

Public Safety Employees Association Health And Welfare Trust

HeritageSelect™

9000132

July 1, 2009

HOW TO CONTACT PREMERA BLUE CROSS BLUE SHIELD OF ALASKA

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

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

Customer Service

Mailing Addresses:

Premera Blue Cross Blue Shield of Alaska

For Claims Only

P.O. Box 240609
Anchorage, Ak 99524-0609

Premera Blue Cross Blue Shield of Alaska
P.O. Box 91059
Seattle, WA 98111-9159

Physical Addresses:

2550 Denali St. #1404
Anchorage, AK 99503

7001 220th St. S.W.
Mountlake Terrace, WA 98043-2124

Phone Numbers:

Local and toll-free number: 1-800-508-4722
Local and toll-free TDD number
for the hearing impaired: 1-800-842-5357

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

You will find answers to most of your questions about your plan in this benefit booklet. You also can explore our Web site at www.premera.com anytime you want to:

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

You also can call our Customer Service staff at the numbers listed above. We are 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.

HOW TO CONTACT THE PSEA TRUST ADMINISTRATIVE OFFICE

PSEA Trust Administrative Office
P.O. Box 93870
Anchorage, AK 99509
3380 C Street, Suite 107
Anchorage, AK 99503

Local: (907)561-5119

Toll Free:..... 1-800-325-6532

DEAR PARTICIPANTS:

We are pleased to present this updated benefit booklet for the PSEA Health & Welfare Trust coverages.

Your booklet describes medical, prescription drug, vision, dental, and hearing benefits insured through Premera Blue Cross Blue Shield of Alaska. Also included are descriptions of your other Trust benefits, so you have all benefit information in one place. The other benefits are the death benefit, and business travel accident insurance.

We intend to continue this plan indefinitely. However, in accordance with the trust agreement, we reserve the right to change benefits at any time, or to terminate the plan if necessary.

If you have any detailed questions about your benefits, please contact the Trust administrative office at 800-325-6532 or (for health coverage or claim questions) Premera Blue Cross Blue Shield of Alaska at 800-508-4722.

As your Trustees, we are always available to discuss your concerns regarding your Health & Welfare Trust.

Sincerely,

Board of Trustees

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INTRODUCTION

Dear Group Member:

We are pleased to welcome you as a member of Premera Blue Cross Blue Shield of Alaska, an Independent Licensee of the Blue Cross and Blue Shield Association. This booklet describes your benefits under this program and replaces any other benefit booklet issued by us which you may have been given.

The benefits, limitations, exclusions, and other coverage provisions described on the following pages are subject to the terms and conditions of the contract we have issued to the Trust. The complete contract, of which this booklet is a part, is on file in the Trust's office and at the headquarters of Premera Blue Cross Blue Shield of Alaska.

Throughout the booklet, we use many terms that have a specific meaning under this program. These are defined in the "Definitions" section of this booklet. The terms "you" and "your" refer to the members under this program. The terms "we," "us," and "our" refer to Premera Blue Cross Blue Shield of Alaska in the State of Alaska, and Premera Blue Cross in Washington State.

Group Name	PUBLIC SAFETY EMPLOYEES ASSOCIATION HEALTH AND WELFARE TRUST
Effective Date	July 1, 2009
Group Number	9000132
Program	ALASKA HERITAGESELECT
Contract Form Number	6536T

SUMMARY OF BENEFITS

This summary provides a brief description of your benefits and provisions of coverage. Please refer to other parts of your booklet for a complete description of covered services and supplies, limitations, and exclusions.

MEDICAL BENEFITS

Waiting Period For Pre-existing Conditions

Your program has a 12-month waiting period for pre-existing conditions. (See "Waiting Period For Pre-existing Conditions" later in this booklet for details.)

Deductible

- \$250 calendar year deductible per member;
- \$750 calendar year deductible per family.

Benefit Payments

After all applicable deductibles are satisfied, benefits for covered services and supplies are payable for each member at the following percentages, up to a Medical Benefits lifetime maximum of \$2,000,000:

Emergency Room Copay

For each emergency room visit, you pay \$100. Emergency room visits are also subject to any applicable calendar year deductible and coinsurance. The emergency room copay will be waived if you are admitted directly to the hospital from the emergency room.

Professional Visit Copay

For each office visit or visit in your home by a physician or other professional, including spinal manipulations, you pay a \$25 copay per visit. This is your professional visit copay. Separate copays will apply for each provider you receive services from, even if those services are received on the same day. After your copay, benefits subject to a copay are provided at 100% of allowable charges and aren't subject to your calendar year deductible, coinsurance or out-of-pocket maximum.

The professional office visit copay does not apply to:

- Inpatient visits
- Therapeutic injections, including allergy injections, and allergy testing

Heritage Provider Benefit Level

We will pay 90% of allowable charges for covered services received by each member in a calendar year. The percentage of allowable charges that each member is responsible for is called "coinsurance." After a member reaches the out-of-pocket maximum, benefits will be provided at 100% of allowable charges for covered services received by that member during the remainder of that calendar year.

Non-Heritage Provider Benefit Level

For services of hospital or hospital-based chemical dependency programs, we will pay 60% of allowable charges. We will pay 90% of allowable charges for all other facility and professional services. The coinsurance for non-network providers' services does not accrue toward the Out-of-Pocket Maximum below.

Out-Of-Pocket Maximum

Each calendar year, the amount each member could pay toward the calendar year deductible and coinsurance for certain services listed under "Medical Benefits" is limited to a specific total. This total is called an "out-of-pocket maximum."

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

For each member, the out-of-pocket maximum is \$1,250.

Emergency Services

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

COVERED SERVICES AND SUPPLIES

We provide Medical Benefits for the following services and supplies when medically necessary:

Hospital Inpatient Care

Room and board, plus services and supplies furnished by the hospital.

Hospital Outpatient Care

Services and supplies furnished by the hospital's outpatient department or emergency room.

Skilled Nursing Facility

Room and board, plus services and supplies furnished by the facility for 60 days each calendar year

Ambulatory Surgical Center

Services and supplies furnished by the surgical center

Professional Visit Copay

For each office visit or visit in your home by a physician or other professional, including spinal manipulations, you pay a \$25 copay per visit. This is your professional visit copay. Separate copays will apply for each provider you receive services from, even if those services are received on the same day. After your copay, benefits subject to a copay are provided at 100% of allowable charges and aren't subject to your calendar year deductible, coinsurance or out-of-pocket maximum.

