Premera Blue Cross Standard Silver CSR3

$0 deductible (individual),

$0 deductible (family)

Contract for Individual and Families Residing in Alaska

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

An Independent Licensee of the Blue Cross Blue Shield Association

PREMERA BLUE CROSS BLUE SHIELD OF ALASKA

Premera Blue Cross Standard Silver CSR3

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 Participating 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 premiums 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 premiums after notice to the subscriber will be considered acceptance by the subscriber. Failure to pay premiums 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

If any provision of this plan is superseded by state or federal law, the plan will comply with the applicable law as it relates to those provisions.

OUT-OF-AREA PROVIDERS

This plan covers care received in Premera's service area (Alaska and Washington (except Clark County)). Non-emergency care received outside of the service area is covered at the out-of-network reimbursement rate regardless of if the provider has a contract with a local Blue Cross Blue Shield Licensee. To access non-emergency care from a non-preferred or non-participating provider at the in-network benefit level you must request prior authorization. See ***Prior Authorization*** for details. This request is in addition to any other required prior authorization for services. Please contact customer service for assistance locating providers or submitting a prior authorization request.

PREMERA BLUE CROSS BLUE SHIELD OF ALASKA



Kristin Meadows

General Manager and Vice President
Individual 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. 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

PO Box 21762
Eagan, MN 55121

Telephone Numbers:

Local and toll-free number: 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
PO Box 21762
Eagan, MN 55121

Mail Your Prescription Drug Claims To:

Express Scripts
ATTN: Commercial Claims
PO Box 14711
Lexington, KY 40512-4711

Contact the Pharmacy Benefit Administrator at:

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

COMPLAINTS AND APPEALS

Premera Blue Cross
Attn: Appeals Department
PO Box 21762
Eagan, MN 55121

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

PEDIATRIC DENTAL ESTIMATE OF BENEFITS

Premera Blue Cross
Attn: Dental Review
PO Box 21762
Eagan, MN 55121

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

BLUECARD

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

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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, 2026. Your costs are subject to 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 and Participating Providers)*	**Non-Participating Providers** **Providers Outside The Service Area** *(except emergencies)*
Individual Deductible:	$0	$0
Family Deductible:	$0	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 and Participating Providers)*	**Non-Participating Providers** **Providers Outside The Service Area** *(except emergencies)*
Individual Out-of-Pocket Maximum:	$2,200	Not Applicable
Family Out-of-Pocket Maximum:	$4,400	Not Applicable

- The out-of-pocket maximum does not apply for services you get from Participating 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	
Covered Services	**Preferred INN Providers** (*also applies to Accepted Rural Providers and Participating Providers*)	**Non-Participating Providers** **Providers Outside The Service Area** *(except emergencies)*
Acupuncture Limited to 12 visits per calendar year. You may have additional charges for hospital facility services. See those covered services for details.	No charge	Deductible, then 60% coinsurance
Allergy Testing and Treatment	Deductible, then 25% coinsurance	Deductible, then 60% coinsurance
Ambulance		
• Emergency ground, water or air ambulance transport	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
• Non-emergency ground or water transport		
• Non-emergency air ambulance, including transfer from one facility to another facility	Deductible, then 25% coinsurance	Deductible, then 60% coinsurance
Blood Products and Services	Deductible, then 25% 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 25% 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
• Transportation for cancer clinical trials only	Deductible, then 25% coinsurance	In-network deductible, then 25% coinsurance
Dental Care		
• **Dental Anesthesia** When medically necessary	Deductible, then 25% 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
Diagnostic X-ray, Lab and Imaging		
• Preventive screenings and tests	No charge	Deductible, then 60% coinsurance
• Basic diagnostic X-ray, lab, and imaging	Deductible, then 25% coinsurance	Deductible, then 60% coinsurance

	YOUR COSTS OF THE ALLOWED AMOUNT	
Covered Services	**Preferred INN Providers** (*also applies to Accepted Rural Providers and Participating Providers*)	**Non-Participating Providers** **Providers Outside The Service Area** *(except emergencies)*
• Major diagnostic X-ray, lab, and imaging	Deductible, then 25% coinsurance	Deductible, then 60% coinsurance
• Diagnostic and supplemental breast exams	No charge	Deductible, then 60% coinsurance
Dialysis	Deductible, then 25% coinsurance	Deductible, then 60% coinsurance
Emergency Room	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
Foot Care When medically necessary	Deductible, then 25% 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	No charge	Deductible, then 60% coinsurance
• Outpatient services to treat chronic conditions, unlimited	No charge	Deductible, then 60% coinsurance
• Inpatient, limited to 30 days per calendar year	Deductible, then 25% coinsurance	Deductible, then 60% coinsurance
Hearing Care For hearing loss, often due to age or noise exposure. See ***Office and Clinic Visits*** for hearing loss from disease or injury.		
• Hearing Exam Limited to 1 exam per calendar year	$10 copay, deductible waived	$10 copay, deductible waived
• Hearing Test Limited to 1 test per calendar year	No charge	No charge
• Hearing Hardware Limited to 1 device per ear every 3 years	20% coinsurance, deductible waived	20% coinsurance, deductible waived
Home Health Care Limited to 130 visits per calendar year.	Deductible, then 25% coinsurance	Deductible, then 60% coinsurance
Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies	Deductible, then 25% coinsurance	Deductible, then 60% coinsurance

	YOUR COSTS OF THE ALLOWED AMOUNT	
Covered Services	**Preferred INN Providers** (*also applies to Accepted Rural Providers and Participating Providers*)	**Non-Participating Providers** **Providers Outside The Service Area** *(except emergencies)*
Hospice Care Limited to a lifetime maximum of 6 months. All hospice services are subject to the lifetime maximum. • Unlimited hospice home visits • 10 days of inpatient care • 240 hours of respite care	Deductible, then 25% coinsurance	Deductible, then 60% coinsurance
Hospital • Inpatient care • Facility • Professional • Outpatient Care • Facility • Professional	 Deductible, then 25% coinsurance Deductible, then 25% coinsurance Deductible, then 25% coinsurance Deductible, then 25% coinsurance	 Deductible, then 60% coinsurance Deductible, then 60% coinsurance Deductible, then 60% coinsurance Deductible, then 60% coinsurance
Infusion Therapy	Deductible, then 25% coinsurance	Deductible, then 60% coinsurance
Massage Therapy Limited to 20 visits per calendar year	$10 copay, deductible waived	Non-Participating: Deductible, then 60% coinsurance
Mastectomy and Breast Reconstruction	Deductible, then 25% 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 25% coinsurance	Deductible, then 60% coinsurance
Medical Foods Metabolic formula and low protein food for inborn errors of metabolism	Deductible, then 25% 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.	 No charge	 No charge

