[Group Name]

HeritageSelect™ Envoy

[Group Number]

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 99503-2737

Telephone Numbers:

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

Local and toll-free TDD number
for the hearing-impaired: 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 Web site at **www.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:	[Group Name]
Effective Date:	[Effective Date]
Group Number:	[Group Number]
Plan:	Alaska HeritageSelect Envoy (Non-Grandfathered)
Certificate Form Number:	AKSGDIM H-SLCT ENVOYN (01-2013)

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

PREMERA BLUE CROSS BLUE SHIELD OF ALASKA
GROUP CONTRACT ENDORSEMENT

Applies to:
2014 Non-Grandfathered Extended Small Group (2-50) Medical
Certificate Form Numbers:

AKSGDIM GLBN (01-2013) Kacey Kemp
AKSGDIM H-PLUSN (01-2013)
AKSGDIM H-SLCTN (01-2013)
AKSGDIM H-PLUS HSAN (01-2013)
AKSGDIM H-SLCT HSAN (01-2013)
AKSGDIM H-SLCT ENVOYN (01-2013)
AKSGDIM H-PLUS ENVOYN (01-2013)

This endorsement makes an important change to the group contract issued by Premera Blue Cross Blue Shield of Alaska to your group. This change is required due to changes in state or federal law, or due to administrative changes.

Notwithstanding any other provision of the contract, the provisions below apply. In the event of a conflict between the provision of any other section of your contract and the provisions of this endorsement, the provisions of this endorsement shall prevail.

- Annual Maximum

The $2,000,000 annual Plan Maximum has been removed. All references in your benefit booklet to an annual plan maximum are also removed.

- ICD-9

All references to ICD-9 are deleted and replaced by the term ICD.

- CPT-4

All references to CPT-4 are deleted and replaced by the term CPT.

- Exclusions

The Telehealth Virtual Care Services exclusion has been deleted.

Transplants

The daily dollar limits for transportation, lodging and meal expenses related to a covered transplant have now been removed. These services 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 child, lodging and meal expenses are limited to the recipient and one companion.

An Independent Licensee of the Blue Cross Blue Shield Association

Dependent Eligibility

We have removed the paragraph below from the "Eligible Dependent" definition exclusion:

Foster children aren't eligible for coverage

We have modified the fourth bullet under the bullet "An eligible child under 26 years of age". It reads:

- A minor or foster child for whom the subscriber or spouse has a legal guardianship. There must be a court order or other order signed by a judge or state agency, which grants guardianship of the child to the subscriber or spouse as of a specific date. When the court order terminates or expires, the child is no longer an eligible child.

All other provisions of the plan remain unchanged. This Endorsement should be kept with your benefit booklet for future reference.

If you have questions regarding this information, please contact our Customer Service Department. The phone numbers are located on the back of your booklet. You can also refer to our website at **premera.com**.

Premera Blue Cross Blue Shield of Alaska

Jeffrey Roe
President and Chief Executive Officer

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INTRODUCTION

This plan will comply with the 2010 federal health care reform law, called the Affordable Care Act (see "Definitions"). If Congress, federal or state regulators, or the courts make further changes or clarifications regarding the Affordable Care Act and its implementing regulations, 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 Web site 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 and your waiting period for pre-existing conditions
- **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 prescription drug benefits, these benefits are described in a separate section. You'll find it in the table of contents.
- **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 refer to the "Definitions" section of this booklet for a complete 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 levels of benefits available under this plan for non-emergent hospital services, you must use a **preferred** or **participating** hospital in the network. Other covered services and supplies you receive from providers other than hospitals also receive the higher level of benefits under the plan.

When you receive services from a **preferred 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 may substantially reduce your healthcare costs.

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

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

Preferred and participating 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 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.
- Categories of providers with whom we do not have a contract, including accepted rural providers (see "Definitions")

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

Important Note: Please see "Benefit Level Exceptions For Non-Emergent Care" for more information on requesting the in-network level of benefits when you choose to receive covered services and supplies from non-network providers.

WHEN YOU GET CARE OUTSIDE ALASKA

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

Important Note: You're entitled to receive a provider directory automatically, without charge.

For the most current information on preferred or participating network hospitals, please refer to our Web site at **www.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. We'll pay our 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 physicians, anesthesiologists, radiologists or other professionals who are not part of our network. When you receive services from these non-network providers, including services received from non-network ambulances, 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.

BENEFIT LEVEL EXCEPTIONS FOR NON-EMERGENT CARE

A "benefit level exception" is our decision to provide the highest in-network benefits for covered services from a non-network provider.

You, your provider, or medical facility may ask us for the benefit level exception. However, the request must be made before you get the service or supply. If we approve the request, benefits for covered services and supplies will be provided at the in-network benefit level. Payment of your claim will be based on your eligibility and benefits available at the time you get the service or supply. You'll be responsible for amounts applied towards your applicable calendar year deductible, coinsurance, amounts that exceed the benefit maximums, amounts above the allowable charge, and charges for non-covered services. If we deny the request, in-network level benefits won't be provided for non-network providers.

Please call Customer Service at the phone number listed on the inside the front cover of this booklet to request a benefit level exception for non-emergent care.

You may also refer to the "What Are My Prescription Drug Benefits?" section for information on benefits from non-

participating pharmacies.

Our benefit level exception shouldn't be considered a guarantee of payment. Payment of any service will be based on your eligibility and benefits available at the time services are rendered.

Important Note: There are special circumstances when a benefit level exception is not required. Please see "How Does Selecting A Provider Affect My Benefits?" for a description of these special circumstances.

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.

WAITING PERIOD FOR PRE-EXISTING CONDITIONS

You're responsible for all charges for services and supplies described in the "What Are My Medical Benefits?" section of this booklet that you receive for pre-existing conditions during this plan's pre-existing conditions waiting period.

A pre-existing condition is a condition for members who are age 19 or older, regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received in the 6 months before your "enrollment date" (please see the "Definitions" section in this booklet).

The waiting period for pre-existing conditions is 12 months from your enrollment date. Except as noted below, benefits won't be provided for pre-existing conditions until:

- After your coverage becomes effective; and
- Your 12-month waiting period for pre-existing conditions has been met. This waiting period may be reduced by prior periods of creditable coverage as explained below.

How Creditable Coverage Can Reduce Your Waiting Period For Pre-Existing Conditions

This plan's waiting period for pre-existing conditions may be reduced by periods of "creditable" coverage you've accrued under other health care plans prior to your enrollment date for this plan. Most medical health care coverage is considered creditable coverage (see list below). You'll receive credit for prior creditable coverage that occurred without a break in coverage of more than 90 days. Any coverage you had before a break in coverage that exceeds 90 days isn't credited toward your waiting period for pre-existing conditions. Eligibility waiting periods won't be considered creditable coverage or a break in coverage. Your prior employer or health insurance carrier will provide you with a certificate of health coverage that includes information about your prior health coverage. You may contact our Customer Service department if you're unable to obtain a certificate of health coverage from a prior health plan. If you haven't received a certificate, or have misplaced it, you have the right to request one from a prior employer or health carrier within 24 months of the date your coverage under that plan terminated.

