City and Borough of Sitka

HeritagePlus™

1011203

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

HOW TO CONTACT US

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

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

CUSTOMER SERVICE

Mailing Address:

Premera Blue Cross Blue Shield of Alaska
For Claims Only
P.O. Box 240609
Anchorage, AK 99524-0609

Physical Address

2550 Denali St. #1404
Anchorage, AK 99503

Telephone Numbers:

Local and toll-free number: 1-800-508-4722

Local and toll-free TTY number: 1-800-842-5357

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

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

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

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

Group Name:	City and Borough of Sitka
Effective Date:	April 1, 2016
Group Number:	1011203
Plan:	Alaska HeritagePlus (Non-Grandfathered)
Certificate Form Number:	1011203A

TABLE OF CONTENTS

INTRODUCTION

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

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

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

HOW TO USE THIS BOOKLET

We realize that using a health care plan can seem complicated, so we've prepared this booklet to help you understand how to get the most out of your benefits. Please familiarize yourself with the Table of Contents, which lists sections that answer many frequently asked questions.

Every section in this booklet contains important information, but the following sections may be particularly useful to you.

- **HOW TO CONTACT US** – our website address, phone numbers, mailing addresses and other contact information are conveniently located inside the front cover
- **HOW DOES SELECTING A PROVIDER AFFECT MY BENEFITS?** – how using network providers will affect this plan's benefits and reduce your out-of-pocket costs
- **WHAT DO I NEED TO KNOW BEFORE I GET CARE?** – the types of expenses you must pay for covered services
- **WHAT ARE MY MEDICAL BENEFITS?** – what's covered under this plan. Described within each benefit, you'll find a summary of what's covered and what you're responsible for paying. If your plan has routine vision benefits and/or routine hearing benefits, these benefits are described in separate sections. Your prescription drug benefits are also described in a separate section. You'll find them in the table of contents.
- **CARE MANAGEMENT** – describes prior authorization, personal health support programs and clinical review provisions
- **WHAT'S NOT COVERED?** – services that are either limited or not covered under this plan
- **WHO IS ELIGIBLE FOR COVERAGE?** – eligibility requirements for this plan
- **HOW DO I FILE A CLAIM?** – step-by-step instructions for claims submissions
- **YOUR IDEAS, QUESTIONS, COMPLAINTS AND APPEALS** – addresses and processes to follow if you want to share ideas, ask questions, file a complaint or submit an appeal
- **DEFINITIONS** – many terms that have specific meanings under this plan. Example: The terms "you" and "your" refer to members under this plan. The terms "we," "us" and "our" refer to Premera Blue Cross Blue Shield of Alaska in the state of Alaska and Premera Blue Cross in the state of Washington.

HOW DOES SELECTING A PROVIDER AFFECT MY BENEFITS?

The benefits of this plan are based on allowable charges for covered services and supplies. Please see the ***"Definitions"*** section of this booklet for a description of "allowable charge."

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

If your plan requires you to pay a higher deductible and/or more coinsurance, if any, for services of non-network providers, emergency care will always be the exception. You pay the same deductible and/or coinsurance, if any, no matter whether the emergency care is provided by in-network or non-network providers. If you see a non-network provider, you are always responsible for any amounts that exceed the allowable charge.

You may receive covered services from any provider licensed to provide the service. However, within Alaska, in order to receive the higher level of benefits available under this plan for non-emergent provider or hospital services you must use a provider or a hospital in the preferred or participating network.

When you receive services from a **preferred provider or hospital**, you will have the lowest out-of-pocket expenses and you are not responsible for amounts above the allowable charge. Therefore, receiving services from these hospitals or providers may substantially reduce your healthcare costs.

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

When you receive services from a **non-network provider or hospital**, your out-of-pocket expenses will be higher than if you receive services from a network hospital or provider. You are also responsible for amounts above the allowable charge for these providers.

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

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

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

- Emergency care
- Non-emergency care services received from non-network providers in Alaska when there isn't a network provider located within 50 miles of your home. We suggest that you contact us before you receive non-emergency care covered services from a non-network provider.
- Care received from non-network providers for covered stays at in-network hospitals when you have no choice as to who performs the services
- Categories of providers with whom we do not have a contract, including accepted rural providers. Please see the ***"Definitions"*** section of this booklet for a definition of "accepted rural providers."

Benefits are provided at the highest benefit level, but you will be required to pay any amounts that exceed the allowable charge.

This table outlines the amounts you pay for the types of services and providers you use. Please see "What Do I Need To Know Before I Get Care?" for more details on copays and coinsurance.

	Your Copay or Coinsurance		
Service Type	**Providers In The Alaska Heritage Preferred Network (including Accepted Rural Providers*):**	**Providers In The Alaska Heritage Participating Network**	**Providers Not In The Alaska Heritage Network***
Provider Office Visits (MD, DO, DPM)	$30 per visit	40%	60%
Other Provider Office Visits	$30 per visit	40%	60%
Other Provider services (MD, DO, DPM)	20%	40%	60%
Hospital-Based Services	20%	40%	60%
Other Provider Covered Services	20%	40%	60%

***You are responsible for amounts that exceed the allowable charge.**

Important Note: There are some benefits in this plan that have different copays or coinsurance than shown above. See the specific benefit for details.

WHEN YOU RECEIVE CARE IN WASHINGTON

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

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

WHEN YOU GET CARE OUTSIDE ALASKA AND WASHINGTON

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

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

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

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

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

PROVIDER STATUS

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

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

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

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

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

EMERGENCY SERVICES

Benefits for medical emergencies will be provided at the higher level when you see any covered provider. The plan will pay its allowable charge for these services and you'll only pay your applicable calendar year deductible, coinsurance, copays, amounts that exceed the benefit maximums, amounts above the allowable charge for non-network providers and charges for non-covered services.

Please Note: Services you receive in a preferred or participating network facility may be provided by providers, anesthesiologists, radiologists or other professionals who are not part of our network. When you receive services from these non-network providers, you will be responsible for amounts over the allowable charge. Amounts in excess of the allowable charge don't count toward any applicable calendar year deductible, coinsurance or out-of-pocket maximum.

WHAT DO I NEED TO KNOW BEFORE I GET CARE?

This section of your booklet explains the amounts you must pay for covered services before the benefits of this plan are provided. To prevent unexpected out-of-pocket expenses, it's important for you to understand the amounts you're responsible for.

COPAYS AND COINSURANCE

A "copay" is a fixed up-front dollar amount that you're required to pay for each occurrence of certain covered services. Your provider of care may ask you to pay the copay at the time of service.

Unless stated otherwise, benefits subject to a copay aren't subject to your deductible or coinsurance, if any.

Professional Visit Copay

For each office visit or visit in your home by a provider or other professional, you pay a $30 copay per visit. This is your professional visit copay. **Please note that the professional visit copay doesn't apply when you use a participating provider or a provider who isn't in the network.** Instead, after any calendar year deductible is met, you pay the coinsurance shown in the table in the "How Does Selecting A Provider Affect My Benefits?" section. "Coinsurance" is defined below in this section.

Certain services don't require a professional visit copay. However, the professional visit copay may apply if you also have a consultation with the **preferred** provider or receive other services. Separate professional visit copays will apply for each separate **preferred** provider you receive services from even if those services are received on the same day.

In addition to office or home visits, the professional visit copay also applies to the following services when performed in an office setting:

- Exams, other than adult vision exams covered under the "What Are My Vision Benefits?" section

- Spinal and other manipulations
- Acupuncture
- Biofeedback
- Rehabilitation therapy
- Neurodevelopmental therapy
- Electronic visits (e-visits) received from an approved provider are also subject to the professional visit copay. See the Electronic Visits benefit for additional information.

This copay doesn't apply to services listed as covered under the Home and Hospice Care benefit, services listed under the Preventive Care benefit and under the Contraceptive Management and Sterilization benefit.

Ambulance Services Copay

Medical Emergency Transport

Each time you receive licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat your medically emergent condition, you pay a $75 copay per trip. These services are also subject to your in-network calendar year deductible and preferred level coinsurance, which are explained below.

Non-Emergent Transport

Each time you receive surface (ground or water) transportation from any licensed ambulance to the nearest medical facility equipped to treat your non-emergent medical condition, the ambulance services $75 copay will apply, in addition to your in-network calendar year deductible and preferred level coinsurance.

Each time you receive air ambulance transportation from an **in-network** air ambulance to the nearest medical facility equipped to treat your non-emergent medical condition, the ambulance services $75 copay will apply, in addition to your in-network calendar year deductible and coinsurance.

The ambulance services copay does not apply when you receive licensed air ambulance transportation from a **non-network** ambulance to the nearest medical facility equipped to treat your non-emergent medical condition. For those services, the out-of-network calendar year deductible and coinsurance will apply. You are also responsible for amounts over the allowable charge.

Emergency Room Copay

Each time you receive services in an emergency room you pay a $75 copay per visit. The services you receive in an emergency room are also subject to your in-network calendar year deductible and preferred coinsurance which are explained below.

Important Note! The emergency room copay will be waived if you're admitted directly to the hospital from the emergency room.

COINSURANCE

"Coinsurance" is a defined percentage of allowable charges for covered services and supplies you receive. The benefit level provided by this plan and the remaining percentage you're responsible for, not including required copays, are both referred to as "coinsurance."

Professional Visit And Facility Coinsurance

When you get care from a preferred provider or preferred hospital, you pay less coinsurance for covered services than you would for participating hospitals or non-network providers or hospitals. Your coinsurance percentages are shown in the table in the "How Does Selecting A Provider Affect My Benefits?" section. Please see Ambulance Services for details regarding the coinsurance amounts for that benefit.

Please Note: When the "What Are My Medical Benefits?" section of this booklet refers to coinsurance, it means that either the in-network or out-of-network coinsurance shown in "How Does Selecting A Provider Affect My Benefits?" applies, depending on the provider.

CALENDAR YEAR DEDUCTIBLE

A deductible is an amount you must pay in each calendar year for covered services and supplies before this plan provides certain benefits. The amount credited toward the calendar year deductible doesn't include any copays required by this plan, and won't exceed the "allowable charge" for any covered service or supply.

Individual Deductible

For each member, the individual calendar year deductible is $1,000.

While some benefits have dollar maximums, others have different kinds of maximums, such as a maximum number of visits or days of care that can be covered. We don't count allowable charges that apply to your individual calendar year deductible toward dollar benefit maximums. But if you receive services or supplies covered by a benefit that has any other kind of maximum, we do count the services or supplies that apply to your individual calendar year deductible toward that maximum.

Family Deductible

We also keep track of the expenses applied to the individual calendar year deductible that are incurred by all enrolled family members combined. When the total equals $3,000, we'll consider the individual deductible of every enrolled family member to be met for the year. The $3,000 is called the "family" calendar year deductible. Only the amounts used to satisfy each enrolled family member's individual deductible will count toward the family deductible.

What Doesn't Apply To The Calendar Year Deductible?

The calendar year deductible needn't be met before some benefits of this plan can be provided. These exceptions are stated in the specific benefits shown in the "What Are My Medical Benefits?" section.

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

- Amounts that exceed the allowable charge
- Charges for excluded services
- Copays
- Prior authorization penalties

OUT-OF-POCKET MAXIMUM

Each calendar year, the amount each member could pay toward the calendar year deductible and coinsurance, for services listed under the "What Are My Medical Benefits?" section is limited to a specific total. This total is called an "out-of-pocket maximum." In addition, any copays listed below that the member pays also accrue towards the out-of-pocket maximum:

- Professional visit copays, except for the **Adult** Vision Exam copay
- Emergency room copay
- Ambulance services copay
- The copay(s) required in "What Are My Prescription Drug Benefits?"

Once this maximum has been satisfied, the benefits of this plan that are subject to the out-of-pocket maximum will be provided at 100% of allowable charges for the remainder of that calendar year.

If the family deductible is met before you meet your individual deductible, you must pay the difference in coinsurance, if any, in order to meet your individual out-of-pocket maximum.

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

Service Type	Providers In The Alaska Heritage Preferred Network (including Accepted Rural Providers*):	Providers In The Alaska Heritage Participating Network	Providers Not In The Alaska Heritage Network*
Provider Office Visits (MD, DO, DPM)	Yes, out-of-pocket maximum applies	Yes, out-of-pocket maximum applies	No, out-of-pocket maximum doesn't apply
Other Provider Services (MD, DO, DPM)	Yes, out-of-pocket maximum applies	Yes, out-of-pocket maximum applies	No, out-of-pocket maximum doesn't apply
Hospital-Based Services	Yes, out-of-pocket maximum applies	Yes, out-of-pocket maximum applies	No, out-of-pocket maximum doesn't apply
Other Covered Services (Except As Stated In Specific Benefits)	Yes, out-of-pocket maximum applies	Yes, out-of-pocket maximum applies	No, out-of-pocket maximum doesn't apply

Individual Maximum

For each member, the out-of-pocket maximum is $2,000 for care from network providers. Once this maximum has been satisfied, the benefits of this plan that are subject to the out-of-pocket maximum will be provided at 100% of allowable charges for the remainder of that calendar year for covered services from network providers.

Family Maximum

We also keep track of the total deductible and coinsurance amounts applied to individual out-of-pocket maximums that are incurred by all enrolled family members combined. When this total equals $6,000, we'll consider the individual out-of-pocket maximum of every enrolled family member to be met for that calendar year. The $6,000 is called the "family maximum." Only the amounts used to satisfy each enrolled family member's individual out-of-pocket maximum will count toward the family out-of-pocket maximum.

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

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

- **Adult** Vision exam copay
- Amounts that exceed the benefit maximums under this plan
- Amounts that exceed the allowable charge
- Services and supplies not covered under this plan
- The coinsurance required in "What Are My Hearing Benefits?"
- Prior authorization penalties

WHAT ARE MY MEDICAL BENEFITS?

This section explains the medical services covered and the amount you pay for each service. It also describes benefit specific limitations and maximums as well as identifying services that are subject to the calendar year deductible. Benefits are available for covered services and supplies when they meet all of the following requirements.

- It must be furnished in connection with either the prevention or diagnosis and treatment of a covered illness, disease or accidental injury
- It must be medically necessary and must be furnished in a medically necessary setting. Inpatient care is only covered when you require care that couldn't be provided in an outpatient setting without adversely affecting your condition or the quality of care you would receive.
- It mustn't be excluded from coverage under this plan
- The expense for it must be incurred while you're covered under this plan and after any applicable waiting period required under this benefit plan is satisfied
- It must be furnished by a "provider" who is performing services within the scope of his or her license or certification. Please see the ***"Definitions"*** section of this booklet for a definition of "provider."
- Prior Authorization. Some services or supplies must be authorized in writing by us before you receive them. Please see "Prior Authorization" later in this booklet for more information.
- Medical and Payment policies are used to administer the terms of the plan. Medical policies are generally used to further define medical necessity or investigational status for specific procedures, drugs, biologic agents, devices, level of care or services. Payment policies define our provider billing and payment rules. Our policies are based on accepted clinical practice guidelines and industry standards accepted by organizations like the American Medical Association (AMA), other professional societies and the Center for Medicare and Medicaid Services.

Benefits for some types of services and supplies may be limited or excluded under this plan. Please refer to the actual benefit provisions below and the "What's Not Covered?" section for a complete description of covered services and supplies, limitations and exclusions.

MEDICAL BENEFITS

For each of the benefits below, any deductible, coinsurance, or copays that you have to pay are listed first. Next, the booklet describes the terms of each benefit. Last, you'll find any services or supplies that aren't covered.

Acupuncture

This benefit is subject to the $30 professional visit copay for each visit in an office setting unless services are performed by a participating provider or a provider not in the network. For these providers, acupuncture benefits are subject to the calendar year deductible and non-network coinsurance. See the "Professional Visit Copay" section of "What Do I Need To Know Before I Get Care?" in this booklet for details about this copay.

When acupuncture isn't done in an office setting, benefits are subject to the calendar year deductible and coinsurance. Please see the "How Does Selecting A Provider Affect My Benefits?" section.

Benefits are provided for acupuncture services when medically necessary to relieve pain, induce surgical anesthesia, or to treat a covered illness, injury or condition.

Benefits are provided for up to 12 visits per member per calendar year.

Air Or Surface Transportation

This benefit is subject to the in-network calendar year deductible and preferred coinsurance.