	YOUR COSTS OF THE ALLOWED AMOUNT	
Covered Services	**Preferred INN Providers** (*also applies to Accepted Rural Providers and Participating Providers*)	**Non-Participating Providers** **Providers Outside The Service Area** *(except emergencies)*
• 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.**		
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 25% coinsurance	Deductible, then 25% coinsurance
Mental Health Care 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 (including virtual care)	No charge	Deductible, then 60% coinsurance
• Other professional services	Deductible, then 25% coinsurance	Deductible, then 60% coinsurance
• Outpatient facility services	Deductible, then 25% coinsurance	Deductible, then 60% coinsurance
• Outpatient facility services	Deductible, then 25% coinsurance	Deductible, then 60% coinsurance
• Inpatient, partial hospital, and residential facilities	Deductible, then 25% coinsurance	Deductible, then 60% coinsurance
Newborn Care	Deductible, then 25% coinsurance	Deductible, then 60% coinsurance

	YOUR COSTS OF THE ALLOWED AMOUNT	
Covered Services	**Preferred INN Providers** (*also applies to Accepted Rural Providers and Participating Providers*)	**Non-Participating Providers** **Providers Outside The Service Area** *(except emergencies)*
Office and Clinic Visits (including virtual care providers)		
• Office, clinic, telehealth or home visits per calendar year with your designated PCP	No charge	Deductible, then 60% coinsurance
• E-visits	No charge	Deductible, then 60% coinsurance
• Office, clinic or home visits with your OB/GYN (if not your designated PCP)	No charge	Deductible, then 60% coinsurance
• All other provider office, clinic or home visits, including specialist office visits	$10 copay, deductible waived	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
• 1 comprehensive low vision evaluation and 4 follow up visits in a 5-calendar year period	$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
• Low vision devices, high powered spectacles, magnifiers and telescopes when medically necessary	No charge	No charge

	YOUR COSTS OF THE ALLOWED AMOUNT	
Covered Services	**Preferred INN Providers** (*also applies to Accepted Rural Providers and Participating Providers*)	**Non-Participating Providers** **Providers Outside The Service Area** *(except emergencies)*
Pediatric Dental Care		
Class I Services	No charge	Deductible, then 30% coinsurance
Class II Services	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance
Class III Services	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
Premera-Designated Centers of Excellence Program Special criteria are required for coverage. Please see benefit for coverage details. For providers other than Premera-Designated Centers of Excellence, see ***Hospital*** and ***Surgery***.	No charge	Covered as any other service
Preventive Care Limited to how often you can get services based on your age and gender.		
• Routine care such as exams, screening, immunizations, contraceptive management and nutritional therapy	No charge	Deductible, then 60% coinsurance
• Seasonal and travel immunizations you get at a pharmacy or mass immunizer	No charge	No charge
• Health education and tobacco cessation programs	No charge	No charge
Psychological and Neuropsychological Testing	Deductible, then 25% coinsurance	Deductible, then 60% coinsurance
Rehabilitation Therapy		
• Outpatient services to treat non-chronic conditions, limited to 45 visits per calendar year	No charge	Deductible, then 60% coinsurance
• Outpatient services to treat chronic conditions, unlimited	No charge	Deductible, then 60% coinsurance
• Inpatient, limited to 30 days per calendar year	Deductible, then 25% coinsurance	Deductible, then 60% coinsurance

	YOUR COSTS OF THE ALLOWED AMOUNT	
Covered Services	**Preferred INN Providers** (*also applies to Accepted Rural Providers and Participating Providers*)	**Non-Participating Providers** **Providers Outside The Service Area** *(except emergencies)*
Skilled Nursing Facility Care Limited to 60 days per calendar year.	Deductible, then 25% coinsurance	Deductible, then 60% coinsurance
Spinal and Other Manipulations Limited to 20 visits per calendar year. You may have additional charges for hospital facility services. See those **C*overed Services*** for details.	No charge	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 (including virtual care)	No charge	Deductible, then 60% coinsurance
• Other professional services	Deductible, then 25% coinsurance	Deductible, then 60% coinsurance
• Outpatient facility services	Deductible, then 25% coinsurance	Deductible, then 60% coinsurance
• Inpatient, partial hospital, and residential facilities	Deductible, then 25% 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 25% coinsurance	Deductible, then 60% coinsurance
Surgical Center Care - Outpatient	Deductible, then 25% coinsurance	Deductible, then 60% coinsurance
Tempromandibular Joint Disorders (TMJ) Care		
• Office visits	See Office and Clinic Visits	Non-Participating: Deductible, then 60% coinsurance
• Other professional services	Deductible, then 25% coinsurance	Non-Participating: Deductible, then 60% coinsurance
• Outpatient facility services	Deductible, then 25% coinsurance	Non-Participating: Deductible, then 60% coinsurance
• Inpatient facility services	Deductible, then 25% coinsurance	Non-Participating: Deductible, then 60% coinsurance

	YOUR COSTS OF THE ALLOWED AMOUNT	
Covered Services	**Preferred INN Providers** (*also applies to Accepted Rural Providers and Participating Providers*)	**Non-Participating Providers** **Providers Outside The Service Area** *(except emergencies)*
Therapeutic Injections	Deductible, then 25% 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*
• Other inpatient and outpatient care services	Deductible, then 25% coinsurance	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 • 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.**	Deductible, then 0% coinsurance	Deductible, then 0% coinsurance
Urgent Care		
• Non-hospital urgent care centers	$5 copay, deductible waived	Deductible, then 60% coinsurance
• Urgent care centers attached to or part of a hospital	Deductible, then 25% coinsurance	Deductible, then 25% coinsurance
You may have additional costs for other services such as x-rays. See those covered services for details.		
Virtual Care Virtual care select providers		
• General Medical Services	No Charge	Not covered
• Mental Health	No charge	Not covered
• Substance Use Disorder	No charge	Not covered

	YOUR COSTS OF THE ALLOWED AMOUNT	
Covered Services	**Preferred INN Providers** (*also applies to Accepted Rural Providers and Participating Providers*)	**Non-Participating Providers** **Providers Outside The Service Area** *(except emergencies)*
Virtual care select providers can be found at **https://www.premera.com/visitor/virtual-care** or contact Customer Service for assistance. See the ***Office and Clinic Visits***, ***Mental Health Care*** and ***Substance Use Disorder*** benefits for virtual care benefits.		

