Alyeska Pipeline Service Company

Consumer Choice Medical Plan On The Yukon Network

Active Employees

9000000

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

An Independent Licensee of the Blue Cross Blue Shield Association

HOW TO CONTACT THE CLAIMS ADMINISTRATOR

Please call or write Premera Blue Cross Blue Shield of Alaska's 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

Website:

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

Phone Numbers

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

Local and toll-free TTY number
for the deaf and hard-of-hearing:
800-842-5357 (TTY 711)

Alaska Travel Line: 800-364-2994

WHERE TO SEND CLAIMS

Mail Claims To:

Premera Blue Cross Blue Shield of Alaska
PO Box 91059
Seattle, WA 98111-9159

SALES OFFICE

Physical Address

Premera Blue Cross Blue Shield of Alaska
3800 Centerpoint Dr., Suite 940
Anchorage, AK 99503-5825

PRESCRIPTION DRUG CLAIMS

Mail Your Prescription Drug Claims To

Express Scripts
PO Box 14711
Lexington, KY 40512-4711

Contact the Pharmacy Benefit Administrator At

800-391-9701

www.express-scripts.com

COMPLAINTS AND APPEALS

Premera Blue Cross
Attn: Appeals Coordinator
PO Box 91102
Seattle, WA 98111-9202

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

Fax 800-843-1114

CARE MANAGEMENT

Prior Authorization

Premera Blue Cross
Attn: Appeals Coordinator
PO Box 91059
Seattle, WA 98111-9159

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

Fax 800-843-1114

BLUECARD

800-810-BLUE(2583)

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

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

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

Please go to **www.premera.com/ak/sbc** for your Notice of Protection provided by the Alaska Life and Health Insurance Guaranty Association.

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:	Alyeska Pipeline Service Company
Effective Date:	March 1, 2026
Group Number:	9000000
Plan:	Consumer Choice Medical Plan (Active Employees)
Certificate Form Number:	APNGF2T26A

INTRODUCTION

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

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

This booklet is for members of the Alyeska Pipeline Service Company medical plan. This plan is self-funded by Alyeska Pipeline Service Company, which means that Alyeska Pipeline Service Company is financially responsible for the payment of plan benefits. Alyeska Pipeline Service Company ("the Group") has the final discretionary authority to determine eligibility for benefits and construe the terms of the plan.

Alyeska Pipeline Service Company has contracted with Premera Blue Cross Blue Shield of Alaska, an independent licensee of the Blue Cross Blue Shield Association, to perform administrative duties under the plan, including the processing of claims. Alyeska Pipeline Service Company has delegated to Premera Blue Cross Blue Shield of Alaska the discretionary authority to determine eligibility for benefits and to construe the terms used in this plan to the extent needed to perform our duties. Premera Blue Cross Blue Shield of Alaska does not insure the benefits of this plan. In this booklet, Premera Blue Cross Blue Shield of Alaska is called the "Claims Administrator." The terms "we," "us," and "our" also refer to Premera Blue Cross Blue Shield of Alaska. This booklet replaces any other benefit booklet you may have.

HOW TO USE THIS BOOKLET

This booklet will help you get the most out of your benefits. Every section contains important information, but the ones below may be particularly useful:

- **HOW TO CONTACT THE CLAIMS ADMINISTRATOR** – our website address, phone numbers, mailing addresses and other contact information are conveniently located inside the front cover
- **SUMMARY OF YOUR COSTS** – A quick overview of what the plan covers and your costs
- **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
- **COVERED SERVICES** – what's covered under this plan
- **CARE MANAGEMENT** – describes prior authorization and clinical review provisions
- **EXCLUSIONS AND LIMITATIONS** – 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
- **COMPLAINTS AND APPEALS** – processes to follow to 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.

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SUMMARY OF YOUR COSTS

This is a summary of your costs for covered services. Your costs are subject to all the following:

- The **allowed amount**. This is the most this plan allows for a covered service. For providers that do not have agreements with us, you are responsible for any amounts over the allowed amount, except for emergency services, covered air ambulance services, or as prohibited by law.
- The **coinsurance**. This is a defined percentage of allowed amounts for covered services and supplies you receive. The benefit level provided by this plan and the remaining percentage you are responsible for, not including required copays, are both referred to as "coinsurance."

Coinsurance	**Providers in the Alaska Yukon Network (including Accepted Rural Providers)**	**Providers Not In The Alaska Yukon Network**
	20%	50%

- The **copay**. This is a fixed up-front dollar amount that you're required to pay for each occurrence of certain covered services. Your provider of care may ask you to pay the copay at the time of service. Unless stated otherwise, benefits subject to a copay aren't subject to your deductible or coinsurance if any.
- The **deductible**. This is the amount you must pay in each plan year for covered services and supplies before this plan provides certain benefits. The amount credited toward the plan year deductible doesn't include any copays required by this plan and won't exceed the "allowed amount" for any covered service or supply.

	In-Network Providers	**Out-of-Network Providers**
Individual medical deductible	$2,500	Shared with In-Network Deductible

Family medical deductible	$7,500	Shared with In-Network Deductible

- The **out-of-pocket maximum**. This is the amount you could pay toward the plan year deductible and coinsurance, if any, for services listed under the ***Medical Benefits*** section.

	In-Network Providers	**Out-of-Network Providers**
Individual out-of-pocket maximum	$6,500	Not applicable

Family out-of-pocket maximum	$15,200	Not applicable

- **Prior authorization.** Some services must be prior authorized before you get them to be eligible for benefits. See ***Prior Authorization*** for details.
- **Conditions, time limits and maximum limits.** This plan has certain conditions, time limits and maximum limits that are described in this booklet. Some services have special rules. See ***Covered Services*** for details.
- **Health Reimbursement Account (HRA).** Please see page 94 for details.

The benefits listed in the ***Summary of Your Costs*** table below are for outpatient professional services, unless otherwise indicated. You may have additional out-of-pocket expenses for inpatient facility services, if incurred. See ***Hospital Inpatient Care*** and ***Hospital Outpatient Care*** for details.

	Providers in the Alaska Yukon Network (including Accepted Rural Providers)	Providers Not In The Alaska Yukon Network
MEDICAL SERVICES		
Acupuncture Benefits are provided for up to 12 visits per member per plan year.	Deductible, then 20% coinsurance	**MD, DO and DPM:** Deductible, then 50% coinsurance **Other professional:** Same as in network
Allergy Testing and Injections – Outpatient Professional	Deductible, then 20% coinsurance	**MD, DO and DPM and Hospital:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
Ambulance • Emergency surface transport • Emergency air transport • Non-emergent surface transport • Non-emergent air transport	In-network deductible, then 20% coinsurance	
Ambulatory Surgical Center	20% coinsurance, deductible waived	**MD, DO and DPM and Hospital:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
Blood Products and Services Benefits are provided for the cost of blood and blood derivatives.	Deductible, then 20% coinsurance	**MD, DO and DPM and Hospital:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
Cellular Immunotherapy and Gene Therapy	Covered as any other service depending where the service is performed	
Chemotherapy and Radiation Therapy See the ***Ambulatory Surgical Center***, ***Hospital Inpatient Care***, and ***Hospital Outpatient Care*** for facility charges.	Deductible, then 20% coinsurance	**MD, DO and DPM and Hospital:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
Clinical Trials Medically necessary care of a qualified clinical trial. Transportation for **Cancer Clinical Trials** only	Covered as any other service depending where the service is performed. You may have additional costs for other services such as x-rays, lab, and hospital facility charges. See those covered services for details. In-network deductible, then 20% coinsurance	
Contraception Management and Sterilization	Covered in full	**MD, DO and DPM and Hospital:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
• Prescription contraceptives dispensed in a pharmacy	Prescription contraceptives including emergency contraception and prescription barrier devices or supplies that are dispensed by a licensed pharmacy are covered under the ***Prescription Drugs*** benefit.	

Dental Injury and Facility Anesthesia **Dental Anesthesia** Hospital or ambulatory surgical center care for dental procedures are provided for general anesthesia and related facility services that are medically necessary.	Deductible, then 20% coinsurance	**Hospital:** Deductible, then 50% coinsurance **Other facility:** Same as in network
Dental Injury When services are related to an accidental injury, benefits are provided when such repair is performed within 12 months of the accidental injury.	Covered as any other service depending where the service is performed. You may have additional costs for other services such as x-rays, lab, and hospital facility charges. See those covered services for details.	
Diagnostic Lab, X-ray and Imaging • Basic diagnostic lab, x-ray and imaging	Deductible, then 20% coinsurance	**MD, DO and DPM, Hospital and Hospital-based substance abuse programs:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
• Major diagnostic lab, x-ray and imaging	Deductible, then 20% coinsurance	**MD, DO and DPM, Hospital and Hospital-based substance abuse programs:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
• Diagnostic and supplemental breast exams **Note:** For preventive diagnostic services see the **Preventive Care** benefit**.**	Deductible, then 20% coinsurance	**MD, DO and DPM, Hospital and Hospital-based substance abuse programs:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
Dialysis Benefits for end stage renal disease (ESRD). • During Medicare's waiting period	Deductible, then 20% coinsurance	**MD, DO and DPM and Hospital:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
• After Medicare's waiting period	No cost share	
Emergency Room	In-network deductible, then 20% coinsurance	
Foot Care Routine medically necessary foot care.	Covered as any other service depending where the service is performed	

Habilitation Therapy		
• Professional outpatient therapy	Deductible, then 20% coinsurance	**MD, DO and DPM:** Deductible, then 50% coinsurance **Other professional:** Same as in network
• Outpatient facility services Benefits for outpatient care will be provided for physical, speech, and occupational therapy services, up to a combined maximum benefit of 60 visits per member each plan year.	Deductible, then 20% coinsurance	**Hospital:** Deductible, then 50% coinsurance **Other facility:** Same as in network
• Inpatient professional services	Deductible, then 20% coinsurance	**MD, DO and DPM and Hospital:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
• Inpatient facility services Benefits for inpatient facility and professional care are provided up to 45 days per member each plan year.	Deductible, then 20% coinsurance	**Hospital:** Deductible, then 50% coinsurance **Other facility:** Same as in network
Health Management • Health Education • Nicotine Dependency Programs	No cost share, however you must pay for the cost of the class or program and send us proof of payment along with a reimbursement form.	
Health Reimbursement Account	See page 94 for details.	
Hearing		
• Hearing exam Benefits are provided for one hearing examination (or screening) per member each plan year.	No cost share	**MD, DO and DPM and Hospital:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
• Hearing hardware Limit 1 device per ear every 3 years.	No cost share	
Home Health Care **Professional Home Health** Intermittent home health visits limited to 120 visits per member each plan year.	Deductible, then 20% coinsurance	**MD, DO and DPM, Hospital and Hospital-based substance abuse programs:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network

Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies • Home medical equipment (HME), prosthetics, supplies • **Foot orthotics** Benefits are provided for foot orthotics (shoe inserts) and therapeutic shoes (orthopedic), including fitting expenses, up to a maximum of $300 per member each plan year. Items prescribed for the treatment of diabetes are not subject to this benefit limit. • **Wigs or Hairpieces** Benefits are provided for wigs or hairpieces due to medically induced hair loss. Examples of medically induced hair loss include, but are not limited to, hair loss resulting from injury, disease or treatment of disease, medication, radiation therapy or chemotherapy. (Not subject to a benefit limit)	Deductible, then 20% coinsurance	**MD, DO and DPM, Hospital care and Hospital-based substance abuse programs:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
Hospice Care Benefits for a terminally ill member shall not exceed 6 months of covered hospice care. • Inpatient hospice care up to a maximum of 10 days	Deductible, then 20% coinsurance	**Hospital care and hospital-based substance abuse programs:** Deductible, then 50% coinsurance **Other facility:** Same as in network
• Professional in-home intermittent hospice visits (not subject to Home Health Care visit limit)	Deductible, then 20% coinsurance	**MD, DO and DPM and Hospital:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
• Respite care up to a maximum of 240 hours	Deductible, then 20% coinsurance	**MD, DO and DPM and Hospital:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
Hospital Inpatient Care • Inpatient facility	Deductible, then 20% coinsurance	**Hospital care and hospital-based substance abuse programs:** Deductible, then 50% coinsurance **Other facility:** Same as in network
• All other hospital services and supplies For inpatient hospital maternity care and newborn care, see the ***Maternity Care*** and ***Newborn Care*** benefits.	Deductible, then 20% coinsurance	**MD, DO and DPM, Hospital and Hospital-based substance abuse programs:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network

Hospital Outpatient Care	Deductible, then 20% coinsurance	**MD, DO and DPM, Hospital and Hospital-based substance abuse programs:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
Infusion Therapy – Outpatient Professional	Deductible, then 20% coinsurance	**MD, DO and DPM and Hospital:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
Massage Therapy When medically necessary and provided by a licensed massage therapist, is not subject to a benefit limit. Please note that benefits are subject to review by Evicore.	Deductible, then 20% coinsurance	**MD, DO and DPM and Hospital:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
Mastectomy and Breast Reconstruction Mastectomy necessary due to disease, illness or accidental injury and for breast reconstruction needed in connection with a mastectomy.	Covered as any other service depending where the service is performed	
Maternity Care 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.	Covered as any other service depending where the service is performed	
• Birthing center	20% coinsurance, deductible waived	**MD, DO and DPM and Hospital:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
Medical Foods	Deductible, then 20% coinsurance	**MD, DO and DPM and Hospital:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network

Medical Transportation Benefits **Elective Procedure Travel** Cellular Immunotherapy and Gene Therapy travel and lodging benefits are limited to $7,500 per episode of care. Benefits are provided for: • One round trip airfare by a licensed commercial carrier for the member and one companion per episode Reimbursement rates: • Ferry transportation limited up to $50 per person each way • Lodging expenses are limited up to $50 per day per person • Mileage expenses are reimbursed at 20 cents per mile per trip • Surface transportation and parking limited up to $35 per day **Note:** Reimbursement rates are based on IRS guidelines and are subject to change due to IRS regulations.	No cost share	
Mental Health Care		
• Professional outpatient therapeutic visits (including virtual care)	In-network deductible, then 20% coinsurance	**MD, DO and DPM:** Deductible, then 50% coinsurance **Other professional:** Same as in network
• Outpatient facility services	In-network deductible, then 20% coinsurance	**Hospital:** Deductible, then 50% coinsurance **Other facility:** Same as in network
• Inpatient professional	In-network deductible, then 20% coinsurance	**MD, DO and DPM and Hospital:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
• Inpatient facility	In-network deductible, then 20% coinsurance	**Hospital:** Deductible, then 50% coinsurance **Other facility:** Same as in network
Newborn Care Benefits for routine hospital nursery charges and related inpatient well-baby care for an eligible newborn are provided up to: • 48 hours after a normal vaginal birth; or • 96 hours after a normal cesarean birth. Any deductible or coinsurance required for the newborn is separate from that of the mother.	Covered as any other service depending where the service is performed	
Orthognathic Surgery (Jaw Augmentation or Reduction)	Covered as any other surgery depending where the service is performed	

Premera Designated Centers of Excellence Program • Knee and Hip Total Joint Replacement • Spinal Surgery • Gynecology Surgery Special criteria are required for coverage. See the ***Premera Designated Centers of Excellence Program*** benefit for details.	**Premera Designated Centers of Excellence:** Covered in full **For all other providers:** Covered as any other surgery depending on whether the services are provided by a preferred or out-of-network provider and where the services are performed.	
Preventive Care		
• Preventive exams, screenings and immunizations (including seasonal immunizations in a provider's office)	Covered in full	**MD, DO and DPM:** Deductible, then 50% coinsurance **Other professional:** Same as in network
• Preventive diagnostic services	Covered in full	No cost share
• Seasonal and travel immunizations provided by a pharmacy or other mass immunizer	No cost share	
Professional Visits and Services (including virtual care) You may have additional costs for other services like x-rays, lab, and facility charges if incurred.		
• Professional office visit. Covered services include professional office and home visits. *Coverage for office visits throughout this plan includes real-time visits using online and telephonic methods with your doctor or other provider (telemedicine) when appropriate.*	Deductible, then 20% coinsurance	**MD, DO and DPM:** Deductible, then 50% coinsurance **Other professional:** Same as in network
• Inpatient and other outpatient professional visits	Deductible, then 20% coinsurance	**MD, DO and DPM, Hospital care and Hospital-based substance abuse programs:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
Psychological and Neuropsychological Testing	Deductible, then 20% coinsurance	**MD, DO and DPM and Hospital:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network

Rehabilitation Therapy and Chronic Pain • Outpatient professional services (including virtual care) • Outpatient facility services Physical, speech, occupational and massage therapy services, including cardiac and pulmonary rehabilitation, up to a combined maximum benefit of 60 visits per member each plan year. • Inpatient professional services • Inpatient facility Benefits for inpatient facility and professional care are available up to 45 days per member each plan year. This benefit covers Inpatient 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. This limitation does not apply to chronic pain care. See ***Mental Health*** and ***Substance Abuse*** for therapies provided for mental health conditions such as autism.	Deductible, then 20% coinsurance Deductible, then 20% coinsurance Deductible, then 20% coinsurance Deductible, then 20% coinsurance	**MD, DO and DPM:** Deductible, then 50% coinsurance **Other professional:** Same as in network **Hospital:** Deductible, then 50% coinsurance **Other facility:** Same as in network **MD, DO and DPM and Hospital:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network **Hospital:** Deductible, then 50% coinsurance **Other facility:** Same as in network
Skilled Nursing Facility Care Benefits are provided up to 120 days per member each plan year.	Deductible, then 20% coinsurance	**Hospital:** Deductible, then 50% coinsurance **Other facility:** Same as in network
Spinal and Other Manipulations Benefits for spinal and other manipulations are provided up to a combined maximum benefit of 12 visits per member each plan year.	Deductible, then 20% coinsurance	**MD, DO and DPM:** Deductible, then 50% coinsurance **Other professional:** Same as in network

