mentally able to agree to a contract when the domestic partnership begins
  - Is the subscriber's only domestic partner

  If all of these statements above are true, the plan will give a spouse's rights and benefits to the domestic partner. Where this contract 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 old. An eligible child is one of the following:
  - A biological child of either the subscriber, spouse or domestic partner
  - A legally adopted child of either the subscriber, spouse or domestic partner
  - 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 Child” 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.
  - A child placed with the subscriber, spouse or domestic partner for legal adoption. A child is placed when the subscriber, spouse or domestic partner take the legal duty to support the child. The child must be less than 18 years old when the child was placed.
  - 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. The order must make the subscriber, spouse or domestic partner the child's guardian as of a specific date. When the court order terminates or expires, the child is no longer an eligible child.

How to Apply

You can only apply during an open enrollment period. The open enrollment period is set by the Exchange each year.

To enroll, a subscriber must fill out and sign a Premera/an Exchange enrollment application. The enrollment application becomes part of the contract.

On the effective date of this contract, the subscriber and any enrolled dependents whose subscription charges have been accepted become members. Applicants may not be denied enrollment because of health reasons.

ADDING NEW DEPENDENTS

New Dependents Due to Marriage or Domestic Partnership

New dependents due to marriage or domestic partnership must apply for coverage no later than 60 days after the date of marriage or the date the domestic partnership is established. Coverage will be effective on the date of marriage or domestic partnership.

If they do not apply for coverage within 60 days, they must wait until the next open enrollment period to apply for coverage.

Newborn Child

A newborn child of a covered individual born after the subscriber's effective date will be covered for the first 31 days from the date of birth. Coverage ends after 31 days unless the newborn qualifies as an eligible child and is properly enrolled.

The subscriber must enroll the child and pay the subscription charges needed to cover the child within 60 days from the child's date of birth. If the enrollment and payment is not made within this time period, the child cannot enroll until the next open enrollment period.

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.

Adoptive Child

A child who is adopted or placed for adoption after the subscriber's effective date will be covered for the first 31 days from the date of adoption or placement. Coverage ends after 31 days unless the adoptive child qualifies as an eligible child and is properly enrolled.

The subscriber must enroll the child and pay the subscription charges needed to cover the child within 60 days from the child's date of birth. If the enrollment and payment is not made within this time period, the adoptive child cannot enroll until the next open enrollment period.

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.

CHANGING TO ANOTHER PLAN

You may want to change to another individual health plan. When there is no gap in coverage between the plans, any amounts that we applied to this plan's deductibles, out of pocket maximum, and benefit limits will be applied to your new plan. We will do this only if both plans have deductibles, out of pocket maximums, and benefit limits.

You may have to fill out a new application to change plans. We will review your application and let you know if this plan change is approved.

WHEN COVERAGE BEGINS

Upon acceptance of your application and payment of the required subscription charges, the initial coverage for you and your enrolled dependents will become effective as determined by the Exchange.

SUBSCRIPTION CHARGES AND GRACE PERIOD

This contract is issued in consideration of an eligibility validation by the Exchange or us and the payment of

required subscription charges by the subscriber.

Due Date for Initial Subscription Charges

If you applied for coverage through the Exchange, we must receive your initial subscription charge payment no later than the first day of the month your coverage is to become effective. Your coverage will begin upon receipt of those subscription charges. If we do not receive your subscription charge payment by the due date, the contract will terminate as if it were never effective.

If you applied for coverage directly with us we will send you a notice of the initial subscription charge amount and the due date. You have 20 days from the date you received the notice to pay the full subscription charges. Coverage will begin with payment of those subscription charges. If the initial subscription charges are not paid when due, this contract will terminate as if it were never effective.

Due Date for Subsequent Subscription Charges

Subsequent subscription charges are due on the first day of the month, unless otherwise stated on your statement. Premera will set up a monthly bank draft or provide a monthly billing statement. A grace period is allowed for payment. If the subscription charges are not received by the end of the grace period, this contract will terminate for non-payment.

This coverage is issued as individual health coverage, is not sold or issued for use as a government or third-party sponsored health plan, and is not partially or fully paid for by third-party payers including employers, business accounts, providers, not-for-profit agencies, government agencies, or any other third-party payer, either directly or indirectly, except as required by law.

