

Premera Blue Cross Family Dental

Contract for Individual and Families Residing in
Alaska

PREMERA BLUE CROSS BLUE SHIELD OF ALASKA

PLAN NAME

FOR INDIVIDUALS AND FAMILIES WHO LIVE IN ALASKA

Premera Blue Cross Blue Shield of Alaska is a nonprofit dental, 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 or dentally necessary, as defined by this plan. Your benefits are subject to all the terms and conditions of this contract.

In-network (INN) providers will not make you pay a cash deposit. You pay only 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If any provision of this plan is superseded by state or federal law, the Plan will comply with the applicable law as it relates to those provisions.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. Please contact customer service for assistance locating providers.

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 dental healthcare coverage. We're looking forward to taking great care of you.

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.

Important Note: Pediatric dental coverage is one of the ten Essential Health Benefits that is required by the Affordable Care Act (ACA). This plan will only provide benefits for pediatric dental services to members under the age 19 (the end of the month following the member's 19th birthday).

This is your health plan. It tells you what services we cover, your costs, and how to contact us. We know that health care can be complicated, and we want to help.

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 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.

CONTACT INFORMATION

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

COMPLAINTS AND APPEALS

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

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

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.

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

The service area for this plan is Alaska and Washington.

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 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 INN provider cost share, the INN provider deductible applies.

	In-Network (INN) Providers	Out-of-Network Providers Providers
Pediatric Individual Deductible:	\$65	Shared with In-network
Adult Individual Deductible	None	None

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

	In-Network (INN) Providers	Out-of-Network Providers
Pediatric Individual Out-of-Pocket Maximum:	\$450	Not Applicable
Pediatric Family Out-of-Pocket Maximum:	\$900	Not Applicable
Adult Individual Annual Benefit Maximum:	\$1,100	Shared with In-network

- The out-of-pocket maximum does not apply for services you get from Out-of-Network 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.
- 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	In-Network (INN) Providers	Out-of-Network Providers
<p>Adult Dental Services</p> <ul style="list-style-type: none"> • Class I – Diagnostic and Preventive Services • Class II – Basic Services • Class III – Major Services • \$1,100 maximum per calendar year • Specified routine dental services are limited to members age 19 and older. 	<p>20% coinsurance</p> <p>40% coinsurance</p> <p>Not Covered</p>	<p>40% coinsurance</p> <p>60% coinsurance</p> <p>Not Covered</p>
<p>Pediatric Dental Care</p> <ul style="list-style-type: none"> • Class I – Diagnostic and Preventive Services • Class II – Basic Services • Class III – Major Services • Orthodontic Services When medically necessary for conditions such as cleft lip or cleft palate 	<p>No charge</p> <p>Deductible, then 20% coinsurance</p> <p>Deductible, then 50% coinsurance</p> <p>Deductible, then 50% coinsurance</p>	<p>Deductible, then 30% coinsurance</p> <p>Deductible, then 40% coinsurance</p> <p>Deductible, then 50% coinsurance</p> <p>Deductible, then 50% coinsurance</p>

IMPORTANT PLAN INFORMATION

Benefits are available for the services described in this section that are furnished for a covered dental condition. "Covered dental condition" means a covered member's illness, injury or disease, or a dependent child's congenital malformation. Such services must meet all of the following requirements:

- They must be medically or dentally necessary. See definition of **Medically Necessary** or **Dentally Necessary**.
- They must be named in this benefit as covered.
- The expense for it must be incurred while you're covered under this plan.
- They must be furnished by a licensed dentist (DMD or DDS) or dentist. Services may also be provided by a dental hygienist under the supervision of a licensed dentist, or other individual, such as a Registered Nurse (RN) or an Advanced Registered Nurse Practitioner (ARNP) performing within the scope of their license or certification, as allowed by law. These providers are referred to as "dental care providers."
- They must not be excluded from coverage under this benefit.
- Some types of services may be limited or excluded under this plan.

At times we may need to review diagnostic materials such as dental x-rays to determine your available benefits. These materials will be requested directly from your dental care provider. If we're unable to obtain necessary materials, we'll provide benefits only for those dental services we can verify as covered.

Coverage under this dental plan is based on the allowed amount for medically and dentally necessary covered services. The percentage of an allowed amount you're responsible for is called coinsurance. See **Definitions** in this booklet for a detailed explanation of "allowed amount."