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	No charge	No charge
• Formulary Preferred brand-name drugs	$15 copay, deductible waived	$15 copay, deductible waived
• Formulary Non-Preferred drugs	$50 copay, deductible waived	$50 copay, deductible waived
• Anti-cancer drugs	Deductible, then 25% coinsurance	In-network deductible, then 25% coinsurance
Prescription Drugs – Mail Order Pharmacy Limited up to a 90-day supply. 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	No charge	Not covered
• Formulary Preferred brand-name drugs	$45 copay, deductible waived	Not covered
• Formulary Non-Preferred drugs	$150 copay, deductible waived	Not covered
• Anti-cancer drugs	Deductible, then 25% coinsurance	Not covered
Specialty Pharmacy Drugs Limited up to a 30-day supply		
• Specialty drugs (specialty or retail pharmacy)	$150 copay, deductible waived	$150 copay, deductible waived
• Specialty drugs requiring special handling, provider coordination, and patient education	Deductible, then 25% 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 and Participating INN providers, and a separate individual deductible for covered services received from Non-Participating providers and providers outside the service area.

After you have met the individual deductible for services received from Preferred and Participating 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-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 and Participating 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 or Participating 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-Participating providers and providers outside the service area. Each enrolled family member must satisfy the individual deductible for 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 toward 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 or Participating 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 or Participating 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-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 or Participating 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 or Participating 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-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-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.

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

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

Non-Emergency Services Protected From Balance Billing

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

Emergency Services

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

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

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

Air Ambulance

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

Pediatric Dental Services

- **Providers Who Have Signed A Contracting Agreement With Us**

  The allowed amount is the fee that we have negotiated with contracting dental providers.

- **Providers Who Have Not Signed A Contracting Agreement With Us**

  The allowed amount will be the maximum allowed amount in the geographical area where the services were provided. In no case will the allowed amount be higher than the 90th percentile of provider fees in that area where services are received.

BALANCE BILLING PROTECTION

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

Emergency Services

Emergency services from a Non-Participating hospital or facility or from a non-participating provider at the hospital or facility.

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

Non-Emergency Services from a non-participating provider at an in-network hospital or outpatient surgery center.

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

Air Ambulance

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

Note: Ground ambulance providers are always paid based on billed charges.

For more information, refer to www.premera.com/visitor/quick-help/care-costs.

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**.**

IMPORTANT NOTE: Certain services received from out-of-network providers are not covered under this plan. See ***Summary of Your Costs.***

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.

Participating Providers

Participating providers are not included in our network. However, they have contracted with us and will accept our

allowed amount as payment in full. 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 except for emergency services, covered air ambulance services, or as prohibited by law. 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. Benefits for services from accepted rural providers are provided at the higher, preferred provider benefit level. If they are not in our network, you may also pay for charges over the allowed amount except for emergency services, covered air ambulance services, or as prohibited by law. You may have to pay for services and send us a claim for reimbursement. Amounts over the allowed amount do not count towards the deductible or out-of-pocket maximum.

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

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

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

Continuity Of Care

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

COC applies in these situations:

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

How you qualify for Continuity of Care

If a professional provider contract is terminated without cause, continuing care will be provided according to the details included in the member's notice of the contract termination. During this time, Premera will consider the professional provider to still have an agreement only while this policy remains in effect and

- For the period that is the longest of the following:
  - The end of the current policy year
  - Up to 90 days after the termination date, if the event triggering the right to continuing treatment is part of an ongoing course of treatment
  - through completion of postpartum care, if the member is pregnant on the date of termination; or
- until the end of the medically necessary treatment for the medical condition if the member has a terminal medical condition. In this paragraph, "terminal" means a life expectancy of less than one year.

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

Duration of Continuity of Care

If you are 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.)

Continuity of care does not apply if your provider:

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

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

LEVELS OF CARE

Healthcare is delivered in many settings with distinct levels of care. Each level of care involves a different intensity of service to treat your medical and behavioral health symptoms. Premera covers the least intensive level of care

that is medically necessary to treat your symptoms. Care is often provided in a continuum beginning with acute care and transitioning to outpatient care as symptoms or condition improve. Please see Premera medical policies for Medical Necessity criteria for each type of care.

Acute Inpatient Level of Care

- Medical, surgical or behavioral health hospitals (see Definitions for Hospital or Inpatient)
- Acute facilities provide treatment for severe episodes of Illness, Injury, or behavioral health symptoms, and for recovery from surgery. You are monitored for medical, surgical and psychiatric symptoms, with 24-hour availability of appropriate medical and psychiatric practitioners, and 24/7 onsite nursing services. Care may begin in the emergency room or an outpatient medical, surgical, or behavioral health setting with transition to an acute inpatient level of care to address your needs. Specialty-appropriate physicians, nurse practitioners, or physician assistants perform physical examinations or psychiatric evaluations within one day of hospital admission. Hospitals provide daily physical examination or psychiatric evaluation, daily nursing observation, and daily treatment during the stay. A plan for treatment and transition to lower levels of care is established shortly after admission. A brief hospital stay while on Observation is considered to be Outpatient care.

Acute care facilities are licensed by the applicable state health department as a hospital or as a behavioral health evaluation and treatment facility.

Intermediate Level Facilities

- Long-term Acute Care Hospitals (LTAC or LTACH)
- Inpatient Rehabilitation Hospitals or Units
- Skilled Nursing Facilities (see Definitions for Skilled Nursing Facility and Skilled Nursing Care)
- Residential Treatment Programs in residential treatment centers or wilderness settings

Intermediate care facilities are a bridge between acute and outpatient care settings. They serve patients who do not require the intensity of service that acute hospitals provide, but are not yet ready to step-down to outpatient care. Their purpose is to improve function and stabilize you for transition to outpatient services. Intermediate level facilities provide care for patients' medical needs as well as daily living support. Patients typically reside in the facility for the duration of their treatment.

Intermediate level care may be provided in a free-standing facility or in a segregated location within another facility. Wilderness programs providing behavioral health care in an outdoor setting and with the structure and intensity of a residential treatment program are also intermediate level care. Inpatient Hospice and facilities providing Custodial Care are not intermediate level facilities.

Intermediate care facilities are licensed by the applicable state health department as a healthcare or behavioral health facility. A program operating under another type of state licensure, such as a child-care license, is not an intermediate facility. Intermediate care facilities have the following characteristics:

- Onsite nursing at all times (or, for behavioral health programs, on-call nursing and onsite mental health practitioner)
- Admission evaluation or psychiatric assessment by an appropriately licensed provider by at least shortly after admission and at least weekly (every seven days) thereafter
- Daily treatment by appropriate licensed clinical providers
- A plan for treatment established shortly after admission
- Discharge planning for transition to lower levels of care

Please see Premera medical policies for Medical Necessity criteria for each type of care.