The professional office visit copay does not apply to:

- Inpatient visits
- Therapeutic injections, including allergy injections, and allergy testing

Surgical Services

Surgery and anesthesia administration

Acupuncture

Benefits are subject to the \$25 professional visit copay and include 12 visits per member per calendar year

Mastectomy And Breast Reconstruction Services

Mastectomy, physical complications of mastectomy, breast prostheses, and reconstruction procedures

Therapeutic Nuclear Medicine

Diagnostic Imaging And Laboratory Services

Administration and interpretation of diagnostic imaging (including X-ray and EKG), pathology, and laboratory tests; and diagnostic and screening tests for prostate, cervical and colorectal cancer

Diagnostic And Screening Mammography

The calendar year deductible and coinsurance apply to this benefit only when services are rendered by a hospital that isn't in the network.

Transplants

\$250,000 lifetime maximum benefit for all covered organ, bone marrow, and stem cell transplants combined

Rehabilitation and Neurodevelopmental Therapy (Physical, Occupational, And Speech Therapy)

60 days of inpatient care per calendar year; facility services are paid at the regular reimbursement percentages for Heritage and non-Heritage benefit levels as stated on page 1. Outpatient services furnished and billed by a physician (M.D. or D.O.) or by a physical, occupational, or speech therapist are unlimited and are paid at the regular reimbursement percentage for Heritage or non-Heritage benefit levels stated on page 1. Treatment of neurodevelopmental disabilities is provided for members under the age of 7.

Chemical Dependency Treatment

\$16,380 per 24-month period; \$32,750 lifetime maximum benefit

Home Health Care

130 visits each calendar year for services furnished by a home health agency

Hospice Care

Care of a terminally ill member, not to exceed 6 months of covered hospice care

Infusion Therapy

Professional services, supplies, drugs, and solutions

Licensed Ambulance Service

Transport to the nearest medical facility equipped to treat your condition

Round-Trip Air Transportation

Round-trip air or surface transportation by a licensed commercial airline (or railroad or ferry) from the place where the illness or injury occurred to the nearest hospital equipped to treat the condition. Coverage for this benefit is limited, as explained later in this booklet.

Medical Equipment And Supplies

\$5,000 each calendar year

Prosthetic Devices**Prescription Drugs****Blood Transfusions****PKU Dietary Formula****Obstetrical Care**

On the same basis as any other condition. (See benefit for details.)

Routine Newborn Care

Hospital and professional well baby care during the initial hospital confinement of the newborn dependent child at birth.

Diabetes Health Education

Outpatient self-management training and education for diabetes

Mental Health Care

Benefits for inpatient care are unlimited. Outpatient visits are limited to 20 visits per member each calendar year.

Preventive Medical Care Benefit

Routine physicals performed on an outpatient basis are subject to the \$25 professional visit copay. (Hospital outpatient facility services are payable at the regular reimbursement percentages stated under this program.)

Immunizations

Immunizations for polio, flu, small pox, measles, and other communicable diseases dispensed on an outpatient basis are covered at 100% of allowable charges.

Seasonal Immunizations

Flu shots, flu mist and pneumonia immunizations provided at a pharmacy are covered at 100% of allowable charges.

Newborn Hearing Exams and Testing

On the same basis as any other condition (see page 20 for details.)

PHARMACY DRUG BENEFIT

See Page 21

MAIL-ORDER PHARMACY PROGRAM

See Page 25

VISION BENEFIT

See Page 26

DENTAL BENEFIT

See Page 28

HEARING BENEFIT

See Page 32

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.

This program's benefits do not require preauthorization for coverage. You must be eligible on the dates of service and services must be medically necessary. We encourage you to call Customer Service to verify that you meet the required criteria for claims payment and to help us identify admissions which might benefit from case management.

CASE MANAGEMENT

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

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

APPEALS REVIEW

Should you or your provider disagree with a Care Management determination, please refer to the procedures outlined under "Your Ideas, Questions, Complaints, And Appeals."

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

THE BLUECARD^(R) PROGRAM

Premera Blue Cross Blue Shield of Alaska, like all Blue Cross and/or Blue Shield Licensees, participates in a program called "BlueCard." Members can take advantage of BlueCard when they receive covered services outside Alaska and Washington or in Clark County, Washington from hospitals, doctors, and other medical care providers who have contracted with the local Blue Cross and/or Blue Shield Licensee, called the "Host Blue" in this section. The national BlueCard program is available throughout the United States, the Commonwealth of Puerto Rico, Jamaica and the British and U.S. Virgin Islands.

Your identification card tells contracting providers which independent Blue Cross and/or Blue Shield Licensee covers you. It is important to note that receiving services through BlueCard does not change covered benefits, benefit levels, or any stated residence requirements of this program. When you use your identification card, you will receive many of the conveniences you're accustomed to from Premera Blue Cross Blue Shield of Alaska. In most cases, there are no claim forms to submit because contracting providers will handle claim submission for you. In addition, your out-of-pocket costs may be less, as explained below.

Here's How BlueCard Helps Keep Costs Down

When you obtain health care services outside Alaska and Washington or in Clark County, Washington through BlueCard (excluding BlueCard Worldwide; see below), the amount you pay for covered services is calculated on the lower of:

- The billed charges for your covered services, or
- The "negotiated price" that the Host Blue passes on to Premera Blue Cross Blue Shield of Alaska for your covered services.

The methods used to determine the negotiated price will vary among Host Blues according to the terms of their provider contracts. Often, the negotiated price will consist of a simple discount, which reflects the actual price allowed as payable by the Host Blue. But, sometimes, it is an estimated price that factors in aggregate payments expected to result from the Host Blue's settlements, withholds, other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be a discount from billed charges that reflects an **average** expected savings with your health care provider or a specified group of providers. The price that reflects average savings may result in greater variation above or below the actual price than will the estimated price. In accordance with national BlueCard policy, these estimated or average prices will also be adjusted from time to time to correct for overestimation or underestimation of past prices. However, the amount on which your payment is based remains the final price for the covered services billed on your claim.

Some states may mandate a surcharge or a method of calculating what you must pay on a claim that differs from BlueCard's usual method noted above. If such a mandate is in force on the date you received care in that state, the amount you must pay for any covered services will be calculated using the methods required by that mandate. Such methods might not reflect the entire savings expected on a particular claim.

Clark County Providers

Some providers in Clark County, Washington do not have contracts with Premera Blue Cross. These providers will submit claims directly to us and benefits will be based on our allowable charge for the service or supply.

Non-BlueCard Claim Submission

If a hospital, doctor, or other medical care provider does not contract with the Host Blue, that claim may not be filed on your behalf. For instructions on how to file a claim in this situation, refer to the "How To Submit A Claim" section of this booklet.