Creditable coverage shall mean coverage under one or more of the following types of health coverage:

- Group health coverage (including self-funded plans and COBRA)
- Individual health coverage
- Part A or B of Medicare
- Medicaid
- Military health coverage
- Indian Health Service or tribal coverage
- State high risk pool
- Federal or any public health care plan, including state children's health care plans
- Peace Corps Plan
- Government health coverage provided for citizens or residents of a foreign country
- Any other health insurance coverage

Creditable coverage doesn't include coverage under a limited policy such as an accident only coverage; disability income insurance; workers' compensation; limited scope dental or vision plans; liability insurance; automobile

medical insurance; specified disease coverage; Medicare supplement policy; or long-term care policy.

The waiting period for pre-existing conditions **doesn't apply** to the following:

- Members under the age of 19
- Pregnancy
- Coverage for PKU dietary formula for members with phenylketonuria
- Genetic information in absence of a diagnosis

COPAYS

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 are provided at 100% of allowable charges after you pay the copay and aren't subject to your:

- Calendar year deductible
- Coinsurance, if any
- Out-of-pocket maximum

Professional Visit Copay

For each office visit or visit in your home by a physician or other professional, you pay a $25 copay per visit. This is your professional visit copay. A "physician" means a provider who is licensed by the state as a Doctor of Medicine and Surgery (M.D.), Doctor of Osteopathy and Surgery (D.O.) or Podiatrist (D.P.M.).

The calendar year deductible and coinsurance, if any, are waived for the **first 6** office or home visits each calendar year related to covered evaluation and management services and biofeedback services. For these first 6 visits, you will pay only the $25 copay. The first 6 visits are an aggregate total, meaning that for each member, office and home visits from all providers combined count toward the 6-visit limit.

After the 6-visit limit is reached, subsequent home and office visits are subject only to the calendar year deductible and coinsurance, if any.

Certain benefits provide a limited number of professional visits each calendar year. These limits apply, regardless of whether a given visit falls within the first 6 visits of the calendar year.

Your share of the cost of some professional services is not the same as described above. Professional office visits received from providers for the services listed below **do not** count towards the 6-visit limit, and are never subject to the deductible or coinsurance, if any. When the services listed below are received in a home or office setting, you pay only the professional visit copay:

- Acupuncture outpatient services
- Autism spectrum disorders outpatient services
- Spinal and other manipulations

Electronic visits (e-visits) received from an approved physician are also subject to the professional visit copay. For additional information, see the Electronic Visits section in the Professional Visits and Services benefit.

Examples of benefits that **do not** require a professional visit copay include, but aren't limited to:

- Emergency room visits
- Health education and training and nicotine dependency treatment programs covered under the Health Management benefit
- Home health or hospice care
- Outpatient professional services received from an outpatient department of a hospital or facility
- Preventive care
- Immunizations
- Professional services received while an inpatient in a facility
- Psychological and neuropsychological testing
- Neurodevelopmental therapy

- Rehabilitation therapy and chronic pain care
- Surgical services; procedures performed in a provider's office, surgical suite or other facility
- Routine hearing exams, if these benefits are included in the plan
- Nutritional therapy
- Contraceptive management and sterilization

See the specific benefit descriptions later in this section for amounts you are responsible to pay for all services.

Emergency Room Copay

Each time you receive services in an emergency room you pay a $100 copay per visit. The services you receive in an emergency room are also subject to your calendar year deductible and preferred coinsurance, if any, 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 hospital that is in the network, you pay less coinsurance, if any, for covered services than you would for other hospitals. Please see Ambulance Services for details regarding the coinsurance amounts for that benefit.

Heritage Providers

When you get care from a physician or from a Heritage preferred hospital, your coinsurance is 20% of allowable charges, unless otherwise stated. When you get care from a Heritage participating hospital, your coinsurance is 40% of allowable charges, unless otherwise stated.

Providers That Aren't Part Of Our Heritage Provider Network

When you get care from hospitals or ambulances that aren't part of our Heritage provider network, your coinsurance is 60% of allowable charges, unless otherwise stated. This is your out-of-network coinsurance.

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 described above applies, depending on the provider.

CALENDAR YEAR DEDUCTIBLE

A calendar year deductible is the 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 will consider the individual deductible of every enrolled family member to be met for the calendar 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
- The coinsurance required in the "What Are My Prescription Drug Benefits?" section

OUT-OF-POCKET MAXIMUM

Each calendar year, the amount each member could pay toward the calendar year deductible and coinsurance for certain 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."

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.

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

Individual Maximum

For each member, the out-of-pocket maximum is $3,500 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.

Other covered services and supplies you receive from providers other than hospitals not in the network are also subject to the out-of-pocket maximum.

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 $10,500, we will consider the individual out-of-pocket maximum of every enrolled family member to be met for that calendar year. The $10,500 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.

- Copays
- Amounts that exceed the benefit maximums under this plan, including the annual plan maximum
- Amounts that exceed the allowable charge
- Services and supplies not covered under this plan
- The coinsurance required for prescription drugs, as specified in the "What Are My Prescription Drug Benefits?" section

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 plan is satisfied.
- It must be furnished by a "provider" (please see the "Definitions" section in this booklet) who's performing services within the scope of his or her license or certification.

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.

ANNUAL PLAN MAXIMUM

The maximum amount of benefits of this plan available to any one member is $2,000,000 per calendar year. The annual plan maximum renews on each January 1.

The following benefits don't accrue toward this maximum:

- Benefits described in the "What Are My Prescription Drug Benefits?" section

MEDICAL BENEFITS

Acupuncture

This benefit is subject to the $25 professional visit copay for each visit in an office setting. When acupuncture isn't done in an office setting, benefits are subject to the calendar year deductible and coinsurance, if any.

Benefits are provided for acupuncture services up to a maximum of 12 visits per member each calendar year. Services must be medically necessary to relieve pain, induce surgical anesthesia, or to treat a covered illness, injury or condition.

Air or Surface Transportation

This benefit is subject to the calendar year deductible and preferred coinsurance, if any.

This benefit is limited to only those services that are for a sudden, life-endangering illness or injury that results in your hospital admission at the end of the transport. Benefits are provided for one-way air or surface transportation, for you only, by a licensed commercial carrier. The trip must begin at the location in Alaska where you became ill or injured and end at the location of the nearest hospital equipped to provide treatment not available in a local facility. Transportation outside Alaska will be limited to Seattle, Washington. Please see "How Do I File A Claim?" for more information on how to submit a claim for these services.

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

- Services that aren't sudden and life-endangering
- 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 (see "Definitions").

Medical Emergency Transport

For a **medical emergency**, this benefit is subject to the in-network calendar year deductible and preferred level 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 in-network calendar year

deductible and preferred level coinsurance, if any.

- **Air Transport:**
  - Benefits for air transport received from an **in-network** air ambulance are subject to the in-network calendar year deductible and coinsurance, if any.
  - Benefits for air transport received from a **non-network** air ambulance are subject to the out-of-network calendar year deductible and out of 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, if any. Benefits are provided for services and supplies furnished by a licensed ambulatory surgical center.

Autism Spectrum Disorders Services

This benefit covers medically necessary services and supplies for members who are under 21 years of age for the diagnosis and treatment of autism spectrum disorders. The Autism Spectrum Disorders Services benefit is not subject to a separate benefit maximum.