Substance Abuse Treatment • Outpatient professional services	In-network deductible, then 20% coinsurance	**MD, DO and DPM:** Deductible, then 50% coinsurance **Other professional:** Same as in network
• Outpatient facility services	In-network deductible, then 20% coinsurance	**MD, DO and DPM, Hospital and Hospital-based substance abuse programs:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
• Inpatient professional	In-network deductible, then 20% coinsurance	**MD, DO and DPM, Hospital and Hospital-based substance abuse programs:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
• Inpatient facility	In-network deductible, then 20% coinsurance	**Hospital and Hospital-based substance abuse programs:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
Surgery This benefit covers surgical services that are not covered under other benefits when performed on an inpatient or outpatient basis, in such locations as a hospital, ambulatory surgical facility, surgical suite or provider's office See the ***Ambulatory Surgical Center***, ***Hospital Inpatient Care***, and ***Hospital Outpatient Care*** for facility charges. For organ, bone marrow or stem cell transplant procedure benefit information, see the ***Transplants*** benefit.	Deductible, then 20% coinsurance	**MD, DO and DPM and Hospital:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network

Temporomandibular Joint Disorders (TMJ) Care • Outpatient professional services, including surgery	Deductible, then 20% coinsurance	**MD, DO and DPM and Hospital:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
• Outpatient facility services	Deductible, then 20% coinsurance	**MD, DO and DPM and Hospital:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
• Inpatient facility services	Deductible, then 20% coinsurance	**Hospital:** Deductible, then 50% coinsurance **Other facility:** Same as in network
Therapeutic Injections – Outpatient Professional	Deductible, then 20% coinsurance	**MD, DO and DPM and Hospital:** Deductible, then 50% coinsurance **Other professional and facility:** Same as in network
Transplants This benefit covers medical services only if provided by "Approved Transplant Centers." • Outpatient professional visits	Deductible, then 20% coinsurance	Not covered
• Outpatient facility services	Deductible, then 20% coinsurance	Not covered
• Inpatient professional	Deductible, then 20% coinsurance	Not covered
• Inpatient facility **Donor Costs:** Procurement expenses are limited to $20,000 per transplant. All covered donor costs accrue towards the $20,000 maximum, no matter when the donor receives them.	Deductible, then 20% coinsurance	Not covered

Travel and Lodging Covered transportation and lodging incurred by the transplant recipient and companions are limited to $7,500 per transplant. Reimbursement rates: • **Travel:** Travel is reimbursed between the patient's home and the approved transplant center for round trip (air, train, or bus) coach class transportation costs. • Mileage expenses are reimbursed at 20 cents per mile per trip • Surface transportation and parking are limited up to $35 per day • Ferry transportation expenses are limited up to $50 per person each way • **Lodging:** Expenses incurred by a transplant patient and companion for hotel lodging away from home. Lodging expenses are limited up to $50 per day per person **Note:** Reimbursement rates are based on IRS guidelines and are subject to change due to IRS regulations.	Covered as any other service	Not covered

Urgent Care You may have additional costs for other services like x-rays, lab, and hospital services if incurred. • Freestanding urgent care center	20% coinsurance	**MD, DO and DPM:** Deductible, then 50% coinsurance **Other professional:** Same as in network
• Urgent care (Hospital facility)	See ***Emergency Room*** for cost shares	
Virtual Care App-based care select providers Virtual general medical visits Virtual mental health visits App-based care select providers can be found at https://www.premera.com/visitor/virtual-care or contact Customer Service for assistance. See the ***Professional Visits and Services, Mental Health Care and Substance Abuse Treatment*** benefits for virtual care benefits.	Deductible, then 20% coinsurance Deductible, then 20% coinsurance	
Weight Management	Covered as any other service	

	In-Network Pharmacy	**Out-of-Network Pharmacy**
Prescription Drugs		
Prescription Drugs – Retail Pharmacy **Dispensing Limit** Benefits are provided for up to a 34-day supply of covered medication. • Generic Drugs • Preferred Brand Name Drugs • Non-Preferred Brand Name Drugs	$10 copay 30% coinsurance 50% coinsurance	
Prescription Drugs – Mail-Order Must use a participating pharmacy **Dispensing Limit:** Benefits are provided for up to a 90-day supply of covered medication.		
• Generic Drugs	$25 copay	Not covered
• Preferred Brand Name Drugs	$50 copay	Not covered
• Non-Preferred Brand Name Drugs	$80 copay	Not covered

Specialty Drugs **Dispensing Limit for Specialty Drugs:** Benefits for specialty drugs dispensed through a specialty pharmacy program via mail-order are limited to a 34-day supply and are subject to the retail pharmacy cost for each prescription drug purchase.	30% coinsurance up to $600 maximum per refill	Not covered
Prescription Drugs – Anti-Cancer Medication This benefit covers self-administered anti-cancer drugs when the medication is dispensed by a pharmacy. This benefit is covered under this plan's medical cost share.	In-network deductible waived, then 20% coinsurance	

	In-Network Provider	Out-of-Network Provider
Vision Care		
Adult Vision Benefits Vision services are provided for covered members 19 years of age or older. For vision benefits provided for members under age 19, see the ***Pediatric Vision*** Benefit. **Vision Exams** This benefit provides one routine vision exam per member each plan year. **Vision Hardware** The plan pays allowable charges including any applicable sales tax, shipping and handling costs up to a maximum benefit of $350 per member each plan year. Contact fitting fee does not apply towards the benefit limit.	Constant 20% coinsurance, deductible waived Constant 20% coinsurance, deductible waived	
Pediatric Vision Benefit This benefit covers vision services for covered children under the age of 19. **Vision Exam** Benefits are provided for one routine eye exam per plan year. **Vision Hardware** Benefits are provided for: • 1 pair of frames and lenses per plan year, or • 1 pair of hard contact lenses per plan year, or • 12-month supply of disposable contact lenses per plan year	20% coinsurance, deductible waived No cost share	

HOW DOES SELECTING A PROVIDER AFFECT MY BENEFITS?

The benefits of this plan are based on allowed amounts for covered services and supplies. See ***What Do I Need To Know Before Care*** for a definition of “allowed amount.”

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 out-of-network providers, emergency services will always be the exception. You pay the same deductible and/or coinsurance, if any, no matter whether the emergency services is provided by in-network or out-of-network providers. If you see an out-of-network provider, you are always responsible for any charges over the allowed amount, except for emergency services, covered air ambulance services, or as prohibited by law.

To help you manage the cost of health care, Alyeska Pipeline Service Company has made use of our provider networks and our provider network arrangements with Blue Cross and/or Blue Shield Licensees throughout the country to furnish covered services to you through their provider networks. These networks consist of hospitals and other health care facilities, physicians and professionals. Throughout this section of your booklet, you'll find important information on how to manage your health care costs and out-of-pocket expenses through your choice of providers.

This plan's benefits are designed to provide lower out-of-pocket expenses for non-emergent physician care and hospital care when you get care from network physicians and hospitals. For this purpose, 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 provider networks are different depending upon the state in which you receive care.

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 allowed amount:

- Emergency services. You may get care in the emergency room from out-of-network providers. You will not be balance billed for emergency services provided by an out-of-network provider under federal law. See ***What Do I Need To Know Before Care*** for a definition of “Allowed Amount” for more information about allowed amounts for emergency services.
- Non-emergency care services received from out-of-network providers in Alaska when there isn't a network provider located within 30 miles of your home. We suggest that you contact us before you receive non-emergency care covered services from an out-of-network provider.
- Care received from out-of-network providers for covered stays at in-network hospitals when you have no choice as to who performs the services
- Categories of providers with whom we do not have a contract, including accepted rural providers. See ***Definitions*** for a definition of "accepted rural providers."

Benefits are provided at the highest benefit level, but you will be required to pay any charges over the allowed amount except as prohibited by law.

Throughout this booklet, the term "network" refers to the following provider networks:

State	Provider Type
Alaska	Premera Blue Cross Blue Shield of Alaska Yukon network
Washington	Premera Blue Cross Heritage network. In Clark County, Washington, you also have access to providers through the BlueCard Program And Other Inter-Plan Arrangements. See "All Other States" later in this list.
Wyoming	The local Blue Cross and/or Blue Shield Licensee's Traditional (Participating) network
All other states	The local Blue Cross and/or Blue Shield Licensee's PPO (Preferred) network.

Participating pharmacies are also available nationwide.

This booklet uses "out-of-network" or “non-participating” to refer to physicians and hospitals that aren't in the applicable network shown above.

You access network providers in states other than Alaska and Washington and in Clark County, Washington through the BlueCard program. See ***Out-Of-Area Care*** for details about how BlueCard works.

WHEN YOU GET CARE IN WASHINGTON

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

To find an in-network provider in Washington, see our provider directory at **premera.com**, or call customer service.

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

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

HOW SELECTING A PROVIDER AFFECTS YOUR OUT-OF-POCKET EXPENSES

Network physicians and hospitals in Alaska have agreed to accept the allowed amount as payment in full. They have also agreed to bill us directly for the covered portion of the services you receive, and we direct the plan’s payment to them. These commitments are also true of other types of providers in Alaska that have network agreements with us and of network providers outside Alaska.

If you use an out-of-network physician or hospital in Alaska, you’ll be responsible for charges over the allowed amount, except for emergency services, covered air ambulance services, or as prohibited by law. This is also true of any other provider in Alaska that doesn’t have a network agreement with us and of out-of-network providers outside Alaska. Amounts in excess of the allowed amount also don’t count toward any plan year deductible, if any, or as coinsurance.

No matter what covered provider you choose, you're always responsible for all applicable deductibles, copays, coinsurance, amounts that exceed the benefit maximums and charges for non-covered services.

Since the number of providers can be limited outside the Anchorage area or limited due to the nature of the vocation, Alyeska has established an exception to the provider network. If you select a out-of-network provider and there are three (3) or less network providers in that geographic area (within a 30 mile radius), we will administer the service as if it were provided by a network provider and pay 80% of the covered charge.

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 800-810-BLUE (2583) to locate or verify the status of a provider.

CONTINUITY OF CARE

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

COC applies in these situations:

- The contract with your provider ends
- The benefits covered for your provider change in a way that results in a loss of coverage

- The contract between your company and us ends and that results in a loss of benefits for your provider

How you qualify for Continuity of Care If a primary care provider contract is terminated without cause, continuing care will be provided according to the details included in the member's notice of the contract termination. Additionally, you may qualify for continuing care from non-primary care providers if you are in an "active relationship" or treatment with your provider. This means that you have had three or more visits with the provider within the past 12 months and you meet one or more of these conditions with respect to a terminated provider or facility:

- Undergoing a course of treatment for a serious and complex condition
- Undergoing a course of institutional or inpatient care
- Are scheduled for a non-elective surgery, including receipt of postoperative care
- Are pregnant and undergoing a course of treatment for the pregnancy
- Are receiving treatment for a terminal illness

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

You can request continuity of care by contacting customer service. The contact information is on the back cover of this booklet.

Duration of Continuity of Care

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

- For pregnant members, the completion of postpartum care
- For terminally ill members, the end of medically necessary treatment for the terminal illness. ("Terminal" means a life expectancy of less than one year.)
- The end of the current plan year
- Up to 90 days after the provider's contract termination date, if the member is continuing ongoing treatment

Continuity of care does not apply if your provider:

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

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

LEVELS OF CARE

Healthcare is delivered in many settings with distinct levels of care. Each level of care involves a different intensity of service to treat your medical and behavioral health symptoms. Premera covers the least intensive level of care that is medically necessary to treat your symptoms. Care is often provided in a continuum beginning with acute care and transitioning to outpatient care as symptoms or condition improve. Please see Premera medical policies for Medical Necessity criteria for each type of care.

Acute Inpatient Level of Care

- Medical, surgical or behavioral health hospitals (see ***Definitions*** for Hospital or Inpatient)

Acute facilities provide treatment for severe episodes of Illness, Injury, or behavioral health symptoms, and for recovery from surgery. You are monitored for medical, surgical and psychiatric symptoms, with 24-hour availability of appropriate medical and psychiatric practitioners, and 24/7 onsite nursing services. Care may begin

in the emergency room or an outpatient medical, surgical, or behavioral health setting with transition to an acute inpatient level of care to address your needs. Specialty-appropriate physicians, nurse practitioners, or physician assistants perform physical examinations or psychiatric evaluations within one day of hospital admission. Hospitals provide daily physical examination or psychiatric evaluation, daily nursing observation, and daily treatment during the stay. A plan for treatment and transition to lower levels of care is established shortly after admission. A brief hospital stay while on Observation is considered to be Outpatient care.

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

Intermediate Level Facilities

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

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

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

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

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

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

Intermediate Level Ambulatory or Outpatient Care

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

Intermediate level outpatient programs provide intensive services to those who can function safely in a community-based setting but require a higher level of care than is provided in an outpatient office visit. Intermediate level outpatient programs may be provided by inpatient or intermediate level facilities however patients typically reside at their own homes and visit the facilities for treatment only. Some may offer programs where you can pay to reside within the facility while an outpatient level of care is provided when facility is away from your home.

Outpatient Care

- Hospital Observation
- Hospital Emergency Department
- Ambulatory Surgical Center or Outpatient Surgical Center

- Ambulatory or Outpatient Rehabilitation
- Urgent Care
- Office Visits
- Virtual Care

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

BALANCE BILLING PROTECTION

Out-of-network providers have the right to charge you more than the allowed amount for a covered service. This is called “surprise billing” or “balance billing.” However, federal law protects you from balance billing for:

Emergency Services

Emergency services from an out-of-network hospital or facility or from an out-of-network or non-participating provider at the hospital or facility.

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

Non-Emergency Services from an out-of-network provider at an in-network hospital or outpatient surgery center

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

Air Ambulance

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

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

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

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. Please see the ***Summary of Your Costs*** for your deductible, copays (if any), coinsurance and benefit limits.

Allowed Amount

The allowed amount shall mean one of the following:

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

  For any given service or supply, the allowed amount is the lesser of the following:

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

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

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

  For covered services and supplies received outside Alaska and Washington or in Clark County, Washington, allowed amounts 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 allowed amount for Alaska or Washington providers that don't have a contract with us is the least of the three amounts shown below. The allowed amount for providers outside Alaska or Washington that don't have a contract with us or the local Blue Cross and/or Blue Shield Licensee is also the least of the three amounts shown below.

  - An amount that is no less than the lowest amount the plan allows for the same or similar service from a comparable provider that has a contracting agreement with us
  - 185% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), if available
  - The provider's billed charges. Ambulance providers that do not have agreements with us or another Blue Cross Blue Shield Licensee are always paid based on billed charges.

  If applicable law requires a different allowed amount than the least of the three amounts above, this plan will comply with that law.

- **Dialysis Due To End-Stage Renal Disease**

  Providers Who Have Agreements With Us Or Other Blue Cross Blue Shield Licensees

  The allowed amount is the amount explained above in this definition.

  Providers In Alaska and Washington Who Don't Have Agreements With The Claims Administrator Or Another Blue Cross Blue Shield Licensee

  The amount the Plan allows for dialysis during Medicare's waiting period will be no less than 300 percent of the amount allowed by Medicare and no more than 90 percent of billed charges.

  The amount the Plan allows for dialysis after Medicare's waiting period is 185 percent of the Medicare-approved amount, even when a Member who is eligible for Medicare does not enroll in Medicare.

  Providers Outside of Alaska and Washington Who Don't Have Agreements With The Claims Administrator Or Another Blue Cross Blue Shield Licensee

  The amount the Plan allows for dialysis during Medicare's waiting period will be no less than 300 percent of the amount allowed by Medicare and no more than 90 percent of billed charges.

  The amount the Plan allows for dialysis after Medicare's waiting period is 125 percent of the Medicare-approved amount, even when a Member who is eligible for Medicare does not enroll in Medicare.

- **Non-Emergency Services Protected From Balance Billing**

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

- **Emergency Services**

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

- **Air Ambulance**

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

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

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

We reserve the right to determine the amount allowed for any given service or supply unless otherwise specified in the Group's administrative services agreement with us.

COPAYS AND COINSURANCE

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

Unless stated otherwise, benefits subject to a copay aren't subject to your deductible or coinsurance if any. Your copays and coinsurance amounts for this plan is shown on the ***Summary of Your Costs***.

COINSURANCE

"Coinsurance" is a defined percentage of allowed amounts 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." Your coinsurance amount for this plan is shown on the ***Summary of Your Costs***.

Note: When this booklet refers to coinsurance, it means that either the in-network or out-of-network coinsurance shown on the ***Summary of Your Costs*** applies, depending on the provider.

PLAN YEAR DEDUCTIBLE

A deductible is an amount you must pay in each plan year for covered services and supplies before this plan provides certain benefits. The amount credited toward the plan year deductible doesn't include any copays required by this plan and won't exceed the "allowed amount" for any covered service or supply. Your plan year deductible amount for this plan is shown on the ***Summary of Your Costs***.