Intermediate Level Ambulatory or Outpatient Care

- Partial Hospitalization Programs for Psychiatric or Substance Use Disorder Treatment
- Intensive Outpatient Psychiatric or Substance Use Disorder Treatment Programs
- Home Health Care
- Residential Neurological Rehabilitation or Rehab Without Walls

Intermediate level outpatient programs provide intensive services to those who can function safely in a community-based setting but require a higher level of care than is provided in an outpatient office visit. Intermediate level outpatient programs may be provided by inpatient or intermediate level facilities however you

typically reside at their own homes and visit the facilities for treatment only. Some may offer programs where you can pay to reside within the facility while an outpatient level of care is provided when facility is away from your home.

Outpatient Care

- Hospital Observation
- Hospital Emergency Department
- Ambulatory Surgical Center or Outpatient Surgical Center
- Ambulatory or Outpatient Rehabilitation
- Urgent Care
- Office Visits
- Virtual Care

Outpatient care may be provided in hospital, surgical center, clinic, or office settings, or remotely through virtual care. Outpatient services are unstructured and provide maximum freedom.

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 and the ***Pediatric 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 800-810-BLUE (2583). The center is open 24 hours a day, seven days a week. You can also call collect at 804-673-1177.

More Questions

If you have questions or need to find out more about the ***BlueCard® Program***, please call customer service. To find a provider, go to premera.com or call 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 Participating Or Non-Participating Providers** You must get prior authorization in order for the plan to:
   - Cover a Participating or Non-Participating provider in Alaska at the Preferred INN benefit level.

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

- Cover a provider who is outside the service area at the Preferred INN benefit level.

How Prior Authorization Works

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

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

Our prior authorization will be valid for 90 calendar days. This 90-day period depends on your continued coverage under the plan. If you do not receive the services within that time, you will have to ask us for another prior authorization. A prior authorization may not be retroactively denied unless it was based on materially incomplete or inaccurate information provided to us by you or your provider.

1. Prior Authorization for Benefit Coverage

Medical Services, Supplies or Equipment

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

You can find our medical policies at premera.com. You can also find the list of services requiring prior authorization on our website at www.premera.com/visitor/preapproval.

- **Preferred INN and Participating providers or facilities** are required to request prior authorization for the service.
- **Non-Participating and out-of-area providers and facilities and all providers and facilities outside Alaska and Washington** will not request prior authorization for the service. You have to ask Premera to prior authorize the service.

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

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 ***Sending Us A Claim*** for details.

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

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

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

Exceptions To Prior Authorization For Benefit Coverage

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

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

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

2. Prior Authorization For Participating, Non-Participating and Out-Of-Area Provider Coverage

Generally, non-emergent care by Participating and Non-Participating providers and providers outside the service area is covered at lower benefit levels. However, you may ask for a prior authorization to cover one of these providers at the Preferred INN level if the services are medically necessary and are available from a Preferred INN provider within 50 miles from your home. You or the Participating, Non-Participating or Out-Of-Area provider must ask for prior authorization before you receive the services in order for the plan to:

- Cover a Participating or Non-Participating provider in Alaska at the Preferred INN benefit level.

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

Please notify us by calling customer service when you receive non-emergency care covered services from a Participating or Non-Participating provider so that we can apply your benefits correctly.

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

The prior authorization request for a Participating, Non-Participating or out-of-network provider must include the following:

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

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

Exceptions To Prior Authorization For Participating, Non-Participating And Out-Of-Area Providers

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

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

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

CLINICAL REVIEW

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

- Accepted clinical practice guidelines
- 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.

Additionally, you also have access to software that creates targeted wellness programs, identifies health risks and tracks all steps on any device.

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 define medical necessity criteria for specific procedures, drugs, biological agents, devices, level of care or services. They also identify medical services that are not covered because they are experimental and investigational. Medical policies may be developed by Premera Blue Cross Blue Shield of Alaska or licensed from national organizations that create evidence-based utilization standards. 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 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

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

This benefit covers acupuncture to:

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

Allergy Testing and Treatment

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

This benefit covers:

- Testing
- Allergy shots
- Serums

Ambulance

This benefit covers:

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

These services are only covered when:

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

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

This benefit does not cover:

- Services from an unlicensed ambulance

Blood Products and Services

Blood components and services, like blood transfusions, which are provided by a certified or licensed healthcare provider.

- Blood products and services that either help with prevention or diagnosis and treatment of an illness, disease or injury.

Chemotherapy and Radiation Therapy

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

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

This benefit covers:

- Outpatient chemotherapy and radiation therapy
- Supplies, solutions and drugs used during chemotherapy or radiation visit

For drugs you get from a pharmacy, see ***Prescription Drugs***. Some services need 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

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.

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 Lab, X-ray and Imaging***.

Diagnostic X-ray, Lab and Imaging

Diagnostic x-ray, lab and imaging services are basic and major medical tests that help find or identify diseases. The same test can be either Preventive or Diagnostic. If the test was ordered to evaluate a sign, symptom or health concern, it is Diagnostic. For more information about what services are covered as preventive, see ***Preventive Care.***

A typical test can result in multiple charges for things like an office visit, test, and anesthesia. You may receive separate bills for each charge. Some tests need to be approved before you receive them. See ***Prior Authorization*** for details.

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

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:

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

Genetic testing may be covered in some cases. Call customer service before seeking testing since it may require Prior Authorization.

Additional information:

Diagnostic breast examination for the purpose of this ***Diagnostic X-ray, Lab, and Imaging*** benefit means a medically necessary and appropriate examination of the breast, including an examination using diagnostic mammography, breast resonance imaging, advanced imaging (including magnetic resonance imaging and ultrasound), breast ultrasound, or pathology evaluations (including biopsies and consultations) or other services based on guidelines established by government agencies and professional medical societies that is used to evaluate an abnormality:

- Seen or suspected from a screening examination for breast cancer, or
- Detected by another means of examination

Supplemental breast examination for the purpose of this ***Diagnostic X-ray, Lab, and Imaging*** benefit means a medically necessary and appropriate examination of the breast, including an examination using breast magnetic resonance imaging or breast ultrasound, that is:

- Used to screen for breast cancer when there is no abnormality seen or suspected; and
- Based on personal or family history, or additional factors that may increase the member's risk of breast cancer

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

Dialysis

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

When covered dialysis services are provided by a non-participating provider, the in-network cost shares will apply. For non-participating providers in our service area the allowed amount is 300% of the fee schedule determined by the Center for Medicare and Medicaid Services (Medicare). For non-participating providers outside of our service area the allowed amount is 125% of the fee schedule determined by the Center for Medicare and Medicaid Services (Medicare). If the dialysis services are provided by a non-participating provider and you do not enroll in Medicare, you will owe the difference between any billed charges and the payment the plan will make for the covered services.

Emergency Room

This benefit covers:

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

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

You may get care in the emergency room from non-participating providers. You will not be balance billed for emergency services provided by a non-participating provider or hospital emergency room under federal law.