QUICK CARE GUIDE

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. 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 Pediatric Deductible

This plan includes an individual pediatric deductible for covered services received from providers,

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

The individual pediatric 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
- 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

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**.

For **Adult Dental Services**, you are responsible for the cost-shares from all providers for that benefit.

OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is the most you pay for covered services in a year before Premera pays 100% of the allowed amount for covered services from Dental Value in-network providers. The out-of-pocket maximum includes an Individual and a Family Out-of-Pocket Maximum.

However, if you get out-of-network care, you are still responsible for any charges above the allowed amount, except as prohibited by state or federal law.

Expenses that do not apply to the out-of-pocket maximum include, but not limited to:

- Charges above the allowed amount.
- Services above any benefit maximum limit or durational limit.
- Services not covered by this plan.
- Services from out-of-network providers, except as prohibited by state or federal law.
- Covered services that do not apply to the out-of-pocket maximum. See **Covered Services**.

ANNUAL BENEFIT MAXIMUM

The annual benefit maximum is the most that Premera pays for dental benefits within a calendar year. After the limit is met, you pay 100% of costs out of pocket.

Amounts that apply to your deductible don't count toward your dollar maximums.

ALLOWED AMOUNT

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

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. The allowed amount will be no less than the 80th percentile of fees for the geographical area.

ALTERNATIVE TREATMENT

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. Frequently, several alternate treatments exist to treat a dental condition. For example, a tooth can be restored with a crown or a filling, and missing teeth can be replaced either with a fixed bridge or a partial denture. 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.

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 Dental Select network.

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 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.

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

The service area is the state of Alaska and the state of Washington.

Dental Providers

In-Network (INN) Dental Providers

This plan is designed to provide the lowest out-of-pocket costs when you receive services from In-network (INN) 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 Dental Select network of providers when you receive care in Washington. Like In-network (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 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 In-network (INN) providers benefit level based on the allowed amount:

- Emergency services. You may get care in the emergency room from Out-of-Network providers. You will not be balance billed for emergency services provided by a Out-of-Network provider under federal law. See **Allowed Amount** for more information about allowable charges for emergency services.
- Non-emergency care services received from an Out-of-Network provider in Alaska when the nearest In-network (INN) providers is more than 50 miles from your home. We suggest that you contact us before you receive non-emergency care covered services from Out-of-Network providers in Alaska.
- Care received from Out-of-Network providers for covered stays at In-Network (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, coinsurance and any charges over the allowed amount except as prohibited by law.

WHEN YOU ARE OUTSIDE ALASKA OR WASHINGTON

Except for emergency care, you pay the Out-of-Network cost-share for services you get from any state-licensed or certified provider outside the service area of Alaska or Washington.

Your out-of-pocket costs will be lower if the provider has a contract with us these providers accept our allowed amount as payment in full.

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 that do not have a contract with us. In most cases, we will base the amount you pay for such services on either our allowed amount for these providers or the pricing requirements under applicable law. See the **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.

CLINICAL REVIEW

Clinical review is a summary of dental, 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 dental and medical policies at premera.com.

COVERED SERVICES

ADULT DENTAL SERVICES

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

Specified adult routine dental services are covered as stated on the **Summary of Your Costs**.

The covered services under this plan are classified as Class I –Diagnostic and Preventive 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 does not cover services received or ordered when this plan isn't in effect, or when you aren't covered under this plan (including services and supplies started before your effective date or after the date coverage ends).

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

- They must be dentally or medically necessary. See **Definitions**.
- They must be named in this plan as covered
- They must be furnished by a licensed dentist (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

Class I – Diagnostic and Preventive Services

- Routine comprehensive and periodic oral evaluations, including second opinions are limited to 2 visits per calendar year. See the definition of **Comprehensive Oral Evaluation**.
- Limited oral evaluations – problem focused (including emergency evaluations) are not limited. See the definition of a Dental Emergency.
- Comprehensive periodontal evaluations, re-evaluations, and detailed and extensive oral evaluations are limited to 2 per calendar year.
- Prophylaxis (cleaning) is limited to 2 per calendar year
- Periodontal maintenance, as a follow-up to active periodontal treatment is limited to 4 visits per calendar year
- X-rays include:
 - Either a complete series (full-mouth) x-ray or panoramic films, once every 5 calendar years, but not both
 - Bitewing x-rays, once per calendar year
 - Periapical x-rays once every 60 months
- Topical application of fluoride is limited to once every 60 months treatment per calendar year
- Sealants or preventive resin restorations are limited to once every 60 months

Class II – Basic Services

- Fillings, consisting of amalgam and composite resins on any given tooth surface are covered once every 2 calendar years.
- Periodontal scaling and root planing is limited to once per quadrant once every 24 months
- Localized delivery of antimicrobial agents
- Emergency palliative treatment. We require a written description and/or office records of services provided.