Individual Deductible

For each member, there is an individual plan year deductible for covered services and supplies.

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 allowed amounts that apply to your individual plan 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 plan year deductible toward that maximum.

Family Deductible

We also keep track of the expenses applied to the individual plan year deductible that are incurred by all enrolled family members combined. When the total equals the family deductible, we'll consider the individual deductible of every enrolled family member to be met for the year.

What Doesn't Apply To The Plan Year Deductible?

The plan year deductible needn't be met before some benefits of this plan can be provided. These exceptions are stated in the specific benefits shown on the ***Summary of Your Costs***.

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

- Amounts that exceed the allowed amount
- Charges for excluded services
- Copays
- The coinsurance required in the ***Prescription Drugs*** benefit on the ***Summary of Your Costs***
- The value of manufacturer assistance coupons for certain drugs

OUT-OF-POCKET MAXIMUM

The out-of-pocket maximum is the most you or your family will pay each plan year for deductible, coinsurance, and copay amounts (if any) for covered services received from network providers before this plan begins to pay 100%. Your out-of-pocket maximum amount for this plan is shown on the ***Summary of Your Costs***.

Individual Out-of-Pocket Maximum

For each member, there is an out-of-pocket maximum 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 allowed amounts for the remainder of that plan year for covered services from network providers.

Family Out-of-Pocket Maximum

We also keep track of the total deductible, coinsurance, and copay amounts (if any) applied to individual out-of-pocket maximums that are incurred by all enrolled family members combined. When this total equals the family out-of-pocket maximum, we'll consider the individual out-of-pocket maximum of every enrolled family member to be met for that plan year.

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

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

Service Type	**Providers In The Alaska Yukon Network (including Accepted Rural Providers):**	**Providers Not In The Alaska Yukon Network***
Physician Office Visits (MD, DO, DPM)	Yes, out-of-pocket maximum applies	No, out-of-pocket maximum doesn't apply
Other Physician Services (MD, DO, DPM)	Yes, out-of-pocket maximum applies	No, out-of-pocket maximum doesn't apply
Hospital-Based Services	Yes, out-of-pocket maximum applies	No, out-of-pocket maximum doesn't apply
Other covered services paid at the highest in-network benefit such as ***Emergency Services***. See ***Emergency Services*** for details.	Yes, out-of-pocket maximum applies	Yes, out-of-pocket maximum applies

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

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

- Amounts that exceed the benefit maximums under this plan
- Amounts that exceed the allowed amount
- Services and supplies not covered under this plan
- Services from out-of-network providers or as otherwise stated in specific benefits
- Routine vision exam and hardware
- The value of manufacturer assistance coupons for certain drugs

COVERED SERVICES

This section explains the medical services covered by this plan. Benefits are available for covered services and supplies when they meet all 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
- It mustn't be excluded from coverage under this plan
- The expense for it must be incurred while you're covered under this plan and after any applicable waiting period required under this benefit plan is satisfied
- It must be furnished by a provider who is performing services within the scope of their license or certification. See ***Definitions*** for a definition of "provider."
- Prior authorization. Some services or supplies must be approved in writing by us before you receive them. See ***Prior Authorization*** for details.
- Medical and Payment policies are used to administer the terms of the plan. Medical policies define medical necessity criteria for specific procedures, drugs, biologic agents, devices, level of care or services. They also identify medical services that are not covered because they are experimental & investigational. Medical policies may be developed by Premera Blue Cross Blue Shield of Alaska or licensed from national organizations that create evidence-based utilization standards. Payment policies define our provider billing and payment rules. Our policies are based on accepted clinical practice guidelines and industry standards accepted by organizations like the American Medical Association (AMA), other professional societies and the Centers for Medicare and Medicaid Services (CMS). Our policies are available to you and your provider at premera.com or by calling customer service.

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 ***Exclusions and Limitations*** section for a complete description of covered services and supplies, limitations and exclusions.

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

Acupuncture

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

This benefit covers acupuncture to:

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

Allergy Testing and Treatment

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

This benefit covers:

- Testing
- Allergy shots
- Serums

Ambulance

This benefit covers:

- Transport to the nearest facility that can treat your condition
- Medical care you get during the trip

- Transport from one medical facility to another as needed for your condition
- Transport to your home when medically necessary

These services are only covered when:

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

Air or sea emergency medical ambulance transportation is covered when:

- Transport takes you to the nearest available facility that can treat your condition
- The above requirements for ambulance services are met
- Geographic restraints prevent ground transport
- Ground emergency transportation would put your health or safety at risk

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

This benefit does not cover:

- Services from an unlicensed ambulance

Ambulatory Surgical Center

This benefit covers:

- Doctor and nurse services
- Operating rooms, procedure, and recovery rooms
- Surgical supplies and anesthesia
- Surgical services, including injections, when performed on an outpatient basis
- Drugs, blood, medical equipment, and oxygen for use in the ambulatory surgical center
- Diagnostic colonoscopy and sigmoidoscopy services not covered under ***Preventive Care***
- X-ray, lab, and testing billed by the ambulatory surgical center
- Medically necessary detoxification

Blood Products and Services

- Blood components and services, like blood transfusions, which are provided by a certified or licensed healthcare provider.
- Blood products and services that either help with prevention or diagnosis and treatment of an illness, disease, or injury

Cellular Immunotherapy and Gene Therapy

Treatment which uses your body's own immune system or genes to treat disease.

These therapies are fairly new, and their use is evolving. They must meet three criteria in order to be covered:

- Prescribed by a doctor
- Meet Premera's medical policy (See **premera.com** or call customer service), and
- Approved by Premera before they can happen (See ***Prior Authorization***)

This benefit covers:

- Medically necessary cellular immunotherapy and gene therapy, like CAR-T

If you travel more than 50 miles for these therapies, keep all receipts. You can be reimbursed for some expenses, up to $7,500 per episode of care. See ***Medical Transportation Benefits***.

See ***Prior Authorization*** for more information on getting prior approval for services.

See the ***Summary of Your Costs*** under ***Medical Transportation Benefits*** for travel benefit limits.

Chemotherapy and Radiation Therapy

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

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

This benefit covers:

- Outpatient chemotherapy and radiation therapy
- Supplies, solutions and drugs used during chemotherapy or radiation visit
- Tooth extractions to prepare your jaw for radiation therapy

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

Clinical Trials

A qualified clinical trial (see ***Definitions***) is a scientific study that tests and improves treatments of cancer and other life-threatening conditions.

This benefit covers qualified clinical trial medical services that are already covered under this plan. The clinical trial has to be suitable for your health condition. You also have to be enrolled in the trial at the time of the treatment.

Benefits are based on the type of service you get. For example, if you have an office visit, it's covered under ***Professional Visits and Services***, and if you have a lab test it's covered under ***Diagnostic Lab, X-ray and Imaging***.

Cancer Clinical Trials

In addition to routine medical care described above, benefits for a cancer clinical trial also include:

- Palliative care, diagnosis and treatment of the symptoms of cancer, any complications and the FDA approved drug or device used in the clinical trial.
- Costs for reasonable and necessary travel for the person enrolled in the clinical trial and one companion. These services are limited to the following:
  - Travel to the place of the clinical trial
  - Commercial coach (economy) fare for air transportation
  - Travel for follow-up care that cannot be provided near your home

You must complete a Travel Claim Form for these services. A separate claim form is needed for each patient and each commercial carrier or transportation service used. You can get a Travel Claim Form on our website at **premera.com**. You can also call us for a copy of the form.

This benefit doesn't cover:

- Costs for treatment that aren't primarily for your care (such as lab tests performed just to collect information for the clinical trial)
- The drug, device or services being tested
- Travel costs, except as described under ***Cancer Clinical Trials***
- Housing, meals, or other nonclinical expenses
- A service that isn't part of an approved clinical trial. See ***Definitions*** for a definition of "clinical trials."
- Services, supplies or drugs that would not be charged to you if there were no coverage
- Services provided to you in a clinical trial that are fully paid for by another source
- Services that are not routine costs normally covered under this plan

Contraceptive Management and Sterilization

Benefits include the following services and supplies:

- Office visits and consultations related to contraception

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

Prescription Contraceptives Dispensed by a Pharmacy

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

This benefit doesn't cover:

- Non-prescription contraceptive drugs, supplies or devices (not including emergency contraceptive methods) except as required by law
- Prescription contraceptive take-home drugs dispensed and billed by a facility or provider's office
- Hysterectomy (Covered on the same basis as other surgeries, see ***Surgery*** for details)
- Sterilization reversal
- Assisted reproduction services, procedures, supplies and drugs

Dental Injury and Facility Anesthesia

Dental Anesthesia

Anesthesia and facility care done outside of the dentist's office for medically necessary dental care

This benefit covers:

- Hospital or other facility care
- General anesthesia provided by an anesthesia professional other than the dentist or the physician performing the dental care

This benefit is covered for any one of the following reasons:

- The member is under age 19 and failed patient management in the dental office
- The member has a disability, medical or mental health condition making it unsafe to have care in a dental office
- The severity and extent of the dental care prevents care in a dental office

Dental Injury

Treatment of dental injuries to teeth, gum and jaw.

This benefit covers:

- Exams
- Consultations
- Dental treatment
- Oral surgery

This benefit is covered on sound and natural teeth that:

- Do not have decay
- Do not have a large number of restorations such as crowns or bridge work
- Do not have gum disease or any condition that would make them weak

Care is covered within 12 months of the injury. If more time is needed, please ask your doctor to contact customer service.

This benefit does not cover injuries from biting or chewing, including injuries from a foreign object in food.

Benefits are based on the type of service you get. For example, if you have an office visit, it's covered under ***Professional Visits and Services***, and if you have a lab test it's covered under ***Diagnostic Lab, X-ray and Imaging***.

Diagnostic Lab, X-ray and Imaging

Diagnostic lab, x-ray and imaging services are basic and major medical tests that help find or identify diseases. For more information about what services are covered as preventive see ***Preventive Care.*** A typical test can result in multiple charges for things like an office visit, test, and anesthesia. You may receive separate bills for each charge. Some tests need to be approved before you receive them. See ***Prior Authorization*** for details.

Basic services include:

- Bone density screening for osteoporosis
- Cardiac testing
- Pulmonary function testing
- Diagnostic imaging and scans such as x-rays
- Lab services
- Mammograms (including 3-D mammograms) for a medical condition
- Neurological and neuromuscular tests
- Pathology tests
- Echocardiograms
- Ultrasounds
- Diagnosis and treatment of the underlying medical conditions that may cause infertility

Major services include:

- Computed Tomography (CT) scan
- Nuclear cardiology
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Positron Emission Tomography (PET) scan
- Vitamin D testing

For additional details, see the following benefits:

- ***Emergency Room***
- ***Hospital***
- ***Maternity Care***
- ***Preventive Care***
- Genetic testing may be covered in some cases. Call customer service before seeking testing, since it may require Prior Authorization.

This benefit does not cover non-diagnostic testing required for employment, schooling, screening or public health reasons that is not for the purpose of treatment. Some tests need to be prior authorized before you receive them. See ***Prior Authorization*** for details.

Additional information:

Diagnostic breast examination for the purpose of this ***Diagnostic X-ray, Lab, and Imaging*** benefit means a medically necessary and appropriate examination of the breast, including an examination using diagnostic mammography, breast resonance imaging, advanced imaging (including magnetic resonance imaging and ultrasound) breast ultrasound, or pathology evaluations (including biopsies and consultations) or other services

based on guidelines established by government agencies and professional medical societies that is used to evaluate an abnormality:

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

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

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

Dialysis

When you have end-stage renal disease (ESRD) you may be eligible to enroll in Medicare. If eligible, it is important to enroll in Medicare as soon as possible. When you enroll in Medicare, this plan and Medicare will coordinate benefits. In most cases, this means that you will have little or no out-of-pocket expenses.

When covered dialysis services are provided by a non-participating provider, the in-network cost shares will apply. For non-participating providers during Medicare's waiting period, the allowed amount is 300% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare). After Medicare's waiting period, the allowed amount for non-participating providers is 125% of the fee schedule determined by the Centers for Medicare and Medicaid Services.

If the dialysis services are provided by a non-participating provider and you do not enroll in Medicare, then you will owe the difference between the non-participating provider's billed charges and the plan's payment for the covered services. See ***Definitions*** for a definition of "Allowed Amount."

Emergency Room

This benefit covers:

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

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

You may get care in the emergency room from out-of-network providers. You will not be balance billed for emergency services provided by an out-of-network provider or hospital emergency room under federal law.

Foot Care

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

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

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

Habilitation Therapy

The following inpatient and outpatient habilitation 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 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. This benefit includes physical, speech, and occupational therapy assessments and evaluations related to treatment of covered habilitation therapy.

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

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

This benefit does not cover:

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

Health Management

Health Education

Benefits are provided for outpatient health education services to manage pain or cope with a covered condition like heart disease, diabetes, or asthma.

Nicotine Dependency Programs

Benefits are provided for outpatient nicotine dependency programs. You pay for the cost of the program and send us proof of payment along with a reimbursement form. Please contact our customer service department for a reimbursement form or for help finding covered providers.

This benefit doesn't cover drugs for the treatment of nicotine dependency. See ***Prescription Drugs*** for details.

Hearing

Hearing Exams

Hearing exam services include:

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

Hearing Hardware

Both of the following must be done in order to receive your hearing hardware benefit:

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

Benefits are provided for the following:

- Hearing aids (monaural or binaural) prescribed as a result of an exam
- Ear molds
- The hearing aid instruments, including bone conduction hearing devices and the initial assessment, adjustment and auditory training
- Hearing aid rental while the primary unit is being repaired
- The initial batteries, cords and other necessary ancillary equipment
- A warranty, when provided by the manufacturer
- A follow-up consultation within 30 days following delivery of the hearing aid with the prescribing licensed provider
- Repairs, servicing and alteration of hearing aid equipment

This benefit does not cover:

- Hearing aids purchased before your effective date of coverage under this plan
- Batteries or other ancillary equipment other than that obtained upon purchase of hearing aids
- Hearing aids that exceed the specifications prescribed for correction of hearing loss
- Expenses incurred after your coverage ends under this plan unless hearing aids were ordered before that date and were delivered within 90 days after the date your coverage ended
- Charges in excess of this benefit. These expenses are also not eligible for coverage under other benefits of this plan.

Home Health Care

General Home Health Care

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

The following are covered under the Home Health Care benefit:

- Home visits and short-term nursing care
- Home medical equipment, supplies and devices
- Prescription drugs given by the home health care agency
- Therapy, such as physical, occupational or speech therapy to help regain function

Only the following employees of a home health agency are covered:

- A registered nurse
- A licensed practical nurse
- A licensed physical or occupational therapist
- A certified speech therapist
- A certified respiratory therapist
- A home health aide directly supervised by one of the above listed providers
- A social worker

This benefit does not cover:

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

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

This benefit covers:

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

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

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

Covered items include:

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

Medical Supplies such as:

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

External Prosthetics and Orthotic Devices used to:

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

Orthopedic Shoes and Shoe Inserts

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

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

Wigs or Hairpieces

Benefits are provided for wigs or hairpieces due to medically induced hair loss. Examples of medically induced hair loss include, but are not limited to, hair loss resulting from injury, disease or treatment of disease, medication, radiation therapy or chemotherapy.

This benefit does not cover:

- Hypodermic needles, syringes, lancets, test strips, testing agents and alcohol swabs. These services are covered under the ***Prescription Drugs*** benefit.
- Supplies or equipment not primarily intended for medical use
- Special or extra-cost convenience features
- Items such as exercise equipment and weights
- Over bed tables, elevators, vision aids and telephone alert systems
- Over the counter orthotic braces and or cranial banding
- Non-wearable defibrillator, trusses and ultrasonic nebulizers

- Blood pressure cuff/monitor (even if prescribed by a physician)
- Enuresis alarm
- Compression stockings which do not require a prescription
- Physical changes to your house and/or personal vehicle
- Orthopedic shoes used for sport, recreation or similar activity
- Penile prostheses
- Routine eye care
- Prosthetics, intraocular lenses, equipment or devices which require surgery. These items are covered under the ***Surgery*** benefit.
- Medical vision hardware

Hospice Care

To be covered, 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 hospice services.

This plan provides benefits for covered services furnished and billed by a hospice that is Medicare-certified or is licensed or certified by the state it operates in.

Covered employees of a 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 social worker.

This benefit covers:

- **In-home intermittent hospice visits** by one or more of the hospice employees above.
- **Inpatient hospice care** 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** to relieve anyone who lives with and cares for the terminally ill member.
- **Palliative care** in cases where the member has a serious or life-threatening condition that is not terminal. Coverage of palliative care can be extended based on the member's specific condition. Coverage includes expanded access to home based care and care coordination.
- **Insulin and Other Hospice Provider Prescribed Drugs** Benefits are provided for prescription drugs and insulin when furnished and billed by a home health care provider, home health agency or hospice.

This benefit does not cover:

- Over-the-counter drugs, solutions and nutritional supplements
- 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
- 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

Hospital

This benefit covers:

- Inpatient room and board
- Doctor and nurse services
- Intensive care or special care units
- Operating rooms, procedure rooms and recovery rooms
- Surgical supplies and anesthesia
- Drugs, blood, medical equipment and oxygen for use in the hospital

- X-ray, lab and testing billed by the hospital

For inpatient hospital maternity care and newborn care, see ***Maternity Care*** and ***Newborn Care*** for details.