Foot Care

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

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

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

Habilitation Therapy

This plan covers medically necessary and appropriate services and devices for development of bodily or cognitive functions to perform activities of daily living that never developed or did not develop appropriately based on the chronological age of the member.

Habilitative services include:

- 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
- Massage therapy
- Custodial care
- Treatment for mental health, behavioral health or substance use disorder. See ***Mental Health Care*** and ***Substance Use Disorder*** for those covered services.

Hearing Care

This plan covers hearing exams and hardware.

Hearing Exams

Hearing exam services include:

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

Hearing Hardware

Before you receive your hearing hardware benefit:

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

Covered services include:

- A follow-up consultation within 30 days following delivery of the hearing aids with the prescribing provider
- A warranty
- Ear molds

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

This benefit does not cover:

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

Home Health Care

General Home Health Care

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

The following are covered under the Home Health care benefit:

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

The Home Health Care benefit does not cover:

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

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

This benefit covers:

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

Covered items include:

- Wheelchairs

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

Medical Supplies such as:

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

Medical Vision Hardware for members age 19 and older to correct vision due to the following medical eye conditions:

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

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

External Prosthetics and Orthotic Devices used to:

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

Orthopedic Shoes and Shoe Inserts

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

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

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

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.

Massage Therapy

Benefits are provided for the manipulation and treatment of the soft tissues to enhance the function of those tissues.

Services must be part of a physical therapy treatment plan or otherwise medically necessary to treat a covered illness, injury or condition and provided by a licensed physician, massage therapist or other provider.

Mastectomy and Breast Reconstruction

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

This benefit covers:

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

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

Maternity Care

This 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
- Donor breast milk

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, and specialized infant formulas not used to treat inborn errors of metabolism or any of the above listed conditions
- Lactose-free or gluten 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. The plan will also reimburse certain travel expenses when traveling within Alaska if the member lives more than 50 miles from a Premera Designated Centers of Excellence. Prior authorization is required.

This benefit provides reimbursement of certain travel costs up to IRS guidelines for members who reside in Alaska and travel 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 an Elective 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 an Elective Travel Claim Form:

To make a claim for travel expenses covered under this benefit, please complete an Elective Travel Claim Form. A separate Elective 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 website. The itinerary must identify the name of the passenger(s), the dates of travel and total cost of travel, and the origination and final destination points.
- A 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 Medical Access Transportation Claim Form. A separate Medical Access Transportation Claim Form is needed for each patient and each commercial carrier or transportation service used. You can get a Medical Access Transportation Claim Form on our website at premera.com. You can also call us for a copy of the form.
- 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 use disorder.

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 (including virtual care) 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 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

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 ***App-Based Care*** 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, including virtual care, 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.

Please call customer service for help in finding a physician approved to provide virtual care.

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.
- 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.
- Services used to improve your appearance, such as services to increase hair growth or alter the appearance of your skin.

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 (DMD or DDS) or denturist. Services may also be provided by a dental hygienist under the supervision of a licensed dentist, or other individual, performing within the scope of his or her license or certification, as allowed by law.
- They must not be excluded from coverage under this benefit

At times we may need to review diagnostic materials such as dental x-rays to determine your available benefits. We will request these materials directly from your dental provider. If we'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.

Dental Estimate of Benefits

You can ask for a ***Dental Estimate of Benefits*** before you receive dental services. A ***Dental Estimate of Benefits*** verifies your eligibility and benefits 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.

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

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

Dental care coverage includes the following:

Class I – Diagnostic and Preventive Services

- Collection and preparation of genetic sample for laboratory analysis is limited to once per lifetime
- Genetic test and analysis for susceptibility to diseases is limited to once per lifetime
- Routine comprehensive, periodic and non-routine oral evaluations, including problem focused oral evaluations are limited to 2 per calendar year
- Covered x-rays or images include:
  - 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

Premera-Designated Centers of Excellence Program

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

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

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

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

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

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

Knee and Hip Total Joint Replacement

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

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

Spinal Surgery

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

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

Gynecological Surgery

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

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

Travel

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

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

Prescription Drugs

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

This plan also 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.

Formulary Drug List

This benefit uses a specific list of covered prescription drugs, sometimes referred to as a “formulary drug list”. Our Pharmacy and Therapeutics Committee, which includes providers and pharmacists from the community, frequently reviews current medical studies and pharmaceutical information. The Committee makes recommendations on which drugs are included in our formulary drug lists. The formulary drug lists are updated quarterly based on the Committee’s recommendations.

The formulary drug list includes both generic and brand name drugs. Consult the List of Covered Drugs (Formulary Drug List) on our website or contact customer service for a complete list of your plan’s covered prescription drugs.

Drugs not included in the drug list (non-formulary drugs) are not covered by this plan

You or your provider may request that you get a non-formulary drug or dose that is not on the formulary 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, and would not be as effective as the non-formulary drug, or would have adverse side effects. We will review your request and let you or your provider know within 72 hours in writing if it is approved. If approved, your cost will be as shown on the ***Summary of Your Costs*** for formulary generic and brand name drugs, and will be covered for the length of time outlined in the approval letter. If your request is not approved and you choose to purchase the non-formulary drug, the drug will not be covered.

Expedited Exceptions Request for Non-Formulary Drugs

If exigent circumstances exist, you or your provider may request an expedited review for a non-formulary drug or a dose that is not on the formulary 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). We will respond to the request within 24 hours of receipt of the required information from the provider.

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***.

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 drugs. These drugs require a prescription and may be limited to a certain age, condition, dosage or type. After one of these limits is reached, these services are not covered in full and you may have to pay more out-of-pocket costs. 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.

Some of these drugs need special handling, storage, administration or patient monitoring, and therefore may only be available at a specialty pharmacy.

Note: There may be times when a specialty drug is not available through a pharmacy. When the specialty drug is not available the pharmacies will contact you or your provider. In some instances, the pharmacy will assist with the transfer of the prescription to the pharmacy that carries the drug.