Class III – Major Services

- None

The **Adult Dental Services** benefit does not cover:

- Dental services other than specified above
- Class III - Major Services
- Orthodontia services
- Services received or ordered when this plan is not in effect, or when you are not covered under this plan (including services and supplies started before your coverage effective date or after the date

coverage ends).

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

PEDIATRIC DENTAL

This plan covers 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.

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.

Dental care coverage includes the following:

Class I – Diagnostic and Preventive Services

- Routine comprehensive and periodic oral evaluations are limited to once every 6 months. See definition of **Comprehensive Oral Evaluation**.
- X-rays include:
 - Complete series (full-mouth) x-ray including bitewings once every 60 months
 - Bitewing x-rays once every 6 months
 - Routine x-rays
- Prophylaxis (cleaning) is limited to once every 6 months
- Fluoride treatment (including fluoride varnish) is limited to once every 6 months
- Sealants to unrestored permanent molars are limited once per tooth every 36 months.
- Space maintainers

Class II – Basic Services

- Limited oral evaluations – problem focused or emergent. See definition of **Limited Oral Evaluation-Problem Focused**.
- Oral and facial photographic images are subject to review for dental necessity.
- Other x-rays include:
 - Periapical x-rays
 - Occlusal intraoral x-rays
 - Cephalometric film
 - Panoramic film
 - Oral and facial photographic images and other non-routine x-rays are subject to review for dental necessity

- Fillings per tooth, consisting of amalgam and resin-based composite on any tooth surface are limited to once per tooth every 24 months. Multiple restorations on any tooth surface will be considered one surface regardless of the number or combination of restorations.
- Prefabricated stainless steel crowns including those made with porcelain, ceramic or resin material are limited to once per tooth every 60 months for members under age 15.
- Repair to crowns (indirect), onlay, inlay, bridge (fixed partial denture), complete and partial dentures is limited to once per tooth every 60 months
- Recement or rebond permanent crown, onlay, inlay, bridge or fixed partial denture once in a 36-month period 6 months after the initial installation
- Pulp vitality tests
- Non-surgical periodontics include:
 - Full mouth debridement is limited to once per lifetime
 - Periodontal maintenance following periodontal therapy is limited to 4 per 12 months combined with prophylaxis after the completion of active periodontal therapy
 - Periodontal scaling and root planing is limited to once per quadrant every 24 months
- Simple extractions
- Emergency palliative treatment. We require a written description and/or office records of services provided.
- House/extended care facility call is limited to 2 per facility per day, when medically or dentally necessary
- Behavior management (behavior guidance techniques used by dental provider)
- Occlusal guard (nightguard) is covered for members over 13 once every 12 months when dentally necessary

Class III – Major Services

- Inlay, onlay, and crowns (indirect) are covered and limited to once per tooth every 60 months when there is significant loss of clinical crown, and no other dentally appropriate restoration will restore function. For inlays, onlays, and crowns the service start date is the preparation date. The completion date is the seat date.
- Crown build-ups including pins, and cast post and core limited to once per tooth every 60 months.
- Endodontics Services include:
 - Direct pulp cap
 - Therapeutic pulpotomy
 - Pulpal debridement
 - Pulpal therapy (resorbable filling) limited to primary teeth
 - Endodontic treatment For root canals and retreatment of root canals, the service start date is the date the canal is opened. The service completion date is the date the canal is filled.
 - Endodontic retreatment includes the removal of post, pin, and old root canal filling material, and all procedures necessary to prepare the canal with placement of new filling material. Endodontic retreatment provided by the original treating provider or clinic is subject to review for medical or dental necessity.
- Surgical periodontics include:
 - Gingivectomy, gingival flap and gingivoplasty is limited to once every 36 months per quadrant
 - Osseous surgery including flap entry and closure, and mucogingival surgery limited to once every 36 months
- Initial placement of bridges (fixed partial dentures). Replacement is limited to once every 36 months years after the original was placed. For fixed partial bridgework the service start date is the preparation date. The completion date is the seat date.