This benefit is subject to the $25 professional visit copay for each visit in an office setting. Other covered services are subject to the calendar year deductible and coinsurance, if any.

Coverage is provided for the following:

- Habilitative or rehabilitative care, including applied behavior analysis, counseling and treatment programs necessary to develop, maintain, or restore the functioning of an individual
- Psychiatric and psychological care. Covered services include inpatient care and outpatient therapeutic visits.
- Therapeutic care as identified in a treatment plan developed following a comprehensive evaluation, including behavioral, speech, occupational, and physical therapies

Treatment may be provided by the following providers:

- A licensed physician
- A psychologist
- An advanced nurse practitioner
- An autism service provider (see “Definitions”) or a provider supervised by an autism service provider
- Any other provider type that is licensed to practice where the care is provided, is providing a service within the scope of that license

Medically Necessary

For the purposes of this benefit, “Medically Necessary” is defined as care, treatment, intervention, service, or item prescribed by a licensed physician, psychologist, or advanced nurse practitioner in accordance with accepted standards of practice that will, or is reasonably expected to:

- Prevent the onset of an illness, condition, injury or disability
- Reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability
- Assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacity of other person of the individual’s age

Blood Products and Services

This benefit is subject to the calendar year deductible and coinsurance, if any. Benefits are provided for the cost of blood and blood derivatives.

Cancer Clinical Trials

Benefits for routine medical care in an approved cancer clinical trial, including leukemia, lymphoma and bone marrow stem cell disorders are included when your treating physician has determined:

- There is no superior non-investigational treatment alternative; and
- When available clinical or preclinical data provide a reasonable expectation that the treatment provided in the cancer clinical trial will be at least as effective as any non-investigational alternative.

Benefits for covered services are provided based on the type of services received as shown in the "What Are My Medical Benefits?" section. For example, benefits for inpatient care in a hospital are provided as shown under Hospital Inpatient Care; benefits for office visits are provided as shown under the Professional Visits and Services benefits; and benefits for lab and imaging are provided as shown under the Diagnostic Services benefits.

This benefit is subject to the $25 professional visit copay for each visit in an office setting. Other covered services are subject to the calendar year deductible and coinsurance, if any.

Benefits are provided as described below.

Routine Medical Care

Benefits for routine medical care that would otherwise be covered under this plan if the medical care were not in connection with an approved cancer clinical trial are provided as stated above and

include the following:

- Prevention, diagnosis, treatment, and palliative care of cancer
- Items or services necessary to provide an investigational item or service
- Diagnosis and treatment of complications
- A drug or device approved by the FDA whether or not the FDA approved the drug or device for use in treating a particular condition and only to the extent that the drug or device is not paid for by the manufacturer, distributor, or provider of the drug or device
- Services necessary to administer a drug or device under evaluation in the cancer clinical trial

Transportation Expenses

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 to and from the site of usual treatment to the site of the 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?" this Cancer Clinical Trials benefit doesn't cover the following:

- Clinical trials that are not related to cancer
- Clinical trials that are not an approved clinical trial as described in the "Definitions" section in this booklet
- 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 under covered services
- 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 provided in an office setting aren't subject to your calendar year deductible, coinsurance or copays, if any.

This benefit covers the following services and supplies:

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

Prescription Contraceptives Dispensed by a Pharmacy

Prescription contraceptives (including emergency contraception) and prescription barrier devices or supplies are covered when dispensed by a licensed pharmacy. Examples of covered devices are diaphragms and cervical caps. Cost-shares are waived for these devices and for generic and single-source brand name birth control drugs. Please see the "What Are My Prescription Drug Benefits?" section.

In addition to "What's Not Covered?" this Contraceptive Management and Sterilization benefit doesn't cover the following:

- Hysterectomy. (Covered on the same basis as other surgeries. See the Surgical Services benefit.)
- Non-prescription contraceptive drugs, supplies or devices (except emergency contraceptive methods)
- Prescription contraceptive take-home drugs dispensed and billed by a facility or provider's office
- Sterilization reversal
- Testing, diagnosis, and treatment of infertility, including fertility enhancement services, procedures, supplies and drugs

Dental Services

The $25 professional visit copay applies to dentist visits in an office setting to examine the damage done in a dental accident and recommend

treatment. Benefits for a dentist's services to treat dental accidents are subject to the calendar year deductible and coinsurance, if any. Other covered services are subject to the calendar year deductible and coinsurance, if any.

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

Accidental Injuries

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 our 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 hospital or ambulatory surgical center care for dental procedures aren't provided, except 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 the calendar year deductible or coinsurance, if any, unless services are performed by a hospital that isn't in the network. For these services, benefits are subject to the calendar year deductible and coinsurance.

Preventive diagnostic services are laboratory and imaging services that meet the federal guidelines for preventive care services stated in the Preventive Care benefit.

Benefits for **non-preventive** diagnostic services are subject to the calendar year deductible and coinsurance, if any. However, 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)
- Laboratory services, including routine and preventive
- Pathology tests
- 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 physician
  - Annual cervical cancer pap smears for women 18 years of age and older, or as recommended by a physician
  - 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 physician

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 furnished and 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 Care 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 Care benefits.
- Services related to the testing, diagnosis or treatment of infertility
- Mammography services. Please see the Mammography Services benefit.

Emergency Room Care

Services in the emergency room (ER) are subject to a $100 copay and calendar year deductible and preferred coinsurance, if any. 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 procedure, operating, and recovery rooms; plus services and supplies such as surgical dressings and drugs furnished by and used while at the emergency room. Additionally, when covered outpatient diagnostic services are furnished and 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 treatment of chemical dependency. 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

This benefit isn't subject to the calendar year deductible or coinsurance, and is covered at 100% of allowable charges. There is no calendar year maximum for this benefit.

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.

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 proof of payment along with a reimbursement form. When we receive these items, benefits will be provided as stated above in this benefit. Please contact our Customer Service department (see the "How To Contact Us" section listed 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, if any.

To be covered, home health and hospice care must be part of a written plan of care prescribed, periodically reviewed and approved by a physician. In the plan of care, the physician 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 physician.
- **Respite care** up to a maximum of 240 hours, to relieve anyone who lives with and cares for the terminally ill member.

Insulin and Other Home and Hospice Care Provider Prescribed Drugs

Benefits are provided for prescription drugs and insulin 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, if any.

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 chemical dependency. 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, if any.

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 furnished and 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, if any.

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

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 hospital that isn't in the network. For these services, benefits are subject to the calendar year deductible and 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 physician.

Non-preventive diagnostic mammography services are subject to the calendar year deductible and coinsurance, if any.

Mastectomy and Breast Reconstruction Services

This benefit is subject to the $25 professional visit copay for each visit in an office setting. Surgery and inpatient professional and facility services are subject to calendar year deductible and coinsurance, if any.

Benefits are provided for mastectomy necessary due to disease, illness or accidental injury. 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 physician and the patient.

Medical Equipment and Supplies

This benefit is subject to the calendar year deductible and coinsurance, if any, 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 physician for therapeutic use in direct treatment of a covered illness or injury. We 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, we'll 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 physician because of a change in your physical condition.