Benefits are provided for special transport, if the accidental injury or illness is life endangering, if surgery is required that cannot be performed locally, or if a condition exists that cannot be treated locally. Benefits will be provided for transportation within the states of Alaska and Washington to the nearest facility equipped to furnish special care medically necessary for the treatment of the accidental injury or illness. Transportation must be by commercial airlines on a regularly scheduled flight. Railroad or ferry transportation may be used in lieu of air transportation.

Benefits will be limited to three round-trips per patient in any calendar year.

In addition to the above stated benefit, benefits for an attendant may be allowed if the patient is:

- A child under 18 years of age, round-trip air transportation will be provided for a parent, legal guardian, provider or registered nurse; or
- A covered incapacitated adult, round-trip air transportation will be provided for a provider or registered nurse.

In any case in which benefits for accompaniment are sought, the attending provider must certify the medical necessity for the attendant and we must deem the attendant medically necessary.

Although our prior approval is not required before benefits can be provided, we do encourage you or your provider to contact us to see if the proposed travel will meet the requirements of this benefit.

Travel is usually not covered for diagnostic purposes or second opinions. However, benefits may be provided after we review documentation of these procedures when submitted with the claim.

Transportation benefits apply only to medical conditions covered under the medical benefits of this program. They do not apply to the vision, prescription drug, hearing, dental or any other benefit sections of this program.

In addition to "What's Not Covered?" this Air or Surface Transportation benefit doesn't cover:

- Transport by taxi, bus, private car or rental car
- Meals and lodging

Ambulance Services

Benefits are provided for licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat your condition, when any other mode of transportation would endanger your health or safety. Medically necessary services and supplies provided by the ambulance are also covered. Benefits are also provided for transportation from one medical facility to another, as necessary for your condition. This benefit only covers the member that requires transportation.

Benefits for ambulance transport depend on whether the medical condition is a medical emergency. Please see the ***"Definitions"*** section of this booklet for a definition of "medical emergency."

Medical Emergency Transport

For a **medical emergency**, this benefit is subject to the ambulance services $75 copay, and the in-network calendar year deductible and preferred coinsurance, if any.

Non-Emergent Transport

For a **medically non-emergent** condition, this benefit is subject to the following cost-shares:

- **Surface Transport (ground or water):**

  Benefits for surface (ground or water) transport received from any licensed ambulance are subject to the $75 copay, and the in-network calendar year deductible and preferred level coinsurance.

- **Air Transport**:
  - Benefits for air transport received from an **in-network** air ambulance are subject to the $75 copay, in-network calendar year deductible and coinsurance.
  - Benefits for air transport received from a **non-network** air ambulance are subject to the calendar year deductible and non-network coinsurance. You are also responsible for amounts above the allowable charge.

Ambulatory Surgical Center Services

This benefit is subject to the calendar year deductible and coinsurance.

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

Blood Products and Services

This benefit is subject to the calendar year deductible and coinsurance.

Benefits are provided for the cost of blood and blood derivatives.

Clinical Trials

This benefit is subject to the $30 professional visit copay for each visit in an office setting, unless services are performed by a participating provider or a provider not in the network. For these providers, benefits are subject to the calendar year deductible and non-network coinsurance. See the "Professional Visit Copay" section of "What Do I Need To Know Before I Get Care?" in this booklet for details about this copay. Other covered services are subject to the calendar year deductible and coinsurance.

This plan covers the routine costs of a qualified clinical trial. Routine costs mean medically necessary care that is normally covered under this plan outside the clinical trial. Benefits are based on the type of service you get. For example, benefits for an office visit are covered under the Professional Visits And Services benefit and lab tests are covered under the Diagnostic Services benefit.

A qualified clinical trial is a trial that is funded and supported by the National Institutes of Health, the Center for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veterans Affairs.

We encourage you or your provider to call customer service before you enroll in a clinical trial. We can help you verify that the clinical trial is a qualified clinical trial.

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

Transportation Expenses for Cancer Clinical Trials

Reasonable and necessary expenses for transportation are subject to your in-network calendar year deductible and preferred coinsurance, if any. Covered services are limited as follows:

- Transportation provided for the member enrolled in the approved cancer clinical trial and one companion
- Transportation primarily for and essential to the medical care
- Transportation between where you reside and the site of the cancer clinical trial
- Commercial coach fare for air transportation
- Transportation for follow-up care following the initial treatment when the follow-up care cannot be provided where the member resides

In addition to "What's Not Covered?" the Clinical Trials benefit doesn't cover the following:

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

Contraceptive Management and Sterilization

Benefits for contraceptive management and sterilization are not subject to your calendar year deductible, coinsurance or copays, unless services are performed by a provider or hospital not in the network. For these providers, benefits are subject to the calendar year deductible and non-network coinsurance.

Benefits include the following services and supplies:

- Office visits and consultations related to contraception
- Injectable contraceptives and related services
- Implantable contraceptives (including hormonal implants) and related services
- Emergency contraception methods (oral or injectable)
- Sterilization procedures. When sterilization is performed as the secondary procedure, associated services such as anesthesia, facility expenses will be subject to your deductible and coinsurance and will not be reimbursed under this benefit.

Prescription Contraceptives Dispensed by a Pharmacy

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

This benefit doesn't cover:

- Non-prescription contraceptive drugs, supplies or devices (not including emergency contraceptive methods) except as required by law
- Prescription contraceptive take-home drugs dispensed and billed by a facility or provider's office
- Hysterectomy (covered on the same basis as other surgeries, see the Surgical Services benefit)
- Sterilization reversal
- Testing, diagnosis and treatment of infertility, including fertility enhancement services, procedures, supplies and drugs

Dental Services

The medical benefits of this plan will only be provided for the dental services listed below.

Accidental Injuries

The $30 professional visit copay applies to dentist visits in an office setting to examine the damage done in a dental accident and recommend treatment, unless services are performed by a participating provider or a provider not in the network. For these providers, benefits are subject to the calendar year deductible and coinsurance. See the "Professional Visit Copay" section of "What Do I Need To Know Before I Get Care?" in this booklet for details about this copay.

Benefits for a dentist's services to treat dental accidents are subject to the calendar year deductible and coinsurance.

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

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
- 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

Please Note: An accidental injury doesn't include damage caused by biting or chewing, even if due to a foreign object in food.

If necessary services can't be completed within 12 months of an accidental injury, coverage may be extended if your dental care meets the plan's extension criteria. We must receive extension requests within 12 months of the accidental injury date.

When Your Condition Requires Hospital Or Ambulatory Surgical Center Care

Benefits for the services listed below are subject to the calendar year deductible and coinsurance.

- Inpatient hospital services related to general anesthesia for dental procedures
- Outpatient facility services related to general anesthesia for dental procedures

Benefits for hospital or ambulatory surgical center care for dental procedures are provided for general anesthesia and related facility services that are medically necessary for one of two reasons:

- The member is under age 7 or is disabled physically or developmentally and has a dental condition that can't be safely and effectively treated in a dental office; or
- The member has a medical condition in addition to the dental condition needing treatment that the attending provider finds would create an undue medical risk if the treatment weren't done in a hospital or ambulatory surgical center.

Please Note: This benefit won't cover the dentist's services unless the services are to treat a dental accident and meet the requirements described above.

Diagnostic Services

Benefits for preventive diagnostic services aren't subject to your calendar year deductible or coinsurance. The calendar year deductible and coinsurance, apply to this benefit when services are rendered by a provider or hospital that isn't in the network.

Benefits for **non-preventive diagnostic services** are subject to the calendar year deductible and coinsurance.

Preventive diagnostic services are laboratory and imaging services that meet the guidelines for preventive care services stated in the Preventive Care benefit. These services are paid according to state and federal law.

Diagnostic surgeries, including scope insertion procedures, such as endoscopies, can only be covered under the Surgical Services benefit.

Benefits are provided for diagnostic services, including administration and interpretation. Some examples of what's covered are:

- Diagnostic imaging and scans (including x-rays and EKGs)
- Cancer Screening tests, to include at a minimum:
  - Annual tests for prostate cancer for high risk men under 40; all men over 40 years of age, or as recommended by a provider
  - Annual cervical cancer pap smears for women 18 years of age and older, or as recommended by a provider
  - Screening tests for colorectal cancer for high risk individuals under 50 years of age; all individuals over 50 years of age, or as recommended by a provider. Coverage for colonoscopy and sigmoidoscopy includes medically necessary sedation. Benefits include anesthesia services performed in connection with the preventive colonoscopy if the attending provider determines that anesthesia would be medically appropriate for the member.
  - BRCA genetic testing for women at risk for certain breast cancers
- Laboratory services, including routine and preventive
- Pathology Tests

Please Note: When covered inpatient diagnostic services are furnished and billed by an inpatient facility, they are only eligible for coverage under the applicable inpatient facility benefit. When covered outpatient diagnostic services are billed by an outpatient facility or emergency room and received in combination with other hospital or emergency room services, benefits are provided under the Hospital Outpatient or Emergency Room Services benefits.

In addition to "What's Not Covered?" this Diagnostic Services benefit doesn't cover:

- Diagnostic surgeries and scope insertion procedures, such as colonoscopy or endoscopy. These services can only be covered under the Surgical Services benefit.
- Allergy testing. See the Professional Visits and Services benefit for coverage of allergy testing.
- Covered inpatient diagnostic services that are furnished and billed by an inpatient facility. These services are only eligible for coverage under the applicable inpatient facility benefit.
- Covered outpatient diagnostic services that are billed by an outpatient facility or emergency room and received in combination with other hospital or emergency room services. Benefits are provided under the Hospital Outpatient or Emergency Room Services benefit.
- Services related to the treatment of infertility
- Mammography services. Please see the Diagnostic and Preventive Mammography Services benefit below.

Diagnostic and Preventive Mammography Services

Preventive mammography services that meet the guidelines for preventive care as described in the Preventive Care benefit aren't subject to the calendar year deductible and coinsurance, if any, unless services are performed by a provider or hospital that isn't in the network. For these services, benefits are subject to the calendar year deductible and non-network coinsurance.

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

Non-preventive mammography services are subject to the calendar year deductible and coinsurance.

Emergency Room Care

Each visit to the emergency room (ER) is subject to the $75 emergency room copay, the in-network calendar year deductible, and preferred coinsurance. See the "Emergency Room Copay" section of "What Do I Need To Know Before I Get Care?" in this booklet for details about this copay. The copay will be waived if you're admitted to the hospital directly from the emergency room.

This benefit is provided for emergency room facility services including related procedure, operating, and recovery rooms; plus services and supplies such as surgical dressings and drugs furnished by and used in the emergency room. Additionally, when covered outpatient diagnostic services are billed by an emergency room and received in combination with other emergency room services, benefits are provided under this benefit.

In addition to "What's Not Covered?" this Emergency Room Care benefit doesn't cover the treatment of substance abuse. Benefits for these services are provided under the Substance Abuse Treatment benefit located earlier in this booklet. However, benefits for the treatment of medically necessary detoxification services are provided under this benefit on the same basis as any other emergency medical condition.

Health Management

The calendar year deductible and coinsurance do not apply.

Health Education

Benefits are provided for outpatient health education services to manage a covered condition, illness or injury. These services aren't subject to a calendar year benefit limit. Examples of covered health education services are diabetes health education, asthma education, pain management, and childbirth and newborn parenting training.

Community Wellness

This benefit allows you to participate in classes and programs that promote positive health and lifestyle choices. Benefits are provided up to a maximum benefit of $250 per member each calendar year for community wellness classes and programs. Examples of these classes and programs are adult, child, and infant CPR; safety; babysitting skills; back pain prevention; stress management; bicycle safety; and parenting skills.

You pay for the cost of the class or program and send us proof of payment along with a reimbursement form. When we receive these items, the plan will provide benefits as stated above in this benefit. Please contact our Customer Service department (see the "How To Contact Us" section inside the front cover of this booklet) for a reimbursement form.

Nicotine Dependency Programs

Benefits are provided for outpatient nicotine dependency programs. These services aren't subject to a calendar year benefit limit. You pay for the cost of the program and send us proof of payment along with a reimbursement form. Please contact our Customer Service department (see the "How To Contact Us" section inside the front cover of this booklet) for a reimbursement form or for help finding covered providers.

In addition to "What's Not Covered?" this Health Management benefit doesn't cover drugs for the treatment of nicotine dependency. Please see the "What Are My Prescription Drug Benefits?" section.

Home and Hospice Care

This benefit is subject to the calendar year deductible and coinsurance.

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

Benefits are provided, up to the following maximums, for covered services furnished and billed by a home health agency, home health care provider, or hospice that is Medicare-certified or is licensed or certified by the state it operates in.

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

Home Health Care

This benefit provides up to 130 intermittent home visits per member each calendar year by a home health care provider or one or more of the home health agency employees above. Other therapeutic services, such as respiratory therapy and phototherapy, are also covered under this benefit.

Hospice Care

Benefits for a terminally ill member shall not exceed 6 months of covered hospice care. Covered hospice services are:

- **In-home intermittent hospice visits** by one or more of the hospice employees above. These services don't count toward the 130 intermittent home visit limit shown above under "Home Health Care."
- **Inpatient hospice care** up to a maximum of 10 days. This benefit provides for inpatient services and supplies used while you're a hospice inpatient, such as solutions, medications or dressings, when ordered by the attending provider.
- **Respite care** up to a maximum of 240 hours, to relieve anyone who lives with and cares for the terminally ill member.
- **Palliative care** The hospice care benefit also covers palliative care for members facing serious, life-threatening conditions but who are not in imminent danger of death, including expanded access to home based care and care coordination. Participation in palliative care is usually approved for 12 months at a time and may be extended based on the member's specific condition.

Insulin and Other Home and Hospice Care Provider Prescribed Drugs

Benefits are provided for prescription drugs and insulin when furnished and billed by a home health care provider, home health agency or hospice.

In addition to "What's Not Covered?" this Home and Hospice Care benefit doesn't cover any of the following:

- Charges in excess of the average wholesale price shown in the "Pharmacist's Red Book" for prescription drugs, insulin, and intravenous drugs and solutions
- Over-the-counter drugs, solutions and nutritional supplements
- Drugs and solutions received while you're an inpatient, except for covered inpatient hospice care
- Services provided to someone other than the ill or injured member
- Services of family members or volunteers
- Services, supplies or providers not in the written plan of care or not named as covered in this benefit
- Custodial care, except for hospice care services
- Non-medical services, such as spiritual, bereavement, legal or financial counseling
- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care; and transportation services
- Dietary assistance, such as "Meals on Wheels," or nutritional guidance

Hospital Inpatient Care

This benefit is subject to the calendar year deductible and coinsurance.

Benefits are provided for the following inpatient medical and surgical services:

- Room and board expenses, including general duty nursing and special diets
- Use of an intensive care or coronary care unit equipped and operated according to generally recognized hospital standards

- Operating room, surgical supplies, hospital anesthesia services and supplies, drugs, dressings, equipment and oxygen
- Diagnostic and therapeutic services
- Blood, blood derivatives and their administration

Please Note: For inpatient hospital obstetrical care and newborn care, please see the Obstetrical Care and Newborn Care benefits.

In addition to "What's Not Covered?" this Hospital Inpatient Care benefit doesn't cover any of the following:

- Hospital admissions for diagnostic purposes only, unless the services can't be provided without the use of inpatient hospital facilities, or unless your medical condition makes inpatient care medically necessary
- Any days of inpatient care that exceed the length of stay that is medically necessary to treat your condition
- The treatment of substance abuse. Coverage for the treatment of substance abuse is available under the Substance Abuse Treatment benefit located earlier in this booklet. However, benefits for the treatment of medically necessary detoxification services are provided under this benefit on the same basis as any other emergency medical condition.

Hospital Outpatient Care

This benefit is subject to the calendar year deductible and coinsurance.

This benefit covers operating rooms, procedure rooms, and recovery rooms. Also covered are services and supplies, such as surgical dressings and drugs, furnished by and used while at the hospital. Additionally, when covered outpatient diagnostic services are billed by an outpatient facility and received in combination with other outpatient hospital services, benefits are provided under this benefit.

Infusion Therapy

This benefit is subject to the calendar year deductible and coinsurance.