Even though you stay at an in-network hospital, you may get care from doctors or other providers who do not have a network contract at all. In that case, you will have to pay any amounts over the allowed amount except for emergency services, covered air ambulance services, or as prohibited by law.

You pay out-of-network cost shares if you get care from a provider not in your network. See ***How Providers Affect Your Costs*** for details.

We must approve all planned inpatient stays before you enter the hospital. See ***Prior Authorization*** for details.

This benefit does not cover:

- Hospital stays that are only for testing, unless the tests cannot be done without inpatient hospital facilities, or your condition makes inpatient care medically necessary
- Any days of inpatient care beyond what is medically necessary to treat the condition

Infusion Therapy

Fluids infused into the vein through a needle or catheter as part of your course of treatment.

Infusion examples include:

- Drug therapy
- Pain management
- Total or partial parenteral nutrition (TPN or PPN)

This benefit covers:

- Outpatient facility and professional services
- Professional services provided in an office or home
- Prescription drugs, supplies and solutions used during infusion therapy

This benefit does not cover over-the-counter:

- Drugs and solutions
- Nutritional supplements

Mastectomy and Breast Reconstruction

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

This benefit covers:

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

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

Maternity Care

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

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 single fee that includes prenatal, delivery and/or postpartum services received on multiple dates of service, this plan will cover those services as it would any other surgery. See ***Surgery*** for details on surgery coverage.

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

Maternity care benefits cover the following.

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

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

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

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

This benefit does not cover donor breast milk.

Medical Foods

Medical foods are foods that are specially prepared to be consumed or given directly into the stomach under strict supervision of a doctor. They provide most of a person's nutrition. They are designed to treat a specific problem that can be detected using medical tests.

This benefit covers:

- Dietary replacement to treat inborn errors of metabolism (example phenylketonuria (PKU))
- Dietary replacement when you have a severe allergy to most foods based on white blood cells in the stomach and intestine that cause inflammation (eosinophilic gastrointestinal associated disorder)
- Other severe conditions when your body cannot take in nutrient from food in the small intestine (malabsorption) disorder
- Disorders where you cannot swallow due to a blockage or a muscular problem and need to be fed through a tube

Medical foods must be prescribed and supervised by doctors or other health care providers.

This benefit does not cover:

- Oral nutrition or supplements, and specialized infant formulas not used to treat inborn errors of metabolism or any of the above listed conditions
- Lactose-free or gluten free foods

Medical Transportation Benefits

This plan includes Medical Transportation Benefits that provide reimbursement as described below. For ambulance benefits see ***Ambulance***.

Elective Procedure Travel

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

This benefit provides reimbursement of certain travel costs up to IRS guidelines for members who reside in Alaska and travel outside of Alaska only for specified non-emergent medical procedures performed at certain in-network providers. Please contact customer service for a list of eligible procedures and providers. Before you travel, you must get prior authorization. Approval is based on the member's medical condition, and the provider who will be performing the services. Please contact customer service for assistance with the process.

Benefits are provided for:

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

- Surface transportation, car rental, taxicab fares and parking fees for the member and a companion between the hotel and the medical facility where the services will be provided based on current IRS guidelines

If the member using the Elective Procedure Travel benefit is a child under age 19, one companion is automatically permitted, however a second companion will only be permitted if medically necessary.

Some reimbursement rates are based on IRS guidelines for the date(s) the expenses were incurred. These reimbursement amounts are subject to change due to IRS regulations. Please refer to the IRS website, **www.irs.gov**, for additional information. The information in this benefit should not be assumed as tax advice.

Air travel and lodging arrangements can be made by Premera's travel partner or by the member. Expenses must be incurred while the member is covered under the plan.

Note: Companion travel and lodging expenses are only covered if they must, as a matter of medical necessity or safety, to accompany the member. A second companion or if a companion is required to travel separately will only be permitted if medically necessary.

You may choose to pay for travel and lodging services up front and submit a claim for reimbursement. See ***How To File An Elective Travel Claim*** section for more information. If you would like assistance from Premera in booking and prepaying for some travel accommodations, please contact customer service to discuss these options.

This benefit does not cover:

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

How To File An Elective Travel Claim:

Travel services may be arranged through Premera. Contact customer service if you wish to take advantage of this service.

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

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

You must also attach the following documents:

- A Utilization Management Authorization number for travel to providers not on the list
- The boarding pass and a copy of the ticket from the airline or other transportation carrier. The ticket(s) must indicate the name(s) of the passenger(s), the dates of travel and total cost of the travel, and the origination and final destination points.
- Receipts for all covered travel expenses

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

Mental Health Care

This benefit covers treatment of mental conditions. A mental health condition is any condition listed in the current **Diagnostic and Statistical Manual (DSM)**, published by the American Psychiatric Association, excluding diagnosis and treatments for substance use disorder.

Covered services include all the following:

- Inpatient, residential and outpatient facility treatment, and outpatient therapeutic visits (including virtual care) to manage or reduce the effects of a mental health condition, including treatment of eating disorders (such as anorexia nervosa, bulimia or any similar condition)
- Individual, family or group therapy
- Lab and testing
- Take-home drugs you get in a facility
- Biofeedback
- Physical, speech and occupational therapy provided to treat mental health conditions, such as autism spectrum disorders
  - Applied behavior analysis (ABA) for the treatment of autism spectrum disorders, including services provided by an autism service provider. See ***Definitions*** for a definition of "autism service provider."

“Outpatient therapeutic visit” (outpatient visit including virtual care) means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards as defined in the Physician's Current Procedural Terminology, published by the American Medical Association. Outpatient therapeutic visits can include real-time visits with your doctor or other provider via telephone, online chat or text, or other electronic methods.

This benefit does not cover:

- Psychological treatment of sexual dysfunctions, including impotence and frigidity
- Psychological and neuropsychological testing and evaluations. These services are covered under the ***Psychological and Neuropsychological Testing*** benefit.
- Substance abuse treatment. These services are covered under the ***Substance Use Disorder*** benefit.
- Mental health evaluations for purposes other than evaluating the presence of or planning treatment for covered mental health disorders, including, but not limited to, custody evaluations, competency evaluations, forensic evaluations, vocational, educational or academic placement evaluations

Newborn Care

Newborn children 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 an eligible newborn are provided up to:

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

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

Benefits are also provided for routine circumcision.

This benefit does not cover immunizations. See ***Preventive Care*** for coverage of immunization and outpatient well-baby care.

Orthognathic Surgery (Jaw Augmentation or Reduction)

When medical necessity criteria are met, benefits are provided for procedures to lengthen or shorten the jaw (orthognathic and/or maxillofacial surgery).

Premera Designated Centers of Excellence Program

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

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

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

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

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

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

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

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

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

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

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

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

Benefits for travel expenses related to covered services in this benefit are provided under the ***Medical Transportations*** benefit. See ***Elective Procedure Travel***.

Prescription Drugs

This benefit provides coverage for medically necessary prescription drugs, including agents (like insulin) 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 diabetic injectable supplies. For the purposes of

this plan, a prescription drug is any medical substance that, under federal law, must be labeled as follows: "Caution: Federal law prohibits dispensing without a prescription." In no case will the member's out-of-pocket expense exceed the cost of the drug or supply. This plan covers FDA-approved drugs only if they are medically necessary.

Some prescription drugs require prior authorization. See ***Prior Authorization*** for details.

Note: When using manufacturer assistance coupons for certain drugs, the value of the coupons may not apply to your plans deductible and out-of-pocket maximum.

The Plan offers you two ways in which to obtain prescription medications: either at a local pharmacy or through a mail order pharmacy program. Members will be required to use the mail order pharmacy program for prescription drug orders exceeding 68 days (2 fills at retail).

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.

“Coinsurance” is defined as the percentage of the allowed amount that you’re required to pay to the retail pharmacy or the participating mail-order pharmacy for each prescription drug purchase.

If you need prescription medication for ongoing, chronic conditions such as diabetes, arthritis or high blood pressure, you can use the mail order pharmacy program to have your medications delivered right to your door.

PV Core Preventive Drugs The plan covers other preventive drugs. These drugs are on our PV Core list. These drugs are effective in controlling health problems such as heart disease. Preventive care prescription drugs are drugs taken regularly by a member to prevent a condition or to prevent the reoccurrence or specific conditions.

Please call customer service or log in to the member portal on our Web site to find out if a drug is on the PV Core list. The phone number and our Web address are on the back of this booklet.

Retail Pharmacy Prescriptions

Dispensing Limit

Benefits are provided for up to a 34-day supply of covered medication unless the drug maker’s packaging limits the supply in some other way. Dispensing of a greater than 34-day supply is permitted when the drug maker’s packaging doesn’t allow for a lesser amount. Prescription drug benefits will not be provided for prescription drug orders exceeding 68 days (2 fills at retail or pay 100% out-of-pocket at retail). See Mail-Order Pharmacy Program.

Participating Pharmacies

When you get your prescriptions from participating pharmacies, the plan will pay the participating pharmacy directly. To avoid paying the retail cost for a prescription drug instead of the allowed amount, be sure to present your identification card for all prescription drug purchases. See ***What Do I Need To Know Before Care*** for a definition of “allowed amount.”

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. See ***How Do I File A Claim?*** 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.

If the pharmacy does not submit your claim for you, you will have to pay the full cost for your prescriptions. You will also 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.

Prescriptions received from non-participating pharmacies are subject to the allowed amount. See ***What Do I Need To Know Before Care*** for a definition of “allowed amount.” Amounts in excess of the allowed amount do not count toward any applicable calendar year deductible, coinsurance or out-of-pocket maximum.

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

Mail-Order Pharmacy Program

Certain drugs, such as Viagra, Cialis, Levitra, birth control patches, and oral contraceptives are available only through the mail-order pharmacy program and must be purchased in 90-day supplies. These drugs are not available through the retail pharmacy.

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

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 healthcare provider to prescribe medications for up to a 90-day supply, plus refills. If you are presently taking medication, ask your provider for a new prescription. Make sure that you have at least a 14- to 21-day supply on hand for each drug at the time you submit a prescription to the mail-order pharmacy. See ***How Do I File A Claim?*** for more information on submitting claims.

After you've paid any required deductible, and copays or coinsurance, the plan will pay the participating mail-order pharmacy directly. This benefit is limited to prescriptions filled by the mail-order pharmacy. **Please note:** Maintenance drugs are only covered when you get them through mail-order.

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

You may also call the mail-order pharmacy's customer service department or visit their website at:

800-391-9701
express-scripts.com

You can mail your prescription drug claims to:

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

Diabetic Supplies and Drugs

When insulin needles and syringes are purchased along with insulin, only the copay for the insulin will apply. When insulin needles and syringes are purchased separately, the Preferred List Brand Name Drug copay will apply for each item purchased. The prescription drug deductible, if any, and the Preferred List Brand Name Drug copay will apply to purchases for alcohol swabs, test strips, testing agents and lancets. A separate copay will apply to each item purchased. Over the counter diabetic supplies are covered under retail and mail-order pharmacy.

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." See ***Definitions*** for details.
- Prescriptive oral agents for controlling blood sugar levels
- Prescribed injectable medications for self-administration (such as insulin)
- Glucagon and allergy emergency kits
- Compounded medications of which at least one ingredient is a covered prescription drug
- Hypodermic needles, syringes and alcohol swabs used for self-administered injectable prescription medications. Also covered are the following disposable diabetic testing supplies: test strips, testing agents and lancets.
- Inhalation spacer devices and peak flow meters
- Drugs for the treatment of nicotine dependency, including over the counter (OTC) nicotine patches, gum or lozenges purchased through a participating retail pharmacy. Over the counter nicotine products are subject to

the generic drug cost-share. Your normal cost-share for drugs received from a participating pharmacy is waived for certain prescription nicotine dependency drugs that meet the guidelines for preventive services described in the ***Preventive Care*** benefit.

- Prescription drugs for the treatment of autism
- Prescription contraceptive drugs and devices (e.g. oral drugs, diaphragms and cervical caps). See ***Contraceptive Management and Sterilization*** for details.
- Testopel pellets
- Drugs to treat sexual dysfunction
- Drugs to treat infertility, including assisted reproduction medications

For benefit information on therapeutic devices, appliances, medical equipment, medical supplies, diabetic equipment and accessories (except for those specifically stated as covered in this benefit), see ***Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies*** for details.

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

Additional Information About Your Prescription Drug Benefit

Generic Drugs

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 will apply. If you or the prescriber request a brand name drug instead of a generic when a generic equivalent is available, you’ll be required to pay the difference in price between the brand name drug and the generic equivalent, in addition to paying the applicable brand name cost-share. However, if you cannot tolerate the generic equivalent, or the prescriber determines that the generic equivalent is not effective in treating your condition, the prescriber can request a medical necessity review. If approved, you’ll be required to pay only the applicable cost-share of the brand name drug. Please consult with your pharmacist on the higher costs you’ll pay if you select a brand name drug.

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

Refills

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

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

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

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

Specialty Pharmacy Program

"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.

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

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

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

Split Fill Program

Initial fills of new prescriptions for certain Specialty Drugs with a higher instance of intolerance are filled as two 15-day prescriptions. During the first 15-day fill, you will be contacted to ensure the medication is working as intended prior to the second fill and your cost for the medication will be prorated accordingly. If the drug is tolerated, standard days' supply will apply for subsequent fills. This program only applies to the initial fill of a new prescription. Contact customer service for more information about which Specialty Drugs are applicable or visit www.premera.com/splitfill-ak.

Pharmacy Management

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

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

These limitations are based on medical standards, the drug maker's recommendations, and the circumstances of the individual case. They are also based on U.S. Food and Drug Administration guidelines, published medical literature and standard medical references.

Anti-Cancer Medication

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

This Prescription Drug benefit doesn't cover:

- Some prescription drugs are not covered if a lower cost generic, therapeutic equivalent or an over-the-counter alternative is available. This is true even if the prescribed medication is listed as covered on your plan's list of covered drugs, sometimes referred to as a "formulary." Contact customer service for more information about which drugs listed on your formulary are excluded or visit www.premera.com/otc-ak and www.premera.com/hclv-ak
- Over the counter (OTC) drugs and medicines unless prescribed by a practitioner, or as required by law. Even when prescribed by a practitioner, OTC drugs and supplies are not covered unless otherwise stated in this plan. 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).
- Over the counter (OTC) contraceptives (e.g. jellies, creams, foams or devices) unless prescribed by a practitioner or as required by law
- Cosmetic drugs for the purpose of cosmetic use, or to promote or stimulate hair growth (e.g. wrinkles or hair loss) or to alter the appearance of your skin
- Drugs for experimental or investigational use
- Biologicals, blood or blood derivatives
- Any prescription refilled in excess of the number of refills specified by the prescribing provider, or any refill dispensed after one year from the prescribing provider's original order

- Drugs dispensed for use or administration in a health care facility or provider's office, or take-home drugs dispensed and billed by a medical facility
- Replacement of lost or stolen medication
- Infusion therapy drugs or solutions and drugs requiring parenteral administration or use, and injectable medications. (The exception is injectable drugs for self-administration, such as insulin and glucagon). See ***Infusion Therapy*** for details.
- Drugs to treat sexual dysfunction of organic origin, except where otherwise stated
- Weight management drugs

Preventive Care

Preventive services are a specific set of evidence-based services expected to prevent future illness. These services are based on guidelines established by government agencies and professional medical societies.

Please go to this government website for more information:
https://www.healthcare.gov/coverage/preventive-care-benefits/

Preventive services provided by in-network providers are covered in full. But they have limits on how often you should get them. These limits are often based on your age and gender. After a limit has been exceeded, these services are not covered in full and may require you to pay more out-of-pocket costs.

Some of the services your doctor does during a routine exam may not meet preventive guidelines. These services are then covered the same as any medical service and are not covered in full and you may be responsible for part of the costs.

For example:

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

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

Preventive services under this plan are those services with an “A” or “B” rating by the United States Preventive Services Task Force (USPSTF); immunizations recommended by the Centers for Disease Control (CDC) and Prevention and as required by state law. When federal or state preventive requirements change, this plan will administer preventive care consistent with those changes, as of their effective date, even if they are not specifically referenced in this document.

Covered preventive services include and are unlimited unless otherwise specified:

Preventive Exams

- Routine physical exams
- Well-baby exams from birth to three years and well-child exams, including those provided by a qualified health aide, from four to eighteen years
- Physical exams related to school, sports, and employment
- Depression screenings, including screening for adults and pregnant/postpartum members

Immunizations

- Preventive immunizations
- Seasonal and certain other immunizations provided by a pharmacy or other mass immunizer location. Covered services include flu shots, flu mist, pneumonia immunizations, whooping cough, adult shingles immunizations and travel immunizations.

Screening Tests and Imaging

- Routine lab tests and imaging
- Mammograms (including 3D)
- Pap smears

- BRCA genetic testing for women at risk for certain breast cancers
- Cervical cancer annual pap smear for women 18 years of age and older, or as recommended by a physician
- Patient navigation services are also available to ensure timely diagnosis, treatment and support for breast and cervical cancer screenings. These services include, but are not limited to:
  - Person centered assessment and planning.
  - Healthcare access and health navigation system
  - Referrals to appropriate support services (language translation, transportation and social services)
  - Patient education
- Navigation services include person-to-person contact. This can be in person, virtual or both
- Diabetes screening
- Prostate cancer screening. Includes digital rectal exams and prostate-specific antigen (PSA) tests. Annual tests for prostate cancer for high-risk men under 40; all men over 40 years of age, or as recommended by a physician.