Foot Orthotics and Therapeutic Shoes

When prescribed for the condition of diabetes, or for corrective purposes, benefits are provided for foot orthotics (shoe inserts) and therapeutic shoes (orthopedic), including fitting expenses, up to a maximum of $300 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, Sjorgren's disease, 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?" 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.

Neurodevelopmental Therapy

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

Benefits are provided for the treatment of neurodevelopmental disabilities for members under the age of 7, or for members under the age of 21 who are diagnosed with autism spectrum disorder. 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 physician.
  - Services must be furnished and billed by a hospital, rehabilitation facility, physician, 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 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.

Please Note: Inpatient care and outpatient therapeutic care for autism spectrum disorders related treatment for members under the age of 21 are not subject to the above noted benefit maximums.

This benefit won't be 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:

- 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

Routine inpatient newborn care benefits are subject to the child's own calendar year deductible and coinsurance requirements, if any.

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

Benefits for routine hospital nursery charges and related inpatient well-baby care for a newborn dependent child or newborn dependent grandchild 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 Care Management at 1-800-722-4714 for discharge planning and potential case management.

Benefits are also provided for routine circumcision.

Newborn Hearing Exams and Testing

This benefit provides for one screening hearing exam for newborns up to 30 days after birth.

Benefits are also provided for diagnostic hearing tests, including administration and interpretation, for 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 the child receives inpatient care in a hospital, you pay the share of allowable charges shown under the Hospital Inpatient Care 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

Nutritional Therapy benefits aren't subject to the calendar year deductible and coinsurance, if any, unless services are performed by a hospital that isn't in the network. For these services, benefits 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, including services to manage diabetes or eating disorders. Nutritional therapy services that meet the federal guidelines designated as preventive care will be subject to applicable frequency limits.

Obstetrical Care

This benefit is subject to the calendar year deductible and coinsurance, if any. Benefits for pregnancy, childbirth and voluntary termination of pregnancy are provided on the same basis as any other condition for all female members.

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 Web site or by calling Customer Service.

Please Note: Attending provider as used in this benefit means a physician, a physician'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 global 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.

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 Care Management at 1-800-722-4714 for discharge planning and potential case management.

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

Phenylketonuria (PKU) Dietary Formula

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

Benefits are provided for dietary formula that's medically necessary for the treatment of phenylketonuria (PKU). This benefit isn't subject to the waiting period for pre-existing conditions, explained in the "What Do I Need To Know Before I Get Care?" section.

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.
- 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.

A full list of these preventive services is available on our Web site or by calling Customer Service. The list also provides the guidelines on how often the services should be provided and who should receive them. Not all services recommended or billed by your doctor as part of your routine physical may comply with these guidelines. The list and guidelines are subject to change as required by law and regulation.

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 aren't subject to the deductible and coinsurance, if any.

The following exam services are covered as long as they fall within the federal guidelines above in this benefit:

- 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

Preventive Immunizations

Preventive immunization benefits aren't subject to a copay, calendar year deductible or coinsurance, if any, unless services are furnished by a hospital that isn't in the network. For these services, benefits are subject to the calendar year deductible and coinsurance.

Seasonal and Other Immunizations

Seasonal and certain other immunizations provided by a pharmacy or other mass immunizer location aren't subject to a copay, calendar year deductible and coinsurance, if any.

Benefits are provided at 100% of allowable charges. Covered services include flu shots, flu mist, pneumonia immunizations, whooping cough and adult shingles 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 and coinsurance, if any, unless services are performed by a hospital that isn't in the network. For these services, benefits are subject to the calendar year deductible and 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

A full-list of preventive services is available on our Web site or by calling Customer Service.

Please see the Medical Equipment and Supplies benefit for details on breast pump coverage. Please also see the Contraceptive Management and

Sterilization, Diagnostic Services, Health Management, and Obstetrical Care benefits for further detail.

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

- Charges for services or items that don't meet the federal guidelines for preventive services described at the beginning of this benefit, except as required by law. This includes services or items provided more often than as stated in the guidelines.
- Inpatient 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
- 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 benefits for available coverage.
- Physical exams for basic life or disability insurance
- Work-related or medical disability evaluations
- Routine hearing exams
- Routine vision exams

Professional Visits and Services

This benefit is subject to the $25 professional visit copay for each visit in an office setting. Benefits for inpatient and other outpatient professional services are subject to the calendar year deductible and coinsurance, if any.

Please Note: If therapeutic or allergy injections are the only services performed by a physician in the network, your calendar year deductible and coinsurance, if any, will apply.

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 (see "Definitions") when provided by a qualified provider
- Routine foot care when the member is a diabetic
- Therapeutic injections, including allergy injections
- Consultations and treatment for nicotine dependency

Electronic Visits

This benefit will cover electronic visits (e-visits) when all the requirements below are met. You pay the same cost-shares for e-visits as you do for in-person visits to the doctor's office. This benefit is only provided when three things are true:

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

An e-visit is a structured, secure online consultation between the approved physician and the member. Each approved physician will determine which conditions and circumstances are appropriate for e-visits in their practice.

Please call Customer Service at the number shown on the front cover of this booklet for help in finding a physician 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 and laboratory services. These services are covered under the Diagnostic Services 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 and treatment of temporomandibular joint disorder
- Services related to the diagnosis or treatment of psychiatric conditions, including biofeedback services
- Contraceptive injections or implantable contraceptives. These 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, if any.

Benefits are provided up to a maximum benefit of 12 hours per member each calendar year for all services combined.

Please Note: This benefit maximum does not apply to autism spectrum disorders related testing and services for members who are under 21 years of age.

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 are provided under the Rehabilitation Therapy and Chronic Pain Care benefit.

See the Neurodevelopmental Therapy benefit for physical, speech or occupational therapy assessments and evaluations related to neurodevelopmental disabilities.

Rehabilitation Therapy and Chronic Pain Care

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

Rehabilitation Therapy

Benefits for the following inpatient and outpatient rehabilitation therapy services are provided when such services are medically necessary to either 1) 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 2) 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.

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 physician 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 physician
- Services must be furnished and billed by a hospital, rehabilitation facility, physician, 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 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.

Please Note: Inpatient care and outpatient care for autism spectrum disorders related treatment for members who are under 21 years of age are not subject to the above noted benefit maximums.

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 for inpatient rehabilitative care.

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 the rehabilitation services necessary

Skilled Nursing Facility Services

This benefit is subject to the calendar year deductible and coinsurance, if any, and 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 physician must actively supervise your care while you're confined in the skilled nursing facility.

Benefits are provided up to 60 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 chemical dependency

Spinal and Other Manipulations

This benefit is subject to the $25 professional visit copay for each visit in an office setting.

Benefits for spinal and other manipulations are provided up to a combined maximum benefit of 12 visits per member each calendar year. Services must be medically necessary to treat a covered illness, injury or condition.

If covered outpatient rehabilitation therapy services are received, they are only eligible for coverage under the Rehabilitation Therapy benefit.

Surgical Services

This benefit is subject to the calendar year deductible and coinsurance, if any, except where stated otherwise.