This benefit is provided for outpatient professional services, supplies, drugs and solutions required for infusion therapy. Infusion therapy (also known as "intravenous therapy") is the administration of fluids into a vein by means of a needle or catheter, most often used for the following purposes:

- To maintain fluid and electrolyte balance
- To correct fluid volume deficiencies after excessive loss of body fluids
- Members that are unable to take sufficient volumes of fluids orally
- Prolonged nutritional support for members with gastrointestinal dysfunction

In addition to "What's Not Covered?" this Infusion Therapy benefit doesn't cover any of the following:

- Charges in excess of the average wholesale price shown in the "Pharmacist's Red Book" for drugs and solutions
- Over-the-counter drugs, solutions and nutritional supplements
- Drugs and solutions received while you're an inpatient in a hospital or other medical facility

Mastectomy and Breast Reconstruction Services

Benefits are provided for mastectomy necessary due to disease, illness or accidental injury and for breast reconstruction needed in connection with a mastectomy. You pay the same share of the allowable charges for mastectomy and breast reconstruction as for any other surgery. What you pay depends on where the surgery is performed. For example, if surgery is done while you're an inpatient in a hospital, you pay the share of allowable charges shown under the Hospital Inpatient benefit.

For any member electing breast reconstruction in connection with a mastectomy, this benefit covers:

- Reconstruction of the breast on which mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Physical complications of all stages of mastectomy, including lymphedemas

Services are to be provided in a manner determined in consultation with the attending provider and the patient.

Medical Equipment and Supplies

This benefit is subject to your calendar year deductible and coinsurance, except as otherwise stated below.

Benefits are provided for the following covered medical equipment, prosthetics, orthotics and supplies (including sales tax for covered items):

Medical and Respiratory Equipment

Benefits are provided for the rental of such equipment (including fitting expenses), but not to exceed the purchase price, when medically necessary and prescribed by a provider for therapeutic use in direct

treatment of a covered illness or injury. The plan may also provide benefits for the initial purchase of equipment, in lieu of rental

Examples of medical and respiratory equipment are a wheelchair, hospital-type bed, traction equipment, ventilators, and diabetic equipment such as blood glucose monitors, insulin pumps and accessories to pumps, and insulin infusion devices.

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

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

Medical Supplies, Orthotics (Other Than Foot Orthotics), and Orthopedic Appliances

Covered items include, but aren't limited to, dressings, braces, splints, rib belts and crutches, as well as related fitting expenses.

Prosthetics

Benefits for external prosthetic devices (including fitting expenses) are provided when such devices are used to replace all or part of an absent body limb or to replace all or part of the function of a permanently inoperative or malfunctioning body organ. Benefits will only be provided for the initial purchase of a prosthetic device, unless the existing device can't be repaired, or replacement is prescribed by a provider because of a change in your physical condition.

Foot Orthotics and Therapeutic Shoes

When prescribed for corrective purposes, benefits are provided for foot orthotics (shoe inserts) and therapeutic shoes (orthopedic), including fitting expenses, up to a maximum of $600 per member each calendar year. Items prescribed for the treatment of diabetes are not subject to this benefit limit.

Medical Vision Hardware

Benefits are provided for vision hardware for the following medical conditions of the eye; corneal ulcer, bullous keratopathy, recurrent erosion of cornea, tear film insufficiency, aphakia, Sjogren's syndrome, congenital cataract, corneal abrasion and keratoconus.

Breast Pumps

This benefit covers the purchase of standard electric breast pumps. Rental of hospital grade breast pumps is also covered when medically necessary. Purchase of hospital-grade pumps is not covered.

When you use an in-network supplier, benefits for covered breast pumps are not subject to your calendar year deductible and coinsurance, if any. For suppliers not in the network, benefits are subject to the out-of-network calendar year deductible and coinsurance.

For further information, please see the Preventive Care benefit.

Please Note: When covered inpatient medical supplies and equipment are furnished and billed by an inpatient facility, they are only eligible for coverage under the applicable inpatient facility benefit.

In addition to "What's Not Covered?" the Medical Equipment and Supplies benefit doesn't cover any of the following.

- Supplies or equipment not primarily intended for medical use
- Special or extra-cost convenience features
- Items such as exercise equipment and weights
- Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities
- Penile prostheses
- Whirlpools, whirlpool baths, portable whirlpool pumps, sauna baths, and massage devices
- Over bed tables, elevators, vision aids and telephone alert systems
- Structural modifications to your home and/or personal vehicle
- Eyeglasses, contact lenses and other vision hardware for conditions not listed as a covered medical condition, including routine eye care
- Prosthetics, intraocular lenses, appliances or devices requiring surgical implantation. These items are covered under the Surgical Services benefit. Items provided and billed by a hospital are covered under the Hospital Inpatient Care or Hospital Outpatient Care benefits.
- Hypodermic needles, syringes, lancets, test strips, testing agents and alcohol swabs used for self-administered medications, except as specified in the "What Are My Prescription Drug Benefits?" section

Medical Travel Support

The calendar year deductible and coinsurance do not apply.

This benefit provides travel costs for members who reside in Alaska only for specified non-emergent medical procedures performed at certain in-network facilities. Please contact Customer Service for a list of eligible procedures and facilities. Before you travel to a facility not on the list you must get authorization.

Please contact Customer Service for assistance with the process.

Benefits are provided for:

- One round trip airfare by a licensed commercial carrier for the member and one companion per episode
- Air transportation expenses for the member and a companion from the member's home in Alaska to and from the medical facility where services will be provided. Air travel expenses cover unrestricted, flexible and fully refundable round trip airfare from a licensed commercial carrier.
- Surface transportation, car rental, taxicab fares and parking fees, for the member and a companion between the hotel and the medical facility where services will be provided, limited to $35 per day
- Mileage expenses for the member's personal automobile are covered based on IRS guidelines
- Ferry transportation expenses for the member and a companion from the member's home community, limited to $50 per person each way
- Lodging expenses at commercial establishments (hotels and motels) for the member and a companion while traveling between home and the medical facility where services will be provided, limited to $50 per day per person

Air travel and lodging arrangements can be made by Premera's travel partner or by the member.

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

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

This benefit does not cover:

- Reimbursement for travel to an in-network facility not on the list of eligible facilities before contacting us and receiving authorization. If a procedure is performed at a facility that is not on the list, travel expenses will not be reimbursed if the total cost of the procedure, plus travel expenses, exceeds the cost of having that procedure performed at a facility in Alaska.
- Travel to facilities outside the network
- International travel
- Airline charges and fees for booking changes
- Reimbursement for mileage rewards or frequent flier coupons
- Travel for ineligible medical procedures
- Lodging at any establishment that is not a hotel or motel
- Travel in a mobile home, RV, or travel trailer
- Meals
- Personal care items
- Pet care, except for service animals
- Phone service and long distance calls

How To File a Medical Travel Support Claim:

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

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

You must also attach the following documents:

- The boarding pass and a copy of the ticket from the airline or other transportation carrier. The tickets must indicate the name(s) of the passenger(s), dates and total cost of travel, and the origination and final destination points; or
- A copy of the detailed itinerary as issued by the airline, transportation carrier, travel agency or online travel website. The itinerary must identify the name(s) of the passenger(s), the dates of travel and total cost of travel, and the origination and final destination points.
- Receipts for all covered travel expenses
- A Utilization Management Authorization number for travel to facilities not on the list

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

Mental Health Care

This benefit is subject to the $30 professional visit copay for each therapeutic visit in an office setting, unless services are performed by a provider not in the network. For these providers, benefits are subject to the calendar year deductible and non-network coinsurance.

Benefits for the services listed below are subject to your in-network calendar year deductible and preferred level coinsurance, unless services are performed by providers that aren't in the network. For these providers, benefits are subject to the calendar year deductible and non-network coinsurance.

- Inpatient professional services
- Inpatient facility services
- Therapeutic visits in an office setting provided by a provider who isn't in the network
- Outpatient therapeutic visits not in an office setting

- Outpatient facility services
- This benefit covers medically necessary services for treatment of psychiatric conditions. Please see the ***"Definitions"*** section of this booklet for a definition of "psychiatric conditions." Covered services include all of the following:
  - Inpatient, residential and outpatient facility treatment, and outpatient visits to manage or reduce the effects of a psychiatric condition, including treatment of eating disorders (such as anorexia nervosa, bulimia or any similar condition)
  - Individual, family or group therapy
  - Lab and testing
  - Take-home drugs you get in a facility
  - Biofeedback
  - Physical, speech and occupational therapy provided to treat psychiatric conditions, such as autism spectrum disorders
- Applied behavior analysis (ABA) for the treatment of autism spectrum disorders, and including services provided by an autism service provider. Please see the ***"Definitions"*** section of this booklet for a definition of "autism service provider."

"Outpatient therapeutic visit" (outpatient visit) means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards as defined in the **Physician's Current Procedural Terminology**, published by the American Medical Association.

In addition to "What's Not Covered?" this Mental Health Care benefit doesn't cover:

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

Neurodevelopmental Therapy

This benefit is subject to the $30 professional visit copay for each visit for therapy in an office setting, unless services are performed by a participating provider or a provider not in the network. For these providers, benefits are subject to the calendar year deductible and non-network coinsurance. See the "Professional Visit Copay" section of "What Do I Need To Know Before I Get Care?" in this booklet for details about this copay.

Benefits for the services listed below are subject to the calendar year deductible and coinsurance.

- Outpatient facility services
- Inpatient facility services
- Inpatient professional services
- Therapy in an office setting performed by a participating provider or a provider who isn't in the network
- Outpatient therapy not in an office setting

Benefits are provided for the treatment of neurodevelopmental disabilities for members under the age of 7.

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

- **Inpatient Care** Benefits for inpatient facility and professional care are provided up to 30 days per member each calendar year. Inpatient facility services must be furnished and billed by a hospital or by a rehabilitation facility, and will only be covered when services can't be done in a less intensive setting.
- **Outpatient Care** Benefits for outpatient care are subject to the following provisions:
  - The member mustn't be confined in a hospital or other medical facility.
  - The therapy must be part of a formal written treatment plan prescribed by a provider.
  - Services must be furnished and billed by a hospital, rehabilitation facility, provider, physical, occupational or speech therapist.

  When the above criteria are met, benefits will be provided for physical, speech, and occupational therapy services, up to a combined maximum benefit of 45 visits per member each calendar year.

  This benefit includes physical, speech, and occupational therapy assessments and evaluations related to treatment of covered neurodevelopmental therapy.

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

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

In addition to "What's Not Covered?" this Neurodevelopmental Therapy benefit doesn't cover the following.

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

Newborn Care

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

Routine newborn care is subject to the same share of the allowable charges for inpatient newborn care as for other covered services. For inpatient hospital care, you pay the share of allowable charges shown under the Hospital Inpatient benefit. For inpatient professional care, you pay the share of allowable charges shown under the Professional Visits and Services benefit. Any deductible or coinsurance required for the newborn is separate from that of the mother.

Benefits for routine hospital nursery charges and related inpatient well-baby care for an eligible newborn are provided up to:

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

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

Benefits are also provided for routine circumcision.

In addition to "What's Not Covered?" this Newborn Care benefit doesn't cover immunizations. See the Preventive Care benefit for coverage of immunization and outpatient well-baby care.

Newborn Hearing Exams and Testing

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

What you pay depends on where the service is performed. For example, if you receive inpatient care in a hospital, you pay the share of allowable charges shown under the Hospital Inpatient benefit. For office visits, you pay the share of allowable charges shown under the Professional Visits and Services benefit. For diagnostic testing, you pay the share of allowable charges shown under the Diagnostic Services benefit.

Nutritional Therapy

Benefits for covered services are subject to the calendar year deductible and coinsurance.

Benefits are provided for outpatient nutritional therapy services to manage your covered condition, illness or injury. See "Nutritional Counseling" under the Preventive Care benefits for preventive services.

Obstetrical Care

Obstetrical care is subject to the same share of the allowable charges as for other covered services. For example, for inpatient hospital care, you pay the share of allowable charges shown under the Hospital Inpatient benefit. For a birthing center, you pay the share of allowable charges shown under the Ambulatory Surgery Center benefit.

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

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

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

Obstetrical care benefits cover the following.

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

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

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

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

Phenylketonuria (PKU) Dietary Formula

This benefit is subject to the calendar year deductible and coinsurance.

Benefits are provided for dietary formula that's medically necessary for the treatment of phenylketonuria (PKU).

Preventive Care

What Are Preventive Services?

Preventive services are defined as follows:

- Evidence-based items or services with a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force (USPSTF). Also included are additional preventive care and screenings for women not described in this paragraph as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control (CDC) and Prevention.
- Evidence-informed infant, child and adolescent preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

You can get a complete list of the preventive care services with the limits on our website at: https://www.premera.com/ak/member/stay-healthy/preventive-health/ or call us for a list.

This list may be changed as required by state and federal preventive guidelines change. The list will include website addresses where you can see current federal preventive guidelines.

Services designated as preventive care when they meet the federal guidelines include periodic exams, routine immunizations described below, and laboratory and imaging services that are covered as preventive under the Diagnostic Services benefit and the Mammography benefits.

Preventive Exams

Your calendar year deductible, coinsurance and copay, if any, don't apply to benefits for preventive exams unless services are performed by a provider who isn't in the network. For these services, benefits are subject to the calendar year deductible and non-network coinsurance, if any. Please see the "How Does Selecting A Provider Affect My Benefits?" section.

The following exam services are covered as long as they fall within the preventive guidelines:

- Routine physical exams
- Well-baby exams and well-child exams, including those provided by a qualified health aide
- Physical exams related to school, sports, and employment

Please note: Not all services recommended or billed by your provider as part of your routine physical may meet these preventive guidelines and may be covered under other medical benefits.

Preventive Immunizations

Your calendar year deductible, coinsurance and copay, if any, don't apply to benefits for preventive immunizations, unless services are performed by a provider that isn't in the network. For these services, benefits are subject to the calendar year deductible and non-network coinsurance. Please see the "How Does Selecting A Provider Affect My Benefits?" section.

Seasonal and Other Immunizations

Seasonal and certain other immunizations provided by a pharmacy or other mass immunizer location aren't subject to the calendar year deductible, coinsurance or copay, if any. Benefits are provided at 100% of allowable charges. Covered services include flu shots, flu mist, pneumonia immunizations, whooping cough, adult shingles immunizations and travel immunizations.

Women's Preventive Care

Benefits for women's preventive care, when they meet the federal guidelines as defined for women's health, aren't subject to the calendar year deductible, coinsurance or copay, if any, unless services are performed by a provider or hospital that isn't in the network. For these services, benefits are subject to the calendar year deductible and non-network coinsurance. Please see the "How Does Selecting a Provider Affect My Benefits?" section.

Examples of covered women's preventive care services include, but are not limited to:

- Contraceptive counseling
- Breast feeding counseling
- Maternity diagnostic screening
- Screening for gestational diabetes
- Counseling for sexually transmitted infections

Fall Prevention

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

Nutritional Counseling

Health eating assessments and dietary counseling.

In addition to "What's Not Covered?" this Preventive Care benefit doesn't cover any of the following:

- Charges for services or items in excess of the preventive care benefits, including services that exceed the frequency, age and gender guidelines
- Inpatient routine newborn exams while the child is in the hospital following birth. These services are covered under the Newborn Care benefit.
- Services not named above as covered
- Routine or other dental care
- Routine vision and hearing exams
- Services that are related to a specific illness, injury or definitive set of symptoms exhibited by the member. Please see the plan's non-preventive benefit for available coverage.
- Physical exams for basic life or disability insurance
- Work-related disability evaluations or medical disability evaluations
- Facility charges when preventive care is received at a hospital-based clinic or a hospital-based provider's office. See the Hospital Outpatient Care benefit for your cost-share.
- Breast pumps. See Medical Equipment and Supplies.

Please see the Contraceptive Management and Sterilization, Diagnostic Services, Health Management, and Obstetrical Care for those benefits.

Professional Visits and Services

This benefit is subject to the $30 professional visit copay for each visit in an office setting and for each visit to your home when services are provided by a preferred provider.

Therapeutic injections, including allergy injections, and allergy testing aren't included in the services covered by the professional visit copay. However, the copay may apply if you also have a consultation with the provider or receive other services during the visit.

The calendar year deductible and coinsurance apply to the benefits listed below:

- Visits in an office setting and visits to your home provided by a participating provider or a provider who's not in the network
- Inpatient and other outpatient professional visits
- Therapeutic injections, including allergy injections, and allergy tests

The Professional Visits and Services benefit covers the examination, diagnosis and treatment of an illness or injury when such services are performed on an inpatient or outpatient basis, including your home.