Grace Period

For Plans Purchased Through the Exchange

If the federal government is paying a portion of your subscription charge as an advance payment of the premium tax credit, you have a 3-month grace period to pay your portion of the monthly subscription charges. For the first month of the 3-month grace period, we will continue to process and pay claims for the covered services under this plan. Beginning on the first day of the second month and through the last day of the third month, we will suspend all of your claims. If we have not received all outstanding subscription charges by the last day of the third month, we will terminate your coverage as of the last day of the first month of the grace period. We will also deny all pended claims for services you received in the second and third months of the grace period. Providers can seek reimbursement directly from you for those services.

For members whose subscription charges are not subsidized by the federal government, you have a 1-month grace period to pay subsequent subscription charges. If a payment is not received by the end of the grace period, your coverage will terminate as of the last day of the period for which subscription charges were paid. Claims for services received after the termination date will be denied. Providers can seek reimbursement directly from you for those services.

Rate Changes to Subscription Charges

Consistent with state law, Premera reserves the right to change subscription charges. We will provide written notice of any rate changes no later than 60 days prior to the date of the change. The effective date of the change will be stated in the notice. Paying the subscription charges means that you accept the change.

Your subscription charges will change as follows:

- When you have a change in your family and add or delete family members
- When you move to a new rate area. This change will be effective the first day of the month following your move to a new rate area.
- When a member resumes tobacco use, we also reserve the right to change the subscription charge for a member who is getting a non-tobacco user's discount, to the full undiscounted rate. This change will be effective the first day of the month following the date the member resumes tobacco use.

When permitted by state law, your subscription charges may also change when the federal or state government changes or eliminates premium subsidies, cost share reduction payments, or other monies owed to Premera.

TERMINATION OF COVERAGE

This contract is renewable at the option of the subscriber. The coverage under this contract will end when requested by the subscriber or as allowed by law as described below.

Should this contract be terminated due to fraud or intentional misrepresentation of material fact, failure to abide by the terms and conditions of the contract including non-payment of subscription charges or by the subscriber request, the subscriber and their dependents must wait until the next open enrollment to apply for a new contract.

SUBSCRIBER CANCELLATION

The subscriber may cancel this contract by notifying the Exchange within 14 days prior to the termination date. Coverage will be cancelled effective the last day of the month for which subscription charges were paid.

CONTRACT TERMINATED BY PREMERA

This contract will be terminated by Premera for the following reasons:

- When the subscriber does not pay the subscription charges
- The first of the month following the date the subscriber is no longer a permanent resident of the state of Alaska
- Upon our discovery of fraud, material misrepresentation or concealment by the subscriber or member. We will provide written notice to the subscriber 30 days prior to the termination of the contract.
- You materially breach the contract. This includes, but is not limited to, failure to meet the eligibility requirements.
- Federal or state laws no longer permit us to offer this contract
- We replace or discontinue this contract as allowed by state law. We will notify you at least 90 days before the termination date.
- We discontinue offering all individual coverage as allowed by law

Termination of this contract by either party or nonpayment cancels the coverage of all members.

WHEN DEPENDENT COVERAGE ENDS

An enrolled dependent's coverage will end as follows:

- On the date the subscriber's coverage ends
- On the last day of the month following the subscriber's death
- For a spouse, the last day of the month following the date of divorce
- For a domestic partner and their children, the last day of the month following the termination of a domestic partnership. Termination of a domestic partnership means a change in one or more of the eligibility requirements described under the ***Eligibility and Enrollment*** section.
- For a child, the end of the plan year following the date he or she no longer meets the requirements of an eligible child described under the ***Eligibility and Enrollment*** section, or if a special enrollment event occurs, whichever comes first

Failure of the subscriber to notify us when one of these events happens will not be taken as a waiver of our right to terminate this coverage.

CONTRACT TERMINATED BY THE EXCHANGE

Coverage will end if the subscriber or dependent no longer meets the eligibility requirements as determined by the Exchange. Coverage will end as of the date established by the Exchange.

CONTINUATION OF COVERAGE

Notwithstanding any other terms of this contract, if you are an inpatient in a hospital or skilled nursing facility upon termination of the contract, you shall continue to receive benefits for the condition that caused the confinement, until the first of the following occurs:

- Discharge from the facility in which you are confined
- Care is no longer medically necessary
- Limits of coverage under this contract have been reached. Benefits will not renew upon onset of a new

calendar year.