- Initial placement of resin base partial dentures, complete dentures, including overdentures is covered when the denture cannot be made serviceable by a less costly procedure. For dentures the service start date is the impression date. The completion date is the delivery date.
 - Includes six-months post-delivery care (e.g., adjustments, soft relines, and repairs) after placement.
- Replacement of resin partials, complete denture or overdenture is limited to once every 36 months after the original was placed. Denture rebase, reline and adjustment is limited to once in a 36 month period when performed at least six-months after placement and post delivery care
- Dental implants subject to review for dental necessity
- Dental implant crown and implant abutment related procedures are limited to once every 60 months. For implant supported crowns the service start date is the preparation date. The completion date is the seat date.
- Other oral surgery related to the teeth and supporting structures in a dental office including:
 - Surgical extraction and removal of erupted or impacted tooth
 - Biopsy of oral tissue, hard or soft
 - Removal of odontogenic cyst or tumor
 - Alveoplasty
 - Vestibuloplasty
 - Frenuloplasty/frenulectomy
- Hospital call including emergency care limited to 1 visit per day, when dentally necessary
- Anesthesia in conjunction with covered services in a dental care provider's office includes:
 - General anesthesia, deep sedation or intravenous (conscious) sedation when necessary due to age, condition or degree of difficulty

PEDIATRIC 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.

DENTAL CARE SERVICES FOR INJURIES

When services are related to an accidental injury, benefits are provided for the reparation or repair of the natural tooth structure when such repair is performed within 12 months of the injury.

When services or supplies listed in another benefit of this plan are performed in the treatment of accidental dental injuries as described in this section, any calendar year deductibles, or coinsurance and limitations of that other benefit apply to this benefit.

Important things to know:

These services are only covered when they're:

- Necessary as a result of an accidental injury
- Performed within the scope of the provider's license
- Not required due to damage from biting or chewing, and
- On the natural tooth structure and the teeth were free from decay and functionally sound when the injury happened. Rendered on natural teeth that were free from decay and otherwise functionally sound at the time of the injury. Functionally sound means that the affected teeth don't have:
 - Extensive restoration, veneers, crowns or splints
 - Periodontal disease or other condition that would cause the tooth to be in a weakened state prior to the injury

An accidental injury doesn't include damage caused by biting or chewing, even when caused by a foreign object in food.

If necessary services can't be completed within 12 months of an injury, coverage may be extended if your dental care meets our extension criteria. We must receive extension requests within 12 months of the injury date. To request an extension, please have your provider contact customer service. In order for us to review an extension request, we will ask the provider to send additional information that would show the necessity for the extension; such as, the severity of the accident or other circumstances. Services included must be related to an accidental injury; benefits are provided for the reparation or repair of the natural tooth structure when such repair is performed within 12 months of the injury. You may have additional costs for other services such as x-rays, restorative procedures and exam charges. See those covered services for details.

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.

Adult Non-Covered Dental Services

- Pre-diagnostic services such as screening or assessments
- Oral pathology laboratory
- Cone beams, MRI and ultrasounds
- Tests and examinations such as genetic, caries, pulp vitality, diagnostic casts and risk assessment
- Lab collection, testing, processing and analysis
- Nutritional and tobacco counseling
- Oral hygiene instructions
- Preventive resin restorations or interim carries arresting medicament application
- Space maintainers, including recement or removal
- Resin infiltration and resin-based composite crowns
- Resin infiltration
- Gold foils, inlay and onlay restorations
- Crowns and provisional crowns including re-cement, re-bond and repair of crowns
- Crown core buildups including any pins/posts
- Veneers
- Endodontic services including root canals, apexification/recalcification, pulpal regeneration, and apicoectomy/periradicular services
- Periodontal surgery
- Provisional splinting
- Full mouth debridement
- Complete and partial dentures including adjustments, repairs, rebase, reline, and tissue conditioning. This includes inspection and removal
- Interim complete and partial dentures
- Overdentures
- Precision attachments
- Maxillofacial prosthetics including fluoride, medicament and radiation carriers
- Implant and implant related services
- Fixed partial dentures or bridges including re-cement and re-bond
- Temporary partial dentures or bridges
- Precision attachments
- Oral and maxillofacial surgery including extraction and removal of teeth
- Alveoloplasty and vestibuloplasty