Benefits are also available for the following professional services:

- Allergy testing
- Second opinions for any covered medical diagnosis or treatment plan when provided by a qualified provider
- Prostate, colorectal, and cervical cancer screening exams, unless they meet the guidelines for preventive medical services described in the Preventive Care benefit.
- Biofeedback for migraines and other conditions for which biofeedback is not deemed experimental or investigational when provided by a qualified provider. Please see the ***"Definitions"*** section of this booklet for a definition of "experimental/ investigational."
- Routine foot care when the member is a diabetic
- Consultations and treatment for nicotine dependency
- Telehealth virtual care services. This benefit includes access to care via online and telephonic methods when medically appropriate, and is real-time communication between the Telehealth doctor and you. Eligible services must be medically necessary to treat a covered illness, injury or condition. Visit **teladoc.com/premeraAK**, click “Set up account” and provide the required information. You can also call Teladoc at **855.332.4059** for assistance.
- Electronic visits. This benefit includes electronic visits (e-visits). E-visits are structured, secure online messaging protocol (email) consultations between your doctor and you. They are not real-time visits. Your doctor will determine which conditions and circumstances are appropriate for e-visits in their practice. E-visits are covered when all of the following are true:

- Premera Blue Cross Blue Shield of Alaska has approved the provider for e-visits. Not all doctors have agreed to or have the software capabilities to provide e-visits.
- The member has previously been treated in the doctor's office and has established a patient-provider relationship with that doctor
- The e-visit is medically necessary for a covered illness or injury

Please call Customer Service at the number listed inside the front cover of this booklet for help in finding a provider approved to provide e-visits.

In addition to "What's Not Covered?" this Professional Visits and Services benefit doesn't cover the following:

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

Psychological and Neuropsychological Testing

This benefit is subject to the calendar year deductible and coinsurance.

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

Rehabilitation Therapy and Chronic Pain Care

This benefit is subject to the $30 professional visit copay for each visit in an office setting unless the services are performed by a participating provider or a provider that isn't in the network. For these providers, benefits are subject to the calendar year deductible and non-network coinsurance.

Benefits for the services listed below are subject to the calendar year deductible and coinsurance.

- Inpatient facility services
- Outpatient facility services
- Inpatient professional services
- Outpatient professional services not in an office setting

Rehabilitation Therapy

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

- Restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an accidental injury, illness or surgery; or
- Treat disorders caused by physical congenital anomalies. Please see the Neurodevelopmental Therapy Benefit earlier in this section for coverage of disorders caused by neurological congenital anomalies.

Covered services include all of the following:

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

Inpatient Care Benefits for inpatient facility and professional care are available up to 30 days per

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

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

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

When the above criteria are met, benefits will be provided for physical, speech and occupational therapy services, including cardiac and pulmonary rehabilitation, up to a combined maximum benefit of 45 visits per member each calendar year. Benefits are also included for physical, speech, and occupational assessments and evaluations related to rehabilitation.

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

Chronic Pain Care

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

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

In addition to "What's Not Covered?" this Rehabilitation Therapy and Chronic Pain Care benefit doesn't cover the following:

- Recreational, vocational or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Treatment that isn't actively engaged in by the ill, injured or impaired member
- Gym or swim therapy
- Custodial care
- Inpatient rehabilitation received more than 24 months from the date of onset of the member's accidental injury or illness or from the date of the member's surgery that made rehabilitation necessary
- Services to treat a psychiatric condition; see the Mental Health Care benefits.

Skilled Nursing Facility Services

This benefit is subject to the calendar year deductible and coinsurance.

This benefit is only provided when you're at a point in your recovery where inpatient hospital care is no longer medically necessary, but skilled care in a skilled nursing facility is. Your attending provider must actively supervise your care while you're confined in the skilled nursing facility.

Benefits are provided up to 20 days per member each calendar year for services and supplies, including room and board expenses, furnished by and used while confined in a skilled nursing facility.

In addition to "What's Not Covered?" this Skilled Nursing Facility Services benefit doesn't cover the following:

- Custodial care
- Care that is primarily for senile deterioration, mental deficiency or retardation or the treatment of substance abuse

Spinal and Other Manipulations

This benefit is subject to the $30 professional visit copay for each visit in an office setting, unless the services are performed by a participating provider or a provider that isn't in the network. See the "Professional Visit Copay" section of "What Do I Need To Know Before I Get Care?" in this booklet for details about this copay.

Benefits for spinal and other manipulations are provided up to a combined maximum benefit of 24 visits per member each calendar year. Services must be medically necessary to treat a covered illness, injury or condition.

Substance Abuse Treatment

The $30 professional visit copay applies to visits in an office setting, unless services are performed by a provider not in the network. For these providers, benefits are subject to the calendar year deductible and non-network coinsurance.

Benefits for in-network services listed below are subject to the in-network calendar year deductible and preferred level coinsurance, unless services are rendered by providers that aren't in the network. For these For these providers, benefits are subject to the calendar year deductible and non-network coinsurance.

- Inpatient professional services
- Visits in an office setting provided by a provider not in the network
- Outpatient professional visits, except for office visits
- Inpatient facility services
- Outpatient facility services

This benefit covers inpatient, residential and outpatient visits to manage or reduce the effects of substance abuse, including individual, family or group therapy, lab and testing, and take-home drugs you get in a facility. Covered services must be medically necessary and furnished by a provider who is licensed or certified by the state to provide these services.

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

In addition to "What's Not Covered?" this Substance Abuse Treatment benefit doesn't cover the following:

- Treatment of alcohol or drug use or abuse that does not meet the definition of substance abuse. Please see the ***"Definitions"*** section of this booklet for a definition of "substance abuse."
- Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing, or to driving rights, unless such services are medically necessary
- Halfway houses, quarterway houses, recovery houses, and other sober living residences
- Outward bound, wilderness, camping or tall ship programs or activities

Surgical Services

This benefit is subject to the calendar year deductible and coinsurance, if any, except where stated otherwise. Please see the ***"How Does Selecting A Provider Affect My Benefits?"*** section.

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

- Anesthesia or sedation and postoperative care as medically necessary. Please see the **"*Definitions*"** section of this booklet for a definition of "medically necessary." Benefits include anesthesia services performed in connection with the preventive colonoscopy if the attending provider determines that anesthesia would be medically appropriate for the member. Please see the Diagnostic Services benefit for coverage of preventive diagnostic services.
- Cornea transplantation, skin grafts, and the transfusion of blood or blood derivatives
- Sexual reassignment surgery if medically necessary and not for cosmetic purposes
- Colonoscopy and other scope insertion procedures are also covered under this benefit unless they qualify as preventive services described in the Preventive Care benefit. Please see the "*Diagnostic Services"* benefit for coverage of preventive diagnostic services.

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

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

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

Transplants

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

You pay the same share of the allowable charges for covered transplants and transplant-related medical services that you would pay for any other surgery and related services when services are performed by a preferred or participating provider.

The Transplants benefit is not subject to a separate benefit maximum other than the maximums for transport and lodging and for donor costs described below.

What you pay depends on where the service is performed. For example, if you receive inpatient care in a hospital, you pay the share of allowable charges shown under the Hospital Inpatient benefit. For office visits, you pay the share of allowable charges shown under the Professional Visits and Services benefit.

The transport and lodging benefits below are subject to the calendar year deductible. Your coinsurance does not apply.

Specific services under this benefit have individual benefit maximums so it's important to read this entire section to understand this benefit.

Covered Transplants

Solid organ transplants and bone marrow/stem cell reinfusion procedures mustn't be considered experimental or investigational for the treatment of your condition. Please see the ***"Definitions"*** section of this booklet for a definition of "experimental/ investigational." The plan reserves the right to base coverage on all of the following:

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

  Please Note: For the purposes of this plan, the term "transplant" doesn't include cornea transplantation, skin grafts or the transplant of blood or blood derivatives (except for bone marrow or stem cells). Benefits for such services are provided under other benefits of this plan.
- Your medical condition must meet the plan's written standards, which are found by referring to our website at **premera.com** or by contacting Customer Service.
- The transplant or reinfusion must be furnished in an approved transplant center. ("Approved Transplant Center" is a hospital or other provider that's developed expertise in performing solid organ transplants, or bone marrow or stem cell reinfusion.) Premera Blue Cross Blue Shield of Alaska has agreements with approved transplant centers in Alaska and Washington, and Premera Blue Cross Blue Shield of Alaska has access to a special network of approved transplant centers around the country. Whenever medically possible, you'll be directed to an approved, contracted transplant center for transplant services.

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

Recipient Costs

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

Donor Costs

Procurement expenses are limited to $75,000 per transplant. All covered donor costs accrue towards the $75,000 maximum, no matter when the donor receives them. Covered donor services include selection, removal (harvesting) and evaluation of the donor organ, bone marrow or stem cell; transportation of donor organ, bone marrow and stem cells, including the surgical and harvesting teams; donor acquisition costs such as testing and typing expenses; and storage costs for bone marrow and stem cells for a period of up to 12 months.

Transportation and Lodging Expenses

Reasonable and necessary expenses for transportation, lodging and meals for the transplant recipient (while not confined) and one companion, except as stated below, are covered but limited as follows:

- The transplant recipient must reside more than 50 miles from the approved transplant center, unless medically necessary treatment protocols require the member to remain closer to the transplant center.
- The transportation must be to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.

- Covered transportation, lodging and meal expenses incurred by the transplant recipient and companions are limited to $7,500 per transplant. When the recipient is a dependent minor child, expenses for the child and two companions are included. If not a dependent minor child, lodging and meal expenses are limited to the recipient and one companion.

In addition to "What's Not Covered?" this Transplant benefit doesn't cover the following:

- Services and supplies that are payable by any government, foundation or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers.
- Donor costs for a solid organ transplant or bone marrow or stem cell reinfusion that isn't covered under this benefit, or for a recipient who isn't a member
- Donor costs for which benefits are available under other group or individual coverage
- Non-human or mechanical organs, unless they aren't experimental or investigational services. Please see the ***"Definitions"*** section of this booklet for a definition of "experimental/ investigational."
- Personal care items
- Anti-rejection drugs, except those administered by the transplant center during the inpatient or outpatient stay in which the transplant was performed
- Planned storage of blood for more than 12 months against the possibility it might be used at some point in the future
- Take-home prescription drugs dispensed by a licensed pharmacy. See the *"What Are My Prescription Drug Benefits?"* section for benefit information.

WHAT ARE MY VISION BENEFITS?

Please Note: Optometrists are always paid at the in-network benefit level.

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

Vision Exams

You pay a $30 copay for each vision exam rendered by a provider in the network. Services performed by a provider who's not in the network are subject to the calendar year deductible and coinsurance.

The adult vision exam copay is a fixed, up-front dollar amount. Your provider may ask that you pay this amount at the time of service. The copay amount doesn't vary with the cost of the service and doesn't apply toward applicable calendar year deductible, and does not accrue to the out-of-pocket maximum.

This benefit provides one routine vision exam per member each calendar year. Covered routine exam services include:

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

Vision Hardware

Vision hardware benefits aren't subject to the calendar year deductible or coinsurance.

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

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

The plan pays allowable charges including any applicable sales tax, shipping and handling costs up to a maximum benefit of $300 per member every 2 consecutive calendar years.

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

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

Important Note! Prescribed vision hardware necessitated by surgery, injury or disease is covered under the "Medical Benefits" section of this plan.

Vision hardware benefits are based on allowable charges for covered services and supplies. Please see the ***"Definitions"*** section of this booklet for a definition of "allowable charge." Charges for vision services or supplies that exceed what's covered under this benefit aren't covered under other benefits of this plan.

This Vision Exam and Hardware benefit doesn't cover any of the following:

- Services or supplies that aren't named above as covered, or that are covered under other provisions of this plan
- Non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments) or light-sensitive lenses, even if prescribed
- Vision therapy, eye exercise or any sort of training to correct muscular imbalance of the eye (orthoptics), or pleoptics
- Supplies used for the maintenance of contact lenses
- Services and supplies (including hardware) received after your coverage under this benefit has ended, except when all of the following requirements are met:
  - You ordered covered contact lenses, eyeglass lenses and/or frames before the date your coverage under this benefit or plan ended; and
  - You received the contact lenses; eyeglass lenses and/or frames within 30 days of the date your coverage under this benefit or plan ended.

Pediatric Vision Benefit

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

Vision Exam

Benefits are provided for one routine eye exam per calendar year.

The vision exam is subject to the $30 professional visit copay for a visit in an office. This is true even if you get the exam from a provider who isn't in the network.

Vision Hardware

Benefits are provided for:

- One pair of frames and lenses per calendar year, ***or***
- One pair of hard contact lenses per calendar year, ***or***
- 12-month supply of disposable contact lenses per calendar year

Vision hardware benefits aren't subject to the calendar year deductible or coinsurance.

WHAT ARE MY PRESCRIPTION DRUG BENEFITS?

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

Some prescription drugs require Prior Authorization. See Prior Authorization under the "Care Management" section of this booklet for details.

Each member must pay a copay for each separate new prescription or refill. A "copay" is defined as a fixed up-front dollar amount that you're required to pay to the retail pharmacy or the mail-order pharmacy for each prescription drug purchase.

Retail Pharmacy Prescriptions

Generic Drugs ..... $15 copay

Preferred List Brand Name Drugs ..... $25 copay

Non-Preferred List Brand Name Drugs ..... $50 copay

Dispensing Limit

Unless the drug maker's packaging limits the supply in some other way:

- Benefits are provided for up to a 90-day supply of covered medication
- You pay 1 copay for each 30-day supply
- Dispensing of a greater than 90-day supply is permitted when the drug maker's packaging doesn't allow for a lesser amount. You'll pay a copay for each additional 30-day supply, or the cost of the drug if that cost doesn't exceed the cost of the copay.

Tablet Splitting Program The Tablet Splitting Program allows members to have reduced copays on certain prescription medications. Participation in the program is voluntary. When you participate, selected drugs are dispensed at double strength. The individual tablets are then split by the member into half-tablets for each use. We will provide you with a tablet splitter. The drugs eligible for the program have been selected because they are safe to split without jeopardizing quality or effectiveness.

If you participate in the program, you will pay one-half the copays specified above for retail or mail order drugs included in the program. If your plan requires coinsurance rather than copays, the coinsurance

percentage will remain the same, but you will have lower out-of-pockets costs because the double strength tablets are less expensive than the single-strength medication.

Because the drugs are dispensed at double strength and will be split, they will be dispensed at one-half the normal dispensing limits listed above.

Contact Customer Service to find out which drugs are eligible for the tablet splitting program.

Participating Pharmacies When you get your prescriptions from participating pharmacies, the plan will pay the participating pharmacy directly. To avoid paying the retail cost for a prescription drug instead of the allowable charge, be sure to present your identification card to the pharmacist for all prescription drug purchases.

Non-participating Pharmacies When you get your prescriptions from non-participating pharmacies, you pay the same cost-share you would as if purchased at a participating pharmacy. You pay the full price for the drugs and submit a claim for reimbursement. Please see the "How Do I File a Claim?" section in this booklet for more information on submitting claims. This benefit applies to all prescriptions filled by a non-participating pharmacy, including those filled via mail or other home delivery.

Prescriptions received from non-participating pharmacies are subject to the allowable charge. Please see the ***"Definitions"*** section of this booklet for a definition of "allowable charge." Amounts in excess of the allowable charge do not count toward any applicable calendar year deductible, coinsurance or out-of-pocket maximum.

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

Mail-Order Pharmacy Program

Generic Drugs.....$37 copay

Preferred List Brand Name Drugs.....$62 copay

Non-Preferred List Brand Name Drugs.....$125 copay

Dispensing Limit

Benefits are provided up to a 90-day supply of covered medication unless the drug maker's packaging limits the supply in some other way. Dispensing of a greater than 90-day supply is permitted when the drug maker's packaging doesn't allow for a lesser amount. When the drug maker's packaging exceeds the 90-day supply, you'll pay only 1 mail-order copay for each prescription.

How To Use The Mail-Order Pharmacy Program

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

After you've paid any required deductible, and copays or coinsurance, the plan will pay the participating mail-order pharmacy directly. This benefit is limited to prescriptions filled by the mail-order pharmacy.

To obtain additional details about the mail-order pharmacy program, or to obtain order forms, you may call our Customer Service department at the number listed inside the front cover of this booklet.

You may also call the mail order pharmacy's Pharmacy Benefit Administrator's Customer Service department or visit their website at:

1-800-391-9701

www.express-scripts.com

You can mail your prescription drug claims to:

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

Injectable Supplies

When insulin needles and syringes are purchased along with insulin, only the copay for the insulin will apply.

When insulin needles and syringes are purchased separately, the Preferred List Brand Name Drug copay will apply for each item purchased.