The provision will not apply if your coverage is terminated due to subscriber-requested cancellation, nonpayment of subscription charges or member fraud. However, exceptions will be made if proof is provided that the termination is due to circumstance beyond your control such as your medical or legal incapacitation.

OPEN AND SPECIAL ENROLLMENT PERIODS

Enrollment on this plan is limited to an annual open enrollment period, or if an individual experiences a special enrollment event as defined below.

OPEN ENROLLMENT PERIOD

An annual enrollment period is the time period each year when an individual can enroll for coverage on this plan. The completed enrollment application must be postmarked or received electronically before the end of the open enrollment period. You can go to our website at **premera.com** for the dates of an open enrollment period.

If you are enrolling through the Exchange, please contact the Exchange at 1-800-318-2596 for open enrollment periods and enrollment requirements.

SPECIAL ENROLLMENT PERIOD

Individuals may enroll outside the annual open enrollment period if they experience a qualifying life event. Special enrollment qualifying life events are limited to the following:

- Adding a dependent or becoming a dependent through marriage, birth, adoption, foster care placement, or court order
- Losing a dependent or dependent status due to death, divorce, or reaching the maximum child age (26)
- Losing other health coverage such as loss of employer sponsored coverage, loss of Medicaid or other public program providing health benefits, loss of Qualified Health Plan due to a permanent move, loss of eligibility for a student health plan.
- Becoming a state resident or moving from outside of the United States
- Change in citizenship or lawful presence status
- Loss of COBRA coverage (except voluntary termination or termination for failure to pay)
- Experiencing an exceptional circumstance that prevented enrollment in coverage
- Victims of domestic abuse/violence or spousal abandonment
- Change in eligibility for the premium tax credit or cost-sharing reductions
- Other exceptional circumstances evaluated on a case by case basis such as, breach of contract by the health plan, an error, misrepresentation, or inaction of the Exchange or the Department of Health and Human Services, etc.

Enrollment is subject to verification at the time of application. Please visit **premera.com** or contact The Exchange for information on if you qualify for a special enrollment period and the required documentation to prove your eligibility.

***Note:** The ACA allows additional opportunity for special enrollment in the event of an error, misrepresentation, or inaction of an exchange or the Department of Health and Human Services, breach of contract by your prior health plan, or certain changes to your eligibility for advance payments of the premium tax credit or cost-sharing reductions.

An application for enrollment must be made within 60 days of the qualifying event. The completed enrollment application must be postmarked or received electronically before the end of the special enrollment period. The coverage start date will vary depending on the special event. Please contact Premera or the Exchange for more information.

If you are enrolling through the Exchange, please contact the Exchange at 1-800-318-2596 for open enrollment periods and enrollment requirements.

OTHER PLAN INFORMATION

This section tells you more about how this plan works. It tells you about federal and state requirements we must follow. It also has 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 this plan. We may also take legal action against you.

CHANGES TO BENEFITS AND SUBSCRIPTION CHARGES

We may change this plan's benefits and subscription charges. We will send you a written description of any changes at least 60 days before they happen. We will change this plan only if we make the same changes to all contracts on this form. If we make changes while you are an inpatient, your benefits will not change until you are discharged or transferred to another facility.

No producer or agent of Premera, or any other person, is authorized to make any changes, additions or deletions to the 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.

No rights to receive benefits are vested under this contract.

CONFORMITY WITH THE LAW

This 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 health care reform). It is governed by the laws of Alaska, except to the extent pre-empted by federal law. If any part of this contract, or any amendment to it, is found to be in conflict with state or federal laws or regulations, we will administer this contract to comply with those laws and regulations as of their effective date.

ENTIRE CONTRACT

The entire contract between you and Premera consists of all of the following:

- The contract
- All applications used to apply for coverage
- All attachments and endorsements included now or issued later

EVIDENCE OF MEDICAL NECESSITY

Before we provide benefits, we have the right to require proof that a service you get is medically necessary. See the ***Definitions*** section to learn how the plan defines medically necessary. You may give us this proof, or your healthcare providers may give it to us for you. We will not provide benefits if we do not receive this proof.

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.

INDEPENDENT CORPORATION

The subscriber hereby expressly acknowledges the understanding that this contract constitutes a contract solely between the subscriber and Premera Blue Cross Blue Shield of Alaska.