Colon Cancer Screenings

- Pre-colonoscopy consultation and exam
- Barium enema
- Colonoscopy, sigmoidoscopy, and fecal occult blood tests.
- If polyps are found during the screening, their removal and lab tests are covered as preventive.
- Medically necessary anesthesia.
- Colonoscopies as follow-up to positive non-invasive stool-based screening tests.

Routine Maternity Care

- Routine prenatal exams and tests
- Breastfeeding support and counseling
- Standard breast pump (bought from approved suppliers). Call Premera customer service for a list of approved suppliers.
- Rental of hospital-grade breast pumps
- Maternity diagnostic screening
- Screening for gestational diabetes

Counseling

- Contraceptive counseling. See ***Contraceptive Management and Sterilization*** for additional information.
- Counseling for sexually transmitted infections

Health Education and Training

- Outpatient programs and classes to help you manage pain or cope with covered conditions like heart disease, diabetes, or asthma.
- The program or class must take place in an approved setting, like a hospital.

Nutritional Counseling and Therapy

- Healthy diet and eating habits for members at risk for health conditions that are affected by diet and nutrition
- Obesity screening and counseling for weight loss

Pre-exposure (PrEP) for members at high-risk for HIV infection

Tobacco Habit Breaking Programs

Fall Prevention

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

This Preventive Care benefit does not cover:

- Gym memberships or exercise classes and programs

- Inpatient routine newborn exams while the child is in the hospital following birth. These services are covered under the ***Newborn Care*** benefit.
- Physical exams for basic life or disability insurance
- Prescription contraceptives, including over the counter (OTC) items, dispensed, and billed by your provider or a hospital. See ***Prescription Drugs*** for prescribed contraceptives.
- Work-related disability evaluations or medical disability evaluations

Professional Visits and Services

Benefits are provided for the examination, diagnosis and treatment of an illness or injury when such services are performed on an inpatient or outpatient basis, including your home and virtual care. Benefits are also provided for the following professional services when provided by a qualified provider:

- Biofeedback for migraines and other conditions for which biofeedback is not deemed experimental or investigational when provided by a qualified provider. See ***Definitions*** for a definition of "experimental/investigational."
- Consultations and treatment for nicotine dependency
- Real time visits via online and telephonic methods with your doctor or other provider
- Prostate, colorectal, and cervical cancer screening exams, unless they meet the guidelines for preventive medical services described in the ***Preventive Care*** benefit
- Second opinions for any covered medical diagnosis or treatment plan when provided by a qualified provider

This benefit does not cover:

- Surgical procedures performed in a provider's office, surgical suite or other facility. These services are covered under the ***Surgery*** benefit, unless they meet the guidelines for preventive medical services described in the ***Preventive Care*** benefit.
- Professional diagnostic imaging and laboratory services. These services are covered under the ***Diagnostic Lab, X-ray and Imaging*** 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 Health Care*** and ***Hospice Care*** benefits.
- Hair analysis or non-legend drugs or medicines, such as herbal, naturopathic or homeopathic medicines or devices
- Services used to improve your appearance, such as services to increase hair growth or alter the appearance of your skin
- Services related to the diagnosis or treatment of psychiatric conditions. These services are covered under the ***Mental Health Care*** benefit.
- Services related to the diagnosis and treatment of temporomandibular joint disorder
- Services related to the diagnosis and treatment of temporomandibular joint disorder. See the ***Temporomandibular Joint Disorders (TMJ) Care*** benefit for coverage of such services.
- Injectable or implantable contraceptives and related services. These drugs and services are covered under the ***Contraceptive Management and Sterilization*** benefit.

Psychological and Neuropsychological Testing

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

Rehabilitation Therapy and Chronic Pain Care

Rehabilitation Therapy

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

- Restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an accidental injury, illness or surgery; or
- Treat disorders caused by physical congenital anomalies. See ***Habilitation Therapy*** for coverage of disorders caused by neurological congenital anomalies.

Covered services include all the following:

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

Inpatient Care 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. Benefits are also included for physical, speech, and occupational assessments and evaluations related to rehabilitation.

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

Chronic Pain Care

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

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

This benefit does not cover:

- Recreational, vocational or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Treatment that isn't actively engaged in by the ill, injured or impaired member
- Gym or swim therapy

- Custodial care
- Inpatient rehabilitation received more than 24 months from the date of onset of the member's accidental injury or illness or from the date of the member's surgery that made rehabilitation necessary
- Services to treat a psychiatric condition; see the ***Mental Health Care*** benefit
- Therapy for flat feet except to help you recover from surgery to correct flat feet

Skilled Nursing Facility Care

This benefit includes:

- Room and board
- Skilled nursing services
- Supplies and drugs
- Skilled nursing care during some stages of recovery
- Skilled rehabilitation provided by physical, occupational or speech therapists while in a skilled nursing facility
- Short or long term stay immediately following a hospitalization
- Active supervision by your doctor while in the skilled nursing facility

We must approve all planned skilled nursing facility stays before you enter a skilled nursing facility. See ***Prior Authorization*** for details.

This benefit does not cover:

- Acute nursing care
- Skilled nursing facility stay not immediately following hospitalization or inpatient stay
- Skilled nursing care outside of a hospital or skilled nursing facility
- Care or stay provided at a facility that is not qualified per our standards

Spinal and Other Manipulations

This benefit covers manipulations to treat a covered illness, injury or condition.

Rehabilitation therapy, such as massage or physical therapy, provided with manipulations is covered under the ***Rehabilitation Therapy*** and ***Habilitation Therapy*** benefits.

Substance Use Disorder

This benefit covers treatment of substance use disorder (see ***Definitions***). Benefits are limited to the least costly treatment setting that is medically necessary for your condition. This plan complies with federal parity requirements.

Some services require prior authorization before you receive treatment. See ***Prior Authorization*** for details.

This plan covers all of the following services:

- Individual, family or group therapy
- Inpatient, residential treatment, partial hospitalization and outpatient visits to manage or reduce the effects of the alcohol or drug dependence
- Lab and testing
- Take-home drugs you get in a facility

For this benefit, “outpatient visit” means a clinical treatment session with a substance use provider. Outpatient visits can include real-time visits with your doctor or other provider via telephone, online chat or text, or other electronic methods.

Medically necessary detoxification is covered in any medically necessary setting. Detoxification in the hospital is covered under the ***Ambulatory Surgical Center, Emergency Room*** and ***Hospital*** benefits.

In determining whether services for substance use disorder treatment are medically necessary, Premera Blue Cross Blue Shield of Alaska will use the current edition of the Patient Placement Criteria for the Treatment of Substance-Related Disorders as published by the American Society of Addiction Medicine.

This benefit does not cover:

- Alcohol or drug use or abuse that does not meet the definition of substance use disorder as stated in ***Definitions***.
- Halfway houses, quarterway houses, recovery houses, and other sober living residences

Surgery

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

- Anesthesia or sedation and postoperative care as medically necessary. Benefits include anesthesia performed in connection with the preventive colonoscopy that your provider determines would be medically appropriate for you.
- Cornea transplantation, skin grafts, and the transfusion of blood or blood derivatives
- Sexual reassignment surgery if medically necessary and not for cosmetic purposes
- Colonoscopy and other scope insertion procedures are also covered under this benefit unless they qualify as preventive services described in the ***Preventive Care*** benefit
- Surgical services that are considered medically necessary to correct the cause of infertility
- The repair of a dependent child’s congenital anomaly

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

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

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

Temporomandibular Joint Disorders (TMJ) Care

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

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

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

This benefit covers:

- Exams
- Consultations
- Treatment

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

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

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

Therapeutic Injections

This benefit covers:

- Shots given in the doctor's office
- Supplies used during visit, such as serums, needles and syringes
- Three teaching doses for self-injectable specialty drugs

This benefit does not cover:

- Immunizations (see ***Preventive Care***)
- Self-injectable drugs (see ***Prescription Drugs***)
- Infusion therapy (see ***Infusion Therapy***)
- Allergy shots (see ***Allergy Testing and Treatment***)

Transplants

This 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.

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. See ***Definitions*** for a definition of "experimental/ investigational."

The plan reserves the right to base coverage on all the following:

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

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

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

Recipient Costs

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

Donor Costs

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

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

Travel and Lodging

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. Travel and lodging expenses will be based on current IRS guidelines on the date(s) the expenses were incurred. Please see the ***Summary of Your Costs*** to find out what the reimbursement rates are.

- **Travel:** Travel is reimbursed between the patient's home and the Approved Transplant Center for round-trip (air, train, or bus) coach class transportation costs. If traveling by car, mileage, parking and toll costs are reimbursed.
- **Lodging:** Expenses incurred by a transplant patient and companion for hotel lodging away from home.

Companion travel and lodging expenses are covered if the companion must, as a matter of medical necessity, accompany the member. If the member receiving the transplant is a child under age 19, one companion is automatically permitted. A second companion will only be permitted if medically necessary.

Reimbursement amounts are subject to change due to IRS regulations. Please refer to the IRS website, **www.irs.gov**, for additional information. The information in this benefit should not be assumed as tax advice.

This benefit does not cover:

- 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. See ***Definitions*** for a definition of "experimental/ investigational."
- 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
- Meals
- Alcohol or tobacco
- Car rentals
- Personal care items, such as shampoo or a toothbrush
- Souvenirs or other tourist items such as T-shirts, sweatshirts, or toys
- Entertainment such as movies, visits to museums or mileage for sightseeing
- Phone calls
- Costs for people other than you and your covered companion(s)
- Take-home prescription drugs dispensed by a licensed pharmacy. See ***Prescription Drugs*** for benefit information.

Urgent Care

This benefit covers:

Exams and treatment of:

- Minor sprains
- Cuts
- Ear, nose and throat infections
- Fever

Some services done during the urgent care visit may be covered under other benefits of this plan with different or additional cost shares, such as:

- X-rays and lab work
- Shots or therapeutic injections
- Office surgeries

This benefit does not cover emergency room or an urgent care facility attached to or part of a hospital, see ***Emergency Room*** for benefit details.

Virtual Care

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

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

Vision Benefits

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

Vision Exams

Covered routine exam services include:

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

Vision Hardware

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

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

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

- Prescription eyeglass lenses (single vision, bifocal, trifocal, quadrifocal or lenticular)
- Frames for eyeglasses
- Prescription contact lenses (soft, hard or disposable)
- Prescription safety glasses

- Prescription sunglasses
- Special features, such as tinting or coating

Fitting of eyeglass lenses to frames

- Fitting of contact lenses to the eyes

Vision hardware benefits are based on allowed amounts for covered services and supplies. See ***What Do I Need To Know Before Care*** for a definition of "allowed amount." Charges for vision services or supplies that exceed what's covered under this benefit aren't covered under other benefits of this plan.

This benefit does not cover:

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

Pediatric Vision Benefit

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

Vision Exam

Covered routine exam services include:

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

The Vision Exam benefit for members under 19 will provide coverage until the end of the month in which the member turns 19.

Vision Hardware

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

The Vision Hardware benefit for members under 19 will provide coverage until the end of the month in which the member turns 19.

Weight Management

Non-Surgical Weight Management

Benefits for non-surgical weight management are covered on the same basis as any other covered condition, subject to the applicable benefits, limitations and exclusions.

Non-surgical weight management benefits include, but aren’t limited to, coverage of the following outpatient medical services:

- Behavioral health visits
- Nutritional/dietician visits
- Physical therapy visits

- Physician visits
- Related lab and diagnostic services

For specific benefit information, see the ***Mental Health Care, Preventive Care***, ***Rehabilitation Therapy***, ***Professional Visits And Services***, and ***Diagnostic X-Ray, Lab, And Imaging*** benefits.

Surgical Weight Loss Treatment

Benefits for surgical treatment of morbid obesity are covered the same as any other covered condition subject to the medical policy on bariatric surgery, applicable benefits, limitations and exclusions.

Weight loss surgery requires prior authorization. See ***Prior Authorization***.

Coverage is available for bariatric procedures listed as medically necessary, when conservative measures have proven ineffective. Examples of conservative measures include but aren't limited to covered services under the Non-Surgical Weight Management benefit, diet and exercise programs.

To qualify for surgical weight loss treatment, the member must meet the criteria stated in the Claims Administrator's medical policy on bariatric surgery. See the Bariatric Surgery medical policy at premera.com.

For specific surgical treatment benefit information, see the ***Hospital***, ***Ambulatory Surgical Center*** and ***Surgery*** benefits.

The *Weight Management* benefit does not cover:

- Procedures or treatments that are experimental and investigational (see ***Definitions***)
- Liposuction or surgical removal of excess skin unless medically necessary
- Over-the-counter medications for weight loss
- Liquid diet or fasting programs
- Other food replacement and nutritional supplements
- Membership in diet programs
- Exercise programs and health clubs
- Wiring of the jaw
- Weight management drugs

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

OUT-OF-AREA CARE

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

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

Getting services through these Inter-Plan Arrangements does not change covered benefit levels, or any stated eligibility requirements. Please call us if your care needs prior authorization. See ***Prior Authorization*** for details.

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

BlueCard Program

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

- The provider's billed charges for your covered services; or
- The allowed amount that the Host Blue made available to us. See ***What Do I Need To Know Before Care*** for a definition of "allowed amount."

Often, the allowed amount is a discount that reflects an actual price that the Host Blue pays to the provider. Sometimes it is an estimated price that takes into account a special arrangement with a single provider or a group of providers. In other cases, it may be an average price, based on a discount that results in expected average savings for services from similar types of providers.

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

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

Value-Based Programs

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

Taxes, Surcharges and Fees

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

Out-of-Network Providers

It could happen that you receive covered services from providers outside Alaska and Washington and in Clark County, Washington that do not have a contract with the Host Blue. In most cases, we will base the amount you pay for such services on either our allowed amount for these providers or the pricing requirements under applicable law. See ***What Do I Need To Know Before Care*** for a definition of "allowed amount."

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

Blue Cross Blue Shield Global® Core Program

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

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

Further Questions?

If you have questions or need to find out more about the BlueCard Program, please call our customer service department. To find a provider outside our service area, go to **premera.com** or call 800-810-BLUE (2583). You can also get Blue Cross Blue Shield Global Core information by calling the toll-free phone number.

CARE MANAGEMENT

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

You must be eligible on the dates of service and services must be medically necessary. We encourage you to call customer service to verify that you meet the required criteria for claims payment.

PRIOR AUTHORIZATION

You must get Premera's approval for some services before the service is performed, or you may pay a penalty. This process is called prior authorization. You can find our medical policies at **premera.com**.

There are two different types of prior authorization required:

1. **Prior Authorization for Benefit Coverage** You must get prior authorization for certain types of medical services, equipment, and for most inpatient facility stays, as listed below. This is so that Premera can confirm that these services are medically necessary and covered by the plan.
2. **Prior Authorization for In-Network Cost Shares for Out-of-Network Providers** Except for emergency services (Please see ***Exceptions to Prior Authorization for Out-of-Network and Out-Of-Area Providers*** below for more information), you must get prior authorization in order for the plan to:
   - Cover an out-of-network provider in Alaska at the in-network benefit level.

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

How Prior Authorization Works

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

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

The prior authorization will be valid for 90 calendar days. This 90-day period depends on your continued coverage under the plan. If you do not receive the services within that time, you will have to ask the plan for another prior authorization.

1. **Prior Authorization for Benefit Coverage**

   Prior Authorization for Medical Services, Supplies or Equipment

   The plan has a list of services, equipment, and facility types that must have prior authorization before you receive the service or are admitted as an inpatient at the facility. Please contact your in-network provider or Premera Customer Service before you receive a service to confirm that your service requires prior authorization. You can find our medical policies at **premera.com**. You can also find the list of services requiring prior authorization on our website at www.premera.com/visitor/preapproval.

   - **In-network providers or facilities** are required to request prior authorization for the service.
   - **Out-of-network providers and facilities and all providers and facilities outside Alaska and Washington** will not request prior authorization for the service. You have to ask Premera to prior authorize the service. Certain services, devices and drugs need to be reviewed to make sure that they are medically necessary for you and meet this plan's other standards for coverage. It is to your advantage to know in advance if the plan would not cover them.

   Prior Authorization for Prescription Drugs

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

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

You can still buy the drug before it is prior authorized, but you must pay the full cost. If the drug is authorized after you bought it, you can send us a claim for reimbursement. Reimbursement will be based on the allowed amount. ***See How Do I File A Claim?*** for details.

Exceptions to Prior Authorization for Benefit Coverage

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

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

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

2. Prior Authorization for In-Network Cost Shares for Out-of-Network Providers

Generally, non-emergent care by out-of-network providers in Alaska and providers outside the service area are covered at lower benefit levels. However, you may ask for a prior authorization to cover one of these providers at the in-network level if the services are medically necessary and are available from a in-network provider within 50 miles of your home. You or the out-of-network or out-of-area provider must ask for prior authorization before you receive the services.

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

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

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

Notify us by calling customer service when you receive non-emergency covered services from a non-participating provider so that we can apply your benefits correctly.