The prescription drug deductible, if any, and the Preferred List Brand Name Drug copay will apply to purchases for alcohol swabs, test strips, testing agents and lancets. A separate copay will apply to each item purchased.

What's Covered?

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

- Prescription drugs and vitamins (federal legend and state restricted drugs as prescribed by a

licensed provider). This benefit covers off-label use of FDA-approved drugs as provided under this plan's definition of "Prescription Drug." Please see the ***"Definitions"*** section in this booklet.

- Prescriptive oral agents for controlling blood sugar levels
- Prescribed injectable medications for self-administration (such as insulin)
- Glucagon and allergy emergency kits
- Compounded medications of which at least one ingredient is a covered prescription drug
- Hypodermic needles, syringes and alcohol swabs used for self-administered injectable prescription medications. Also covered are the following disposable diabetic testing supplies: test strips, testing agents and lancets.
- Inhalation spacer devices and peak flow meters
- Drugs for the treatment of nicotine dependency, including over the counter (OTC) nicotine patches, gum or lozenges purchased through a participating retail pharmacy. Over the counter nicotine products are subject to the generic drug cost-share. Your normal cost-share for drugs received from a participating pharmacy is waived for certain prescription nicotine dependency drugs that meet the guidelines for preventive services described in the Preventive Care benefit.
- Prescription contraceptive drugs and devices (e.g. oral drugs, diaphragms and cervical caps). See the Contraceptive Management and Sterilization benefit for additional detail.
- Prescription drugs for the treatment of autism

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

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

Additional Information About Your Prescription Drug Benefit

Generic Drugs

When available and indicated by the prescriber, a generic drug will be dispensed in place of a brand name drug. In the event a generic equivalent isn't manufactured, the applicable brand name copay will apply. If you request a brand name drug when a generic equivalent is available and substitution is allowed by the prescriber, you'll be required to pay the difference in price between the brand name drug and the generic equivalent, in addition to paying the applicable brand name copay.

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

Refills

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

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

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

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

Prescription Drug Formulary

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

The formulary (Formulary B3) includes both generic and brand name drugs. Consult the Pharmacy Benefit Guide or RX search tool listed on our website at **premera.com**. You can also call Customer Service for a complete list of this plan's covered prescription drugs.

Your provider may request that you get a non-formulary drug or a dose that is not on the drug list. A non-formulary drug will be covered if one of the following is true:

- There is no formulary drug or alternative available
- You cannot tolerate the formulary drug

- The formulary drug or dose is not safe or effective for your condition

You must also provide medical records to support your request. We will review your request and let you know in writing if it is approved. An expedited review will be completed within 24 hours, and a standard review will be completed within 72 hours. During this review process, the drug will be covered. If approved, your cost will be as shown in this contract for formulary generic and formulary non-preferred brand name drugs. If your request is not approved, the drug will not be covered.

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

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

Specialty Pharmacy Program

Benefits for specialty drugs dispensed through a specialty pharmacy program via mail-order are limited to a 30-day supply and are subject to the retail pharmacy cost for each prescription drug purchase.

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

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

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

Clinical Pharmacy Management

The plan may limit benefits to a specific dispensed days' supply, drug, or drug dosage appropriate for a usual course of treatment. The plan may also limit benefits for certain drugs to specific diagnoses or require prescriptions to be obtained from an appropriate medical specialist. Benefits for certain drugs may be subject to step therapy where you are required to first try a generic or specified brand name drug.

Drug Volume Discount Program

Premera Blue Cross Blue Shield of Alaska may receive drug rebates from its drug benefit manager. Such rebates are Premera Blue Cross Blue Shield of Alaska's property. These rebates are retained by Premera Blue Cross Blue Shield of Alaska and may be taken into account in setting subscription charges and are not reflected in your cost-share.

In addition, the allowable charge that your payment for drugs is based upon may be higher than the price Premera Blue Cross Blue Shield of Alaska pays its drug benefit manager for those drugs. The difference constitutes Premera Blue Cross Blue Shield of Alaska's property. Premera Blue Cross Blue Shield of Alaska is entitled to retain and shall retain the difference and may apply it to the cost of Premera Blue Cross Blue Shield of Alaska's operations. If your drug benefit includes a copayment, coinsurance calculated on a percentage basis, or a deductible, the amount you pay and your account calculations are based on the allowable charge.

What's Not Covered?

This Prescription Drug benefit doesn't cover:

- Drugs and medicines that may be lawfully obtained over the counter (OTC) without a prescription, except as required by law. OTC drugs are excluded even if prescribed by a practitioner, unless otherwise stated in this benefit. Examples of such excluded items include, but aren't limited to, non-prescription drugs and vitamins, food and dietary supplements, herbal or naturopathic medicines and nutritional and dietary supplements (e.g. infant formulas or protein supplements).
- Non-prescription contraceptive methods (e.g. jellies, creams, foams or devices)
- Drugs for the purpose of cosmetic use, or to promote or stimulate hair growth (e.g. wrinkles or hair loss)
- Drugs for experimental or investigational use
- Biologicals, blood or blood derivatives
- Any prescription refilled in excess of the number of refills specified by the prescribing provider, or any refill dispensed after one year from the prescribing provider's original order
- Drugs dispensed for use or administration in a health care facility or provider's office, or take-home drugs dispensed and billed by a medical facility
- Replacement of lost or stolen medication
- Infusion therapy drugs or solutions and drugs requiring parenteral administration or use, and

injectable medications. (The exception is injectable drugs for self-administration, such as insulin and glucagon). Please see the Infusion Therapy benefit.

- Drugs to treat infertility, including fertility enhancement medications
- Drugs to treat sexual dysfunction
- Weight management drugs

WHAT ARE MY HEARING BENEFITS?

You pay 20% of the allowable charge for the hearing services and hardware below. The maximum benefit is $800 in a period of three consecutive calendar years.

Any copays, calendar year deductible, coinsurance or out-of-pocket maximums in this plan don't apply to this benefit.

Both of the following must be done in order to receive this benefit:

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

The plan provides benefits for:

- 1 otologic (ear) examination by a provider every 3 consecutive calendar years
- 1 audiologic (hearing) examination and hearing evaluation by a certified or licensed audiologist, including a follow-up consultation every 3 consecutive calendar years
- Hearing aids (monaural or binaural) prescribed as a result of the examinations
- Ear molds
- The hearing aid instruments
- Hearing aid rental while the primary unit is being repaired
- The initial batteries, cords and other necessary ancillary equipment
- A warranty, when provided by the manufacturer
- A follow-up consultation within 30 days following delivery of the hearing aids with either the prescribing provider or audiologist
- Repairs, servicing and alteration of hearing aid equipment

In addition to "What's Not Covered?" this Hearing benefit doesn't cover any of the following:

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

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

OUT-OF-AREA CARE

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

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

Your getting services through these Inter-Plan Arrangements does not change covered benefit levels, or any stated eligibility requirements. Please call us if your care needs prior authorization.

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

BlueCard Program

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

- The provider's billed charges for your covered services; or
- The allowable charge that the Host Blue made available to us. Please see the "Definitions" section of this booklet for a definition of "allowable charge."

Often, the allowable charge is a discount that reflects an actual price that the Host Blue pays to the provider. Sometimes it is an estimated price that takes into account a special arrangement with a

single provider or a group of providers. In other cases, it may be an average price, based on a discount that results in expected average savings for services from similar types of providers.

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

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

Value-Based Programs

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

Taxes, Surcharges and Fees

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

Non-Network Providers

It could happen that you receive covered services from providers outside our service area that do not have a contract with the Host Blue. In most cases, we will base the amount you pay for such services on either our allowable charge for these providers or the pricing requirements under applicable law. Please see the "Definitions" section of this booklet for a definition of "allowable charge."

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

BlueCard Worldwide® Program

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

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

Further Questions?

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

CARE MANAGEMENT

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

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

PRIOR AUTHORIZATION

Your coverage for some services depends on whether the service is approved by us before you receive it. This process is called prior authorization.

A planned service is reviewed to make sure it is medically necessary and eligible for coverage under this plan. We will let you know in writing if the service is authorized. We will also let you know if the services are not authorized and the reasons why. If you disagree with the decision, you can request an

appeal. Please see ***"When You Have An Appeal"*** in your booklet or call us.

There are three situations where prior authorization is required:

- Before you receive certain medical services and drugs, or prescription drugs
- Before you schedule a planned admission to certain inpatient facilities
- When you want to receive the in-network benefit level for services you receive from non-network providers

Each situation has different requirements.

How To Ask For Prior Authorization

The plan has a specific list of services or supplies that must have prior authorization with any provider. The detailed list of medical services requiring prior authorization can be obtained by contacting Customer Service, or at our website at **premera.com**.

Services from in-network providers: It is your in-network provider's responsibility to get prior authorization. They must call us at the number listed on your ID card to request a prior authorization.

Services from non-network providers: It is your responsibility to get prior authorization for any of the services on the Prior Authorization list when you see a non-network provider. **The non-network provider may agree to make the request for you. However, you should call us to make sure we have approved the prior authorization request in writing before you receive the services.**

The following services require prior authorization:

- Planned admission into hospitals or skilled nursing facilities
- Planned admission to an inpatient rehabilitation facility
- Non-emergency ground air or ambulance transport
- Transplant and donor services
- Injectable medications you get in a healthcare provider's office
- Prosthetics and orthotics other than foot orthotics or orthopedic shoes
- Reconstructive surgery, including repairs of defects caused by injury and correction of functional disorders
- Home medical equipment costing $500 or more
- Surgical, medical therapeutic, diagnostic and reconstructive procedures, including:
  - Abdominoplasty/Panniculectomy
  - Bone anchored and implantable hearing aids
  - Cardiac devices, including implantation
  - Cardiac percutaneous interventions
  - Corneal remodeling
  - Deep brain stimulation
  - Endoscopy upper gastrointestinal
  - Hysterectomy
  - Knee arthroplasty and arthroscopy
  - Implantation or application of electric stimulator
  - Radiation therapy such as gamma knife, proton beam, intensity modulated radiation therapy (IMRT), intraoperative radiation therapy
  - Spine surgery/treatments, such as cervical spinal fusion and lumbar spinal fusion
  - Blepharoplasty (eyelid surgery), non-cosmetic
  - Breast surgeries such as implant removal, mastectomy, prophylactic mastectomy, reduction mammoplasty
  - Cochlear implantation
  - Hyperbaric oxygen therapy
  - Facility based sleep studies (polysomnography)
  - Radiofrequency tumor ablation
- Outpatient imaging tests, including:
  - Positron Emission Tomography (PET and PET/CT)
  - Contrast Enhanced Computed Tomography (CT) Angiography of the heart
  - Computed Tomography (CT) Scans
  - Magnetic Resonance Imaging (MRI)
  - Magnetic Resonance Angiography (MRA)
  - Magnetic Resonance Spectroscopy
  - Nuclear Cardiology
  - Echocardiograms

Certain prescription drugs require a prior authorization review to approve coverage. Please see ***Prior Authorization for Prescription Drugs*** below. You can also see the Pharmacy section on our website at **premera.com**.

You or your provider can call us at the number listed on your ID card to request a prior authorization. You can also call us to ask about a specific service that your provider is planning for you.

We will respond to your request for prior authorization within 72 hours of receipt of all information necessary to make a decision. If your situation is clinically urgent (meaning that your life or health would be put in serious jeopardy if you did not receive treatment right away), you may request an expedited review. Expedited reviews are responded to as soon as possible, but no later than 24 hours after we get all

the information necessary to make a decision. We will provide our decision in writing.

Our prior authorizations will be valid for 30 calendar days. This 30-day period is subject to your continued coverage under the plan. If you don't receive the service, drug or item within that time, you will have to ask us for another prior authorization.

Prior Authorization Penalty

For services from in-network providers: In-network providers will get a prior authorization for you. You should verify with your network provider that a prior authorization request has been approved in writing by us before you receive the services.

For services from non-network providers: It is your responsibility to get prior authorization when you receive services from a non-network provider. If you do not get prior authorization for a covered service or supply that is on the prior authorization list, you will have to pay a penalty. **The prior authorization penalty is 50 percent of the allowable charge. The maximum penalty is $1,500 per occurrence. You pay this penalty plus any cost-share that your plan requires for the covered services.**

The prior authorization penalty does not count toward this plan's deductible or out-of-pocket maximum, if any.

Exceptions: The following services are not subject to this prior authorization requirement, but they have separate requirements:

- Emergency hospital admissions, including admissions for drug or alcohol detoxification. They do not require prior authorization, but you must notify us soon as reasonably possible.

  If you are admitted to a non-network hospital due to an emergency condition, those services will always be covered under your in-network cost-share. The plan will continue to cover those services until you are medically stable and can safely transfer to a network hospital. If you choose to remain at the non-network hospital after you are stable to transfer, coverage will revert to the out-of network benefit level. We will pay services based on the allowable charge. If the hospital is non-contracted, you may be billed for charges over the allowable charge.
- Childbirth admission to a hospital, or admissions for newborns who need medical care at birth. They do not require prior authorization, but you must notify us as soon as reasonably possible. Admissions to a non-network hospital will be covered at the non-network cost-share unless the admission was an emergency.

Prior Authorization for Prescription Drugs

Certain prescription drugs you receive through a pharmacy must have prior authorization before you get them at a pharmacy, in order for the plan to provide benefits. Your provider can ask for a prior authorization by faxing a prior authorization form to us. This form is on the pharmacy section of our website at **premera.com**.

You can find out if a specific drug requires prior authorization by contacting Customer Service, or checking our website at **premera.com**. If your prescription drug requires prior authorization and you do not get prior authorization, when you go to a network pharmacy to fill your prescription, your pharmacy will tell you that it needs to be prior authorized. You or your pharmacy should call your provider to let them know. Your provider can fax us a prior authorization form for review.

The categories of drugs that require prior authorization are:

- Androgens, Estrogens, Hormones and related drugs
- Angiotensin II Receptor Blockers
- Anticonvulsants
- Antidepressant agents
- Antipsoriatic/Antiseborrheic
- Antipsychotics
- Drugs with significant changes in product labeling
- Glaucoma drugs
- Growth hormones
- Headache therapy
- Hypnotic agents
- Hypoglycemic agents
- Interferons
- Intranasal steroids
- Miscellaneous analgesics
- Miscellaneous antineoplastic drugs
- Miscellaneous antivirals
- Miscellaneous gastrointestinal agents
- Miscellaneous neurological therapy drugs
- Miscellaneous psychotherapeutic agents
- Miscellaneous pulmonary agents
- Miscellaneous rheumatological agents
- Narcotics
- Newly FDA-approved drugs
- NSAIDS/Cox II inhibitors
- Osteoporosis therapy
- Proton pump inhibitors

- Smoking deterrents
- Specialty drugs
- Tetracyclines

Please contact Customer Service or check **premera.com** for the detailed list of drugs requiring prior authorization.

You can buy the prescription drug before it is prior authorized, but you must pay the full cost. If the drug is authorized after you bought it, you can send us a claim for reimbursement. Reimbursement will be based on the allowable charge. Please see the "How Do I File A Claim?" section in this booklet for more information on submitting claims.

Services from Non-Network Providers

This plan provides benefits for non-emergency services from non-network providers at a lower benefit level. You may receive benefits for these services at the in-network cost-share if the services are medically necessary and not available from an in-network provider within 50 miles of your home. You or your provider may request a prior authorization for the in-network benefit before you see the non-network provider.

These services will be covered at the in-network cost-share. In addition to the cost-shares, you will be required to pay any amounts over the allowable charge if the provider does not have an agreement with us or, for out-of-state providers, with the local Blue Cross and/or Blue Shield Licensee.

If there are in-network providers who can give you the same non-emergency care within 50 miles of your home, your request will not be approved.

CLINICAL REVIEW

Premera has developed or adopted guidelines and medical policies that outline clinical criteria used to make medical necessity determinations. The criteria are reviewed annually and are updated as needed to ensure our determinations are consistent with current medical practice standards and follows national and regional norms. Practicing community doctors are involved in the review and development of our internal criteria. You or your provider may request a copy of the criteria used to make a medical necessity decision for a particular condition or procedure. To obtain the information, please send your request to Care Management at the address or fax number located on the inside front cover of this benefit booklet.

Premera reserves the right to deny payment for services that are not medically necessary or that are considered experimental or investigational. A decision by Premera following this review may be appealed in the manner described in the "Your Ideas, Questions, Complaints and Appeals" section. When there is more than one alternative available, coverage will be provided for the least costly among medically appropriate alternatives.