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

INDIVIDUAL MEDICAL PLAN

This contract is sold and issued in the state of Alaska as an individual medical plan. It is not issued for use as an employer-sponsored or group health plan. Premera specifically disclaims any liability for state or federal group plan requirements.

This contract does not replace, affect, or supplement any state or federal requirement for worker's compensation, employer's liability, or similar insurance. When an employer is required by law to provide or has the option to

provide worker's compensation or similar insurance and does not provide such coverage for its employees, the benefits available under this plan will not be provided for conditions arising out of the course of employment which are or would be covered by such insurance.

INTENTIONALLY FALSE OR MISLEADING STATEMENTS

If a member has committed fraud or lied on purpose on any application, health statement or enrollment form that affects their eligibility for coverage or the risks we assumed, we may take one or more of the actions below:

- Deny the claim
- Reduce the amount of benefits we provide for the claim
- Rescind, or cancel, coverage under this plan if this happens during the first two years of coverage. This type of cancellation is retroactive. That means it treats the contract as void from the initial effective date or voids benefits paid up to a year before the cancellation. We will tell members in writing at least 30 days before we rescind coverage.

We have the right to get back, any amounts we paid in error due to fraud or intentional misrepresentation. Recoveries made under this provision will be made no later than 365 days from the date we discovered, or could have reasonably discovered, the fraud or intentional misrepresentation.

If we deny or reduce your claim, or rescind your coverage, under this provision, you have the right to appeal. Please see ***Complaints and Appeals*** for information about asking for an appeal. You can also call Customer Service for help with an appeal.

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.

LIMITATION OF LIABILITY

We are not legally responsible for any of the following:

- Epidemics, disasters, or other situations that prevent members from getting the care they need
- The quality of services or supplies that members get from providers, or the amounts charged by providers
- Providing any type of hospital, medical, dental, vision, or similar care
- Harm that comes to a member while in a provider's care
- Amounts in excess of the actual cost of services and supplies
- Amounts in excess of this plan's maximums. This includes recovery under any claim of breach.
- General or special damages including, without limitation, alleged pain, suffering, mental anguish or consequential damages

MEMBER COOPERATION

You 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.

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 OF INFORMATION USE AND DISCLOSURE

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

We collect, use, or give out this information for routine business operations such as these:

- Determining your eligibility for benefits and paying claims (we do not use genetic information for underwriting or enrollment purposes.)
- Coordinating benefits with other healthcare plans
- Care management, health support programs, or quality reviews
- Meeting other legal obligations that are specified under this contract

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

We protect your privacy by making sure your information stays confidential. We have a company confidentiality policy and we require all employees to sign it.

At times we may give out your PPI when it is not related to a routine business function. When we do this, we remove any information that could easily identify you, or we get your permission in writing ahead of time.

You have the right to look at or change any records we have that contain your PPI. To do this, contact Customer Service and ask us to mail a request form to you.

NOTICE OF OTHER COVERAGE

In order to get benefits under this plan, you must tell us about all of the following:

- 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 company
- The name and address of any insurance carrier that provides:
  - Personal injury protection (PIP)
  - Underinsured motorist coverage
  - Uninsured motorist coverage
  - Any other insurance under which you are, or may be, entitled to compensation
- The name of any other insurance plans that cover you

NOTICES

We may be required to send you certain notices. We will consider such a notice to be delivered if we mail it to your most recent address in our records. The date of the postmark will be the delivery date.

If you are required to send notice to us, the postmark date will be the delivery date. If it is not postmarked, the delivery date will be the date we receive it.

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.

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.

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.

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

- **Preferred and Non-Preferred Providers:** For covered services from these providers, we pay the providers directly. You only have to pay deductibles, copays (if any), coinsurance, and amounts for services that are not covered.
- **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.

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, brought against us by you or anyone claiming any right under this plan must be filed:

- No more than 3 years after the date we denied, in writing, the rights or benefits claimed under this plan, or the date the independent review process ends, if applicable
- In the state of Alaska

DEFINITIONS

Some words we use to describe this plan have special meanings in this contract. This information 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 benefit level, however, since we do not have a contract 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 an infection of a cut or wound
- Over-exertion or muscle strains
- Dental injuries caused by biting or chewing

Adverse Benefit Determination

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

- A member's or applicant's eligibility to be or stay enrolled in this plan or health insurance coverage
- A limitation on otherwise covered benefits

- A clinical review decision
- A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective

Affordable Care Act

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

Allowed Amount

See ***Important Plan Information***.