BlueCard Worldwide^(R)

If you are outside the United States, the Commonwealth of Puerto Rico, Jamaica and the British and U.S. Virgin Islands, you may be able to take advantage of BlueCard Worldwide. BlueCard Worldwide is unlike the national BlueCard program in certain ways. For instance, although BlueCard Worldwide provides a network of contracting hospitals, it offers only referrals to doctors and other health care providers. When receiving care from doctors or other health care providers, you will have to submit claim forms on your own behalf to obtain reimbursement for the services provided through BlueCard Worldwide.

To access health care services through BlueCard Worldwide and to obtain additional information about providers'

charges, please call 1-800-810-BLUE (2583).

Further Questions?

If you have questions or need additional information about using your identification card outside Alaska and Washington or in Clark County, Washington, please call our Customer Service Department. To locate a hospital, hospital-based chemical dependency program or physician in another Blue Cross and/or Blue Shield Licensee service area, call 1-800-810-BLUE (2583).

MEDICAL BENEFITS

DEDUCTIBLES

A deductible is the amount of expense you must incur for covered services and supplies before benefits can be provided under this program. The amount credited toward the deductible will not exceed the allowable charge for the covered service or supply.

Calendar Year Deductible

Each calendar year you must satisfy a deductible before your Medical Benefits are payable. For each member, this amount is \$250. The maximum calendar year deductible for your family is \$750. Only the amounts used to satisfy each enrolled family member's deductible will contribute toward the family's total deductible.

Expenses you incur for covered services and supplies in the last three months of a calendar year which are used to satisfy all or part of the calendar year deductible will also be used to satisfy all or part of the next year's deductible. This is also true for the \$750 family calendar year deductible. However, the expenses carried over to satisfy the next year's deductible will not be applied to the next year's out-of-pocket maximum.

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

What Doesn't Apply To The Calendar Year Deductible?

Amounts that don't accrue toward this plans calendar year deductible are:

- Amounts that exceed the allowable charge
- Charges for excluded services
- Copays
- The calendar year deductible and coinsurance required in the "Dental Benefit"

Emergency Room Copay

A \$100 emergency room copay for each hospital emergency room visit must be satisfied before benefits for covered emergency room services can be provided. Emergency room visits are also subject to any applicable calendar year deductible and coinsurance. **Important Note!** The emergency room copay will be waived if you're admitted directly to the hospital from the emergency room. Emergency room care is for treatment of an accidental injury which is received on the day of the injury or within the next two days after that date.

Benefit Payments

After all applicable deductibles are satisfied, benefits for covered services and supplies are payable for each member at the following percentages, up to a Medical Benefits lifetime maximum of \$2,000,000:

Professional Visit Copay

For each office visit or visit in your home by a physician or other professional, including spinal manipulations, you pay a \$25 copay per visit. This is your professional visit copay. Separate copays will apply for each provider you receive services from, even if those services are received on the same day. After your copay, benefits subject to a copay are provided at 100% of allowable charges and aren't subject to your calendar year deductible, coinsurance or out-of-pocket maximum.

The professional office visit copay does not apply to:

- Inpatient visits
- Therapeutic injections, including allergy injections, and allergy testing

Heritage Provider Benefit Level

We will pay 90% of allowable charges for covered services received by each member in a calendar year. The percentage of allowable charges that each member is responsible for is called "coinsurance." After a member reaches the out-of-pocket maximum, benefits will be provided at 100% of allowable charges for covered services received by that member during the remainder of that calendar year.

Non-Heritage Provider Benefit Level

For services of hospital or hospital-based chemical dependency programs, we will pay 60% of allowable charges. We will pay 90% of allowable charges for all other facility and professional services. The coinsurance for non-

network providers' services does not accrue toward the Out-of-Pocket Maximum below.

Out-Of-Pocket Maximum

Each calendar year, the amount each member could pay toward the calendar year deductible and coinsurance for certain services listed under "Medical Benefits" is limited to a specific total. This total is called an "out-of-pocket maximum."

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

For each member, the out-of-pocket maximum is \$1,250.

The benefits of this plan are based on allowable charges for covered services and supplies. Please refer to the "Definitions" section of this booklet for a complete description of "Allowable Charge."

How Does Selecting A Provider Affect My Benefits

You may seek covered services from any provider licensed to provide the service. However, within Alaska, in order to receive the higher level of benefits available under your plan for non-emergent hospital services and hospital-based chemical dependency programs, you must use a hospital or hospital-based chemical dependency treatment facility in the Alaska Heritage network.

Hospitals and hospital-based chemical dependency programs in the Alaska Heritage network have agreed to accept the allowable charge as payment in full. They have also agreed to bill us directly for the covered portion of the services you receive, and we make payment directly to them. These commitments are also true of other types of providers that have network agreements with us.

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

Services Received Outside Alaska

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

Except as stated below, for the same services outside of Alaska and Washington or in Clark County, Washington, you'll receive the higher level of benefits available by using hospitals and hospital-based chemical dependency programs with PPO agreements with the Blue Cross or Blue Shield plan in the area where you are seeking services. For more information about receiving care outside Alaska and Washington or in Clark County, Washington, please see "Services Received Outside Alaska" in the "Medical Benefits" section of this booklet.

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

Important Note: For the most current information on Heritage hospitals, hospital-based chemical dependency programs, please refer to our Web site at www.premera.com or contact Customer Service. If you are outside Alaska and Washington, or Clark County, Washington, call 1-800-810-BLUE (2583).

Emergency Services

Benefits will be provided at the higher level for covered services and supplies furnished by any covered provider. We will pay the allowable charges for these services and you will only pay the applicable deductibles, coinsurance and amounts that exceed the benefit maximums, amounts above the allowable charge for non-network providers and charges for non-covered services.

Provider Status

Since a provider's agreement with us is subject to change at any time, it is 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 are outside Alaska and Washington or in Clark County, Washington, call 1-800-810-BLUE (2583) to locate or verify the status of a provider.

If you are seeing a provider and their written agreement with us is terminated while you are receiving pregnancy

care or other active treatment, we'll consider the provider to still have an agreement with us for the purpose of that care until one of the following occurs:

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

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

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

Benefit Level Exceptions For Non-emergent Care

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

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

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

Please call Customer Service to request a benefit level exception for non-emergent care.

Lifetime Maximum

The maximum amount of Medical Benefits available to any one member is \$2,000,000. This is a lifetime maximum.

The following benefits don't accrue toward this maximum:

- Benefits described in the "Pharmacy Drug" section
- Benefits described in the "Vision Benefit" section
- Benefits described in the "Dental Benefit" section
- Benefits described in the "Hearing Benefit" section

Certain Medical Benefits of this program are also subject to separate benefit maximums.