PERSONAL HEALTH SUPPORT PROGRAMS

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

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

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

WHAT'S NOT COVERED?

This section of your booklet explains circumstances in which all the benefits of this plan are either limited or no benefits are provided. Benefits can also be affected by your eligibility. In addition, some benefits have their own specific limitations.

LIMITED AND NON-COVERED SERVICES

In addition to the specific limitations stated elsewhere in this plan, benefits aren't available for the following:

Amounts That Exceed The Allowable Charge

Benefits That Have Been Exhausted

Amounts in excess of a maximum benefit for a covered service.

Biofeedback Services

When deemed to be experimental or investigational treatment for the condition. Examples of what is not covered are EEG biofeedback and neurofeedback. See "Definitions" for experimental or investigational treatment.

Caffeine Dependency

Treatment of caffeine dependency, except for services covered under the Health Management benefit.

Charges For Records or Reports

Separate charges from providers for supplying records or reports, except those we request for utilization review.

Charges In Excess Of The Average Wholesale Price For Drugs

Charges in excess of the average wholesale price shown in the **Pharmacist's Red Book** for prescription drugs, insulin, and intravenous drugs and solutions, as specified in the Home and Hospice Care and Infusion Therapy benefits.

Clinical Trials

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

Cosmetic Services

The plan does not cover services, drugs, or supplies for cosmetic purposes, including any direct or indirect complications and aftereffects. Examples of what is not covered are:

- Reshaping normal structures of the body in order to improve or change your appearance and self-esteem and not primarily to restore an impaired function of the body
- Genital surgery for the purpose of changing genital appearance
- Breast mastectomy or augmentation for the purpose of changing the appearance of the breasts, with or without chest reconstruction

The only exceptions to this exclusion are:

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

Counseling, Educational Or Training Services

- Counseling, education or training services, except as stated under the Substance Abuse Treatment, Health Management, Nutritional Therapy and Mental Health Care benefits, or for services that meet the guidelines for preventive medical services in the Preventive Care benefit. This includes vocational assistance and outreach; social, sexual and fitness counseling.
- Non-medical services, such as spiritual, bereavement, legal or financial counseling
- Recreational, vocational or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Gym or swim therapy

Court-Ordered Services

Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing or to driving rights, unless such services are medically necessary.

Custodial Care

Custodial care, except when provided for hospice care (please see the Home And Hospice Care benefit).

Dental Care

Dental services or supplies, except services covered under the Dental Services benefit in the "What Are My Medical Benefits?" section.

Donor Breast Milk

Benefits are not provided for donor breast milk.

Drugs And Food Supplements

Over-the-counter drugs (except as specifically stated), solutions, supplies, food and nutritional supplements; over-the-counter contraceptive drugs, supplies and devices; herbal, naturopathic, or homeopathic medicines or devices; hair analysis; and vitamins that don't require a prescription, except as required by law.

Electronic Visits

Electronic visits (e-visits) received from a non-approved provider.

Environmental Therapy

Therapy designed to provide a changed or controlled environment.

Experimental Or Investigational Services

Any service or supply that is determined to be experimental or investigational on the date it's furnished, and any direct or indirect complications

and after effects thereof. Please see the ***"Definitions"*** section of this booklet for a description of "experimental/ investigational."

If a service is experimental or investigational, and therefore not covered, you may appeal the decision. You can get a description of your appeal rights by calling us or by visiting our Web page at **premera.com**.

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

Family Members Or Volunteers

- Services or supplies that you furnish to yourself or that are furnished to you by a provider who is an immediate relative. Immediate relative is defined as spouse, natural or adoptive parent, child, sibling, stepparent, stepchild, stepsibling, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, spouse of grandparent or spouse of grandchild.
- Services or supplies provided by volunteers, except as specified in the Home and Hospice Care benefit

Governmental Medical Facilities

Services and supplies furnished by a governmental medical facility, except when:

- You're receiving care for a medical emergency. Please see the ***"Definitions"*** section of this booklet for a definition of "medical emergency."
- The plan must provide available benefits for covered services as required by law or regulation

Hair Loss

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

Hearing Hardware

- Hearing aids (including batteries and related equipment) that exceed the maximum benefit per member in a period of 3 consecutive calendar years. These expenses are also not eligible for coverage under other benefits of this plan.
- Batteries or other ancillary equipment other than that obtained upon purchase of hearing aids
- Hearing aids that exceed the specifications prescribed for correction of hearing loss
- Expenses incurred after your coverage under this plan ends unless hearing aids were ordered before that date and were delivered within 90 days after the date your coverage ended

Human Growth Hormone Benefit Limitations

Benefits for human growth hormone are only provided under the Prescription Drug benefit, and are not covered to treat idiopathic short stature without growth hormone deficiency.

Illegal Acts and Terrorism

Benefits are not provided for illness or injury resulting from a member's commission of the following:

- A felony (this exclusion does not apply to a victim of domestic violence)
- An act of terrorism
- An act of riot or insurrection

Infertility, Assisted Reproduction And Sterilization Reversal

- Treatment of infertility, including procedures, supplies and drugs
- Any assisted reproduction techniques, regardless of reason or origin of condition, including but not limited to, artificial insemination, in-vitro fertilization, and gamete intra-fallopian transplant (GIFT) and any direct or indirect complications thereof
- Reversal of surgical sterilization, including any direct or indirect complications thereof

Light Therapy For Vitiligo

Benefits are not provided for light therapy for Vitiligo

Low-Level Laser Therapy

Benefits are not provided for low-level laser therapy

Medical Equipment And Supplies

- Supplies or equipment not primarily intended for medical use
- Special or extra-cost convenience features
- Items such as exercise equipment and weights
- Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities
- Penile prostheses
- Whirlpools, whirlpool baths, portable whirlpool pumps, sauna baths, and massage devices
- Over bed tables, elevators, vision aids and telephone alert systems
- Structural modifications to your home and/or personal vehicle
- Over the counter orthotic braces, such as knee braces
- Non-wearable external defibrillator, trusses and ultrasonic nebulizers
- Blood pressure cuffs or monitor (even if prescribed by a provider)

- Enuresis alarm
- Compression stockings which do not require a prescription
- Hypodermic needles, syringes, lancets, test strips, testing agents and alcohol swabs used for self-administered medications, except as specified in the "What Are My Prescription Drug Benefits?" section

Military And War-Related Conditions

Benefits are not provided for any of the following:

- Acts of war, declared or undeclared, including acts of armed invasion
- Service in the armed forces of any country, including the air force, army, coast guard, marines, national guard, navy, or civilian forces or units auxiliary thereto

No Charge Or You Don't Legally Have To Pay

- Services for which no charge is made, or for which none would have been made if this plan weren't in effect
- Services for which you don't legally have to pay, except as required by law in the case of federally qualified health center services

Non-Treatment Facilities, Institutions or Programs

Benefits are not provided for institutional care, housing, incarceration or programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions. Examples are prisons, nursing homes, juvenile detention facilities, group homes, foster homes and adult family homes. Benefits are provided for medically necessary medical or behavioral health treatment received in these locations.

Not Covered Under This Plan

- Services or supplies received or ordered when this plan isn't in effect, or when the person isn't covered under this plan, except as stated under specific benefits and under "Extended Benefits"
- Services or supplies provided to someone other than the ill or injured member, other than outpatient health education services covered under the Health Education part of the Health Management benefit or donor costs under the Transplant benefit
- Services and supplies that aren't listed as covered under this plan
- Services and supplies directly related to any condition, or related to any other service or supply that isn't covered under this plan
- Charges for broken or missed appointments

Not In The Written Plan Of Care

Services, supplies or providers not in the written plan of care or treatment plan in the Home and Hospice Care and Rehabilitation Therapy and Chronic Pain Care benefits.

Not Medically Necessary

- Services or supplies that aren't medically necessary even if they're court-ordered. This also includes places of service, such as inpatient hospital care.
- Hospital admissions for diagnostic purposes only, unless the services can't be provided without the use of inpatient hospital facilities, or unless your medical condition makes inpatient care medically necessary
- Any days of inpatient care that exceed the length of stay that is medically necessary to treat your condition

Obesity Services (Surgical And Pharmaceutical)

Benefits are not provided for surgical and pharmaceutical treatments of obesity or morbid obesity, including surgery, and any direct or indirect complications, follow-up services, or aftereffects thereof; services and supplies connected with weight loss or weight control, except for health education classes or programs specified as covered under the Health Management benefit and for services covered under the Nutritional Therapy benefit and for assessments or counseling that meets the guidelines for preventive medical services in the Preventive Care benefit. (An example of an after effect that would not be covered is removal of excess skin and/or fat that developed as a result of weight loss surgery or the use of obesity drugs.) This exclusion applies to all surgical obesity procedures (inpatient and outpatient) and all obesity drugs and supplements, even if you also have an illness or injury that might be helped by weight loss.

Orthodontia Services

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

Orthognathic Surgery (Jaw Augmentation or Reduction)

Procedures to lengthen or shorten the jaw (including orthognathic or maxillofacial surgery) aren't covered, regardless of the origin of the condition that makes the procedure necessary.

Outside The Scope Of A Provider's License Or Certification

Services or supplies that are outside the scope of the provider's license or certification, or that are furnished

by a provider that isn't licensed or certified by the jurisdiction in which the services or supplies were received.

Personal Comfort or Convenience Items

- Items for your convenience or that of your family, including medical facility expenses; services of a personal nature or personal care items, such as meals for guests, long-distance telephone charges, radio or television charges, or barber or beautician charges
- Normal living expenses, such as food, clothing and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care (please see the Home and Hospice Care benefit); and transportation services
- Dietary assistance, such as "Meals on Wheels"

Private Duty Nursing Services

Private duty nursing.

Rehabilitation Services

Inpatient rehabilitation received more than 24 months from the date of onset of the member's accidental injury or illness or from the date of the member's surgery that made the rehabilitation necessary.

Routine or Preventive Care

- Charges for services or items that don't meet the federal guidelines for preventive services described in the Preventive Care benefit, except as required by state and federal law. This includes services or items provided more often than stated in the guidelines.
- Routine or palliative foot care, including hygienic care; impression casting for foot prosthetics or appliances and prescriptions thereof, except as stated under the Professional Visits and Services benefit; fallen arches, flat feet, care of corns, bunions (except for bone surgery), calluses, toenails (except for ingrown toenail surgery) and other symptomatic foot problems. This includes foot-support supplies, devices and shoes, except as stated under the Medical Equipment and Supplies benefit.
- Exams to assess a work-related or medical disability

Serious Adverse Events and Never Events

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

- Serious Adverse Event means a hospital injury caused by medical management (rather than an underlying disease) that prolonged the hospitalization, and/or produces a disability at the time of discharge.
- Never Events means events that should never occur, such as a surgery on the wrong patient, a surgery on the wrong body part or wrong surgery.

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

Services Covered By Other Sources

- Motor vehicle medical or motor vehicle no-fault
- Personal injury protection (PIP) coverage
- Commercial liability coverage
- Homeowner policy
- Other type of liability insurance coverage
- Worker's Compensation or similar coverage

Sexual Dysfunction

Diagnosis and treatment of sexual dysfunctions, regardless of origin or cause; surgical, medical or psychological treatment of impotence or frigidity, including drugs, medications, or penile or other implants; and, any direct or indirect complications and aftereffects thereof.

Skilled Nursing Facility Coverage Exceptions

- Custodial care
- Care that is primarily for senile deterioration, mental deficiency or retardation or the treatment of substance abuse

Substance Abuse

Treatment of alcohol or drug use or abuse that does not meet the definition of "Substance Abuse" as stated in the ***"Definitions"*** section of this booklet.

Temporomandibular Joint (TMJ) Disorders

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

Transplant Coverage Exceptions

- Organ, bone marrow and stem cell transplants, including any direct or indirect complications and aftereffects thereof, except as specifically stated under the Transplants benefit

- Services or supplies that are payable by any government, foundation or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers.
- Donor costs for a solid organ transplant, or bone marrow or stem cell reinfusion not specified as covered under the Transplants benefit
- Donor costs for which benefits are available under other group or individual coverage
- Non-human or mechanical organs, unless they aren't experimental or investigational services. Please see the ***"Definitions"*** section of this booklet for a definition of "experimental/ investigational."

Vision Hardware

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

Vision Therapy

Vision therapy, eye exercise or any sort of training to correct muscular imbalance of the eye (orthoptics), and pleoptics. Also not covered are treatment or surgeries to improve the refractive character of the cornea, including the treatment of any results of such treatment.

Voluntary Support Groups

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

Work-Related Conditions

Any illness, condition or injury arising out of or in the course of employment, for which the member is entitled to receive benefits, whether or not proper and timely claim for such benefits has been made under: occupational coverage obtained by the employer; so long as it was required by law; state or federal workers' compensation acts; or any legislative act providing compensation for work-related illness or injury.

WHAT IF I HAVE OTHER COVERAGE?

COORDINATING BENEFITS WITH OTHER HEALTH CARE PLANS

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

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

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

Definitions Applicable To Coordination Of Benefits

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

- **Allowable Medical Expense** means the usual, customary and reasonable charge for any medically necessary health care service or supply provided by a licensed medical professional when the service or supply is covered at least in part under this plan. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense.
- **Allowable Dental Expense** means the usual, customary and reasonable charge for any dentally necessary service or supply provided by a licensed dental professional when the service or supply is covered at least in part under this plan. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense. For the purpose of this plan, only those dental services to treat an accidental injury to natural teeth will be considered an allowable dental expense.
- **Claim Determination Period** means a calendar year.
- **Medical Plan** means all of the following health care coverages, even if they don't have their own coordination provisions:

- Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization group or individual agreements issued by insurers, health care service contractors, and health maintenance organizations
- Labor-management trusteed plans, labor organization plans, employer organization plans or employee benefit organization plans
- Government programs that provide benefits for their own civilian employees or their dependents
- Group coverage required or provided by any law, including Medicare. This doesn't include workers' compensation.
- Group student coverage that's sponsored by a school or other educational institution and includes medical benefits for illness or disease

- **Dental Plan** means all of the following dental care coverages, even if they don't have their own coordination provisions:
  - Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization group or individual agreements issued by insurers, health care service contractors, and health maintenance organizations
  - Labor-management trusteed plans, labor organization plans, employer organization plans or employee benefit organization plans
  - Government programs that provide benefits for their own civilian employees or their dependents

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

Effect On Benefits

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

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

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

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

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

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

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

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

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

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

Right Of Recovery/Facility Of Payment

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

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

COORDINATING BENEFITS WITH MEDICARE

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

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

SUBROGATION AND REIMBURSEMENT

If we make claims payment on your behalf for injury or illness for which another party is liable, or for which uninsured/underinsured motorist (UIM) or personal injury protection (PIP) insurance exists, we are entitled to be repaid for those payments out of any recovery from that liable party. The liable party is also known as the "third party" because it's a party other than you or us. This party includes a UIM carrier because it stands in the shoes of a third party tortfeasor and because we exclude coverage for such benefits.

Definitions The following terms have specific meanings in this contract:

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

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

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

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

WHO IS ELIGIBLE FOR COVERAGE?

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

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

EMPLOYEE ELIGIBILITY

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

- A regular and active employee, owner, partner, or corporate officer of the Group who is paid on a regular basis through the Group's payroll system, and reported by the Group for Social Security purposes. The full time employee must also meet 2 other requirements.
  - Regularly work a minimum of 30 hours per week
  - Complete a 30-day probationary period
- Permanent part-time employees must:
  - Regularly work a minimum of 20 hours per week
  - Complete a 30-day probationary period
- All employees subject to PERS must:
  - Regularly work a minimum of 15 hours per week
  - Complete a 30-day probationary period

Employees Performing Employment Services in Hawaii

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

DEPENDENT ELIGIBILITY

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

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

WHEN DOES COVERAGE BEGIN?

ENROLLMENT

Enrollment is timely when we receive the completed enrollment application and required subscription charges within 60 days of the date the employee becomes an "eligible employee" as defined earlier in this section. When enrollment is timely, coverage for the employee and enrolled dependents will become effective on the exact 31st day from the employee's date of hire.

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

Dependents Acquired Through Marriage After The Subscriber's Effective Date

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

Newborn And Adoptive Children

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

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

period following the dependent child's date of adoption or placement for adoption, we must receive a completed enrollment application and the required additional subscription charges within the 60-day period following the date of adoption or placement for adoption.