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 premiums, 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 drugs
- Drugs from out-of-network specialty pharmacies
- Drugs for cosmetic use such as for wrinkles
- Cosmetic drugs to promote or stimulate hair growth or to alter the appearance of your skin
- 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 healthcare provider administered 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 and are unlimited unless otherwise specified:

- 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. 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 from birth to three years.
- Well child care, including care provided by a qualified health aide, from four to eighteen years.
- Cervical cancer screenings: Annual pap smear cancer screening test for a person who is 18 or more years of age.
- Pregnant women's services such as diabetic supplies, breast feeding counseling before and after delivery, and maternity diagnostic screening.
- Screening mammograms, including 3-D mammograms, See ***Diagnostic X-ray, Lab and Imaging*** for mammograms needed because of a medical condition.
- Patient navigation services are also available to ensure timely diagnosis, treatment and support for breast and cervical cancer screenings. These services include, but are not limited to:
  - Person centered assessment and planning.
  - Healthcare access and health navigation system
  - Referrals to appropriate support services (language translation, transportation and social services)
  - Patient education

- Navigation services include person-to-person contact. This can be in person, virtual or both
- 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.
- Professional services to prevent falling for members who are 65 years and older and have a history of falling or mobility issues
- Prostate cancer screening. Includes digital rectal exams and prostate-specific antigen (PSA) tests. Annual tests for prostate cancer for those who are considered high risk men under 40 years of age, or men 40 years of age and older.
- Colon cancer screening for those who are considered high risk individuals under 45 years of age, or individuals 45 years of age or older, as recommended by American Cancer Society. Includes pre-colonoscopy consultations, exams, colonoscopy, sigmoidoscopy and fecal occult blood tests. Removal and pathology (biopsy) related to polyps found during a screening procedure are covered as part of the preventive screening. Also, pre-colonoscopy consultations are considered part of the preventive screening. Includes anesthesia your doctor considers medically appropriate for you.
- Colonoscopies as follow-up to a positive non-invasive stool-based screening test.
- 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.
- Pre-exposure (PrEP) for members at risk for HIV infection.
- Preventive drugs required by federal law. See ***Prescription Drugs***.
- Approved tobacco use habit breaking programs recommended by your doctor. After you have completed the program, please provide us with proof of payment and a completed reimbursement form. You can get a reimbursement form on our website 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
- Assessments and evaluation related to rehabilitative therapy
- Rehabilitative devices that have been approved by the FDA and prescribed by a qualified provider

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

Inpatient Care

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

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

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

- You 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
- Massage therapy
- 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, Massage Therapy*** and ***Habilitation Therapy*** benefits.

Substance Use Disorder

This benefit covers treatment of substance use disorder (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 use disorder.
- 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).

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 use disorder 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.

Temporomandibular Joint Disorders (TMJ) Care

TMJ disorders are covered on the same basis as any other condition.

TMJ disorders include those conditions that have some of the following symptoms:

- Muscle pain linked with TMJ
- Headaches linked with the TMJ

- Arthritic problems linked with the TMJ
- Clicking or locking in the jawbone joint
- An abnormal range of motion or limited motion of the jawbone joint

This benefit covers:

- Exams
- Consultations
- Treatment

Some services may be covered under other benefits sections of this plan with different or additional cost share, such as:

- X-rays (See ***Diagnostic Lab, X-ray and Imaging***)
- Surgery (See ***Surgery***)
- Hospital (See ***Hospital***)

Some surgeries need to be prior authorized before you get them. See ***Prior Authorization*** for details.

This benefit does not cover:

- Experimental/investigational services
- Orthodontic treatment

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

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

Virtual care select providers can be found at www.premera.com/visitor/virtual-care or contact Premera customer service for assistance.

EXCLUSIONS AND LIMITATIONS

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

Amounts Over the Allowed Amount

Costs over the allowed amount as defined by this plan, for a non-emergency service from a Non-Participating provider.

Assisted Reproduction

Assisted reproduction technologies, including but not limited to:

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

Benefits from other sources

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

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

Benefits that have been exhausted

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

Broken or missed appointments

Charges for records or reports

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

Comfort or Convenience items

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

Complications of a non-covered service

Includes follow-up services or effects of those services.

Cosmetic Services

Drugs, services or supplies for cosmetic services not medically necessary. 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. This also includes drugs, services, or supplies to improve or alter the appearance of your skin or hair.

Counseling, Education and Training

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

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

Court-Ordered Services

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

Custodial Care

Custodial services that are not covered hospice care services.

Dental Care

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

Environmental Therapy

Therapy designed to provide a changed or controlled environment.

Experimental and Investigative Services

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

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

Family Members or Volunteers

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

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

Government Facilities

Services provided by a state or federal facility that are not emergency services or required by law or regulation.

Hair Analysis

Hair Loss

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

Illegal Acts, Illegal Services, and Terrorism

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

Laser Therapy

Low-level laser therapy.

Military Service and War

Illness or injury that is caused by or arises from:

- Acts of war, such as armed invasion, no matter if war has been declared or not
- Service in the armed forces of any country, including any related civilian forces or units

Non-Covered Services

Services or supplies:

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

Non-Treatment Facilities, Institutions or Programs

- Housing
- Incarceration
- Programs from facilities that are not licensed to provide medical or behavioral health treatment for covered

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

Orthodontia

Orthodontic services including casts, models, x-rays, photographs, examinations, appliances, braces and retainers. This does not apply to medically necessary services provided in ***Pediatric Dental***.

Orthognathic Surgery

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

- temporomandibular joint disorder
- injury
- sleep apnea, or
- congenital anomaly

Provider's License or Certification

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

Recreational, Camp and Activity Programs

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

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

Serious Adverse Events and Never Events

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

Members and this plan are not responsible for payment of services provided by 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. Providers may not bill members for these services and members are held harmless.

Not all medical errors are defined as serious adverse events or never events. You can obtain a list of serious adverse events by contacting us or on the Center for Medicare and Medicaid Services (CMS) website.

Services or Supplies Not Medically Necessary

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

Sexual Dysfunctions

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

Skilled Hourly Nursing

Medically intensive care provided by a licensed nurse at home.

Vision Exams

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

older.

Vision Hardware

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

Vision Therapy

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

Voluntary Support Groups

Patient support, consumer or affinity groups or Alcoholics Anonymous.

Weight Loss (Surgery or Drugs)

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

Work-Related Illness or Injury

Any illness or injury 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.

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

Coordination of Prescription Claims

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

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

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

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

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

What Is A Complaint?

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

How to file a complaint

Call customer service at 800-809-9361 (TTY:711)

Send a fax to 866-903-9899

Send the details in writing to:
Premera Blue Cross Blue Shield of Alaska
PO Box 21762
Eagan, MN 55121

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

What Is An Appeal?

A request to review a specific decision or adverse benefit determination Premera has made.

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

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

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

What you can appeal

Claims and prior authorization	Payment	Benefits or charges were not applied correctly, including a limit or restriction on otherwise covered benefits.
	Denied	Coverage of your service, supply, device or prescription was denied or partially denied. This includes prior authorization denials.
Enrollment canceled or not issued	No Coverage	You are not eligible to enroll or stay in the plan

Appeal Levels

You have the right to two levels of appeals:

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

How To Submit An Appeal In Writing

Step 1. **Get the form**	• Complete the **Member Appeal Form**, you can find it on premera.com or call customer service to request a copy. If you need help submitting an appeal, or would like a copy of the appeals process, call customer service at 800-809-9361 (TTY:711)
Step 2. **Collect supporting documents**	• Collect any supporting documents that may help with your appeal. This may include chart notes, medical records, or a letter from your doctor. Within 3 working days, we will confirm in writing that we have your request. • If you would like someone to appeal on your behalf, including your provider, complete a **Member Appeal Form** with authorization, you can find it on premera.com. We can't release your information without this form.
Step 3. **Send in my appeal**	To help process your appeal, be sure to complete the form and return with any supporting documents. **Send your documents to:** Premera Blue Cross Blue Shield of Alaska

	Attn: Appeals Coordinator PO Box 21762 Eagan, MN 55121 Fax to 866-903-9899

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

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

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

Appeal Response Time Limits

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

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

What if you have ongoing care?