COVERED SERVICES AND SUPPLIES

This section of your booklet describes the specific benefits available for covered services and supplies. Benefits are available for a service or supply described in this section when it meets all of these requirements:

- It must be furnished in connection with the diagnosis or treatment of a covered illness or accidental injury.
- It must be medically necessary and must be furnished in a medically necessary setting.
- It must be prescribed by a physician.
- It must not be excluded from coverage under this program.
- The expense for it must be incurred while you are covered under this program and after any applicable waiting period required under this program is satisfied.
- It must be furnished by a provider that is covered under the applicable benefit.

Please Note: Benefits for some types of services and supplies may be limited or excluded under this program. Please refer to the actual benefit provisions below and the "General Limitations And Exclusions" section, for a complete description of covered services and supplies, limitations and exclusions.

Hospital Inpatient Care

Room and board; intensive and coronary care units; plus services and supplies, such as diagnostic imaging (including X-ray) and laboratory services, surgical dressings, and drugs, furnished by and used while confined in the hospital.

In addition to "General Limitations And Exclusions," we will not provide this benefit for:

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

Hospital Outpatient Care

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

Emergency Room Care

Each visit to the emergency room (ER) is subject to the \$100 emergency room copay, the calendar year deductible, and coinsurance as explained under "Emergency Room Copay" earlier in this section. The copay will be waived if you're admitted to the hospital directly from the emergency room or if the emergency room care is for treatment of an accidental injury which is received on the day of the injury or within the next two days after that date.

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

In addition to "General Limitations And Exclusions," we will not provide this benefit for: the treatment of chemical dependency. Coverage for the treatment of chemical dependency is available under the Chemical Dependency Treatment benefit located elsewhere in this benefit booklet.

However, benefits for the treatment of medically necessary detoxification services are provided under this benefit on the same basis as any other emergency medical condition.

Skilled Nursing Facility

Room and board, plus services and supplies, for up to 60 days each calendar year, when furnished by and used while confined in a skilled nursing facility.

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

In addition to "General Limitations And Exclusions," we will not provide this benefit for:

- Custodial care.
- Care that is primarily for senile deterioration, mental deficiency or retardation, or the treatment of chemical dependency.

Ambulatory Surgical Center

Services and supplies furnished by a licensed ambulatory surgical center, such as surgical dressings and drugs.

Professional Visits and Services

For each office visit or visit in your home by a physician or other professional, including spinal manipulations, you pay a \$25 copay per visit. This is your professional visit copay. Separate copays will apply for each provider you receive services from, even if those services are received on the same day. After your copay, benefits subject to a copay are provided at 100% of allowable charges and aren't subject to your calendar year deductible, coinsurance or out-of-pocket maximum.

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

The calendar year deductible and coinsurance also applies to benefits for the following services:

- Outpatient professional visits except visits in an office setting and visits to your home

- Inpatient professional visits

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

The following professional services are also covered:

- Second opinions for any covered medical diagnosis or treatment plan when provided by a qualified provider
- Prostate, colorectal and cervical cancer screening exams
- Biofeedback for migraines and other conditions for which biofeedback is not deemed experimental or investigational (see "Definitions")
- Routine foot care when the member is a diabetic
- Nicotine dependency

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

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

Surgical Services

Benefits are available for surgical services, including anesthesia, postoperative care, cornea transplantation, skin grafts and the transfusion of blood or blood derivatives. Also included are colonoscopies and other scope insertion procedures performed for screening of colorectal cancer.

Benefits are only provided for services of an assistant surgeon when medically necessary, and will not exceed 20% of the primary surgeon's allowable charge.

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

Acupuncture

You pay the \$25 professional visit copay for each visit in an office setting.

When acupuncture isn't done in an office setting, benefits are subject to the calendar year deductible and coinsurance.

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

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

Mastectomy And Breast Reconstruction Services

Benefits are provided for mastectomy necessary due to illness or accidental injury and for reconstruction in connection with a mastectomy. For any member electing breast reconstruction in connection with a mastectomy, this benefit covers:

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

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

Therapeutic Nuclear Medicine

Services and supplies furnished in connection with radium, radioisotope, and X-ray therapy.

Diagnostic Services

Benefits for preventive diagnostic services are not subject to your calendar year deductible or coinsurance. The calendar year deductible and coinsurance apply to this benefit when services are rendered by a hospital or hospital-based chemical dependency program that isn't in the network.

Benefits for all other diagnostic services are subject to the calendar year deductible and coinsurance.

Preventive diagnostic services are defined as laboratory and imaging services done for preventive or screening purposes, based on the U.S. Preventive Services Task Force (USPSTF) guidelines. (These guidelines are available at www.premera.com or by contacting us.) Examples are cholesterol screening, home colon cancer test, colorectal cancer screening and pap smears.

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

- Diagnostic imaging and scans (including X-ray and EKG).
- Screening tests for prostate, cervical and colorectal cancer.
- Laboratory services, including routine and preventive.
- Pathology tests.

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

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

- Diagnostic surgeries and scope insertion procedures, such as colonoscopy or endoscopy. These services can only be covered under the Surgical Services benefit.
- Allergy testing. See the Professional Visits and Services benefit for coverage of allergy testing.
- Services related to the testing, diagnosis or treatment of infertility.

Diagnostic And Screening Mammography

The calendar year deductible and coinsurance apply to this benefit only when services are rendered by a hospital that isn't in the network. Otherwise, the calendar year deductible and coinsurance won't apply.

Benefits are provided for screening and diagnostic mammography as follows:

- A baseline mammogram and annual mammogram screenings thereafter, regardless of age; and,
- As recommended by a physician for a member with symptoms, a history of breast cancer, or whose parent or sibling has a history of breast cancer.

Transplants

Covered Transplants

Solid organ transplants and bone marrow/stem cell reinfusion procedures must not be considered experimental or investigative for the treatment of your condition. (Refer to the definition of "Experimental/Investigative Services.") We reserve the right to base coverage on all of the following:

- Solid organ transplants and bone marrow/stem cell reinfusion procedures must be medically necessary and meet our criteria for coverage. We review the medical indications for transplant, documented effectiveness of the procedure to treat the condition, and failure of medical alternatives.
- The types of solid organ transplants and bone marrow/stem cell reinfusion procedures that currently meet our criteria for coverage are:
 - heart
 - heart/double lung
 - single lung
 - double lung

- liver
- kidney
- pancreas
- pancreas with kidney
- bone marrow (autologous and allogeneic)
- stem cell (autologous)

Please Note: For the purposes of this program, the term "transplant" does not 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 this program's other benefits.