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

The prior authorization request for an out-of-network provider or provider outside of the service area must include the following:

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

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

Exceptions to Prior Authorization for Out-of-Network and Out-Of-Area Providers

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

If you are admitted to an out-of-network or out-of-area hospital due to an emergency condition, those services are always covered at the in-network benefit level. The plan will continue to cover those services until you are medically stable and can safely transfer to an in-network hospital.

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

CLINICAL REVIEW

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

- Accepted clinical practice guidelines

- Industry standards accepted by organizations like the American Medical Association (AMA)
- Other professional societies
- Center for Medicare and Medicaid Services (CMS).

You can find our medical policies at premera.com.

You or your provider may request a copy of the criteria used to make a medical necessity decision. Please send your request to Care Management at the address or fax number located on the inside front cover of this benefit booklet.

Premera may deny payment for services that are not medically necessary or that are considered experimental or investigational. A decision by Premera may be appealed, see ***Complaints and Appeals***. When there is more than one alternative available, coverage will be provided for the least costly among medically appropriate alternatives.

PERSONAL HEALTH SUPPORT PROGRAMS

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

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

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

Chronic Condition Management

Premera has contracted with a consumer digital health company (the program manager) to give members access to a program of monitoring and health management support for certain chronic conditions described below. The program is voluntary. Your readings and other data are not shared with Premera, the Group, or anyone other than the program manager. However, the program manager can share your data with your provider or with someone close to you if you choose.

- **Diabetes Management Plus:** For members who have Type 1 or Type 2 diabetes. If you qualify and join the program, you will get:
  - A blood glucose meter from the program manager that uploads blood sugar readings to a personal online account.
  - A lancing device and lancets.
  - Test strips for this meter. You can reorder test strips using the meter or online. The strips will be sent to you directly.
  - Real-time reminders to check blood sugar or to take medication, and tips based on your blood sugar readings that can help keep your levels within a healthy range.
  - Coaching and support via phone, text, e-mail, or the program manager's mobile app.
- **Diabetes Prevention Plus:** For members who meet pre-diabetes criteria followed by the Centers for Disease Control. If you qualify and join the program, you will get:
  - A digital scale from the program manager that uploads readings to a personal online account.
  - Lessons that cover topics such as nutrition, activity and stress
  - Coaching and support via phone, text, e-mail or the program manager's mobile app.
- **Hypertension Management Plus:** If you qualify and join the program, you will get:
  - A blood pressure cuff from the program manager that uploads blood pressure readings to a personal online account.
  - Real-time reminders to check blood pressure or to take medication, and tips based on your blood pressure readings that can help keep your pressure within a healthy range.

- Coaching and support via phone, text, e-mail, or the program manager's mobile app. Access to online information.

- **Weight Management:** If you qualify and join the program, you will get:
  - An application and cellular scale that logs and tracks results.
  - Messaging and live one-on-one expert coaching.
  - Health summaries to help educate and offer positive reinforcement.

Cancer Support Program

Alyeska Pipeline Service Company provides access to a Cancer Support Program at no cost to all employees and their eligible dependents aged 18 and older with a suspected or confirmed cancer diagnosis and who are covered under the Alyeska Pipeline Service Company's Premera Blue Cross Blue Shield of Alaska health plan. This is a 24/7 evidence-based virtual cancer advocacy and navigation program offering individualized support in-between visits with your oncologist.

If you have cancer, or are caring for someone with cancer, the program provides:

- 24/7 access: Access to expert is available anytime through confidential calls. You can also access the vendor website or text them for support with your questions or concerns.
- On-demand nurse support: On-demand access to providers that can assist with understanding test results, medications and potential side effects, and additional guidance, such as interpreting provider instructions and planning treatment.
- Collaborative care focused on you: Thyme Care takes care of your needs between visits and keeps your doctors and care teams updated, so you can rest assured that all the details are connected and nothing gets lost.
- Support beyond the clinic: Connect to support and services such as financial help, transportation, in-home care, food assistance or community groups dedicated to supporting cancer patients.
- Evidence-based resources: Clinically informed customized content with trusted information and expert tips on preparing for treatment, handling concerns, talking to providers, strategies for improving your sleep, exercise routine, and emotional well-being.
- Support for life after cancer treatment: Regular check-ins providing tips on ongoing care and wellness information, including sleep, nutrition, exercise, and mindfulness.

Members can:

- Learn about cancer diagnosis and treatment options
- Address urgent concerns and unexpected challenges
- Manage symptoms and side effects
- Get emotional and mental health support
- Identify financial assistance and get help with insurance navigation
- Find in-network providers or get help seeking a second opinion
- Connect with other helpful benefits

EXCLUSIONS AND LIMITATIONS

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

Amounts Over the Allowed Amount

Costs over the allowed amount as defined by this plan, for non-emergency services from an out-of-network, non-participating or non-contracted provider.

Assisted Reproduction

Assisted reproduction technologies including but not limited to:

- Drugs to treat infertility or that are required as part of assisted reproduction procedures.

- Artificial insemination or assisted reproduction methods, such as in-vitro fertilization. It does not matter why you need the procedure.
- Services to make you more fertile or for multiple births
- Reversing sterilization surgery

Benefits from other sources

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

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

Benefits that have been exhausted

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

Broken or missed appointments

Broken or missed appointments, including charges from providers for broken or missed appointments.

Caffeine Dependency

Charges for records or reports

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

Comfort or convenience items

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

Complications of a non-covered service

Includes follow-up services or effects of those services.

Cosmetic Services

Drugs, services or supplies for cosmetic services not medically necessary. This includes services performed to reshape normal structures of the body in order to improve or alter your appearance and not primarily to restore an impaired function of the body. This also includes drugs, services, or supplies to improve or alter the appearance of your skin or hair.

Counseling, Educational and Training

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

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

Court-Ordered Services

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

Custodial Care

Custodial services that are not covered hospice care services.

Dental Care

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

Environmental Therapy

Therapy designed to provide a change or controlled environment.

Experimental or Investigational Services

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

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

Family Members or Volunteers

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

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

Governmental Facilities

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

Hair Analysis

Hair Loss

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

Hearing Hardware

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

Illegal Acts, Illegal Services, and Terrorism

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

Low-level laser therapy

Military Service and War

Illness or injury that is caused by or arises from:

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

Non-Covered Services

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

- Ordered when this plan is not in effect or when the person is not covered under this plan, except as stated under specific benefits and under ***Extended Benefits*** section
- That are not listed as covered under this plan
- Services or supplies for which no charge is made, for which none would have been made if this plan were not in effect, or for which you are not legally required to pay
- Non-treatment charges, including charges for provider time
- Transporting a member in place of a parent or other family member or accompanying the member to appointments or other activities outside the home, such as medical appointments or shopping
- Doing housework or chores for the member or helping the member do housework or chores

Non-Treatment Facilities, Institutions or Programs

- Institutional care
- Housing,
- Incarceration
- Programs from facilities that are not licensed to provide medical or behavioral health treatment for covered services. Examples are prisons, nursing homes and juvenile detention facilities.

Orthodontia

Orthodontic services, including casts, models, x-rays, photographs, examinations, appliances, braces, and retainers.

Orthognathic Surgery

Procedures to lengthen or shorten the jaw for cosmetic purposes. This includes services performed to reshape normal structures of the body in order to improve or alter your appearance.

Provider's Licensing or Certification

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

Recreational, Camp and Activity Programs

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

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

Serious Adverse Events and Never Events

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

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

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

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

Services or Supplies Not Medically Necessary

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

Sexual Dysfunction

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

Vision Hardware

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

Vision Therapy

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

Voluntary Support Groups

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

Weight Loss Drugs

This plan does not cover drugs or supplements for weight loss or weight control

Work-Related Illness or Injury

Any illness, condition or injury you get benefits 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

WHAT IF I HAVE OTHER COVERAGE?

COORDINATING BENEFITS WITH OTHER HEALTH CARE PLANS

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

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

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

Definitions Applicable To Coordination Of Benefits

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

- **Allowable Medical Expense** means the usual, customary and reasonable charge for any medically necessary health care service or supply provided by a licensed medical professional when the service or supply is covered

at least in part under this plan. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered, or supply provided shall be considered an allowable expense.

- **Allowable Dental Expense** means the usual, customary and reasonable charge for any dentally necessary service or supply provided by a licensed dental professional when the service or supply is covered at least in part under this plan. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered, or supply provided shall be considered an allowable expense. For the purpose of this plan, only those dental services to treat an accidental injury to natural teeth will be considered an allowable dental expense.
- **Claim Determination Period** means a calendar year
- **Medical Plan** means all 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 the following dental care coverages, even if they don't have their own coordination provisions:
  - Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization group or individual agreements issued by insurers, health care service contractors, and health maintenance organizations
  - Labor-management trusteed plans, labor organization plans, employer organization plans, or employee benefit organization plans
  - Government programs that provide benefits for their own civilian employees or their dependents

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

Effect On Benefits

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

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

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

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

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

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

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

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

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

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

Right Of Recovery/Facility Of Payment

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

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

COORDINATING BENEFITS WITH MEDICARE

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

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

THIRD PARTY RECOVERY

General

If you become ill or are injured by the actions of a third-party, your medical care should be paid by that third party. For example, if you are hurt in a car crash, the other driver or their insurance company may be required under law to pay for your medical care.

This plan does not pay for claims for which a third-party is responsible. However, the plan may agree to advance benefits for your injury with the understanding that it will be repaid from any recovery received from the third party. By accepting plan benefits for the injury, you agree to comply with the terms and conditions of this section.

In addition, the plan maintains a right of subrogation, meaning the right of the plan to be substituted in place of the member who received benefits with respect to any lawful claim, demand, or right of action against any third party that may be liable for the injury, illness or medical condition that resulted in payment of plan benefits. The third party may not be the actual person who caused the injury and may include an insurer to which premiums have been paid.

The plan administrator has discretion to interpret and to apply the terms of this section. It has delegated such discretion to Premera Blue Cross Blue Shield of Alaska and its affiliates to the extent we need in order to administer this section.

Definitions The following definitions shall apply to this section:

- **Recovery** All payments from another source that are related in any way to your injury for which plan benefits have also been paid. This includes any judgment, award, or settlement. It does not matter how the recovery is termed, allocated, or apportioned or whether any amount is specifically included or excluded as a medical expense. Recoveries may also include recovery for pain and suffering, non-economic damages, or general damages. This also includes any amounts put into a trust or constructive trust set up by or for you or your family, beneficiaries or estate as a result of your injury.

- **Reimbursement Amount** The amount of benefits paid by the plan for your injury and that you must pay back to the plan out of any recovery per the terms of this section.
- **Responsible Third Party** A third party that is or may be responsible under the law ("liable") to pay you back for your injury.
- **Third Party** A person; corporation; association; government; insurance coverage, including uninsured/underinsured motorist (UM/UIM), personal umbrella coverage, personal injury protection (PIP) insurance, medical payments coverage from any source, or workers' compensation coverage. The third party may not be the actual party who caused the injury, and may include an insurer.

  Note: For this section, a third party does not include other health care plans that cover you.
- **You** In this section, "you" includes any lawyer, guardian, or other representative that is acting on your behalf or on the behalf of your estate in pursuing a repayment from responsible third parties.

Exclusions

- **Benefits From Other Sources** - Benefits are not available under this plan when coverage is available through:
  - Any type of excess coverage
  - Any type of liability insurance, such as home-owner's coverage or commercial liability coverage
  - Any type of no-fault coverage, such as Personal injury protection (PIP) coverage, Medical Payment coverage or Medical Premises coverage
  - Boat coverage
  - Motor vehicle medical or motor vehicle no-fault
  - School or athletic coverage
- **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.

These exclusions apply when the available or existing contract or insurance is either issued to a member or makes benefits available to a member, whether or not the member makes a claim under such coverage. Further, the member is responsible for any cost-sharing required by motor vehicle coverage, unless applicable state law requires otherwise. If other insurance is available for medical bills, the member must choose to put the benefit to use towards those medical bills before coverage under this plan is available. Once benefits under such contract or insurance have been used and exhausted or considered to no longer be injury-related under the no-fault provisions of the contract, this plan's benefits will be provided.

Reimbursement and Subrogation Rights

If the plan advances payment of benefits to you for an injury, the plan has the right to be repaid in full for those benefits.

- The plan has the right to be repaid first and in full, without regard to lawyers' fees or legal expenses, make-whole doctrine, the common fund doctrine, your negligence or fault, or any other common law doctrine or state statute that the plan is not required to comply with that would restrict the plan's right to reimbursement in full. The reimbursement to the plan shall be made directly from the responsible third party or from you, your lawyer or your estate.
  - The plan shall also be entitled to reimbursement by asking for refunds from providers for the claims that it had already paid.
- The plan's right to reimbursement first and in full shall apply even if:
  - The recovery is not enough to make you whole for your injury.

- The funds have been commingled with other assets. The plan may recover from any available funds without the need to trace the source of the funds.
- The member has died as a result of the injury and a representative is asserting a wrongful death or survivor claim against the third party.
- The member is a minor, disabled person, or is not able to understand or make decisions.
- The member did not make a claim for medical expenses as part of any claim or demand

- Any party who distributes your recovery funds without regard to the plan's rights will be personally liable to the plan for those funds.
- In any case where the plan has the right to be repaid, the plan also has the right of subrogation. This means that the Plan Administrator can choose to take over your right to receive payments from any responsible third party. For example, the plan can file its own lawsuit against a responsible third party. If this happens, you must co-operate with the plan as it pursues its claim.

  The plan shall also have the right to join or intervene in your suit or claim against a responsible third party.
- You cannot assign any rights or causes of action that you might have against a third party tortfeasor, person, or entity, which would grant you the right to any recovery without the express, prior written consent of the plan.

Your Responsibilities

- If any of the requirements below are not met, the plan shall:
  - Deny or delay claims related to your injury
  - Recoup directly from you all benefits the plan has provided for your injury
  - Deduct the benefits owed from any future claims
- You must notify Premera Blue Cross Blue Shield of Alaska of the existence of the injury immediately and no later than 30 days of any claim for the injury.
- You must notify the third parties of the plan's rights under this provision.
- You must cooperate fully with the plan in the recovery of the benefits advanced by the plan and the plan's exercise of its reimbursement and subrogation rights. You must take no action that would prejudice the plan's rights. You must also keep the plan advised of any changes in the status of your claim or lawsuit.
- If you hire a lawyer, you must tell Premera Blue Cross right away and provide the contact information.

  Neither the plan nor Premera Blue Cross Blue Shield of Alaska shall be liable for any costs or lawyer's fees you must pay in pursuing your suit or claim. You shall defend, indemnify and hold the plan and Premera Blue Cross Blue Shield of Alaska harmless from any claims from your lawyer for lawyer's fees or costs.
- You must complete and return to the plan an Incident Questionnaire and any other documents required by the plan.

  Claims for your injury shall not be paid until Premera Blue Cross Blue Shield of Alaska receives a completed copy of the Incident Questionnaire when one was sent.
- You must tell Premera Blue Cross Blue Shield of Alaska if you have received a recovery. If you have, the plan will not pay any more claims for the injury unless you and the plan agree otherwise.
- You must notify the plan at least 14 days prior to any settlement or any trial or other material hearing concerning the suit or claim.

Reimbursement and Subrogation Procedures

If you receive a recovery, you or your lawyer shall hold the Recovery funds separately from other assets until the plan's reimbursement rights have been satisfied. The plan shall hold a claim, equitable lien, and constructive trust over any and all recovery funds. Once the plan's reimbursement rights have been determined, you shall make immediate payment to the plan out of the recovery proceeds.

If you or your lawyer do not promptly set the recovery funds apart and reimburse the plan in full from those funds, the plan has the right to take action to recover the reimbursement amount. Such action shall include, but shall not be limited to one or both of the following:

- Initiating an action against you and/or your lawyer to compel compliance with this section.
- Withholding plan benefits payable to you or your family until you and your lawyer complies or until the reimbursement amount has been fully paid to the plan.

WHO IS ELIGIBLE FOR COVERAGE?

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

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

SUBSCRIBER ELIGIBILITY

As a Regular, Alyeska Employee, you may enroll in the Plan on the date you are hired. Your coverage will take effect when you become eligible (date of enrollment) for coverage, provided you have completed and returned your enrollment form to your HR representative within 30 days of when you first become eligible.

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 Employer is located) be administered according to Hawaii law. If the Employer is not a governmental employer as described in this paragraph, employees who reside and perform any employment services for the Employer in Hawaii are not eligible for coverage. When an employee moves to Hawaii and begins performing employment services for the Employer there, they will no longer be eligible for coverage.

DEPENDENT ELIGIBILITY

As an employee enrolling in the plan, you may elect coverage for your eligible dependent(s).

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

- An Employee's Spouse;
- A Dependent Child: an employee's natural, adopted child, or stepchild until the child is age 26;
- A Dependent child over age 26, who is dependent for support due to a developmental or physical disability which occurred while covered by the Medical Plan;
- A child who, pursuant to a Qualified Child Medical Support Order (QCMSO), must be recognized as a Dependent for the purpose of providing health coverage; and
- An employee's domestic partner, regardless of same or opposite sex, who meets the eligibility requirements outlined in the Affidavit of Domestic Partnership (TAPS Form #10499). The child(ren) of an eligible domestic partner may also be covered under the Plan, provided they meet the Plan's definition of an eligible dependent child.
- A legal dependent or foster child for whom the subscriber or spouse has a legal guardianship. There must be a court or other order signed by a judge or state agency, which grants guardianship of the child to the subscriber or spouse as of a specific date. When the court order terminates or expires, the child is no longer an eligible child.