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

Children Acquired Through Legal Guardianship

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

Children Covered Under Medical Child Support Orders

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

Court-Ordered Dependent Coverage

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

Newborn Grandchildren

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

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

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

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

SPECIAL ENROLLMENT

Involuntary Loss Of Other Coverage

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

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

An eligible employee who qualifies as stated above may also enroll all eligible dependents. When only an

eligible dependent qualifies for special enrollment, but the eligible employee is not enrolled in any of the Group's plans or is enrolled in a different plan sponsored by the Group, the employee is also allowed to enroll in this plan in order for the dependent to enroll.

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

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

Subscriber And Dependent Special Enrollment

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

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

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

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

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

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

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

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

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

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

OPEN ENROLLMENT

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

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

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

CHANGES IN COVERAGE

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

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

PLAN TRANSFERS

Subscribers (with their enrolled dependents) may be allowed to transfer to this plan from another plan offered by the Group. Transfers also occur if the Group replaces another plan with this plan. Also, we may replace the Group's current contract for this plan

with an updated one from time to time. All transfers to this plan must occur during open enrollment or on another date agreed upon by us and the Group.

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

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

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

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

WHEN WILL MY COVERAGE END?

EVENTS THAT END COVERAGE

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

- For the subscriber and dependents when any of the following occur:
  - The Group contract is terminated
  - The next monthly subscription charge isn't paid when due or within the grace period
  - The subscriber dies or is otherwise no longer eligible as a subscriber
  - In the case of an association, the Association Employer's membership in the association ceases
  - In the case of a collectively bargained program, the employer fails to meet the terms of an applicable collective bargaining agreement or to employ employees covered by a collective bargaining agreement
- For a spouse when his or her marriage to the subscriber is annulled, or when he or she becomes legally separated or divorced from the subscriber
- For a child when he or she no longer meets the requirements for dependent coverage shown in "Who Is Eligible For Coverage?"
- For a grandchild of the subscriber or spouse when the grandchild's parent is no longer enrolled in the plan or no longer meets the requirements for dependent coverage shown in "Who Is Eligible For Coverage?"
- For fraud or intentional misrepresentation of material fact under the terms of the coverage by the subscriber or the subscriber's dependents

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

CERTIFICATE OF HEALTH COVERAGE

When your coverage under this plan terminates, you'll receive a "Certificate of Health Coverage." The certificate will provide information about your coverage period under this plan. When you provide a copy of the certificate to your new health plan, you may receive credit toward any waiting period for pre-existing conditions, if your new plan includes one. You'll need a certificate each time you leave a health plan and enroll in a plan that has a waiting period for pre-existing conditions. Therefore, it's important for you to keep the certificate in a safe place.

If you have not received a certificate, or have misplaced it, you have the right to request one from us or your former employer within 24 months of the date coverage terminated.

When you receive your Certificate of Health Coverage, make sure the information is correct. Contact us or your former employer if any of the information listed isn't accurate.

CONTRACT TERMINATION

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

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

The Group may terminate the Group Contract:

- Effective on any subscription charge due date with 30 days' advance written notice to us
- By rejecting in writing the contract changes we make after the initial term. The written rejection must reach us at least 15 days before the changes are to start. The Group Contract will end on the last date for which subscription charges were paid.

We may terminate the Group Contract, **upon 30 days advance written notice to the Group if**:

- The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;
- The Group has failed to comply with a material plan provision relating to minimum participation or employer contribution requirements;
- In the case of a network plan, the Group no longer has any members who reside or work in Alaska or Washington;
- We discontinue offering a particular type of health care plan in the group market on condition that:
  - We furnish written notice of the decision to discontinue coverage to all affected groups, members, and to the insurance regulatory official in each state in which an affected member is known to reside. Such notice must be given at least 180 days before we decide to discontinue the health care plan;
  - We furnish written notice of the decision to discontinue coverage to the director and to the insurance regulatory official in each state in which we're licensed at least 30 days before notice is given to the affected groups and members as described above;
  - We offer each group who is provided the particular type of health care plan the option to purchase another health care plan currently being offered by us to groups in the same market in that state; and
  - We act uniformly without regard to the claims experience of those groups, or to any health status factor of a member or a prospective member who may become eligible for coverage;
- We discontinue offering and renewing all health care plans in the group market if:
  - We furnish written notice of the decision to discontinue coverage to all affected groups, members, and to the insurance regulatory official in each state in which an affected member is known to reside. Such notice must be given at least 180 days before we decide to discontinue the health care plans;
  - We furnish written notice of the decision to discontinue coverage to the director and to the insurance regulatory official in each state in which we're licensed at least 30 days before the notice is given to the affected groups and members as described above; and
  - We don't issue a health care plan in the group market in the applicable states for five (5) years from the date the last group health care plan was discontinued.

HOW DO I CONTINUE COVERAGE?

CONTINUED ELIGIBILITY FOR A DISABLED CHILD

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

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

Note: This provision does not apply to dependent grandchildren.

LEAVE OF ABSENCE

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

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

COBRA

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

At the Group's request, we'll provide qualified members with COBRA coverage under this plan when COBRA's enrollment and payment

requirements are met. But, coverage is provided only to the extent that COBRA requires and is subject to the other terms and limitations of this plan. Members' rights to this coverage may be affected by the Group's failure to abide by the terms of its contract with us. The Group, **not us**, is responsible for all notifications and other duties assigned by COBRA to the "plan administrator" within COBRA's time limits.

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

Qualifying Events and Length of Coverage

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

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

The Group must offer the subscriber and covered dependents an election to continue coverage for up to 18 consecutive months if their coverage is lost because of 1 of 2 qualifying events:

- **The subscriber's work hours are reduced**
- **The subscriber's employment terminates, except for discharge due to actions defined by the Group as gross misconduct**

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

The Group must offer the covered spouse or children an election to continue coverage for up to 36 consecutive months if their coverage is lost because of 1 of 4 qualifying events:

- **The subscriber dies**
- **The subscriber and spouse legally separate or divorce**
- **The subscriber becomes entitled to Medicare**
- **A child loses eligibility for dependent coverage**

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

Conditions of COBRA Coverage

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

You Must Give Notice Of Some Qualifying Events

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

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

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

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

  Note: The subscriber or affected dependent must also notify the Group if a qualified member is deemed by the Social Security Administration to no

longer be disabled. See "When COBRA Coverage Ends."

- For the other events above, the 60-day notice period starts on the **later** of: 1) the date of the qualifying event, or 2) the date the qualified member would lose coverage as a result of the event.

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

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

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

You Must Enroll And Pay On Time

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

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

If you're not notified of your right to elect COBRA coverage within the time limits above, you must elect COBRA coverage no more than 60 days after the date coverage was to end because of the qualifying event in order for COBRA coverage to become effective under this plan. If you're not notified of your right to elect COBRA coverage within the time limit, and you don't elect COBRA coverage within 60 days after the date coverage ends, we won't be obligated to provide COBRA benefits under this plan. The Group will assume full financial responsibility for payment of any COBRA benefits to which you may be entitled.

- You must send your first subscription charge payment to the Group no more than 45 days after the date you elected COBRA coverage
- Subsequent subscription charges must be paid to the Group and submitted to us with the Group's regular monthly billings

Adding Family Members

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

Keep The Group Informed Of Address Changes

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

When COBRA Coverage Ends

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

- The applicable continuation period expires
- The next monthly subscription charge isn't paid when due or within the 30-day COBRA grace period
- When coverage is extended from 18 to 29 months due to disability (see "Qualifying Events And Lengths Of Coverage" in this section), COBRA

coverage beyond 18 months ends if there's a final determination that a qualified member is no longer disabled under the Social Security Act. However, coverage won't end on the date shown above, but on the last day for which subscription charges have been paid in the first month that begins more than 30 days after the date of the determination. The subscriber or affected dependent must provide the Group with a copy of the Social Security Administration's determination within 30 days after the **later** of: 1) the date of the determination, or 2) the date on which the subscriber or affected dependent was informed that this notice should be provided and given procedures to follow.

- You become covered under another group health care plan after the date you elect COBRA coverage. However, if the new plan contains an exclusion or limitation for a pre-existing condition, coverage doesn't end for this reason until the exclusion or limitation no longer applies.
- You become entitled to Medicare after the date you elect COBRA coverage
- The Group ceases to offer group health care coverage to any employee

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

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

If You Have Questions

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

Extended Benefits

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

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

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

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

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

OTHER CONTINUED COVERAGE OPTIONS

Continuation Under USERRA

The Uniformed Services Employment And Reemployment Rights Act (USERRA) protects the job rights (including enrollment rights on employer-provided health care coverage) of individuals who voluntarily or involuntarily leave employment positions to undertake military service. If you leave your job to perform military service, you have the right to elect to continue existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are re-employed, generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

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

Medicare Supplement Coverage

We also offer Medicare supplement coverage for those who are eligible for and enrolled in Parts A and B of Medicare. Also, you **may** be eligible for guarantee-issued coverage under certain Medicare

supplement plans if you apply within 63 days of losing coverage under this plan. For more information, contact your producer or our Customer Service Department.

HOW DO I FILE A CLAIM?

MEDICAL CLAIMS

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

Step 1

Complete a Subscriber Claim Form. A separate Subscriber Claim Form is necessary for each patient and each provider. Subscriber Claim Forms are available from us.

Step 2

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

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

Step 3

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

Step 4

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

Step 5

Sign the Subscriber Claim Form in the space provided.

Step 6

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

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

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

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

PRESCRIPTION DRUG CLAIMS

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

Participating Pharmacies

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

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

Non-Participating Pharmacies

You'll have to pay the full cost for new prescriptions and refills purchased at these pharmacies. You'll need to fill out a prescription drug claim form, attach your prescription drug receipts and submit the information to the address shown on the claim form.

AIR OR SURFACE TRANSPORTATION CLAIMS

To make a claim for covered air or ground transportation services, please follow these steps:

Complete a Subscriber Claim Form. A separate Subscriber Claim Form is necessary for each patient and each carrier or transportation service utilized.

Attach one of the following forms of documentation:

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

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

Your claim also must include a statement or letter from your provider attesting to the medical necessity of the services you received that required the air or service travel.

CLAIMS PROCEDURE

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

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

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

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

CARE RECEIVED OUTSIDE THE UNITED STATES

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

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

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

YOUR IDEAS, QUESTIONS, COMPLAINTS AND APPEALS

As a Premera Blue Cross Blue Shield of Alaska member, you have the right to offer your ideas, ask questions, voice complaints and request a formal appeal to reconsider decisions we have made. Our goal is to listen to your concerns and improve our service to you.

If you need an interpreter to help with oral translation services, please call us. Customer Service will be able to guide you through the service.

WHEN YOU HAVE IDEAS

We would like to hear from you. If you have an idea, suggestion, or opinion, please let us know. You can contact us at the addresses and telephone numbers found on the inside the front cover of this benefit booklet.

WHEN YOU HAVE QUESTIONS

You can call us when you have questions about a benefit or coverage decision, the quality or availability of a health care services or our service. We can quickly and informally correct errors, clarify benefits, or take steps to improve our service.

We suggest that you call your provider of care when you have questions about the health care services they provide.

WHEN YOU HAVE A COMPLAINT

You can call or write to us when you have a complaint about a benefit or coverage decision, customer service, or the quality or availability of a health care service. We recommend, but don't require, that you take advantage of this process when you have a concern about a benefit or coverage decision. There may be times when Customer Service will ask you to submit your complaint for review through the formal appeals process outlined below.

We will review your complaint and notify you of the outcome and the reasons for our decision as soon as possible, but no later than 30 days from the date we received your complaint.

WHEN YOU DISAGREE WITH A PAYMENT OR BENEFIT DECISION

If we declined to provide payment or benefits in whole or in part, and you disagree with that decision, you have the right to request that we review that adverse benefit determination through a formal, internal appeals process.

This plan's appeals process will comply with any new requirements as necessary under state and federal laws and regulations.

What Is An Adverse Benefit Determination?

An adverse benefit determination means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part for services based on:

- An individual's eligibility to participate in a plan or health insurance coverage;
- A determination that a benefit is not a covered benefit;
- A pre-existing condition exclusion, or other limitation on otherwise covered benefits;
- A utilization review determination; or
- A determination that a service is experimental, investigational, or not medically necessary or appropriate.

WHEN YOU HAVE AN APPEAL

After you are notified of an adverse benefit determination, you can request an internal appeal. Your plan includes two levels of internal appeals.

Your Level I internal appeal will be reviewed by individuals who were not involved in the initial adverse benefit determination. If the adverse benefit determination involved medical judgment, the review will be provided by a health care provider. They will review all of the information relevant to your appeal and will provide a written determination. If you are not satisfied with the decision, you may request a Level II appeal.

Your Level II internal appeal will be reviewed by a panel that includes a health care provider who holds the same professional license as the treating provider and individuals who were not involved in the Level I appeal. If the adverse benefit determination involved medical judgment, a health care provider will be included in the panel. You may participate in the Level II panel meeting in person or by phone to present evidence and testimony. Please contact us for additional information about this process.

Once the Level II review is complete, we will provide you with a written determination. If you are not satisfied with the final internal appeal decision, you may be eligible to request an External Review, as described below.

Who May File An Internal Appeal?

You or your authorized representative, someone you have named to act on your behalf, may file an appeal. To appoint an authorized representative, you must sign an authorization form and mail or fax the signed form to the address or phone number listed above. This release provides us with the authorization for this person to appeal on your behalf and allows our release of information, if any, to them.

Please call us for an Authorization For Release form. You can also obtain a copy of this form on our website at **premera.com**.

How Do You File An Internal Appeal?

You or your authorized representative may file an appeal by writing to us at the address listed below. We must receive your appeal request as follows:

- For a Level I internal appeal, within 180 calendar days of the date you are notified of an adverse benefit determination.
- For a Level II internal appeal, within 60 calendar days of the date you are notified of the Level I determination. If you are hospitalized or traveling; or for other reasonable cause beyond your control, we will extend this timeline up to 180 calendar days to allow you to obtain additional medical documentation, provider consultations or opinions.

You must submit your appeal request in writing to:

Premera Blue Cross Blue Shield of Alaska
Attn: Appeals Department, MS 123
P.O. Box 91102
Seattle, WA 98111-9202

Or, you may fax your request to:

Attn: Appeals Department
(425) 918-5592

If you need help filing an appeal, or would like a copy of the appeals process, please call Customer Service at the number listed inside the front cover of this benefit booklet. You can also get a description of the appeals process by visiting our web page at **premera.com**.

How Will You Know That Your Request For An Appeal Was Received?

We will acknowledge our receipt of your request in writing within 7 days.

What If Your Situation Is Clinically Urgent?

If your provider believes that situation is clinically urgent under law, your appeal will be conducted on an expedited basis. A clinically urgent situation means one in which your health may be in serious

jeopardy or, in the opinion of your provider, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. You may request an expedited internal appeal by calling Customer Service at the number listed inside the front cover of this benefit booklet.

If your situation is clinically urgent, you may also request an expedited external review at the same time you request an expedited internal appeal.

Can You Provide Additional Information For Your Appeal?

You may supply additional information to support your appeal at the time you file an appeal or at a later date by mailing or faxing to the address and fax number listed above. Please provide us with this information as soon possible.

Can You Request Copies Of Information Relevant To Your Appeal?

You can request copies of information relevant to the adverse benefit determination. We will provide this information as well as any new or additional information we considered, relied upon or generated in connection to your appeal as soon as possible and free of charge. You will have the opportunity to review this information and respond to us before we make our decision.

What Happens Next?

We will review your appeal and provide you with a written decision as stated below:

- Expedited appeals, as soon as possible, but no later than 72 hours after we received your request. We will call, fax or email our decision and will follow-up with a decision in writing.
- Appeals for benefit determinations made prior to you receiving services, within 15 calendar days of the date we received your request
- Utilization review determinations, within 18 business days of the date we received your request
- All other appeals, within 30 calendar days of the date we received your request

If we uphold our initial decision, you will be provided information about your right to a Level II internal appeal or your right to an External Review at the end of the internal appeals process.

Appeals Regarding Ongoing Care

If you appeal a decision to change, reduce or end coverage of ongoing care for a previously approved course of treatment because the service or level of service is no longer medically necessary or appropriate, we will suspend our denial of benefits during the internal appeal period. Our provision of benefits for services received during the internal appeal period does not, and should not be construed to, reverse our denial. If our decision is upheld, you must repay us all amounts that we paid for such services. You will also be responsible for any difference between our allowable charge and the provider's billed charge.