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

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

What if it's urgent?

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

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

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

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 800-318-2596 for information on this process. If we receive an appeal from you, we will forward it to The Exchange.

How to ask for an external review

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

Step 1. **Complete the form**	**We will send you an External Review Application Form authorizing the release of your medical records to an IRO with the written decision of your internal appeal.** • External appeals are available only for decisions involving a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the service or treatment you received. • You must include the signed External Review Application Form you received from us. You may also include medical records and other information.
Step 2. **Collect supporting documents**	• Collect any supporting documents that may help with your external review. This may include medical records and other information. • You must file your request for external review with the Alaska Division of Insurance within 180 days of the date you got our internal appeal letter. You can request an extension of the 180-day deadline by sending the Alaska Division of Insurance a written request that includes the reason why you believe an extension should be granted.
Step 3. **Send in my external review request**	• The Alaska Division of Insurance will provide your request to Premera within one working day. Premera will complete a preliminary review within five working days to determine whether the request is eligible for external appeal. • For urgent external appeals, Premera will complete the preliminary review immediately. Premera will notify you, your authorized representative, and the Alaska Division of Insurance in writing of the results of our preliminary review within one day after we have completed it. • If your request is eligible for external appeal, the Alaska Division of Insurance will assign an IRO to review your appeal. We will forward your medical records and other information to the IRO. If you have additional information on your appeal, you may send it to the IRO. • If the request is not complete, Premera will notify you, your authorized representative, and the Alaska Division of Insurance in writing of what information or materials are needed to make the request complete. • If the request is not eligible for external appeal, Premera will notify you or your authorized representative and the Alaska Division of Insurance in writing of the reasons why the request is not eligible for external review. If you do not agree with this decision, you may appeal to the Director of the Alaska Division of Insurance.

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

- Cost-sharing and surprise billing for emergency services
- Cost-sharing and surprise billing protections related to care you received from non-participating providers at participating facilities
- Your condition to receive notice and provide informed consent to waive NSA protections; and
- If a claim for care received is coded correctly and accurately reflects the treatments received, and the associated NSA protections related to patient cost-sharing and surprise billing.
- These reviews will be referred to CMS for the HHS-Administered Federal External Review Process.

Once the IRO Decides

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

Premera will accept the IRO decision.

If the IRO:

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

If you have questions about a denial of a claim or your appeal rights, you may call customer service at the number listed on your Premera ID card. Contact the Alaska Division of Insurance at any time during this process 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: 800-INSURAK (467-8725) (within Alaska)
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 premiums.

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. 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, except as provided for in the ***Eligibility For a Disabled Child*** provision. An eligible child is one of the following:
  - A biological child of either 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 premiums 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 premiums 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 premiums 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 premiums, the initial coverage for you and your enrolled dependents will become effective as determined by the Exchange.

PREMIUMS AND GRACE PERIOD

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

Due Date for Initial Premiums

If you applied for coverage through the Exchange, we must receive your initial premium payment no later than the first day of the month your coverage is to become effective. Your coverage will begin upon receipt of those premiums. If we do not receive your premium 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 premium amount and the due date. You have 20 days from the date you received the notice to pay the full premiums. Coverage will begin with payment of those premiums. If the initial premiums are not paid when due, this contract will terminate as if it were never effective.

Due Date for Subsequent Premiums

Subsequent premiums 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 premiums 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 premium as an advance payment of the premium tax credit, you have a 3-month grace period to pay your portion of the monthly premiums. 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 premiums 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 premiums are not subsidized by the federal government, you have a 1-month grace period to pay subsequent premiums. 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 premiums 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 Premiums

Consistent with state law, Premera reserves the right to change premiums. 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 premiums means that you accept the change.

Your premiums 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 premium 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 premiums 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 premiums 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 premiums were paid.

CONTRACT TERMINATED BY PREMERA

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

- When the subscriber does not pay the premiums
- 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 they no longer meet 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 premiums 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 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 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 PREMIUMS

We may change this plan's benefits and premiums. 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.

ID CARD

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

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 they have 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.

The Blue Cross and Blue Shield licenses Premera Blue Cross Blue Shield of Alaska to offer certain products and services under the BLUE CROSS® brand name. Premera Blue Cross Blue Shield of Alaska is an independent organization governed by its own Board of Directors, and responsible for its own obligations. A copy of Premera Blue Cross Blue Shield's most recent audited financial statement is available on request to Premera Blue Cross Blue Shield of Alaska.

ID CARD

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

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 Participating 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 in-network benefit level, however, since there is no contract in effect with these providers you are responsible for amounts above the allowed amount.

Accidental Injury

Physical harm caused by a sudden, unexpected event at a certain time and place.

Accidental injury does not mean any of the following:

- An illness, except for 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 limitation on otherwise covered benefits
- A clinical review decision
- A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective
- A decision related to compliance with protections against balance billing as defined by federal and state law

Affordable Care Act

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

Ambulatory Surgical Center

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

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

Applied Behavior Analysis (ABA)

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

Autism Spectrum Disorders

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

Autism Service Provider

An individual who is licensed, certified, or registered by the applicable state licensing board or by a nationally recognized certifying organization, and who provides direct services to an individual with autism spectrum disorder.

Benefit

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

Benefit Booklet

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

Calendar Year (Year)

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

Claim

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

Clinical Trials

An approved clinical trial means a scientific study using human subjects designed to test and improve prevention, diagnosis, treatment, or palliative care of cancer, or the safety and effectiveness of a drug, device, or procedure used in the prevention, diagnosis, treatment, or palliative care, if the study is approved by the following:

- The United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers
- The United States Food and Drug Administration (FDA)
- The United States Department of Defense
- The United States Department of Veterans' Affairs
- A nongovernmental research entity abiding by current National Institutes of Health guidelines

Complication of Pregnancy

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

- A condition of the fetus that needs surgery while still in the womb (in utero)
- A disease the mother has during pregnancy that is not caused by the pregnancy. The disease is made worse by 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 an infant's body part that's present from birth.

Contract

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

Cosmetic Services

Services that are performed to reshape normal structures of the body in order to improve or alter your appearance and not primarily to restore an impaired function of the body. This includes drugs, services, or supplies to improve or alter the appearance of your skin or hair.