- Excision of lesions and bone tissue
- Surgical incisions
- Treatment of fractures
- Sutures and other repair procedures such as skin grafts
- Bone grafts
- Collection and application of blood
- Frenulectomy and frenuloplasty
- Salivary surgical procedures
- Tracheotomy/coronoideotomy
- Temporomandibular Joint (TMJ) Disorders including any dental services or supplies connected with the diagnosis or treatment of temporomandibular joint (TMJ) disorders, including any direct or indirect complications and aftereffects
- Orthognathic Surgery including procedures to lengthen or shorten the jaw. Orthognathic surgery is not covered other than for treatment of the following: temporomandibular joint disorder, injury, sleep apnea or congenital anomaly
- Orthodontia, regardless of condition, including casts, models, x-rays, photographs, examinations, appliances, braces, and retainers.
- Adjunctive general services such as anesthesia, drugs
- Application of desensitizing medicament
- Occlusal guard (nightguard) and athletic mouthguards, including repair and relines
- Occlusal analysis
- Occlusal adjustment (limited and complete)
- Enamel microabrasion, odontoplasty, and bleaching

Amounts Over the Allowed Amount

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

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

Broken or missed appointments, including charges from providers for 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.

Conditions from Professional Sports

Any condition related to semiprofessional or professional athletics, including practice. Semiprofessional athletics are athletics requiring a high level of skill, for which you are paid, even if the activity is not your full-time occupation

Cosmetic Services

- Drugs, services, or supplies for cosmetic services that are not dentally or 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 alter the appearance of your skin or hair.
- Cosmetic orthodontia

Counseling, Education and Training

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

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

Court-Ordered Services

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

Custodial Care

Custodial services that are not covered hospice care services.

Dental Services Received from a:

- Dental or medical department maintained for employees by or on behalf of an employer; or
- Mutual benefit association, labor union, trustee or similar person or group.

Dietary Services

Dietary planning for the control of dental caries.

Environmental Therapy

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.

Experimental and Investigative Services

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

Extra or Replacement Items

Extra dentures or other duplicate appliances, including replacements due to loss or theft.

Facility Charges

Hospital and ambulatory surgical center care for dental procedures.

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.

Home-Use Products

Services and supplies that are normally intended for home use such as take-home fluoride, toothbrushes, floss and toothpaste.

Home Visits

Dental visits or procedures received in a member's home.

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.

Increase of Vertical Dimensions

Any service to increase or alter the vertical dimension

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

Multiple Providers

Services provided by more than one dental care provider for the same dental procedure.

Non-Covered Services

Services or supplies directly related to any non-covered condition.

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

Testing required for employment, schooling, screening, or public health purposes.

Non-Standard Techniques

Other than standard techniques used in the making of restorations or prosthetic appliances, such as personalized restorations.

Non-Treatment Charges

- Charges for provider travel time.
- Transporting a member in place of a parent or other family member or accompanying the member to appointments or other activities outside the home, such as medical appointments or shopping.
- Housework or chores for the member.

Non-Treatment Facilities, Institutions or Programs

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

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

Not Covered Under This Plan

- Services that are not listed in this booklet as covered or that are directly related to any condition, service or supply that isn't covered under this plan
- Services received or ordered when this plan isn't in effect, or when you aren't covered under this plan (including services and supplies started before your effective date or after the date coverage ends)

Not Medically Necessary

Services or supplies that are not medically necessary even if they are court ordered.

Orthodontia Services

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

Pediatric Non-Covered Dental Services

- Application of any type of desensitizing medicament
- Cast-metal framework, flexible base, and removable unilateral partial dentures
- Cleaning of appliances
- Connector bar or stress breaker
- Coping
- Diagnostic tests and examinations including collection, preparation, analysis, viral culture, genetic and caries susceptibility tests, and adjunctive pre-diagnostic tests.
- Diagnostic tomographic surveys, cone beam, MRI, ultrasound, 3-D imaging, and posterior-anterior or lateral skull and facial bone survey films