- Your medical condition must meet our written standards, which are found by referring to our Web site at **www.premera.com** or by contacting Customer Service.
- The transplant or reinfusion must be furnished in an approved transplant center. ("Approved transplant center" is a hospital or other provider that has developed expertise in performing solid organ transplants, or bone marrow or stem cell reinfusion, and is approved by us.) We have agreements with approved transplant centers in Alaska and Washington, and we have access to a special network of approved transplant centers around the country. Whenever medically possible, we will direct you to an approved transplant center that we have contracted with for transplant services.

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

- The \$250,000 transplant maximum benefit must not have been reached.
- If the condition which requires a transplant or reinfusion procedure is a "pre-existing condition," the 12-month waiting period for pre-existing conditions must first be satisfied. Refer to "Waiting Period For Pre-existing Conditions" for details.

Transplant Maximum

This benefit is provided at the "Heritage Provider Benefit Level" for the services and supplies below, up to a lifetime maximum benefit of \$250,000 for all covered transplants combined.

Recipient Costs

Benefits for transplant or reinfusion related expenses start accruing to the \$250,000 maximum 30 days prior to the date of a solid organ transplant, or in the case of bone marrow or stem cell procedures, 30 days prior to the date of reinfusion. Benefits stop accruing to the \$250,000 maximum 180 days from the date of the transplant or reinfusion. Inpatient stays for episodes of rejection related to a solid organ transplant or bone marrow or stem cell reinfusion beyond the 180-day period will also accrue to the \$250,000 maximum. However, the time limits above do not apply to the Transplant Benefit's coverage for travel and lodging.

Donor Costs

Procurement expenses are charged against the recipient's \$250,000 maximum and are limited to \$75,000 per transplant. 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; and, storage costs for bone marrow and stem cells for a period of up to 12 months.

Transportation And Lodging Expenses

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

- The transplant recipient must reside more than 50 miles from the approved transplant center.
- The transportation must be to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure, or necessary post-discharge follow-up.
- When the recipient is not a dependent minor child, transportation, covered lodging and meal expenses for the recipient and one companion will be reimbursed up to \$80 per day.
- When the recipient is a dependent minor child, transportation, covered lodging and meal expenses for the recipient and two companions will be reimbursed up to \$125 per day.
- Covered transportation, lodging, and meal expenses incurred by the transplant recipient and companion(s) are charged against the recipient's \$250,000 maximum and are limited to \$7,500 per transplant.

In addition to "General Limitations And Exclusions," we will not provide this benefit for:

- 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 is not covered under this benefit, or for a recipient who is not a member.
- Donor costs for which benefits are available under other group or individual coverage.
- Non-human or mechanical organs, unless we determine they are not "Experimental/Investigative Services" according to the criteria stated under "Definitions."
- Personal care items.
- Anti-rejection drugs, except those administered by the transplant center during the inpatient or outpatient hospital stay in which the transplant was performed. Outpatient prescription drugs are covered under your Pharmacy Drug Benefit and Mail-Order Pharmacy Program.
- Take-home prescription drugs dispensed by a licensed pharmacy. See the "Pharmacy Drug Benefit" section for benefit information.

Rehabilitation and Neurodevelopmental Therapy

Benefits for inpatient and outpatient rehabilitative and neurodevelopmental therapy include the initial evaluation required to prescribe an appropriate treatment plan and any later reevaluations to make sure that the services are achieving the desired medical results. Inpatient care is only covered when services cannot be done in a less intensive setting.

Rehabilitative and Neurodevelopmental Services must be medically necessary to either 1) restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an accidental injury, illness, or surgery; or 2) treat disorders caused by physical congenital anomalies. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physician specializing in rehabilitative medicine. Benefits are also included for physical, speech and occupational assessments and evaluations related to the treatment of neurodevelopmental disabilities or rehabilitation.

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

- **Inpatient Care** Up to 60 days per member each calendar year. Services must be furnished in a specialized rehabilitative unit of a hospital and billed by the hospital or by another rehabilitation facility approved by us. Covered services are payable at the regular reimbursement percentages. 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.
- **Outpatient Care** Eligible services are unlimited and are provided when furnished and billed by a physician (M.D. or D.O.), or by a physical, occupational, or speech therapist. Outpatient care will be paid at the regular reimbursement described on page 1.

In addition to "General Limitations And Exclusions," we will not provide this benefit for:

- Recreational, vocational or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy.
- Treatment which is not actively engaged in by the ill, injured, or impaired member.
- Gym or swim therapy.
- Custodial care.
- Inpatient rehabilitation received more than 24 months from the date of onset of the member's accidental injury or illness or from the date of the member's surgery that made the rehabilitation necessary.

Psychological and Neuropsychological Testing

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

Benefits are provided up to a maximum benefit of 12 hours per member each calendar year for all services combined. Covered services include psychological and neuropsychological testing including interpretation and report preparation, necessary to prescribe an appropriate treatment plan. This includes later retesting to make sure the treatment is achieving the desired medical results. Physical, speech or occupational therapy assessments and evaluations for neurodevelopmental disabilities and rehabilitation are provided under the Rehabilitation And Neurodevelopmental Therapy benefit.

Chemical Dependency Treatment

This benefit covers inpatient and outpatient chemical dependency treatment up to a \$16,380 maximum benefit per member during the 24-consecutive-month period that starts on the first day of covered treatment. Covered services must be furnished by a state-approved treatment facility. Chemical Dependency Treatment benefits are also limited to a lifetime maximum benefit of \$32,750 per member.

In determining whether services for chemical dependency 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.

Benefits for therapeutic and supporting services provided to enrolled family members to assist in the chemically dependent member's diagnosis and treatment are applied to the benefit maximums of the chemically dependent member.

Please Note: Benefits for medically necessary detoxification services are provided under the Emergency Room Care and Hospital Inpatient Care benefits and don't accrue toward the chemical dependency treatment benefit maximum above.

In addition to "General Limitations And Exclusions," we will not provide this benefit for:

- Voluntary support groups, such as Alanon or Alcoholics Anonymous.
- Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing, or to driving rights, except as deemed medically necessary by us.

Home And Hospice Care

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

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

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

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

Home Health Care

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

Hospice Care

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

- **In-home intermittent hospice visits** by one or more of the hospice employees above. These services don't count toward the 130 intermittent home visit limit shown above under "Home Health Care."
- **Inpatient hospice care** up to a maximum of 10 days. This benefit provides for inpatient services and supplies used while you're a hospice inpatient, such as solutions, medications or dressings, when ordered by the attending physician.
- **Respite care** up to a maximum of 240 hours, to relieve anyone who lives with and cares for the terminally ill member.