This benefit covers surgical services including anesthesia, postoperative care, cornea transplantation, skin grafts and the transfusion of blood or blood derivatives. Colonoscopy and other scope insertion procedures are also covered under this benefit unless they meet the guidelines for 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, and won't exceed 20% of the primary surgeon's allowable charge.

When multiple or bilateral procedures are performed during the same operative session, we'll 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.

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.

This benefit is subject to the $25 professional visit copay for each visit in an office setting when services are performed by a preferred or participating provider. Other covered services performed by a preferred or participating provider, as well as donor costs are subject to the calendar

year deductible and coinsurance, if any. However, transportation and lodging expenses are subject to the calendar year deductible, but not your coinsurance, if any.

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 in this booklet for the definition of "experimental/ investigational services".) We reserve 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 our criteria for coverage. We review the medical indications for the transplant, documented effectiveness of the procedure to treat the condition and failure of medical alternatives.

  The types of solid organ transplants and bone marrow/stem cell reinfusion procedures that currently meet our 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 our written standards, which are found by referring to our Web site at **www.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 we have 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, we'll provide benefits for your transplant furnished by another transplant center.

If the condition which requires a transplant or reinfusion procedure is a "pre-existing condition," the 12-month waiting period for pre-existing conditions must first be satisfied. Refer to the Waiting Period For Pre-Existing Conditions provision in the "What Do I Need To Know Before I Get Care?" section earlier in this booklet for details.

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 to 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.
- When the recipient is a dependent minor child, benefits for transportation, lodging and meal

expenses for the recipient and 2 companions will be provided up to a maximum of $125 per day.

- When the recipient isn't a dependent minor child, benefits for transportation, lodging and meal expenses for the recipient and 1 companion will be provided up to a maximum of $80 per day.
- Covered transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) are limited to $7,500 per transplant.

In addition to "What's Not Covered?" this Transplants 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 in this booklet)
- 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 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. However, when a brand name drug is prescribed and that drug has equally safe and effective generic alternatives, only the generic alternative will be covered. Generic alternatives are FDA-approved as safe and effective as brand name drugs but are more cost effective.

Additionally, coverage will not be provided for prescribed drugs that have ample availability/variety of over the counter comparables. These contain drugs included in, but not limited to, therapeutic classes for heartburn, allergy and cough/cold remedies. 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.

For generic, preferred and non-preferred brand name drugs or supplies, 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 participating mail-order pharmacy for each prescription drug purchase.

For specialty drugs or supplies, each member must pay coinsurance for each separate new prescription or refill. "Coinsurance" is defined as the percentage of the allowable charge that you're required to pay to the retail pharmacy or the participating mail-order pharmacy for each prescription drug purchase.

Individual Prescription Specialty Drug Out-Of-Pocket Maximum

Each calendar year, the amount each member could pay toward the prescription drug calendar year deductible and/or coinsurance for specialty drugs is limited to a specific total. This total is called the "individual prescription specialty drug out-of-pocket maximum."

The individual prescription specialty drug out-of-pocket maximum is separate from this plan's calendar year out-of-pocket maximum described earlier in this booklet. Amounts credited toward the individual prescription drug out-of-pocket maximum don't accrue toward this plan's calendar year out-of-pocket maximum. Also, amounts credited toward this plan's out-of-pocket maximum don't accrue toward the individual prescription drug out-of-pocket maximum.

When the total equals $5,000, we will pay covered services at 100% of allowable charges for the remainder of that calendar year.

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

- Amounts above the allowable charge
- Amounts that exceed the benefit maximums under this plan

- Services and supplies not covered under this plan

There is no family prescription specialty drug out-of-pocket maximum.

Retail Pharmacy Prescriptions

Generic Drugs................................$10 copay

Preferred List Brand.......................$30 copay
Name Drugs

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

Specialty Drugs......................................30%

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, we'll 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 as subject to the allowable charge (see "Definitions"). Amounts in excess of the allowable charge don't 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.............................. $25 copay

Preferred List Brand..................... $75 copay
Name Drugs

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

Specialty Drugs......................................30%

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. For prescriptions that include a copay, when the drug maker's packaging exceeds the 90-day supply, you'll pay only 1 mail-order pharmacy 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 physician to prescribe needed medications for up to a 90-day supply, plus refills. If you're presently taking medication, ask your physician 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, we'll pay the participating mail-order pharmacy directly. This benefit is limited to prescriptions filled by 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 Pharmacy Benefit Administrator's Customer Service department or visit their Web site at:

1-800-391-9701

www.medco.com

Injectable Supplies

When insulin needles and syringes are purchased along with insulin, only the prescription drug deductible, if any, and the copay or coinsurance for the insulin will apply.

When insulin needles and syringes are purchased separately, the prescription drug deductible, if any, and the preferred list brand name drug copay or coinsurance will apply for each item purchased.

The prescription drug deductible, if any, and the applicable copay or coinsurance will apply to purchases for alcohol swabs, test strips, testing agents and lancets.

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)
- Prescription contraceptive drugs and devices (e.g. oral drugs, diaphragms, patches and cervical caps). See the Contraceptive Management and Sterilization benefit for additional detail.
- Compounded medications of which at least one ingredient is a covered prescription drug
- Inhalation spacer devices and peak flow meters
- Prescription drugs for the treatment of autism
- Glucagon and allergy emergency kits
- 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.
- Drugs for the treatment of nicotine dependency, including over the counter (OTC) nicotine patches, gum or lozenges purchased through a retail participating 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.

For benefit information concerning 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.

Benefits for immunization agents and vaccines, including the professional services to administer them, are provided under the Preventive Care benefit.

Additional Information About Your Prescription Drug Benefit

Generic Drugs This plan requires the use of appropriate "generic drugs". When available 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 or coinsurance will apply.

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.

Pharmacy Drug List

This benefit uses a list of drugs, sometimes called a

“formulary.” This drug list includes medications to treat most medical conditions, including most FDA-approved generic drugs, and many brand name drugs. In addition, certain categories of drugs are excluded. These are listed below under “What’s Not Covered?”

Our Pharmacy and Therapeutics Committee reviews the drug list frequently throughout the year. This committee includes medical practitioners and pharmacists. They review current medical studies and pharmaceutical information to decide which name brand drugs will be approved.

Changes to our drug list do not change your benefits, unless a generic equivalent to a brand name drug becomes allowed by law. If you’re taking a drug which is changed from brand name to generic, we will notify you prior to the change. Drugs and medicines that may be lawfully obtained over the counter (OTC) without a prescription are not covered, unless otherwise stated in this benefit. The pharmacy’s status as participating or non-participating on the date the drug is dispensed is also a factor.

Contact Customer Service to inquire about whether a drug is on our list or to receive a copy of the drug list for your plan. You may also visit our Web site at **www.premera.com**.

Clinical Pharmacy Management

In certain circumstances benefits may be limited to a specific dispensed days’ supply, drug, or drug dosage appropriate for a usual course of treatment. Benefits may also be limited to specific diagnoses or pharmacies 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.

These limitations are based on medical necessity criteria, the recommendations of the manufacturer, the circumstances of the individual case, U.S. Food and Drug Administration Guidelines, published medical literature and standard reference compendia.