- Duplicate appliances
- Duplicate x-rays
- Extra dentures or other duplicate appliances, including replacements due to loss or theft
- Fabrication of an athletic mouthguard
- Facility charges (hospital and ambulatory surgical center) for dental procedures
- Gold foil restorations
- Home use products. Services and supplies that are normally intended for home use such as take-home fluoride, toothbrushes, floss and toothpaste
- Immediate dentures
- Implants and implant related services including but not limited to:
 - Surgical placement of implants including endosteal, eposteal, and transosteal;
 - Interim endosseous implants;
 - Endodontic endosseous implants;
 - Sinus augmentations or lift;
 - Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis;
 - Radiographic/surgical implant index;
 - Unspecified implant procedures.
- Indirect pulp caps
- Labial veneers
- Localized delivery of antimicrobial agents
- Medication and supply such as take-home drugs, pre-medications, therapeutic drug injections and supplies
- Non routine x-rays
- Occlusion analysis and limited and complete occlusal adjustments
- Oral pathology laboratory including collection of tissue samples, cultures and specimens
- Oral surgery treating fracture of the mandible (jaw)
- Pin retention in addition to restoration
- Plaque control programs (dietary instruction and home fluoride kits)
- Precision attachments, replacement of replaceable parts for semi-precision or precision attachments and personalization of appliances
- Provisional Splinting
- Sedative fillings
- Smoking Cessation Counseling
- Surgical procedures including:
 - Exfoliative cytology sample collection or brush biopsy
 - Radical resection of maxilla or mandible
 - Removal of non-odontogenic cyst, tumor or lesion
 - Surgical stent
 - Surgical procedures for isolation of a tooth with rubber dam
- Temporary, interim or provisional services for crowns, bridges or dentures
- Tobacco cessation and nutritional counseling for control of dental disease
- Tooth preparation, acid etching, all adhesives, and liners
- Tooth transplantation including re-implantation from one site to another and splinting and/or

stabilization

Personal comfort or convenience items

- Personal services or items such as 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"

Prescription Drugs

Any prescription drugs or medicines. This includes vitamins and food supplements.

Provider's License or Certification

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

Serious Adverse Events and Never Events

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

Never 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 and never events by contacting us or on the Center for Medicare and Medicaid Services (CMS) website.

Services or Supplies For Which You Don't Legally Have To Pay

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

Services or Supplies Not Dentally Necessary

Services that are not dentally necessary.

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.

Temporomandibular Joint (TMJ) Disorders

Any dental services or supplies connected with the diagnosis or treatment of temporomandibular joint (TMJ) disorders, including any direct or indirect complications and aftereffects thereof.

Testing and Treatment Services

Testing and treatment for mercury sensitivity or that are allergy-related.

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

COORDINATING BENEFITS WITH OTHER HEALTH PLANS

This plan does not coordinate benefits with other dental coverage. It will always provide its benefits on a primary basis.

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.

Key Terms for COB

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

Allowable 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.

THIRD PARTY LIABILITY (SUBROGATION)

If we make claims payment on your behalf for injury or illness for which another party is liable, or for which uninsured/underinsured motorist (UIM) or personal injury protection (PIP) insurance exists, we will be subrogated to any rights that you may have to recover compensation or damages from that liable party related to the injury or illness, and we would be entitled to be repaid for payments we made on your behalf out of any recovery that you obtain from that liable party after you have been fully compensated for your loss. The liable party is also known as the "third party" because it is a party other than you or us. This party includes a UIM carrier because it stands in the shoes of a third-party tortfeasor and because we exclude coverage for such benefits.

Definitions The following terms have specific meanings in this contract:

- **Subrogation** means we may collect directly from third parties or from proceeds of your recovery from third parties to the extent we have paid on your behalf for illnesses or injury caused by the third party and you have been fully compensated for your loss.

- **Reimbursement** means that you are obligated under the contract to repay any monies advanced by us from amounts you have received on your claim after you have been fully compensated for your loss.
- **Restitution** means all equitable rights of recovery that we have to the monies advanced under your plan. Because we have paid for your illness or injuries, we are entitled to recover those expenses from any responsible third-party once you have been fully compensated for your loss.

To the fullest extent permitted by law, we are entitled to the proceeds of any settlement or judgment that results in a recovery from a third party, up to the amount of payments we have made on your behalf after you have been fully compensated for your loss. Our right to recover exists regardless of whether it is based on subrogation, reimbursement or restitution. In recovering payments made on your behalf, we may at our election hire our own attorney to prosecute a subrogation claim for recovery of payments we have made on your behalf directly from third-parties, or be represented by your attorney prosecuting a claim on your behalf. Our right to prosecute a subrogation claim against third-parties is not contingent upon whether or not you pursue the party at fault for any recovery. Our right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine. Notwithstanding such right, if you recover from a third party and we may share in the recovery, we will pay our share of the legal expenses. Our share is that percentage of the legal expenses necessary to secure a recovery against the liable party that the amount we actually recover bears to the total recovery.