Insulin and Other Home and Hospice Care Provider Prescribed Drugs

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

In addition to "General Limitations And Exclusions," we will not provide this benefit for:

- Charges in excess of the average wholesale price shown in the "Pharmacist's Red Book" for prescription drugs, insulin, and intravenous drugs and solutions
- Over-the-counter drugs, solutions, and nutritional supplements.
- Drugs and solutions received while you are an inpatient, except for covered inpatient hospice care.
- Services provided to someone other than the ill or injured member.
- Services of family members or volunteers.
- Services, supplies, or providers not in the written plan of care or not named as covered in the respective Home Health or Hospice Care benefit.
- Custodial care, except under the Hospice Care benefit.
- Nonmedical 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; transportation services.
- Dietary assistance, such as "Meals on Wheels," or nutritional guidance.

Infusion Therapy

Outpatient professional services, supplies, drugs, and solutions required for infusion therapy when furnished and billed by an infusion therapy provider.

In addition to "General Limitations And Exclusions," we will not provide this benefit for:

- Over-the-counter drugs, solutions, and nutritional supplements; or
- Drugs and solutions received while you are an inpatient in a hospital or other medical facility.

Licensed Ambulance Service

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

Round-Trip Air Transportation

Benefits are provided for round trip air or surface transportation by a licensed commercial or private carrier. Benefits are limited to 3 round trip transports per calendar year. Benefits are available for:

- A life-endangering illness or injury
- A required surgery that cannot be performed locally
- An existing condition that cannot be treated locally

The trip must begin in Alaska where you became ill or injured and end at the nearest location equipped to provide treatment not available in a local facility. Transportation outside Alaska will be limited to Seattle, Washington.

When transportation is for a child under the age of 18, this benefit will also cover a parent or guardian to accompany the child.

This benefit doesn't cover:

- Routine dental, vision and hearing services
- Transport by taxi, bus, private car or rental car
- Meals and lodging

Medical Equipment And Supplies

Benefits will be provided up to a maximum benefit of \$5,000 per member each calendar year as follows:

- **Medical And Respiratory Equipment (Durable Medical Equipment)** Benefits will be provided for the rental of such equipment, but not to exceed the purchase price, when medically necessary and prescribed by a physician for therapeutic use in direct treatment of a covered illness or injury. We may also provide benefits for the initial purchase of equipment, in lieu of rental. However, no benefits will be provided in subsequent calendar years for charges not initially reimbursed because the maximum has been reached. Examples of medical and respiratory equipment are a wheelchair, hospital-type bed, traction equipment, ventilators, and diabetic equipment such as blood glucose monitors, insulin pumps and accessories to pumps, and insulin infusion devices.

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

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

- **Medical Supplies, Orthotics (Other Than Foot Orthotics), And Orthopedic Appliances** Covered items include, but aren't limited to, dressings, braces, splints, rib belts and crutches, as well as related fitting expenses.

For diabetic supplies including hypodermic needles and syringes, lancets, test strips, testing and alcohol swabs benefit information, please see the Pharmacy Drug Benefit.

- **Prosthetics** Benefits for external prosthetic devices (including fitting expenses) are provided when such devices are used to replace all or part of an absent body limb or to replace all or part of the function of a permanently inoperative or malfunctioning body organ. Benefits will only be provided for the initial purchase of a prosthetic device, unless the existing device cannot be repaired, or replacement is prescribed by a physician because of a change in your physical condition. Benefits for prosthetics are not subject to the \$5,000 maximum of the Medical Equipment and Supplies benefit.
- **Foot Orthotics and Therapeutic Shoes** When prescribed for the condition of diabetes or for corrective purposes, benefits are provided for foot orthotics (shoe inserts) and therapeutic shoes (orthopedic), including fitting expenses, up to a maximum of \$300 per member each calendar year. Benefits are also subject to the \$5,000 maximum of the Medical Equipment and Supplies benefit.

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

In addition to "General Limitations And Exclusions," the Medical Equipment and Supplies benefit doesn't cover any of the following:

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

Contraception Services

Your program provides benefits for the contraception services, drugs, and supplies stated below on the same basis as any other covered care.

- **Prescription Drugs and Devices for Contraception** Oral contraceptives (including emergency contraception) and prescription barrier devices such as diaphragms and cervical caps dispensed by a licensed pharmacy are covered on the same basis as other covered prescription drugs. See the benefit for pharmacy-dispensed prescription drugs elsewhere in this booklet for important information.
- **Contraceptive Surgeries, Implants and Injections** Surgical sterilization and implantable contraceptives (including hormonal implants) are covered on the same basis as any other surgery. Injectable contraceptives and associated professional services are covered on the same basis as for other injectable drugs.
- **Professional Consultations** Office visits and consultations related to contraception are covered as any other professional office visit.

Benefits are not provided for non-prescription contraceptive drugs, supplies, or devices; reversal of sterilization; testing, diagnosis and treatment of infertility, including services, drugs, or supplies for fertility enhancement.

Prescription Drugs

Prescription drugs (including those for treating diabetes) and insulin directly related to the treatment of an illness or accidental injury and dispensed by a licensed pharmacist or physician.

In addition to the "General Limitations And Exclusions" we will not provide this benefit for:

- Any drugs covered under the Pharmacy Drug Benefit or the Mail-Order Pharmacy Program.
- Vitamins, vitamin prescriptions and dietary supplements.
- Fertility drugs, regardless of their intended use.
- More than a 34-day supply of medication.
- Any prescription or refill that is in excess of the quantity specified by a physician, or that is dispensed after one year from the physician's order.
- Take-home prescription drugs dispensed and billed by a medical facility.
- Any drugs that do not require a physician's prescription.
- Any claim or demand for injury or damage arising in connection with the manufacturing, compounding, dispensing, or use of any prescription drug.

Blood Transfusions

The cost of blood and blood derivatives.

PKU Dietary Formula

Dietary formula which is medically necessary for the treatment of phenylketonuria (PKU). This benefit is not subject to the waiting period for pre-existing conditions, explained in "General Limitations And Exclusions."

Obstetrical Care

Pregnancy, childbirth, and voluntary termination of pregnancy are covered on the same basis as any other condition for all female members.

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.

Inpatient hospital services and related inpatient medical care following childbirth as determined necessary by the attending provider, in consultation with the mother, will be provided up to:

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

If it is determined that the length of stay will exceed the above limitations, we recommend that the hospital contact Care Management at the numbers listed below for discharge planning and potential case management.