Specialty Pharmacy Program

Benefits for specialty drugs are only available when purchased through one of our Specialty Pharmacies. Benefits for specialty drugs dispensed through the Specialty Pharmacy program via mail-order are limited to a 30-day supply.

"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. We have contracted with specific specialty pharmacies that specialize in the delivery and clinical management of specialty drugs. These pharmacies will work with you and your health care provider to arrange ordering and delivery of these drugs.

Contact Customer Service for details on which drugs are included in the Specialty Pharmacy Program and how to locate a Specialty Pharmacy, or visit our Web site at **www.premera.com**.

Prescription Drug Volume Discount Program

Your prescription drug benefit program includes per claim rebates that are received by Premera Blue Cross Blue Shield of Alaska from its pharmacy benefit manager. These rebates are taken into account in setting subscription charges or are credited to administrative charges otherwise payable to us by your group plan and are not reflected in your cost-share. The allowable charge that your payment is based upon for prescription drugs is higher than the price we pay our pharmacy benefit manager for those prescription drugs. Premera Blue Cross Blue Shield of Alaska either retains the difference and applies it to the cost of Premera operations and the prescription drug benefit program or credits the difference to subscription rates for the subsequent benefit year. If your prescription 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. 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 1 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
- Brand name prescription drugs when generic alternatives are available
- Prescription drugs that have ample availability/variety of over-the-counter (OTC) comparables

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

BLUECARD® PROGRAM AND OTHER INTER-PLAN ARRANGEMENTS

Premera Blue Cross Blue Shield of Alaska has relationships with other Blue Cross and/or Blue Shield Licensees generally called "Inter-Plan Arrangements." They include "the BlueCard Program" and arrangements for payments to non-network providers. Whenever you obtain healthcare services outside Alaska and Washington or in Clark County, Washington, the claims are processed through one of these arrangements. You can take advantage of the BlueCard Program when you receive covered services from hospitals, doctors, and other providers that are in the network of the local Blue Cross and/or Blue Shield Licensee, called the "Host Blue" in this section. At times, you may also obtain care from non-network providers. Our payment calculation practices in both instances are described below.

It's important to note that receiving services through these Inter-Plan Arrangements does not change covered benefits, benefit levels, or any stated residence requirements of this plan.

Network Providers

When you receive care from a Host Blue's network provider, you will receive many of the conveniences you're used to from Premera Blue Cross Blue Shield of Alaska. In most cases, there are no claim forms to submit because network providers will do that for you. In addition, your out-of-pocket costs may be less, as explained below.

Under the BlueCard Program, we remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its network providers.

Whenever a claim is processed through the BlueCard Program, the amount you pay for covered services is calculated based on the lower of:

- The provider's billed charges for your covered services; or
- The allowable charge that the Host Blue makes available to us.

Often, this allowable charge will be a simple discount that reflects an actual price that the Host Blue considers payable to your provider. Sometimes, it is an estimated price that takes into account special arrangements with your provider that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of providers after taking into account the same types of transactions as an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the allowable charge we use for your claim because they will not be applied retroactively to claims already paid.

Clark County Providers

Some providers in Clark County, Washington 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.

Non-Network Providers

When covered services are provided outside Alaska and Washington or in Clark County, Washington by non-network providers, the allowable charge will generally be based on the Host Blue's allowable charge for non-network providers unless a different allowable charge is required by applicable state law. You are responsible for the difference between the amount that the non-network provider bills and this plan's payment for the covered services.

Exceptions Required By Law

Federal law or the laws in a small number of states may require the Host Blue to include a surcharge as part of the liability for your covered services. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then use the surcharge and/or other amount that the Host Blue instructs us to use in accordance with those laws as a basis for determining the plan's benefits and any amounts for which you are responsible. However, because this plan is subject to the laws of Alaska, this plan will comply with Alaska pricing requirements to the extent applicable to the Host Blue's pricing and as allowed by federal law.

BlueCard Worldwide®

If you're outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands, you may be able to take advantage of BlueCard Worldwide when accessing covered health services. BlueCard Worldwide is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands in certain ways. For instance, although BlueCard Worldwide provides a network of contracting inpatient hospitals, it offers only referrals to doctors and other outpatient providers. Also, when you receive care from doctors and other outpatient providers outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you'll typically have to submit the claims yourself to obtain reimbursement for these services.

Further Questions?

If you have questions or need more information about the BlueCard Program, please call our Customer Service Department. To locate a provider in another Blue Cross and/or Blue Shield Licensee 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.

The benefits of this plan don't require preauthorization for coverage. 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 case management.

CASE MANAGEMENT

Case Management works cooperatively with you and your physician to consider effective alternatives to hospitalization and other high-cost care to make more efficient use of this plan's benefits. Your participation in a treatment plan through Case Management is voluntary. If an agreement is reached, you or your legal representative, your physician and other providers participating in the treatment plan will be required to sign written agreements which set forth the terms under which benefits will be provided.

Case Management is subject to the terms set forth in the signed written agreements. We may utilize your contract benefits as specified in the signed agreements, but the agreements aren't to be construed as a waiver of our right to administer the Group Contract in strict accordance with its terms in other situations. All parties have the right to re-evaluate or terminate the Case Management agreement at any time, at their sole discretion. Case Management termination must be provided in writing to all parties. Your remaining benefits under this plan would be available to you at that time.

DISEASE MANAGEMENT

Premera Blue Cross Blue Shield of Alaska's Disease Management programs are designed to improve health outcomes for members with certain chronic diseases. These programs seek to identify individuals who may benefit from such programs, and achieve the best possible therapeutic outcomes based on an assessment of the patient needs, ongoing monitoring of care, and consultation with your primary care provider. Participation in disease management programs is voluntary. To learn more about the availability of Disease Management, contact our Customer Service team at the numbers listed inside the front cover of this booklet.

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

- EEG biofeedback, neurofeedback, or biofeedback services for psychiatric conditions

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.

Chemical Dependency

Services and supplies related to the diagnosis or treatment of chemical dependency. Also not covered are:

- Treatment of non-dependent alcohol or drug use or abuse
- Voluntary support groups, such as Alanon or Alcoholics Anonymous

Clinical Trials

- Clinical trials that are not related to cancer
- Clinical trials that are not an approved clinical trial as described under Cancer 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 as described under 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

Cosmetic Services

Services and supplies (including drugs) rendered for cosmetic purposes and plastic surgery, whether cosmetic or reconstructive in nature, regardless of whether rendered to restore, improve, correct or alter the appearance, shape of a body structure, including any direct or indirect complications and aftereffects thereof.

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 Health Management and Nutritional Therapy benefits. This includes vocational assistance and outreach; social, sexual and fitness counseling; family and marital counseling; and family and marital psychotherapy.
- Community wellness classes and programs that promote positive health and lifestyle choices. 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
- Habilitative, education, or training services or supplies for dyslexia, for attention deficit disorders, and for disorders or delays in the development of a child's language, cognitive, motor or social skills, including evaluations thereof. However, this exclusion doesn't apply to treatment of neurodevelopmental disabilities in children under the age of 7 as stated under the Neurodevelopmental Therapy benefit or for members under the age of 21 who are diagnosed with autism spectrum disorder.
- 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.

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 physician.