Before accepting any settlement of your claim against a third party, you must notify us in writing of any terms or conditions offered in a settlement, and you must notify the third party of our interest in the settlement established by this provision. In the event of a trial or arbitration, you must make a claim against, or otherwise pursue recovery from third-parties payments we have made on your behalf, and give us reasonable notice in advance of the trial or arbitration proceeding. See **Notice**. You must also cooperate fully with us in recovering amounts paid by us on your behalf. If you retain an attorney or other agent to represent you in the matter, you must require your attorney or agent to reimburse us directly from the settlement or recovery. If you fail to cooperate fully with us in the recovery of the payments we have paid on your behalf, you are responsible for reimbursing us for payments we have made on your behalf.

You agree, if requested, to hold in trust and execute a trust agreement in the full amount of payments we made on your behalf from any recovery you obtain from any third-party until such time as we have reached a final determination or settlement regarding the amount of your recovery that fully compensates you for your loss.

UNINSURED AND UNDERINSURED MOTORISTS / PERSONAL INJURY PROTECTION COVERAGE

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

HOW DO I FILE 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 the **Claim Reimbursement Form**, you can find it on premera.com or call customer service and we will mail a claim form to you within 10 days.
- A separate form is needed for each patient and each provider.

Step 2

If requesting reimbursement for medical care, include:

- Proof of payment (if applicable).
- An itemized bill that includes:
 - Name of the patient.

- Date of service.
- Name, address, and IRS tax ID of the provider.
- Diagnosis code (ICD-10) – You can get this from your provider.
- American Dental Association (ADA) Current Dental Terminology (CDT) procedure code or (CPT-4, HCPCS, ADA, or B-04) – You can get this from your provider.
- Itemized charge for each service received.
- Member ID number

Step 3

To help process your claim, the form must be fully completed, signed, and returned with all required documents. Send your documents one of two ways:

- **Email through your Secure Inbox**
Sign into your account at and select Secure Inbox.
Scan and send the completed form and any required documents back to us as a secure email attachment.
- **Mail to:**
Premera Blue Cross Blue Shield of Alaska
PO Box 21552
Eagan, MN 55121

Note: Any highlights or modifications to your bill may delay processing your claim.

TIMELY FILING

We must receive claims:

- Within 365 days of discharge for hospital or other medical facility expenses.
- Or within 365 days of the date the expenses were incurred for any other services.

The plan won't provide benefits for claims we receive after the later of these 2 dates except when required by law.

SPECIAL NOTICE ABOUT CLAIMS PROCEDURE

When we process your claim, we will send a written notice explaining how the claim was processed. If the claim is denied in whole or in part, we will send a written notice that states the reason for the denial, and information on how to request an appeal of that decision. You can call customer service to get a paper copy of an explanation of benefits for the service or supply.

ADDITIONAL INFORMATION

Any notice we're required to send to the subscriber will be considered delivered if it's mailed to the most recent address appearing on our records.

We'll use the postmark date when determining the date of our notification. If you're required to send us a notice, it will be considered delivered 3 days after the postmark date, or if not postmarked, the date we receive it.

If you only had to pay a copay to your provider for a covered service, that is not considered a claim for benefits. To get a paper copy of an explanation of benefits call customer service. Or you can visit premera.com for secure online access to your claims.

NOTICE REQUIRED FOR REIMBURSEMENT AND PAYMENT OF CLAIMS

At our option and 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.

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
- Dental or 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 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 Fax to 866-903-9899

Send the details in writing to:

Premera Blue Cross Blue Shield of Alaska
P.O. 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

Dental Estimate of Benefits, 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.
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	<p>If we deny your Level 1 appeal, you can ask for an Independent Review Organization (IRO) to review your appeal.</p> <p>OR</p> <p>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.</p>	<p>180 days from the date you were notified of our Level 1 appeal decision.</p> <p>OR</p> <p>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.</p>

HOW TO SUBMIT AN APPEAL IN WRITING

<p>Step 1. Get the form</p>	<ul style="list-style-type: none"> Complete the Member Appeal Form, you can find it on premera.com or call customer service to request a copy. <p>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)</p>
<p>Step 2. Collect supporting documents</p>	<ul style="list-style-type: none"> 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.
<p>Step 3. Send in my appeal</p>	<p>To help process your appeal, be sure to complete the form and return with any supporting documents.</p> <p>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</p>

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 HAPPENS WITH 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).