Ambulatory Surgical Center

A healthcare facility where people get surgery without staying overnight. An ambulatory surgical center must be licensed or certified by the state it is in. It must also meet all of these criteria:

- It has an organized staff of doctors
- It is a permanent facility that is equipped and run mainly for doing surgical procedures
- It does not provide inpatient services or rooms

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.

Calendar Year (Year)

A 12-month period that starts on 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 45 CFR Part 46; and
- One or more of the following:
  - The United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers
  - The United States Department of Health and Human Services, United States Food and Drug Administration (FDA)
  - The United States Department of Defense
  - The United States Department of Veterans' Affairs

- A nongovernmental research entity abiding by current National Institutes of Health guidelines

Coinsurance

See ***Important Plan Information***.

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 disease the mother has during pregnancy that is not caused by the pregnancy. The disease is made worse by the pregnancy
- 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 complication of pregnancy needs services that are more than the usual maternity services. This includes care before, during, and after birth (normal or cesarean).

Congenital Anomaly

A marked difference from the normal structure of a body part that is different from the normal structure at the time of birth.

Contract

Your contract with us consists of this document, your application form(s) and any attachments or endorsements.

Copay

See ***Important Plan Information***.

Cosmetic Services

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

Cost-Share

The part of healthcare costs that you have to pay. Examples are deductibles, coinsurance, copayments, and similar charges. It does not include subscription charges, amounts over the allowed amount billed by health care providers who are out of the network, or the cost of services not covered by this plan. See ***Summary of Your Costs*** to find out what your cost-shares are.

Covered Service

A medically necessary service that is eligible for benefits under this plan.

Custodial Care

Any part of a covered service that is mainly to:

- Maintain your health over time, and not to treat a specific illness or injury
- Help you with activities of daily living. Examples are help in walking, bathing, dressing, eating, and preparing special food. This also includes supervising the self-administration of medicine when it does not need the constant attention of trained healthcare providers.

Deductible

See ***Important Plan Information***.

Detoxification

Detoxification is active medical management of medical conditions due to substance intoxication or withdrawal, which requires repeated physical examinations appropriate to the substance ingested and use of medication. Observation alone is not active medical management.

Effective Date

The date your coverage begins under this plan.

Emergency Care

- 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.

Emergency Medical Condition

A medical condition that you believe puts your health, a part of your body or the health of an unborn child at risk. Examples are severe pain, a possible heart attack or a broken bone. You need medical care right away. Routine care for sore throats or colds, follow-up care and prescription requests are not emergencies.

Endorsement

A document signed by an officer of Premera 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 care, hospitalization, maternity and newborn care, mental health and substance abuse 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.

Exchange

The entity established by the federal government as part of the Affordable Care Act to facilitate the purchase of health care coverage. Also known as the Federally Facilitated Exchange, the health insurance marketplace, and The Exchange.

Experimental or Investigative Services

Services that meet one or more of the following:

- A drug or device that cannot be lawfully sold 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 indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

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

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, state-approved substance abuse treatment program, or hospice. Not all health care facilities are covered under this contract.

Habilitative Services

Habilitation 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. Habilitation 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. Habilitation devices may be limited to those that have FDA approval and are prescribed by a qualified provider. Habilitation 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 health care provider for everyday or extended use to treat an illness or injury. HME may include: oxygen equipment, wheelchairs or crutches.

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 doctors that provides or supervises the care
- It has 24-hour nursing services provided by or supervised by registered nurses

A facility is *not* 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, medical condition or complication of pregnancy.

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

Someone who is admitted to a healthcare facility for an overnight stay. We also use this word to describe the services you get while you are an inpatient.

Maternity Care

Health services you get during pregnancy (before, during, and after birth) or for any condition caused by pregnancy. This includes the entire time you are pregnant and up to 45 days after birth.

Medically Necessary and Medical Necessity

Services a doctor, 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, physician, or other health care provider. They do not cost 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

Any person covered under this plan.