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 aftereffects thereof. The determination is based on the criteria stated in the definition of "experimental/investigational services" (please see the "Definitions" section in this booklet).

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 **www.premera.com**.

Note: This exclusion does not apply to certain experimental or investigational services provided as part of an approved cancer clinical trial and as specified in the Cancer Clinical Trials benefit.

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 or grandparent or spouse of grandchild.
- Services or supplies provided by volunteers, except as specified in the Home and Hospice Care benefit

Gender Transformations

Treatment or surgery to change gender, including any direct or indirect complications and after effects thereof.

Governmental Medical Facilities

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

- We approve your request for a benefit level exception for non-emergent care to the facility (please see the "Benefit Level Exceptions For Non-Emergent Care" provision in this booklet)
- You're receiving care for a "medical emergency" (please see the "Definitions" section in this booklet)
- We must provide available benefits for covered services as required by law or regulation

Hair Loss

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

Hearing Exams and Testing

Routine hearing exams and testing, except newborn screening hearing exams.

Hearing Hardware

Hearing aids and devices used to improve hearing sharpness.

Human Growth Hormone Benefit Limitations

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

Infertility, Assisted Reproduction And Sterilization Reversal

- Testing, diagnosis and 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

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
- 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.

Mental Health Services

Therapeutic services related to the diagnosis or treatment of psychiatric conditions regardless of the origin of the condition. See the Autism Spectrum Disorders Services benefit for details regarding psychiatric and psychological care related to autism for members who are under 21 years of age.

Military And War-Related Conditions, Including Illegal Acts

This includes:

- 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
- A member's commission of an act of riot or insurrection
- A member's commission of a felony or act of terrorism

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

Not Covered Under This Plan

- Services or supplies 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 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 Benefit 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 after effects 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 meet 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

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

Orthognathic Surgery (Jaw Augmentation)

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.

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 therefore, 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. However, foot-support supplies, devices and shoes are covered 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

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 chemical dependency

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 in this booklet)

Vision Exams

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

Vision Hardware

- Vision hardware (and fittings) used to improve visual sharpness, including eyeglasses and contact lenses and all related supplies
- Non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments), sunglasses or light-sensitive lenses, even if prescribed

Vision Therapy

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

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 a proper and timely claim for such benefits has been made under:

- Occupational coverage required of, or voluntarily obtained by, the employer
- State or federal workers' compensation acts
- Any legislative act providing compensation for work-related illness or injury

However, this exclusion doesn't apply to owners, partners or executive officers who are full-time employees of the Group if they're exempt from the above laws and if the Group doesn't furnish them with workers' compensation coverage. They'll be covered under this plan for conditions arising solely from their occupations with the Group. Coverage is subject to the other terms and limitations of this plan.

WHAT IF I HAVE OTHER COVERAGE?

COORDINATING BENEFITS WITH OTHER HEALTH CARE PLANS

You 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, 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 . 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.

- **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. Coordination of benefits applies only on a per-claim basis, and is not cumulative.

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

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

First: A plan that 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 determine the order of benefits, the plan that's covered the employee or subscriber for the longest time will be primary.

Right Of Recovery/Facility Of Payment

We have the right to recover any payments we make that are greater than those required by the coordination of benefits provisions from 1 or more of the following: the persons we paid or for whom we

have 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, we may also pay directly to another plan any amount that should have been paid by us. Our payment will be considered a benefit under this plan and will meet our 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 tort feasor 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. 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.

Agreement To Arbitrate Any disputes that arise as part of this provision may be resolved by arbitration. Both you and we will be bound by the decision of the arbitration proceedings.

Disputes will be resolved by a single arbitrator. Either party may demand arbitration by serving notice of the demand on the other party. Each party will bear its own costs and share equally in the fees of the arbitrator. Arbitration proceedings pursuant to this provision shall take place in a mutually agreed upon location.

This agreement to arbitrate will begin on the effective date of the contract, and will continue until any dispute regarding this plan's subrogation or reimbursement is resolved.

UNINSURED AND UNDERINSURED MOTORIST/PERSONAL INJURY PROTECTION COVERAGE

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

WHO IS ELIGIBLE FOR COVERAGE?

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

EMPLOYEE ELIGIBILITY

Under this small employer health benefit plan, an “eligible employee” is an employee who works on a full-time basis, with a normal work week of the minimum hours stated on the Group’s application, and includes a sole proprietor, a partner of a partnership or an independent contractor, provided the sole proprietor, partner, or contractor is included as an employee under a health benefit plan of a small employer, but doesn’t include an employee who works on a part-time, temporary, or substitute basis. The employee must also satisfy any probationary period, if one is required by the Group.

Employees Performing Employment Services in Hawaii

For employers other than political subdivisions, such as state and local governments, and public schools and universities, the State of Hawaii requires that benefits for employees living and working in Hawaii (regardless of where the Group is located) be administered according to Hawaii law. If the Group is not a governmental employer as described in this paragraph, employees who reside and perform any employment services for the Group in Hawaii are not eligible for coverage. When an employee moves to Hawaii and begins performing employment services for the Group there, 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 only enroll 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 for whom the subscriber or spouse has a legal guardianship. There must be a court order signed by a judge, 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.

Foster children aren’t eligible for coverage.

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 in the “Who is Eligible for Coverage?” section. When enrollment is timely, coverage for the employee and enrolled dependents will become effective on the first of the month that coincides with or next follows the **latest** of the applicable dates below:

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

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

When we don't receive the employee and/or dependent's completed enrollment application within 60 days of the date prior coverage ended, refer to "Open Enrollment" below.

Subscriber And Dependent Special Enrollment

An eligible employee and otherwise eligible dependents who previously elected not to enroll in any of the employer's group health plans when such coverage was previously offered, may enroll in this plan at the same time a newly acquired dependent is enrolled under "Enrollment" in the case of marriage, birth, adoption, or placement for adoption. The eligible employee may also choose to enroll alone, 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 with us offered by the Group. Transfers also occur if the Group replaces another plan (with us) 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 with us, and there is no lapse in your coverage, the following provisions that apply to this plan will be reduced to the extent they were satisfied and/or credited under the prior plan:

- Waiting period for pre-existing conditions
- Out-of-pocket maximum, if any
- Benefit maximums
- Annual plan maximum
- Calendar year deductible. Please note: 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.

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 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. 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 haven't 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 the 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 providing:
  - 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 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 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 don'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 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. However, extended COBRA coverage is available only when the event would have caused a similar dependent who was not on COBRA coverage to lose coverage under this plan. For example, if a subscriber not on COBRA coverage would be able to remain covered after enrolling in Medicare, then a subscriber's enrolling on Medicare while on COBRA coverage would not be a second qualifying event for dependents.

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 are 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, Medicare entitlement, or, if applicable, loss of retiree coverage because the Group filed for bankruptcy. 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, Medicare entitlement, or, if applicable, loss of retiree coverage because the Group filed for bankruptcy 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 are 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 are 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’s 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. You may also be eligible to apply for our Conversion plan as explained in "Converting To A Non-Group Plan" in the “When Will My Coverage End?” 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 ERISA, COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other 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 Web site at **www.dol.gov/ebsa**. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.