Within Alaska 1-800-722-4714
Within the Seattle area: 1-877-342-5258

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

Routine Newborn Care

Inpatient routine hospital nursery services and related inpatient well-baby care for a newborn dependent child following birth as determined necessary by the attending provider, in consultation with the mother, will be provided up to:

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

If it is determined that the length of stay will exceed the above limitations, we recommend that the hospital contact Care Management at the numbers listed below for discharge planning and potential case management.

Within Alaska 1-800-722-4714
Within the Seattle area: 1-877-342-5258

Benefits are also provided for routine circumcision.

Newborn children are covered from the moment of birth. Please see the dependent eligibility and enrollment guidelines outlined under "Who Is Eligible For Coverage" and "Special Enrollment" in this booklet. Routine newborn care benefits are subject to the child's own deductible and coinsurance requirements.

Diabetes Health Education

Outpatient self-management training and education for diabetes, including medical nutritional therapy, performed by a provider with training in the treatment of diabetes. These services are covered in full and are not subject to your calendar year deductible, coinsurance or a calendar year benefit limit.

Nutritional Therapy

Benefits are provided for outpatient nutritional therapy services to manage a covered condition, illness or injury. Nutritional therapy for conditions other than diabetes are limited to 4 visits per member each calendar year. Nutritional therapy for the condition of diabetes is covered in full and not subject to the visit maximum previously stated.

Mental Health Care

Outpatient therapeutic visits in an office setting are subject to a \$25 copay per visit.

Benefits for the following services are subject to your calendar year deductible and coinsurance:

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

Benefits for treatment of psychiatric conditions (see "Definitions"), including treatment of eating disorders (such as anorexia nervosa, bulimia or any similar condition), are provided up to the benefit maximums shown below. Covered mental health services include inpatient care, partial hospitalization, outpatient biofeedback services for generalized anxiety disorders and outpatient care to manage or lessen the effects of a psychiatric condition. Services must be consistent with published practices that are based on evidence when available or follow clinical guidelines or a consensus of expert opinion published by national mental health professional organizations or other reputable sources. If no such published practices apply, services must be consistent with community standards of practice.

Covered services must be furnished by one of the following types of providers.

- A legally operated hospital
- Physician
- Psychologist
- Psychological associate
- Licensed clinical social worker
- Licensed marital and family therapist
- Licensed marriage and family counselor
- Advanced Nurse Practitioner (A.N.P.)

Benefits are provided up to the following maximums:

Inpatient Care

Facility and professional care benefits are unlimited.

Outpatient Therapeutic Visits

Up to 20 office or home therapeutic visits per member each calendar year.

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

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

- Psychological treatment of sexual dysfunctions, including impotence and frigidity
- Dementia and sleep disorders
- Biofeedback services for psychiatric conditions other than generalized anxiety disorder
- EEG biofeedback or neurofeedback services
- Services furnished in connection with obesity, even if the obesity is affected by psychological factors

- Psychological and neuropsychological testing and evaluations. These services are covered under the Psychological and Neuropsychological Testing benefit
- Family and marital counseling, and family and marital psychotherapy, as distinct from counseling, except when medically necessary to treat the diagnosed psychiatric condition or conditions of a member
- Chemical dependency treatment; these services are covered under the Chemical Dependency Treatment benefit
- Mental health residential treatment

Preventive Medical Care

Benefits are provided for routine and preventive services performed on an outpatient basis and aren't subject to a calendar year benefit limit. You pay the \$25 professional visit copay for each visit in an office setting. The copay doesn't apply to visits only for immunizations. However, the copay may apply if you also have a consultation with the provider or receive other services during the visit.

Please Note: Hospital outpatient facility services are payable at the regular reimbursement percentages.

Your calendar year deductible and coinsurance don't apply to benefits for immunizations.

Seasonal Immunizations

Seasonal immunization benefits provided by a pharmacy aren't subject to the calendar year deductible, coinsurance or copay, if any. Benefits are provided at 100% of allowable charges. Covered services include flu shots, flu mist and pneumonia immunizations.

Covered services include:

- Routine physical exams
- Well-baby exams
- Immunizations
- Physical exams related to school, sports, and employment

Please Note: Benefits for routine or preventive diagnostic imaging (including x-ray), screening and diagnostic mammography, screening tests for prostate, colorectal and cervical cancer, and laboratory services performed on an outpatient basis are provided under the Diagnostic Services benefit and the Diagnostic And Screening Mammography benefit. Office visits related to prostate and cervical cancer screening are covered under the Professional Visits and Services benefit.

In addition to "General Limitations And Exclusions" we do not provide benefits for preventive medical care for:

- Inpatient routine newborn exams while the child is in the hospital following birth. These services are covered under the Newborn Care benefit.
- Services not named above as covered
- Routine or other dental care
- Routine vision and hearing exams
- Services that are related to a specific illness, injury or definitive set of symptoms exhibited by the member
- Physical exams for basic life or disability insurance
- Work-related disability evaluations or medical disability evaluations
- Contraceptive services, drugs or devices. Benefits for these services and supplies are provided under the Contraceptive Management and Sterilization Services and Prescription Drugs benefits.

Newborn Hearing Exams and Testing

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

PHARMACY DRUG BENEFIT

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

BENEFITS

Prescription Drug Copayment

Each member must pay a \$10 copayment for each separate new prescription or refill for **Generic Prescriptions** and a \$30 copayment for **Brand Name Prescriptions**.

Benefit Payment Percentages

After you've paid the required copayment, the following benefits will be provided for covered prescription drugs:

- **Participating Pharmacies** For each new prescription or refill, benefits are available at 100% of the amount a **participating** pharmacy has agreed to accept as payment in full.
To avoid paying the retail cost for a prescription drug reimbursable by us at a lower allowable charge rate, be sure to present your identification card to the pharmacist for all prescription drug purchases.
- **Non-participating Pharmacies** After your copayment, benefits are available at 100% of the amount we would have allowed for the same prescription or refill purchased at a participating pharmacy.

Please Note: The copayments and coinsurance of this benefit cannot be used to satisfy any deductible or coinsurance maximum of any other benefit under this program. The deductibles and coinsurance of the Medical Benefits of this program do not apply to this benefit.

DISPENSING LIMITS

The following dispensing limits apply unless the drug maker's packaging limits the supply in some other way:

Acute Legend Drugs Up to a 30-day supply for each new prescription or refill.

Maintenance Legend Drugs Up to a 30-day supply for each new prescription or refill.

We may limit the supply dispensed based on medical necessity. Contact your prescribing physician if you have questions about medications that are prescribed for you.

Tablet Splitting Program

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

If you participate in the program, you will pay one-half the copays specified above for retail or mail order drugs included in the program. If your plan requires coinsurance rather than copays, the coinsurance percentage will remain the same, but you will have lower out-of-pocket costs because the double strength tablets are less expensive than the single-strength medication.