Coverage may be continued for children who become developmentally or physically disabled while covered under the Medical Plan. Subject to Premera Blue Cross Blue Shield of Alaska's approval, this extended coverage may be continued for as long as the condition lasts.

Coverage under a QCMSO will become effective on the date of the order, if the enrollment information is completed within 60 days of the date of the QCMSO. Otherwise coverage will become effective on the date the enrollment form is received. The enrollment form may be submitted by the Employee, custodial parent, or a state agency. If Dependent coverage was absent to the Employee prior to the QCMSO, Employee contributions for coverage will begin from the child's effective date.

Dependent coverage takes effect on the same date your coverage becomes effective provided you have enrolled for Dependent and Employee coverage.

If your Dependent, such as a Spouse, is also an Employee of the Employer, you may list them as an eligible Dependent when selecting coverage.

WHEN DOES COVERAGE BEGIN?

ENROLLMENT

Enrollment is timely when Alyeska Pipeline Service Company receives the completed enrollment form within 30 days of the date the employee becomes an "eligible employee" as defined earlier in this section. When enrollment is timely, coverage for the employee and enrolled dependents will become effective on the employee's date of hire. If Alyeska Pipeline Service Company does not receive your completed enrollment form within 30 days of the date you became eligible, none of the dates above will apply and your enrollment will be considered waived under the plan. Please see ***Open Enrollment*** and ***Special Enrollment***.

Dependents Acquired Through Marriage After The Subscriber's Effective Date

When Alyeska Pipeline Service Company receives the completed enrollment form within 30 days after the marriage, coverage will become effective on the date of marriage. If Alyeska Pipeline Service Company does not receive the enrollment form within 30 days of marriage, refer to ***Open Enrollment*** section.

Newborn And Adoptive Children

Natural newborn dependent children born on or after the subscriber's effective date will be covered from their date of birth. If the subscriber desires coverage of the newborn child to extend beyond the 30-day period following the newborn child's date of birth, Alyeska Pipeline Service Company must receive a completed enrollment form within the 30-day period following the date of birth.

Adoptive dependent children, including children acquired through legal guardianship, 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. Alyeska Pipeline Service Company must receive a completed enrollment form within the 30-day period following the dependent child's date of adoption or placement for adoption.

If Alyeska Pipeline Service Company does not receive the enrollment form within the 30-day period, initial coverage will be limited to the 30-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.

Please note: This provision applies only for a newborn child of an employee, spouse or domestic partner.

Children Acquired Through Legal Guardianship

When we receive the completed enrollment application, any required premiums, 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.

If the Group does not receive the Health Plans Form within the 30-day period, initial coverage will be limited to the 30-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 Covered Under Medical Child Support Orders

When Alyeska Pipeline Service Company receives the completed enrollment form within 30 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 Alyeska Pipeline Service Company receives the enrollment form for coverage. Contact your Group for detailed procedures.

Court-Ordered Dependent Coverage

When Alyeska Pipeline Service Company receives the completed enrollment form within 30 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 when Alyeska Pipeline Service Company receives the enrollment form for coverage. When premiums being paid don't already include coverage for a spouse and/or dependent children, such charges will begin from the dependent's effective date.

SPECIAL ENROLLMENT

Involuntary Loss Of Other Coverage

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

An eligible employee who qualifies as stated above may also enroll all eligible dependents. When only an eligible dependent qualifies for special enrollment, but the eligible employee is not enrolled in any of Alyeska Pipeline Service Company's plans or is enrolled in a different plan sponsored by Alyeska Pipeline Service Company, the employee is also allowed to enroll in this plan in order for the dependent to enroll.

When Alyeska Pipeline Service Company receives your and/or dependent's completed enrollment form and any required charges within 30 days of the date such other coverage ended, coverage under this plan will become effective on the first of the month following receipt of your enrollment form.

When Alyeska Pipeline Service Company does not receive your completed enrollment form within 30 days of the date prior coverage ended, refer to ***Open Enrollment*** below.

Note: A waiver is allowed if obtaining other coverage as long as the form is completed in 30 days.

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. Refer to ***Open Enrollment*** below.

CHANGES DURING THE YEAR

If you experience a special enrollment event or qualifying status change, you may:

- Enroll for the first time (if you previously elected to waive coverage).
- Change your existing medical coverage election.

Generally, any election change must be consistent with the qualifying status change that affects eligibility for you, your spouse/domestic partner, your dependent children, or your domestic partner’s dependent children under this plan or another employer’s plan. Otherwise, you may make changes only during open enrollment.

OPEN ENROLLMENT

If you're not enrolled when you first become eligible, or as allowed under ***Special Enrollment*** above, you cannot be enrolled until Alyeska Pipeline Service Company's next "open enrollment" period. An open enrollment period occurs once a year unless otherwise set by Alyeska Pipeline Service Company. During this period, eligible employees and their dependents can enroll for coverage under this plan.

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

CHANGES IN COVERAGE

No rights are vested under this plan. Alyeska Pipeline Service Company may change its terms, benefits, and limitations at any time. Changes to this plan will apply as of the date the change becomes effective to all members and to eligible employees and dependents who become covered under this plan after the date the change becomes effective.

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

PLAN TRANSFERS

Subscribers (with their enrolled dependents) may be allowed to transfer to this plan from another plan offered by Alyeska Pipeline Service Company. Transfers also occur if Alyeska Pipeline Service Company replaces another plan with this plan. All transfers to this plan must occur during open enrollment or on another date set by Alyeska Pipeline Service Company.

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

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

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.

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

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:

- You are no longer a Regular Employee of the Employer;
- You stop making required contributions;
- You die;
- The Medical Plan ends; or
- For fraud or intentional misrepresentation of material fact under the terms of the coverage by the subscriber or the subscriber's dependents.

Your Dependent's coverage will stop on the last day of the month if:

- Your coverage ends; or

- Your Dependent is no longer eligible (e.g., divorce, age limitations).

Under certain circumstances, you or your Dependents may continue coverage beyond the time when it would normally end. See “Extension of Coverage” (COBRA) in this SPD for more information.

The subscriber must promptly notify Alyeska Pipeline Service Company when an enrolled family member is no longer eligible to be enrolled as a dependent under this plan.

PLAN TERMINATION

No rights are vested under this plan. Alyeska Pipeline Service Company is not required to keep the plan in force for any length of time. Alyeska Pipeline Service Company reserves the right to change or terminate this plan, in whole or in part, at any time with no liability. Plan changes are made as described in ***Changes In Coverage*** in this booklet. If the plan were to be terminated, you would only have a right to benefits for covered care you receive before the plan's end date.

HOW DO I CONTINUE COVERAGE?

CONTINUED ELIGIBILITY FOR A DISABLED CHILD

Coverage may continue beyond the limiting age shown in ***Dependent Eligibility*** for a dependent child who cannot support themselves 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 or physical disability and is chiefly dependent upon the subscriber for support and maintenance
- The subscriber remains covered under this plan
- The child's premiums, 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 Disabled Dependent form. We must approve the request for certification for coverage to continue.
- The subscriber provides proof of the child's disability and dependent status when requested. Proof won't be requested more often than once a year after the 2-year period following the child's attainment of the limiting age.

LEAVE OF ABSENCE

Coverage for a subscriber and enrolled dependents may be continued for up to 90 days, or as otherwise required by law, when Alyeska Pipeline Service Company grants the subscriber a leave of absence and premiums 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 Alyeska Pipeline Service Company 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 a monthly premium for it.

The plan will provide qualified members with COBRA coverage 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. Alyeska Pipeline Service Company, **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 Alyeska Pipeline Service Company immediately when one of the qualifying events highlighted below occurs. The continuation periods listed extend from the date of the qualifying event.

- Alyeska Pipeline Service Company 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 Alyeska Pipeline Service Company as gross misconduct.**

  However, if one of the events listed above follows the covered employee's entitlement to Medicare by less than 18 months, Alyeska Pipeline Service Company 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.
- Alyeska Pipeline Service Company must offer the covered spouse or children an election to continue coverage for up to 36 consecutive months if their coverage is lost because of 1 of 4 qualifying events:
  - **The subscriber dies**
  - **The subscriber and spouse legally separate or divorce**
  - **The subscriber becomes entitled to Medicare**
  - **A child loses eligibility for dependent coverage**

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

Conditions of COBRA Coverage

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

You Must Give Notice Of Some Qualifying Events

The plan will offer COBRA coverage only after Alyeska Pipeline Service Company receives timely notice that a qualifying event has occurred.

The subscriber or affected dependent must notify Alyeska Pipeline Service Company 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 Alyeska Pipeline Service Company 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 Alyeska Pipeline Service Company this notice for you.

Domestic partners are not qualified beneficiaries under federal COBRA. However, Alyeska offers COBRA-like continuation of coverage to domestic partners who were enrolled under the plan immediately prior to a qualifying event, subject to the same premium and duration rules as COBRA.

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 Alyeska Pipeline Service Company. 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 Alyeska Pipeline Service Company 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 Alyeska Pipeline Service Company.

Note: The subscriber or affected dependent must also notify Alyeska Pipeline Service Company 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.

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

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

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

You Must Enroll And Pay On Time

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

- You must send your first monthly payment to Alyeska Pipeline Service Company no more than 45 days after the date you elected COBRA coverage.
- Subsequent monthly payments must be paid to Alyeska Pipeline Service Company.

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 Alyeska Pipeline Service Company Informed Of Address Changes

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

When COBRA Coverage Ends

COBRA coverage will end on the last day for which any premium for it has been paid in the monthly period in which the first of the following occurs:

- The applicable continuation period expires

- The next monthly premium 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 premiums 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 Alyeska Pipeline Service Company 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.
- Alyeska Pipeline Service Company ceases to offer group health care coverage to any employee.

If You Have Questions

Questions about your plan or your rights under COBRA should be addressed to the plan contacts provided by Alyeska Pipeline Service Company. 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 website at **www.dol.gov/ebsa**. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

Extended Benefits

Under the following circumstances, certain benefits of this plan may be extended after your coverage ends.

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 plan
- 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 plan year ends before a plan 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 plan year maximum benefit won’t be renewed.

OTHER CONTINUED COVERAGE OPTIONS

Continuation Under USERRA

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

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

Medicare Supplement Coverage

If you're eligible for and enrolled in Parts A and B of Medicare, you may be eligible for guaranteed-issue coverage under certain Medicare supplement plans. You must apply within 63 days of losing coverage under this plan.

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 separate Subscriber Claim Form for each patient and each provider. You can get a claim form at **premera.com**. You can also call us and we will mail a claim form to you within 10 days.

Step 2

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

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

Step 3

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

Step 4

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

Step 5

Sign the Subscriber Claim Form in the space provided.

Step 6

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

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

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

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

PRESCRIPTION DRUG CLAIMS

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

Participating Pharmacies

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

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

Non-Participating Pharmacies

If the pharmacy does not submit your claim for you, you will have to pay the full cost for new prescriptions and refills purchased at these pharmacies. You will also 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.

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 days of receipt. You or your provider will have 45 days from our notice to provide the additional information.
- Once we receive the additional information, we will process your claim within 15 days of the date we receive the information

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.

If all you have to pay is a copay for a covered service or supply, your payment of the copay to your provider is not considered a claim for benefits. You can call customer service to get a paper copy of an explanation of benefits for the service or supply. The phone number is on the front cover of your booklet and on your Premera ID card. Or, you can visit our website, **premera.com**, for information and secure online access to claims information. To file a claim, please see the ***How Do I File A Claim?*** section for more detail. If your claim is denied in whole or in part, you may submit a complaint or appeal as outlined under ***Complaints and Appeals*** in this booklet.

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

COMPLAINTS AND APPEALS

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

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

WHAT IS A COMPLAINT?

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

How to file a complaint

Call customer service at 800-508-4722 (TTY: 711)

Send a fax to 425-918-5592

Send the details in writing to:

Premera Blue Cross Blue Shield of Alaska
PO Box 91102
Seattle, WA 98111-9202

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

WHAT IS AN APPEAL?

An appeal is a request to review a specific decision or an adverse benefit determination Premera has made.

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

- A member's or applicant's eligibility to be or stay enrolled in this plan or health insurance coverage
- A limitation on otherwise covered benefits
- A clinical review decision
- A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective

What you can appeal

Claims and prior authorization	Payment	Benefits or charges were not applied correctly, including a limit or restriction on otherwise covered benefits.
	Denied	Coverage of your service, supply, device or prescription was denied or partially denied. This includes prior authorization denials.

Appeal Levels

You have the right to three levels of appeals:

Appeal Level	What it means	Deadline to appeal
Level 1 (Internal)	This is your first appeal. Premera will review your appeal.	180 days from the date you were notified of our decision.
Level 2 (Internal)	If we deny your Level 1 appeal, you can appeal a second time. Premera will review your appeal.	60 days from the date you were notified of our Level 1 decision.
External	If we deny your Level 1 appeal, you can ask for an Independent Review Organization (IRO) to review your appeal. OR You can ask for an IRO review if Premera has not made a decision by the deadline for the Level 1 appeal. There is no cost to you for an external appeal.	180 days from the date you were notified of our Level 1 appeal decision. OR 180 days from the date the response to your Level 1 appeal was due, if you did not get a response or it was late.

HOW TO SUBMIT AN APPEAL IN WRITING

Step 1. **Get the form**	• Complete the **Member Appeal Form**, you can find it on **premera.com** or call customer service to request a copy. If you need help submitting an appeal, or would like a copy of the appeals process, call customer service at 800-508-4722 (TTY 711)
Step 2. **Collect supporting documents**	• Collect any supporting documents that may help with your appeal. This may include chart notes, medical records, or a letter from your doctor. Within 3 working days, we will confirm in writing that we have your request. • If you would like someone to appeal on your behalf, including your provider, complete a **Member Appeal Form** with authorization, you can find it on **premera.com**. We can't release your information without this form.
Step 3. **Send in my appeal**	To help process your appeal, be sure to complete the form and return with any supporting documents. **Send your documents to:** Premera Blue Cross Blue Shield of Alaska Attn: Appeals Coordinator PO Box 91102 Seattle, WA 98111-9202 Fax to 425-918-5592

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

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

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

APPEAL RESPONSE TIME LIMITS

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

Level II internal appeals will be reviewed by a panel of people who are not part of the Level I internal appeal. You may take part in the Level II panel meeting in person or by phone. Please call for more details about this process.

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

WHAT HAPPENS IF YOU HAVE ONGOING CARE?

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

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

WHAT HAPPENS IF IT'S URGENT

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

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

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

HOW TO ASK FOR AN EXTERNAL REVIEW

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

Step 1. **Complete the form**	**We'll tell you about your right to an external review with the written decision of your internal appeal.** • Complete the Independent Review Organization (IRO) Request form, you can find it on **premera.com** or call customer service to request a copy. You may

	also write to us directly to ask for an external appeal.
Step 2. **Collect supporting documents**	• Collect any supporting documents that may help with your external review. This may include medical records and other information. • We'll forward your medical records and other information to the Independent Review Organization (IRO). We will notify you which IRO was selected to review your appeal. If you have additional information on your appeal, you may send it to the IRO directly within five business days.
Step 3. **Send in my external review request**	To help process your external review, be sure to complete the form and return with any supporting documents. **Send your documents to:** Premera Blue Cross Blue Shield of Alaska Attn: Appeals Coordinator PO Box 91102 Seattle, WA 98111-9202 Fax to 425-918-5592

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

- Cost-sharing and surprise billing for emergency services
- Cost-sharing and surprise billing protections related to care you received from non-participating providers at participating facilities
- Your condition to receive notice and provide informed consent to waive NSA protections; and
- If a claim for care received is coded correctly and accurately reflects the treatments received, and the associated NSA protections related to patient cost-sharing and surprise billing.

These reviews will be referred to CMS for the HHS-Administered Federal External Review Process.

ONCE THE IRO DECIDES

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

Premera will accept the IRO decision.

If the IRO:

- Reverses our decision, we will apply their decision quickly
- Stands by our decision, there is no further appeal. However, you may have other steps you can take under state or federal law, such as filing a lawsuit. If you have questions about a denial of a claim or your appeal rights, you may call customer service at the number listed on your Premera ID card.

If your plan is governed by the Federal Employee Retirement Income Security Act of 1974 (ERISA), you can contact the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor. The phone number is 866-444-EBSA (3272)

OTHER INFORMATION ABOUT THIS PLAN

This section tells you about how this plan is administered. It also includes information about federal and state requirements we and the Alyeska Pipeline Service Company must follow and other information that must be provided to you.

Conformity With The Law

If any provision of the plan or any amendment is deemed to be in conflict with applicable state or federal laws or regulations, upon discovery of such conflict the plan will be administered in conformance with the requirements of such laws and regulations as of their effective date.

Evidence Of Medical Necessity

We have the right to require proof of medical necessity for any services or supplies you receive before benefits under this plan are provided. You or your health care providers may submit this proof. No benefits will be available if the proof isn't provided or acceptable to the plan.

Health Care Providers - Independent Contractors

All health care providers who provide services and supplies to a member do so as independent contractors. None of the provisions of this plan or the contract between Premera and Alyeska Pipeline Service Company are intended to create, nor shall they be deemed or construed to create, any employment or agency relationship between Premera and the Group and the provider of service other than that of independent contractors.