Extended Benefits

Under the following circumstances, certain benefits of this plan may be extended after your coverage ends for reasons other than as described under "Intentionally False Or Misleading Statements." 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.
- This plan's annual plan maximum has been provided.

OTHER CONTINUED COVERAGE OPTIONS

Converting To A Non-Group Plan

You may be entitled to coverage under one of our Conversion plans when your coverage under this plan ends. It's an individual plan that differs from this plan. You pay the monthly payment. You must apply and send the first subscription charge payment to us within 31 days of the date your coverage ends under this plan.

You can apply for a Conversion plan if you're not eligible for Medicare coverage and one of two things is true:

- You're not entitled to services or benefits for medical and hospital care under another group plan
- You're entitled to other coverage, but that coverage contains exclusions or waiting periods for any pre-existing conditions you have

For more information about our Conversion plans, contact your employer or our Customer Service Department.

We also offer other types of non-group medical plans, including Medicare supplement coverage (if you're eligible for and enrolled in Parts A and B of Medicare). For more information, contact your producer or our Customer Service Department.

Please Note: The rates, coverage and eligibility requirements of the above non-group plans differ from those of your current group plan.

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 (e.g. pre-existing condition 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 Web site 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 or ICD-9 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.

We won't provide benefits for claims we receive after the later of these 2 dates, nor will we 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 pharmacy 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.

If you need a supply of envelopes or prescription drug claim forms, contact our Customer Service department at the numbers shown on the front cover of this booklet.

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 web site. The itinerary must identify the name of the passenger(s), the dates of travel and total cost of travel, and the origination and final destination points.

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 physician 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.

At any time, you have the right to appoint someone to pursue the claim on your behalf. This can be a doctor, lawyer, or a friend or relative. You must notify us in writing and give us the name, address, and telephone number where your appointee can be reached.

If a claim for benefits or an appeal is denied or ignored, in whole or in part, or not processed within the time shown in these claims procedures, you may have the right to file suit in a state or federal court.

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 of 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 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 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 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 Appeals form. You can also obtain a copy of this form on our website at **www.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 may extend this timeline to allow you to obtain additional medical documentation, physician 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:

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 **www.premera.com**.

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 physician, 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 or 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 physician 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 and us 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 our decision, 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 pre-empted 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"
- This benefit booklet
- The Group's signed application
- All attachments, endorsements and options 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 we provide benefits under this plan. You or your health care providers may submit this proof. No benefits will be available if the proof isn't provided or acceptable to us.

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.) We cannot void your coverage 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.

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, case management 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 3 years of the date we denied, in writing, the rights or benefits claimed under this plan, or of the completion date of the independent review process if applicable; and
- 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.

WHAT ARE MY RIGHTS UNDER ERISA?

The Group has an employee welfare benefit plan that is subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA). This employee welfare benefit plan is called the "ERISA Plan" in this section. The insured Premera Blue Cross Blue Shield of Alaska plan described in this booklet is part of the ERISA Plan.

When used in this section, the term "ERISA Plan" refers to the Group's employee welfare benefit plan. The "ERISA Plan administrator" is the Group or an administrator named by the Group. Premera Blue Cross Blue Shield of Alaska isn't the ERISA plan administrator.

As a participant in an employee welfare benefit plan, the subscriber has certain rights and protections. This statement explains those rights.

ERISA provides that all plan participants shall be entitled to:

- Examine without charge, at the ERISA Plan administrator's office and at other specified locations (such as work sites and union halls), all documents governing the ERISA Plan, including insurance contracts and collective bargaining agreements. (Please note that our contract with the Group by itself doesn't meet all the requirements for an ERISA plan document.) If the ERISA Plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to examine a copy of its latest annual report (Form 5500 Series) filed and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the ERISA Plan administrator, copies of documents governing the operation of the ERISA Plan, including insurance contracts and collective bargaining agreements and updated summary plan descriptions. (Please note that this booklet by itself doesn't meet all the requirements for a summary plan description.) If the ERISA Plan is required to file an annual report with the U.S. Department of Labor, plan participants shall be entitled to obtain copies of the latest annual report (Form 5500 Series). The administrator may make a reasonable charge for the copies.
- Receive a summary of the ERISA Plan's annual financial report, if ERISA requires the ERISA Plan to file an annual report. The ERISA Plan administrator for such plans is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, (if this plan has such an exclusionary period) when you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, if you become entitled to elect continuation coverage, when your continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months

after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late members) after your enrollment date in your coverage.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your ERISA Plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries of Premera Blue Cross Blue Shield of Alaska is a fiduciary only with respect to claims processing and payment. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the ERISA Plan and don't receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the ERISA Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials weren't sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the ERISA Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that ERISA Plan fiduciaries misuse the ERISA Plan's money, or if you're discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you're successful the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Please Note: Under ERISA, the ERISA Plan administrator is responsible for furnishing each participant and beneficiary with a copy of the summary plan description.

If you have any questions about your employee welfare benefit plan, you should contact the ERISA Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the ERISA Plan administrator, you should contact either:

- The office of the Employee Benefits Security Administration, U.S. Department of Labor, 300 Fifth Ave., Suite 1280, Seattle, WA 98104-2397; or
- The Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave. N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272.

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.

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 physicians
- 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 DSM of Mental Disorders-IV-TR, as amended or reissued from time

to time.

Autism Services 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.

Cancer Clinical Trials

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

- An institutional review board that complies with 45 CFR Part 46; and
- One or more of the following:
  - The United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers
  - The United States Department of Health and Human Services, United States Food and Drug Administration (FDA)
  - The United States Department of Defense
  - The United States Department of Veterans' Affairs
  - A nongovernmental research entity abiding by current National Institutes of Health guidelines

Chemical Dependency

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

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 or out-of-pocket maximums.

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.

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 hadn't 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 is 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

entered the eligible class of employees. (For example, the enrollment date for a seasonal employee who was made permanent after 6 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 set in the definition of "Cancer Clinical Trials" above in this section 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 small employer, including a person, firm, corporation, partnership, or political subdivision, that is actively engaged in business and is a party to the Group Contract. The "Group" is responsible for collecting and paying all subscription charges, receiving notice of additions and changes to employee and dependent eligibility and providing such notice to us, and acting on behalf of its employees.

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 physicians
- 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 chemical dependency or tuberculosis

Illness

A sickness, disease, medical condition, complications of pregnancy or pregnancy.

Inpatient

Confined in a medical facility as an overnight bed patient.

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, or hospice.

Medically Necessary

Those covered services and supplies that a physician, 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, physician, 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, physician specialty society recommendations and the views of physicians 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 voluntary termination of pregnancy, or any condition arising from pregnancy, except for complications of pregnancy. This includes the time during pregnancy and within 45 days following delivery.

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

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 drugs, 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 **Diagnostic and Statistical Manual (DSM) IV** published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse, 291.0 through 292.9 and 303.0 through 305.9.

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 physician 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 physician and nursing supervised by a registered nurse, and that's approved by Medicare or would qualify for Medicare approval if so requested.

Small 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 2 but not more than 50 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 plan year.

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.

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:

Medco Health Solutions, Inc.
P.O. Box 14711
Lexington, KY 40512

www.premera.com

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