<p>Step 1. Complete the form</p>	<p>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.</p> <ul style="list-style-type: none"> • 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.
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	<ul style="list-style-type: none"> You must include the signed External Review Application Form you received from us. You may also include medical records and other information.
<p>Step 2. Collect supporting documents</p>	<ul style="list-style-type: none"> 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.
<p>Step 3. Send in my external review request</p>	<ul style="list-style-type: none"> 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 Out-of-Network 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.
- You must have completed a Premera 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.

Upon acceptance of your application and payment of the required premiums, the initial coverage for you and your enrolled dependents will become effective on the first day of the following month. Receipt date is the earlier of the postmark date or the date it is delivered to us.

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 30 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.

For Plans Purchased Directly from Premera

You have a 10-day 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 premiums 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.

Reinstatement

Any premiums received after the grace period will not automatically reinstate coverage under this contract.

As stated above under ***Premiums and Grace Period***, your payment must be received by us on the first day of the month. If we do not receive your payment by the end of the grace period, we will send you a termination notice listing the date your coverage terminated for non-payment and information about reinstating your coverage. If you are eligible for reinstatement, you may request reinstatement by sending us the premiums listed on your last billing statement. When your coverage is reinstated, you will receive a confirmation letter from us. Coverage will begin again without any lapse and benefits will be provided as if the coverage never terminated.

If you are not eligible for reinstatement, any payments you made after the end of the grace period will be returned to you. Your coverage will remain terminated as of the date stated in the termination notice. You may reapply for another contract during the next open enrollment period. Please refer to premera.com for the dates of an open enrollment period. The completed enrollment application must be postmarked or received electronically before the end of the open enrollment period.

You may also be eligible to enroll during a special enrollment period. See ***Open and Special Enrollment Periods*** for details.

Term of Contract

The term of this contract is for one month from its effective date. It will renew from month to month as long as premiums paid as stated above.

This contract is renewable at the option of the subscriber except as described in the **Termination of Coverage** section.

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.

If we receive the subscriber's request to cancel within the first 5 business days of the month, coverage will end on the last day of the prior month. This will not apply if we paid for services received after the date the subscriber requested cancellation. In that case, coverage will end on the last day of the month in which we received the request. If we receive the subscriber's request to cancel after the first 5 business days of the month, coverage will end on the last day of that month. The plan will not pay for services received after the date coverage ends.

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 month following the date they no longer meet the requirements of an eligible child 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 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.

INDIVIDUAL DENTAL PLAN

This contract is sold and issued in the state of Alaska as an individual dental 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:

- **In-network (INN) 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.
- **Out-of-Network 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.

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 performing surgical procedures.
- It doesn't provide inpatient services or accommodations.

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.

Congenital Anomaly

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

Contract

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

Cosmetic Services

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

Cost-Share

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

Covered Service

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

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.

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 reasonably 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 dose, toxicity, safety or efficacy.
- Evaluation of reliable evidence shows that more research is necessary before the service can be classified as equally or more effective than conventional therapies.
- Reliable evidence means only published reports and articles in authoritative medical and scientific literature and 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.

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.

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.

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.

Orthodontia

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

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.

Provider’s Licensing or Certification

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

Serious Adverse Events and Never Events

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

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

Members and this plan are not responsible for payment of services provided by 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.

Reconstructive Surgery

Is surgery:

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

Services

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

Service Area

The service area is the geographic area in Alaska state in which an individual must live in order to be eligible for this plan. The service area for this plan are the following boroughs: Anchorage, Bethel, Chugach, Denali, Dillingham, Fairbanks North Star, Haines, Juneau, Kenai Peninsula, Ketchikan Gateway, Kodiak Island, Kusilvak, Matanuska-Susitna, Northwest Arctic, Petersburg, Prince of Wales-Hyder, Sitka, Skagway, Wrangell, and Yakutat

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.

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.

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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 tologi ma fesoasoani fa'aopo'opo talafeagai ma auaunaga.

ไทเพื่อรับການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ໝາະສົມແບບບໍ່ສຍຄ່າ.

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.

Звертайте 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>.