Mental Health Condition

Any condition listed in the current *Diagnostic and Statistical Manual (DSM)*, published by the American Psychiatric Association, excluding diagnosis and treatments for substance abuse.

Off-Label Use

A drug is prescribed for a different condition than the one it was approved for. The off-label use must be seen as effective by a collection of standard reference materials. Scientific evidence must also show the drug is effective for the off-label use.

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.

Outpatient

A person who gets healthcare services without an overnight stay in a healthcare facility. This word also describes the services you get while you are an outpatient.

Plan

The benefits, terms and limits stated in this contract.

Prescription Drug

Drugs and medications that by law require a prescription. This includes “biologicals” (medicines made from living

things or their products) used in chemotherapy to treat cancer. It also includes biologicals used to treat people with HIV or AIDS. According to the Federal Food, Drug and Cosmetic Act, as amended, the label of a prescription drug must have this statement on it: “Caution: Federal law prohibits dispensing without a prescription.”

Primary Care Providers

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care 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 the requirements for 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 services. Please refer to ***Covered Services*** and ***Exclusions*** for additional information.

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

- **Preferred In-Network Providers** (Preferred INN) are contracted providers that are in your provider network. You receive the highest benefit level when you use a Preferred INN provider. Preferred in-network providers will not bill you for the amount above the allowed amount for a covered service.
- **Non-Preferred 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 Non-Preferred providers. Non-Preferred providers will not bill you the amount above the allowed amount for a covered service.
- **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.

For providers of medical care outside the service area, we use the following terms. These providers are generally referred to as “providers outside the service area”.

- **Host Blues' Network Providers** are providers outside the service area that have agreements with another Blue Cross Blue Shield Licensee. These providers will not bill you for amounts above the allowed amount for a covered service.
- **Non-Contracted Providers** are providers that do not have an agreement another Blue Cross Blue Shield Licensee. These providers can bill you for amounts above the allowed amount for a covered service.

See ***When You Are Outside Alaska or Washington (Outside the Service Area)*** and ***BlueCard® Program*** for additional details, and see the ***Summary of Your Costs*** for the cost-shares required for each provider type.

Reconstructive Surgery

Reconstructive surgery is surgery:

- Which restores features damaged as a result of accidental injury (see ***Definitions***) or illness
- To correct a congenital deformity or anomaly

Rehabilitative Services

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

Rehabilitative 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 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.

Resident

Resident means a person who lives in Alaska and intends to remain in the state permanently or indefinitely. In no event will coverage be extended to a subscriber or dependent who resides in the state for the primary purpose of obtaining health care or health care coverage. The confinement of a person in a nursing home, hospital, or other medical institution shall not by itself be sufficient to qualify such person as a resident. We may require proof of residency from time to time. Examples of proof include, but shall not be limited to, a valid photo ID, current utility bills, tax or financial records. All documents must show the street address of the individual's residence and not a post office box.

Services

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

Service Area

The state of Alaska and the state of Washington (except Clark County, Washington).

Skilled Nursing Care

Medical care you get in your home or in a skilled nursing facility. Care is ordered by a physician and requires the knowledge and training of a licensed registered nurse.

Skilled Nursing Facility

A medical facility licensed by the state to provide nursing services to patients after an illness or injury. A skilled nursing facility must meet all of the following criteria:

- Services it provides are directed by a doctor
- Nursing care is supervised by a registered nurse
- The facility is approved by Medicare, or would qualify for Medicare approval if it were requested

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

Someone who is legally married to the subscriber. A spouse can also be the subscriber's domestic partner.

Subscriber

The person in whose name the plan is issued.

Subscription Charges

The monthly rates that the subscriber pays each month for this plan.

Substance Abuse

Dependent on or addicted to drugs or alcohol. It is an illness in which a person is dependent on alcohol and/or a controlled substance regulated by state or federal law. It can be a physical dependency or a mental dependency, or both. People with a physical or mental dependency usually use drugs or alcohol in a frequent or intense pattern that leads to:

- Losing control over the amount and circumstances of use
- Developing a tolerance of the substance, or having withdrawal symptoms if they reduce or stop the use
- Making their health worse or putting it in serious danger
- Not being able to function well socially or on the job

Urgent Care

Treatment of unscheduled, drop-in patients who have minor illnesses or 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 clinics and medical facilities that have extended hours and are open to the public.

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.

We, Us and Our

Means 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.