WHEN ARE YOU ELIGIBLE FOR EXTERNAL REVIEW?

If you are not satisfied with the final internal adverse benefit determination based on medical judgment, including medical necessity or appropriateness of care, or experimental and investigative care, you may have the right to have our decision reviewed by an Independent Review Organization (IRO). An IRO is an independent organization of medical reviewers who are qualified to review medical and other relevant information. There is no cost to you for an external review.

We will send you an External Review Request form at the end of the internal appeal process notifying you of your rights to an external review. We must receive your written request for an external review within 4 months of the date you received the final internal adverse benefit determination. Your request must include a signed waiver granting the IRO access to medical records and other materials that are relevant to your request.

You can request an expedited external review when your provider believes that your situation is clinically urgent under law. Please call Customer Service at the number listed on the inside front cover of this benefit booklet to request an expedited external review.

We will notify the IRO of your request for an external review. The IRO will let you, your authorized representative and/or your attending provider know where additional information may be submitted directly to the IRO and when the information must be provided. We will forward your medical records and other relevant materials for your external review to the IRO. We will also provide the IRO with any additional information they request that is reasonably available to us.

How Will You Know When The IRO Has Completed The External Review?

The IRO will review your request and notify you of their decision as stated below:

- Expedited external review, as soon as possible, but no later than 72 hours after receiving the request. The IRO will notify you and us immediately by phone, email or fax and will follow up with a written decision by mail.
- All other external review requests, within 21 business days of the IRO's receipt of your request

What Happens Next?

Premera Blue Cross Blue Shield of Alaska is bound by the IRO's decision. If the IRO overturned the final internal adverse benefit determination, we will implement their decision in a timely manner.

If the IRO upheld the final internal adverse benefit determination, there is no further review available under this plan's internal appeals or external review process. If you disagree with the IRO's decision, you may appeal the IRO's decision in Superior Court. You must file this request with the Superior Court within 6 months of the date you were notified of the IRO's decision. You may also have other remedies available under State or Federal law, such a filing a lawsuit.

OTHER RESOURCES TO HELP YOU

If you have questions about understanding a denial of a claim or your appeal rights, you may contact Premera Blue Cross Blue Shield of Alaska Customer Service for assistance at the number listed inside the front cover of your benefit booklet. If you are not satisfied with our decisions and wish to make a complaint or need help filing an appeal, you can contact the Alaska Division of Insurance at any time during this process. If your plan is governed by the Federal Retirement Income Security Act of 1974 (ERISA), you can contact the Employee Benefits Security Administration of the U.S. Department of Labor.

Alaska Division of Insurance
550 W 7th Ave., Suite 1560
Anchorage, Alaska 99501-3567
1-800-INSURAK (467-8725) (within Alaska)
1-907-269-7900 (outside Alaska)
Email: **insurance@alaska.gov**
Online:
www.commerce.state.ak.us/insurance

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

OTHER INFORMATION ABOUT THIS PLAN

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

Conformity With The Law

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

Entire Contract

The entire contract between the Group and us consists of all of the following.

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

No change to this contract, including any change made by a producer of the Group, will be binding upon us unless it's in writing and approved over the signature of an officer of ours.

Evidence Of Medical Necessity

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

Group As The Agent

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

Intentionally False Or Misleading Statements

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

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

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

misrepresentation of material fact that affects your acceptability for coverage.

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

Legal Action

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

Limitations Of Liability

We're not liable for any of the following:

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

Member Cooperation

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

Notice Of Information Use And Disclosure

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

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

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

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

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

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

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

Notice Of Other Coverage

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

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

Notices

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

Recovery Of Claims Overpayments

We have the right to recover amounts we have overpaid in error. Such amounts may be recovered from the subscriber or any other payee, including a provider. Or, such amounts may be deducted from future benefits of the subscriber or any of his or her dependents (even if the original payment wasn't made on that member's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a provider who doesn't have a contract with us. Such recoveries will not be sought more than 365 days after adjudication of the original claim.

Right To And Payment Of Benefits

Benefits of this plan are available only to members. In accordance with the law, we may pay the benefits of this plan to:

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

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

Venue

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

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

Workers' Compensation Insurance

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

DEFINITIONS

The terms listed below have specific meanings under this plan.

Accepted Rural Provider

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

Accidental Injury

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

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).

Allowable Charge

The allowable charge shall mean one of the following:

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

  For any given service or supply, the allowable charge is the lesser of the following:

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

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

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

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

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

  The allowable charge shall be defined as indicated below. When you receive services from a provider who does not have an agreement with us or another Blue Cross Blue Shield Licensee, you are

responsible for any amounts not paid by us, including amounts over the allowable charge.

- **For Services and Supplies Received Within Our Service Area:**

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

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

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

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

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

- **For Services, Supplies Received Outside Our Service Area:**

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

- **Emergency Services**

  Consistent with the requirements of the Affordable Care Act, the allowable charge will be the greatest of the following amounts:

  - The median amount that Heritage network providers have agreed to accept for the same services
  - The amount Medicare would allow for the same services
  - The amount calculated by the same method the plan uses to determine payment to out-of-network providers

  In addition to your deductible, copayments and coinsurance, you will be responsible for charges received from out-of-network providers above the allowed amount.

  When you receive services from providers that do not have agreements with us or the local Blue Cross and/or Blue Shield Licensee, your liability is for any amount above the allowable charge, and for your normal share of the allowable charge (see the "What Are My Benefits?" section for further detail).

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

Ambulatory Surgical Center

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

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

Applied Behavior Analysis

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

Autism Spectrum Disorders

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

Autism Service Provider

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

Calendar Year

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

Congenital Anomaly

A marked difference, from the normal structure of a body part that's physically evident at birth.

Copay

A fixed, up-front dollar amount that you're required to pay for certain covered services. Your provider may ask that you pay this amount at the time of service. The copay amount doesn't vary with the cost of the services and doesn't apply toward applicable calendar year deductibles. Some copays accrue to the out-of-pocket maximums. See Out-of-Pocket Maximum under the ***What Do I Need To Know Before I Get Care*** section.

Cost-share

Member's share of the allowable charge for covered services. Deductibles, copays, and coinsurance are all types of cost-shares. See "What Are My Medical Benefits?" to find out what your cost-share is.

Custodial Care

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

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

Detoxification

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

Effective Date

The date when your coverage under this plan begins. If you re-enroll in this plan after a lapse in coverage, the date that the coverage begins again will be your effective date.

Eligibility Waiting Period

The length of time that must pass before a subscriber or dependent is eligible to be covered under the health care plan. If a subscriber or dependent enrolls under the "Special Enrollment" provisions of this plan or enrolls on a date other than when first eligible to enroll, any period prior to such enrollment isn't considered an eligibility waiting period, unless all or part of the initial eligibility waiting period had not been met.

Enrollment Date

For the subscriber and eligible dependents who enroll when the subscriber is first eligible, the enrollment date is the subscriber's date of hire. There's one exception to this rule. If the subscriber was hired into a class of employees to which the Group doesn't provide coverage under this plan, but was later transferred to a class of employees to which the group does provide coverage under this plan, the enrollment date is the date the subscriber enters the eligible class of employees. (For example, the enrollment date for a seasonal employee who was made permanent after six months would be the date the employee started work as a permanent employee.). For subscribers who don't enroll when first eligible and for dependents added after the subscriber's coverage starts, the enrollment date is the effective date of coverage.

Experimental/Investigational Services

Experimental or investigational services include a treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria:

- A drug or device that can't be lawfully marketed without the approval of the U.S. Food and Drug Administration, and hasn't been granted such approval on the date the service is provided
- The service is subject to oversight by an Institutional Review Board

- No reliable evidence demonstrates that the service is effective, in clinical diagnosis, evaluation, management or treatment of the condition
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy. However, services that meet the standards outlined in the Clinical Trials benefit will not be deemed experimental or investigational.
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies

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

Group

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

Hospital

A facility legally operating as a hospital in the state in which it operates and that meets the following requirements:

- It has facilities for the inpatient diagnosis, treatment and acute care of injured and ill persons by or under the supervision of a staff of providers
- It continuously provides 24-hour nursing services by or under the supervision of registered nurses

A "hospital" will never be an institution that's run mainly:

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

Illness

A sickness, disease, medical condition, complications of pregnancy or pregnancy.

Inpatient

Confined in a medical facility as an overnight bed patient.

Large Employer

An employer, including a person, firm, corporation, partnership, association, or political subdivision, that is actively engaged in business, that employed an average of at least 51 employees on the business days during the preceding calendar year and that employs at least 2 employees on the first day of a health benefit year.

Medical Equipment

Mechanical equipment that can stand repeated use and is used in connection with the direct treatment of an illness or accidental injury. It's of no use in the absence of illness or accidental injury.

Medical Emergency

The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. (A "prudent layperson" is someone who has an average knowledge of health and medicine.)

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

Medical Facility (also called "Facility")

A hospital, skilled nursing facility, state-approved substance abuse treatment program or hospice.

Medically Necessary

Those covered services and supplies that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, provider, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

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

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

A person covered under this plan as an employee or dependent.

Network Provider

Providers that are in one of the networks stated in the "How Does Selecting A Provider Affect My Benefits?" section.

Non-Network Provider

A provider that is not in one of the provider networks stated in the "How Does Selecting A Provider Affect My Benefits?" section.

Obstetrical Care

Care furnished during pregnancy (antepartum, delivery and postpartum), including elective abortion, or any condition arising from pregnancy, except for complications of pregnancy. This includes the time during pregnancy and within 45 days following delivery.

Orthodontia

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

Orthotic

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

Outpatient

A patient receiving treatment in a setting other than as an inpatient in a medical facility.

Participating Pharmacy (Participating Retail/Participating Mail-Order Pharmacy)

A licensed pharmacy which contracts with us or the Pharmacy Benefits Administrator, to provide prescription drugs as specified under the "What Are My Prescription Drug Benefits?" section.

Participating Provider

A provider, who at the time services are received, has a participating contract in effect with us.

Pharmacy Benefits Administrator

An entity that contracts with us to administer prescription drug benefits as specified under the "What Are My Prescription Drug Benefits?" section.

Physician

A state-licensed:

- Doctor of Medicine and Surgery (M.D.)
- Doctor of Osteopathy and Surgery (D.O.)
- Podiatrist (D.P.M.)

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

- An Advanced Nurse Practitioner (A.N.P.)
- A Certified Direct-Entry Midwife
- A Chiropractor (D.C.)
- A Dentist (D.D.S. or D.M.D.)
- A Licensed Clinical Social Worker (L.C.S.W.)
- A Licensed Marital and Family Therapist (L.M.F.T.)
- A Licensed Marriage and Family Counselor (L.M.F.C.)
- A Naturopath (N.D.)
- A Nurse Midwife
- An Occupational Therapist (O.T.)
- An Optometrist (O.D.)
- A Physical Therapist (P.T.)
- A Physician Assistant supervised by a collaborating M.D. or D.O.
- A Psychological Associate
- A Psychologist

Plan (also called "This Plan" or "The Plan")

The benefits, terms and limitations set forth in this booklet.

Preferred Provider

A provider, who at the time services are received, has a preferred contract in effect with us.

Prescription Drug

Any medical substance, including biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication or for the treatment of people with HIV or AIDS, the label of which, under the Federal Food, Drug and Cosmetic Act, as amended,

is required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription."

Benefits available under this plan will be provided for "off-label" use, including administration, of prescription drugs for treatment of a covered condition when use of the drug is recognized as effective for treatment of such condition by:

- One of the following standard reference compendia:
  - **The American Hospital Formulary Service-Drug Information**;
  - **The American Medical Association Drug Evaluation**;
  - **The United States Pharmacopoeia-Drug Information**; or
  - Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services or the Insurance Commissioner.
- If not recognized by one of the standard reference compendia cited above, then recognized by the majority of relevant, peer-reviewed medical literature (original manuscripts of scientific studies published in medical or scientific journals after critical review for scientific accuracy, validity and reliability by independent, unbiased experts); or,
- The Federal Secretary of Health and Human Services.

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

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

Provider (also called "Covered Provider")

A physician or other health care professional or facility named in this plan that is licensed or certified as required by the state in which the services were received to provide a medical service or supply, and who does so within the lawful scope of that license or certification.

Psychiatric Condition

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

Service Area

Service area means the state of Alaska and the state of Washington, except for Clark County Washington.

Skilled Care

Care that's ordered by a provider and requires the medical knowledge and technical training of a licensed registered nurse.

Skilled Nursing Facility

A medical facility providing services that require the direction of a provider and nursing supervised by a registered nurse and that's state-licensed, approved by Medicare or would qualify for Medicare approval if so requested.

Subscriber

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

Subscription Charges

The monthly rates set by us as consideration for the benefits offered in this plan.

Substance Abuse

An illness characterized by physiological or psychological dependency, or both, on alcohol or a state-regulated controlled substance. It's further characterized by a frequent or intense pattern of pathological use to the extent:

- The user exhibits a loss of self-control over the amount and circumstances of use
- The user develops symptoms of tolerance, or psychological and/or physiological withdrawal if use is reduced or discontinued
- The user's health is substantially impaired or endangered, or his or her social or economic function is substantially disrupted

Temporomandibular Joint (TMJ) Disorders

TMJ disorders shall include those disorders which have one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.

We, Us And Our

Means Premera Blue Cross Blue Shield of Alaska in the state of Alaska and Premera Blue Cross in the state of Washington.

APPENDIX A

CITY AND BOROUGH OF STIKA
AFFIDAVIT OF SAME SEX DOMESTIC PARTNERSHIP

Section I.

I, _____, an employee of the City And Borough of Sitka, certify that

I, and _____ are same sex domestic partners, and we:

1. Reside together in the same permanent residence and intend to continue to share the same permanent residence; **and**

2. Have a relationship intended to be permanent; **and**

3. Are financially interdependent according to the following definition:

(a) we share responsibility for our common household by contributing to household expenses including but not limited to the cost of food, shelter, transportation or other living expenses; **OR**

(b) we have joint ownership of one or more of the following: a residence; land; banking account; credit card account; leasehold; or other similar property interest;
OR

(c) we are primary beneficiaries of one another's life insurance policies, or executor's of one another's wills; or have power of attorney over one another's property in the event of death or disability; or similar authority over one another's executory affairs.

and;

4. are not married; **and**

5. are each eighteen (18) years of age or older; **and**

6. are not related by blood to the degree which would bar marriage in the State of Alaska; **and**

7. are mentally competent to consent to contract; **and**

8. are one another's sole domestic partner.

Section II.

The undersigned employee understands that his/her rights to domestic partner benefits for _____ shall be terminated upon the death of the domestic partner or if the domestic partnership no longer qualifies under the definition of Section I.

The undersigned employee agrees to notify the City And Borough of Sitka within thirty (30) days by filing a Statement of Termination of Same Sex Domestic Partnership if the domestic partnership no longer qualifies under the definition in Section I.

Section III.

We understand that this information will be held confidential and will be subject to disclosure only upon our express written authorization unless otherwise required by law.

We understand that accepting benefits as a same sex domestic partner may have federal income tax consequences and that the benefit will be valued and included as taxable income to the employee.

We understand that a civil action may be brought against us for any losses, including reasonable attorney's fees, for any false statement contained in this Affidavit of Same Sex Domestic Partnership.

We certify under penalty of perjury that the foregoing is true and correct.

I, the undersigned City And Borough of Sitka employee understand that falsification of information on this affidavit, or failure to notify the City And Borough of Sitka of the termination of a domestic partner relationship may lead to disciplinary action against me, including termination of employment.

_____
Signature of Employee

SUBSCRIBED and SWORN TO before me this _____ day of _____, 20___.

_____
Notary Public in and for Alaska
My Commission Expires: _____

_____
Signature of Domestic Partner

SUBSCRIBED and SWORN TO before me this _____ day of _____, 20___.

_____
Notary Public in and for Alaska
My Commission Expires: _____

Arranged by

Paula M. Scott
USI
3800 Centerpoint Dr., Suite 540
Anchorage, AK 99503
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where to send claims

MAIL YOUR CLAIMS TO:

Premera Blue Cross Blue Shield of Alaska

P.O. Box 240609

Anchorage, AK 99524-0609

MAIL PRESCRIPTION DRUG CLAIMS TO:

Express Scripts

P.O. Box 747000

Cincinnati, OH 45274-7000

premera.com