Cost-Share

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

Covered Service

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

Custodial Care

Any portion of a service, procedure or supply that is provided primarily:

- For ongoing maintenance of the member's health and not for its therapeutic value in the treatment of an illness or injury
- To assist the member in meeting the activities of daily living. Examples are help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication not requiring constant attention of trained medical personnel.

Dental (Pediatric)

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

Dental Emergency

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

Dentally Necessary and Dental Necessity

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

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

Dependent

The subscriber's spouse or domestic partner and any children who are on this plan.

Detoxification

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

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

Effective Date

The date your coverage under this plan begins.

Emergency Medical Condition (also called "Emergency")

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

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

Emergency Services

- A medical screening examination to evaluate a medical emergency that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department.
- Further medical examination and treatment to stabilize the member to the extent the services are within the capabilities of the hospital staff and facilities, or if necessary, to make an appropriate transfer to another medical facility. "Stabilize" means to provide such medical treatment of the medical emergency as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the member from a medical facility.
- Ambulance transport as needed in support of the services above.

Endorsement

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

Essential Health Benefits

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

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

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

- A drug or device which cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and does not have approval on the date the service is provided.
- It is subject to oversight by an Institutional Review Board

- There is no reliable evidence showing that the service is effective in clinical diagnosis, evaluation, management or treatment of the condition.
- It is the subject of ongoing clinical trials to determine its maximum tolerated does, toxicity, safety or efficacy.
- Evaluation of reliable evidence shows that more research is necessary before the service can be classified as equally or more effective than conventional therapies.
- Reliable evidence means only published reports and articles in authoritative medical and scientific literature and assessments.

Explanation of Benefits

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

Facility (Medical Facility)

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

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. This is also sometimes known as “Durable Medical Equipment” or “DME”.

Hospice

A facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill. Care is focused on comfort and not intended to cure or improve the medical or functional outcome of a patient’s condition or to prepare the patient for outpatient care settings.

Hospital

A healthcare facility that meets all of these criteria:

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

A facility is *not* 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 use disorder or tuberculosis

Illness

A sickness, disease, or medical condition.

Injury

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

Inpatient

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

Lifetime Maximum

The maximum amount that Premera will provide during your lifetime.

Limited Oral Evaluation – Problem Focused

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

Medical Equipment

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

Medically Necessary and Medical Necessity

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

These services must:

- Agree with generally accepted standards of medical practice
- Be clinically appropriate in type, frequency, extent, site and duration. They must also be considered effective for the patient's illness, injury or disease.
- Not be mostly for the convenience of the patient, 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 (also called “You” and “Your”)

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

Mental Health Conditions

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

Observation

Monitoring and evaluation at a hospital or other in order to determine whether an inpatient stay is required.

Orthodontia

The branch of dentistry which specializes in the correction of tooth arrangement problems, including poor relationships between the upper and lower teeth (malocclusion).

Orthotic

A support or brace applied to an existing portion of the body for weak or ineffective joints or muscles, to aid, restore or improve function.

Outpatient

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

Pharmacy Benefit Manager

A person that contracts with a pharmacy on behalf of an insurer to process claims or pay pharmacies for prescription drugs or medical devices and supplies or provide network management for pharmacies.

Physician

A state-licensed:

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

Professional services provided by one of the following types of providers will be covered under this plan but only when the provider is licensed to practice where the care is provided, is providing a service within the scope of that license, is providing a service or supply for which benefits are specified in this plan, and when benefits would be payable if the services were provided by a "physician" as defined above:

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

Plan

The benefits, terms and limits stated in this contract.

Premiums

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

Prescription Drug

Any medical substance, including biological products, the label of which, under the Federal Food, Drug and Cosmetic Act, as amended, is required to bear the legend: “Caution: Federal law prohibits dispensing without a prescription.” Benefits available under this plan will be provided for “off-label” use, including administration, of prescription drugs for treatment of a covered condition when use of the drug is recognized as effective for treatment of such condition by:

One of the following standard reference compendia:

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

If not recognized by one of the standard reference compendia cited above, then recognized by the majority of relevant, peer-reviewed medical literature (original manuscripts of scientific studies published in medical or scientific journals after critical review for scientific accuracy, validity and reliability by independent, unbiased experts).

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

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

Primary Care Providers

A physician (MD – Medical Doctor or DO – 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.
- **Participating Providers** are providers that have a contract with us, but they are not in your provider network. You receive lower benefit coverage for services provided by Participating providers. Participating providers will not bill you the amount above the allowed amount for a covered service.
- **Non-Participating Providers** are providers that do not have a contract with us. You receive the lowest benefit coverage for services provided by Non-Participating providers, and they will bill you for amounts over the allowed amount for a covered service except for emergency services, covered air ambulance services, or as prohibited by law.

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 except for emergency services, covered air ambulance services, or as prohibited by law. 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.

Psychiatric Condition

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

Reconstructive Surgery

Is surgery:

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

Rehabilitative Services

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

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

Services

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

Service Area

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

Skilled Nursing Care

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

Skilled Nursing Facility

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

Specialist

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

Spouse

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

Subscriber

The person in whose name the plan is issued.

Substance Use Disorder Conditions

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

Urgent Care

Treatment of unscheduled, drop-in patients who have minor illnesses 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 a medical facility that is open to the public and has extended hours.

Virtual Care

Healthcare services provided through the use of online technology, telephonic and secure messaging of member-initiated care from a remote location (e.g. home) or an originating site with a provider that is diagnostic and treatment focused.

Originating site: Hospital, rural health clinic, federally qualified health center, physician’s or other health care provider office, community mental health center, skilled nursing facility, home, or renal dialysis center, except an independent renal dialysis center.

Visit

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

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.

Premera Blue Cross Blue Sheild of Alaska is an Independent Licensee of the Blue Cross Blue Shield Association

Notice of availability and nondiscrimination **800-809-9361 | TTY: 711**

Call for free language assistance services and appropriate auxiliary aids and services.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Hu thov kev pab txhais lus pub dawb thiab lwm yam khoom pab dawb thiab kev pab cuam ua tsim nyog.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Vala‘au mo auaunaga tau fesoasoani mo gagana e leai ni totogi ma fesoasoani fa‘aopo‘opo talafeagai ma auaunaga.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
Tumawag para kadagiti libre a serbisio iti tulong iti pagsasao ken dagiti nakanada nga aid ken serbisio iti komunikasion.
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
ติดต่อขอบริการช่วยเหลือด้านภาษาฟรีพร้อมความช่วยเหลือและบริการอื่น ๆ เพิ่มเติม
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d’assistance linguistique et des aides et services auxiliaires appropriés.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

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, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our 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, TTY: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our 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.

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