ID Card

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

Intentionally False Or Misleading Statements

If this plan's benefits are paid in error due to any intentionally false or misleading statements, the plan is 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, as directed by Alyeska Pipeline Service Company:

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

Limitations Of Liability

The plan, Alyeska Pipeline Service Company and Premera Blue Cross Blue Shield of Alaska are 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 and Alyeska Pipeline Service Company in a timely and appropriate manner in our administration of benefits. You're also under a duty to cooperate with us and Alyeska Pipeline Service Company 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 or quality reviews; and
- Fulfilling other legal obligations that are specified under the plan and our administrative service contract with Alyeska Pipeline Service Company

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 the plan provides 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 group or individual insurance plans that cover you

Notices

Any notice we're required to submit to Alyeska Pipeline Service Company or subscriber will be considered to be delivered if mailed to Alyeska Pipeline Service Company or the 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 are 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

On behalf of the plan, we have the right to recover amounts the plan has 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 their 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.

The plan will give written notice to the subscriber, or any other payee, including a provider at least 30 calendar days before the plan seeks recovery of an overpayment. The notice will include how to identify the specific claim and the specific reason for the recovery. You have the right to challenge the recovery of overpayment. The plan may also exercise the right to delegate all or part of the responsibility for recoveries to another third party.

Right To And Payment Of Benefits

Benefits of this plan are available only to members. Except as required by law, we will not honor any attempted assignment, garnishment or attachment of any right of this plan. In addition, members may not assign a payee for claims, payments or any other rights of this plan.

At our option only and in accordance with the law, we may pay the benefits of this plan to:

- The subscriber
- A provider
- A 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 the plan's obligation as to payment of benefits.

Venue

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

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

WHAT ARE MY RIGHTS UNDER ERISA?

Name Of Plan

Alyeska Group Medical Plan for Operating Company Employees

Plan Number

501

Plan Group Number

9000000

This plan is an employee welfare benefit plan that's subject to the Federal Employee Retirement Income Security Act of 1974 (ERISA). The employee welfare benefit plan is called the "ERISA Plan" in this section.

When used in this section, the term "ERISA Plan" refers to Alyeska Pipeline Service Company's employee welfare benefit plan. The "ERISA Plan administrator" is Alyeska Pipeline Service Company or an administrator named by Alyeska Pipeline Service Company. Premera Blue Cross Blue Shield of Alaska is **not** 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. 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 does not 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's 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.

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. (Alyeska Pipeline Service Company has delegated to us the discretionary authority to determine eligibility for benefits and construe the terms used in the plan to the extent stated in our administrative services contract with Alyeska Pipeline Service Company.) 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 were not 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.

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 1110, Seattle, WA 98104; 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. Benefits for services from accepted rural providers are provided at the higher, preferred provider benefit level. If they are not in our network, you may also pay for charges over the allowed amount except for emergency services, covered air ambulance services, or as prohibited by law. You may have to pay for services and send us a claim for reimbursement. Amounts over the allowed amount do not count towards the deductible or out-of-pocket maximum.

Accidental Injury

Physical harm caused by a sudden and unforeseen event at a specific time and place. Accidental injury does not mean any of the following:

- An illness, except for infection of a cut or wound
- Dental injuries caused by biting or chewing
- Over-exertion or muscle strains

Adverse Benefit Determination

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

- A member's or applicant's eligibility to be or stay enrolled in this plan or health insurance coverage
- A limitation on otherwise covered benefits
- A clinical review decision
- A decision that a service is experimental, investigative, not medically necessary or appropriate, or not effective
- A decision related to compliance with protections against balance billing as defined by federal and state law

Affordable Care Act

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

Ambulatory Surgical Center

- A healthcare facility that’s licensed or certified as required by the state it operates in and that meets all of the following:
- It has an organized staff of physicians.
- It has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures.
- It doesn't provide inpatient services or accommodations.

Applied Behavior Analysis (ABA)

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

Autism Spectrum Disorders

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

Autism Service Provider

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

Benefit

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

Benefit Booklet

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

Clinical Trials

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

- An institutional review board that complies with federal standards for protecting human research subjects; and
- The United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers
- 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 Institute of Health guidelines

Complication of Pregnancy

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

- A condition of the fetus that needs surgery while still in the womb (in utero)
- A condition the mother has that is caused by the pregnancy. It is more difficult to treat because of the pregnancy. These conditions are limited to:
  - Ectopic pregnancy
  - Hydatidiform mole/molar pregnancy
  - Incompetent cervix that requires treatment
  - Complications of administration of anesthesia or sedation during labor or delivery
  - Obstetrical trauma, such as uterine rupture before onset or during labor
  - Hemorrhage before or after delivery that requires medical or surgical treatment
  - Placental conditions that require surgical intervention
  - Preterm labor and monitoring
  - Toxemia
  - Gestational diabetes
  - Hyperemesis gravidarum
  - Spontaneous miscarriage or missed abortion
  - A disease the mother has during pregnancy that is not caused by pregnancy. The disease is made worse by pregnancy.
- A complication of pregnancy needs services that are more than the usual maternity services. This includes care before, during, and after birth (normal or cesarean).

Congenital Anomaly

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

Contract

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

Cosmetic Services

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

Cost-share

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

Covered Service

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

Custodial Care

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

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

Dependent

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

Detoxification

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

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

Effective Date

The date your coverage under this plan begins as specified by the Group.

Eligibility Waiting Period

The length of time that must pass before a subscriber or dependent is eligible to be covered under the Group's health care plan. If a subscriber or dependent enrolls under the "Special Enrollment" provisions of this plan or enrolls on a date other than when first eligible to enroll, any period prior to such enrollment isn't considered an eligibility waiting period, unless all or part of the initial eligibility waiting period had not been met.

Emergency Medical Condition (also called "Emergency")

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

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

Emergency Services

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

Essential Health Benefits

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

Experimental/Investigative Services

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

- A drug or device which cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and does not have approval on the date the service is provided.
- It is subject to oversight by an Institutional Review Board.
- There is no reliable evidence demonstrates that the service is effective in clinical diagnosis, evaluation, management or treatment of the condition.
- It is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy.
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.
- Reliable evidence means only published reports and articles in authoritative medical and scientific literature and assessments.

Explanation of Benefits

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

Facility (Medical Facility)

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

Group

The entity that sponsors this self-funded plan.

Habilitation Services

Habilitative services or devices are medical services or devices provided when medically necessary for development of bodily or cognitive functions to perform activities of daily living that never developed or did not develop appropriately based on the chronological age of the insured. Habilitative services include physical therapy, occupational therapy, and speech-language therapy when provided by a state-licensed or state-certified provider acting within the scope or their license. Therapy to retain skills necessary for activities of daily living and prevent regression to a previous level of function is a habilitative service, if medically necessary and appropriate. Habilitative devices may be limited to those that have FDA approval and are prescribed by a qualified provider. Habilitative services do not include respite care, day habilitation services designed to provide training, structured

activities and specialized assistance for adults, chore services to assist with basic needs, educational, vocational, recreational or custodial services.

Home Health Agency

An organization that provides covered home health services to a member.

Home Medical Equipment (HME)

Equipment ordered by a healthcare provider for everyday or extended use to treat an illness or injury. HME may include: oxygen equipment, wheelchairs or crutches. This is also sometimes known as “Durable Medical Equipment” or “DME”.

Hospice

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

Hospital

A healthcare facility that meets all of these criteria:

- It operates legally as a hospital in the state where it is located.
- It has facilities for the diagnosis, treatment and acute care of injured and ill persons as inpatients.
- It has a staff of providers that provides or supervises the care.
- It has 24-hour nursing services provided by or supervised by registered nurses.
- A facility is not considered a hospital if it operates mainly for any of the purposes below:
- As a rest home, nursing home, or convalescent home
- A residential treatment center or health resort
- To provide hospice care for terminally ill patients
- To care of the elderly
- To treat substance abuse or tuberculosis

Illness

A sickness, disease, or medical condition,.

Injury

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

Inpatient

Confined in a medical facility as an overnight bed patient.

Lifetime Maximum

The maximum amount that your insurance benefit will provide during your lifetime.

Maternity Care

Health services you get during pregnancy (before, during, and after birth) or for any condition caused by pregnancy. This includes the time during pregnancy and within 45 days following delivery.

Medical Equipment

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

Medically Necessary and Medical Necessity

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

- Agree with generally accepted standards of medical practice;

- Be clinically appropriate in type, frequency, extent, site and duration. They must also be considered effective for the patient's illness, injury or disease; and
- Not be mostly for the convenience of the patient, physician, or other health care provider. They do not cost more than another service or series of services that are at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature 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 a subscriber or dependent.

Mental Health Conditions

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

Non-Participating Provider

A provider that is not in one of the provider networks stated in the ***How Does Selecting A Provider Affect My Benefits?*** section.

Observation

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

Orthodontia

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

Orthotic

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

Outpatient

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

Participating Pharmacy (Participating Retail/Participating Mail-Order Pharmacy)

A licensed pharmacy which contracts with us or the Pharmacy Benefits Administrator, to provide prescription drugs as specified under the ***Prescription Drugs*** section.

Pharmacy Benefits Manager

An entity that contracts with us to administer prescription drug benefits under this plan.

Physician

A state-licensed:

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

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

- An Advanced Nurse Practitioner (ANP)

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

Plan (also called "This Plan" or "The Plan")

Alyeska Pipeline Service Company's self-funded plan described in this booklet.

Plan Year

The period of 12 consecutive months that starts each March 1 at 12:01 a.m. and ends on the last day in February at midnight.

Premiums

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

Prescription Drugs

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.

Prior Authorization

Prior authorization is a process that requires you or a provider to follow before a service is given, to determine if service is a covered service and meets the requirements for medical necessity, clinical appropriateness, level of care, or effectiveness. You must ask for prior authorization before the service is delivered.

See ***Prior Authorization*** for details.

Provider (also called "Covered Provider")

A physician or other health care professional or facility named in this plan that is licensed or certified as required by the state in which the services were received to provide a medical service or supply, and who does so within the lawful scope of that license or certification.

Psychiatric Condition

A condition listed in the current **Diagnostic and Statistical Manual (DSM)** published by the American Psychiatric Association, excluding diagnoses and treatments for substance use disorder.

Reconstructive Surgery

Is surgery:

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

Rehabilitation Therapy

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

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

Service Area

The area in which we directly operate provider networks. This area is made up of the state of Alaska and the state of Washington (except for Clark County).

Services

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

Skilled Nursing Care

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

Skilled Nursing Facility

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

Subscriber

An enrolled employee of Alyeska Pipeline Service Company. Coverage under this plan is established in the subscriber's name.

Substance Use Disorder Conditions

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

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.

Urgent Care

Treatment of unscheduled, drop-in patients who have minor illnesses and injuries. These illnesses or injuries need treatment right away, but they are not life-threatening. Examples are high fevers, minor sprains and cuts, and ear, nose and throat infections. Urgent care is provided at a medical facility that is open to the public and has extended hours.

Virtual Care

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

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

Visit

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

We, Us And Our

Premera Blue Cross Blue Shield of Alaska.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

This medical plan includes a Health Reimbursement Account (HRA), a feature which works in conjunction with the medical plan to help you manage your health care costs. The HRA provides a benefit to pay some amounts the medical plan would normally require you to pay.

Note: This HRA is owned and funded by the Plan. Premera Blue Cross Blue Shield of Alaska acts as the claims administrator for this benefit, but does not underwrite or insure the HRA, or act as a fiduciary. Discretionary authority as to eligibility and benefits for the HRA is determined by your employer.

The HRA supplements the medical benefits described in this benefit booklet. Eligible expenses are paid from the HRA automatically when claims are processed under the health plan. There are no separate claims to file. Claims filing provisions are the same for the HRA as for medical claims; see ***HOW DO I FILE A CLAIM?*** elsewhere in this booklet.

Annual Allocation

At the beginning of each plan year (or when the HRA becomes effective for the first time), you will receive the HRA benefit. The amount you receive each plan year (or "allocation") is based on whether you are enrolled in the health plan for individual coverage (subscriber only), individual plus one enrolled dependent (subscriber plus one), or family coverage (subscriber plus two or more dependents.) All HRA Funds are shared at the family level. The annual plan year allocation amounts are:

- For subscriber-only enrollment: $1,000
- For subscriber plus one enrolled dependent: $2,000
- For subscriber plus two or more enrolled dependents: $3,000

The full HRA allocation will be credited to you and is available to pay eligible expenses upon your initial enrollment in the HRA (Consumer Choice Medical Plan) or at Alyeska Pipeline Service Company's renewal (March 1), provided you continue to participate in this medical plan.

Maximum HRA Plan Year Rollover

The HRA has a feature called a "rollover" which allows you to carry forward up to a maximum cumulative amount of unused benefits for use in the next plan year. At the end of each year, unused dollars in the HRA will roll forward and become available to pay eligible expenses incurred in the next year, subject to cumulative plan year maximum rollover amounts.

Unused amounts in the HRA will roll forward to the next plan year, up to a maximum total amount of:

- Subscriber only enrollment: $500
- Subscriber plus one enrolled dependent: $1,000
- Subscriber plus two or more enrolled dependents: $1,500

Note: HRA benefits in excess of these amounts are not rolled forward.

The rollover amount, in addition to the annual allocation, will be available to pay eligible expenses in the next year. Please note that this amount may be reduced if eligible claims for the prior year are received after the beginning of the plan year.

Maximum HRA Cap Rollover

The HRA has a feature also allows you to rollover amounts of up to a maximum cumulative cap amount of unused benefits for use in the next year. At the end of each year, unused dollars in the HRA will roll forward and become available to pay eligible expenses incurred in the next year, subject to the following maximum cap rollovers.

Unused amounts in the HRA will roll forward to the next plan year, up to the following maximum cap cumulative amounts:

- Subscriber only: $1,500
- Subscriber plus one enrolled dependent: $3,000
- Subscriber plus two or more enrolled dependents: $4,500

Note: HRA benefits in excess of these amounts are not rolled forward.

The rollover amount, in addition to the annual allocation, will be available to pay eligible expenses in the next year. Please note that this amount may be reduced if eligible claims for the prior year are received after the beginning of the plan year.

HRA-Eligible Expenses

The HRA can be used to pay the following expenses:

- The plan year deductible (see ***Plan Year Deductible*** under ***WHAT ARE MY MEDICAL BENEFITS?***)
- This plan's coinsurance (see ***Coinsurance*** under ***WHAT ARE MY MEDICAL BENEFITS?***)
- Charges for certain medical services that exceed plan coverage limits. Examples are:
  - Benefits for services or supplies in excess of medical plan benefit maximums
  - Services received during a pre-existing condition or other waiting period
  - Amounts in excess of the allowed amount billed by out-of-network providers

In addition, HRA funds may be applied to billed charges for certain other qualified medical expenses if they are not covered by your health plan, provided they meet **all** the following criteria:

- The expense must be an HRA-reimbursable expense for "medical care" as defined by the Internal Revenue Code;
- The service must be provided and billed by a state-licensed or certified health care provider; and,
- The service must be submitted as a medical claim with an approved diagnosis code and standard medical billing code conforming to Physician's Current Procedure Terminology (CPT), Healthcare Common Procedure Code (HCPC) or other coding method acceptable to us.

To the extent they meet these requirements, examples of expenses to which HRA funds may be applied include, but are not limited to, laser eye surgery, hearing aids, TMJ treatment, and infertility treatment.

Examples of services not eligible for payment by the HRA include, but are not limited to: cosmetic surgery, long term care services, health insurance plan premiums, and over-the-counter (OTC) medications.

Note: Your HRA may cover only a portion of the costs of qualified expenses. The HRA will provide benefits only to the extent HRA funds are available. Once the HRA benefit is exhausted, no further benefits are available for the remainder of the year. You are responsible for all amounts not paid by the health plan or the HRA.

Appeals of HRA Claims Decisions If your HRA claim is denied in whole or in part, you will receive a notification of the denial, and the reasons for it. You have the right to appeal any claims determinations for the HRA that are made by the Claims Administrator that you do not agree with.

The appeals process described in your benefit booklet under ***Your Questions, Complaints and Appeals*** does **not** apply to appeals of claims determinations made by the Claims Administrator.

You must submit your appeal request to the Claims Administrator in writing. Appeals requests must be received by the Claims Administrator within 180 days of the date of our notification of claims denial. At the time you submit your request, you may also submit any additional documentation that you wish us to consider in reviewing your appeal.

The Claims Administrator will review your appeal and provide you with a response within 60 days of the date we receive the request.

Exclusions

The HRA is not available to pay any of the following:

- Prescription drugs
- Dental services
- Copays required by your medical plan
- Durable Medical Equipment (the Durable Medical Equipment benefit of your medical plan must be exhausted first)
- Vision Hardware (the Vision Hardware benefit of your medical plan must be exhausted first)

Note: If your coverage ends under this plan, any remaining amounts in your HRA benefit will be forfeited.

Other Provisions Applicable To The HRA

COBRA (Applicable only to group plans subject to COBRA) All COBRA elections of the medical plan also include the HRA benefit.

Subrogation Amounts payable by the HRA are not subject to the subrogation provisions described elsewhere in this benefit booklet.

Timely Filing of Claims Claims for HRA benefits are subject to the claims submission provisions stated elsewhere in this booklet under “Timely Filing.” All claims for HRA payment must be submitted within 365 days of the date expenses for services or supplies were incurred.