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

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

Injectable Supplies

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

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

The Brand Name Drug copay will apply to purchases for alcohol swabs, test strips, testing agents and lancets. A separate copay will apply to each item purchased.

What Is Covered

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

- Prescription drugs (federal legend and state restricted drugs as prescribed by a licensed provider). This benefit covers off-label use of FDA-approved drugs as provided under this plan's definition of "prescription drug" (please see the "Definitions" section in this booklet).
- Compounded medications of which at least one ingredient is a covered prescription drug
- Prescriptive oral agents for controlling blood sugar levels
- Glucagon and allergy emergency kits
- Prescribed injectable medications for self-administration (such as insulin)
- 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 pharmacy, up to \$250 per member each calendar year
- Prescription contraceptive drugs and devices (e.g. oral drugs, diaphragms and cervical caps)

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

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

Additional Information About Your Prescription Drug Benefit

Generic Drugs

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 copay. 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 the member has used three-fourths (75 %) of the current supply. The 75% is calculated based on the number of units and days supply dispensed on the last refill.

Approved Drug List

This benefit uses a list of approved drugs, sometimes called a "formulary." This approved drug list includes medications to treat most medical conditions, including all FDA-approved generic drugs, and many brand name drugs. Drugs not on the approved list are covered under your benefit, but at the highest copay. In addition, certain categories of drugs are excluded. These are listed below under "What's Not Covered?"

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

Changes to our approved drug list do not change your benefits, unless a generic equivalent to a brand name drug becomes allowed by law. If you're taking a drug which is changed from approved status, we'll notify you prior to the change. The amount you pay for a brand name drug is based on the drug's designation (approved brand name) on the date it's dispensed. The pharmacy's status as participating or non-participating on the date the drug is dispensed is also a factor.

You may contact Customer Service to inquire about whether a drug is on our approved list, or to receive a copy of the list.

Specialty Pharmacy Program

Benefits for specialty drugs are only available when purchased through one of our Specialty Pharmacies. Benefits for specialty drugs dispensed through the Specialty Pharmacy program via mail-order are limited to a 30-day supply and are subject to the retail pharmacy cost for each prescription drug purchase.

"Specialty drugs" are drugs used to treat complex or rare conditions that require special handling, storage, administration or patient monitoring. They are high cost, often self-administered injectable drugs for the treatment of conditions such as rheumatoid arthritis, hepatitis or multiple sclerosis. We have contracted with specific Specialty Pharmacies that specialize in the delivery and clinical management of specialty drugs. These pharmacies will work with you and your health care provider to arrange ordering and delivery of these drugs.

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

Clinical Pharmacy Management

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

In making these determinations, we take into consideration medical necessity criteria, the recommendations of the manufacturer, the circumstances of the individual case, U.S. Food and Drug Administration Guidelines, published medical literature and standard reference compendia.

Prescription Drug Volume Discount Program

Your prescription drug benefit program includes per claim rebates that are received by Premera Blue Cross Blue Shield of Alaska from its pharmacy benefit manager. These rebates are taken into account in setting subscription charges or are credited to administrative charges otherwise payable to us by your group plan and are not reflected in your cost share. The allowable charge that your payment is based upon for prescription drugs is higher than the price we pay our pharmacy benefit manager for those prescription drugs. Premera Blue Cross Blue Shield of Alaska either retains the difference and applies it to the cost of Premera operations and the prescription drug benefit program or credits the difference to subscription rates for the subsequent benefit year. If your prescription drug benefit includes a copayment, coinsurance calculated on a percentage basis, or a deductible, the amount you pay and your account calculations are based on the allowable charge.

LIMITATIONS

In addition to "General Limitation And Exclusions," we will not provide this benefit for:

- Drugs and medicines that may be lawfully obtained over the counter (OTC) without a prescription. OTC drugs are excluded even if prescribed by a practitioner, unless otherwise stated in this benefit. Examples of such excluded items include, but aren't limited to, non-prescription drugs and vitamins, food and dietary supplements, herbal or naturopathic medicines and nutritional and dietary supplements (e.g. infant formulas or protein supplements). Prescription vitamins and food supplements.
- Non-prescription contraceptive methods (e.g. jellies, creams, foams or devices) Fertility drugs, regardless of their intended use.
- Therapeutic devices or appliances (including, but not limited to, support garments, and other nonmedical substances), regardless of their intended use.
- Immunization agents; biological sera, such as rabies serum; blood or blood plasma.
- Services other than prescription drugs; administration or injection of any drug; drugs delivered or administered by the prescriber.
- Any prescription or refill that is in excess of the quantity specified, or that is dispensed after one year from the date the prescription was written.
- Take-home prescription drugs dispensed and billed by a medical facility.
- Any claim or demand for injury or damage arising in connection with the manufacturing, compounding, dispensing, or use of any prescription drug.

- Non-legend drugs (over-the-counter), other than insulin and ephedrine-containing products (e.g. emergency allergy treatment kits); drugs which by law do not require a prescription; herbal, naturopathic, or homeopathic medicines or devices.
- Drugs which are prescribed or dispensed for cosmetic use.
- Any infusion therapy drugs or solutions; injectables or other prescriptions requiring parenteral administration or use (other than insulin, or glucagon for diabetes).
- Drugs indicated by labeling to be for experimental or investigative use.
- Replacement of lost or stolen medication
- Drugs to treat sexual dysfunction
- Weight management drugs

Prescription drugs covered under this benefit are not eligible for Medical Benefits.

SUBMISSION OF PRESCRIPTION DRUG CLAIMS

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

- **Participating Pharmacies** All you need to pay is the required copayment for each new prescription or refill. However, in the event you request a brand name drug over a generic equivalent, as described earlier in this section, you will also be required to pay the difference in cost between the brand name drug and the generic equivalent. You don't have to send us a claim; just show your coverage identification card to the pharmacist, and he or she will bill directly. If you don't show your identification card, you will have to pay the full cost of the prescription and submit the claim yourself.
Please call or write to us for a list of pharmacies that participate in our pharmacy drug program.
- **Non-participating Pharmacies** You will have to pay the full cost for new prescriptions and refills purchased at these pharmacies. Fill out a prescription drug claim form, attach your prescription drug receipts and send it to the address shown on the claim form.

MAIL-ORDER PHARMACY PROGRAM

This benefit is designed to supplement your Pharmacy Drug Benefit. You have the choice of having your new prescriptions and refills filled under the Mail-Order Pharmacy Program or the Pharmacy Drug Benefit.

The Medco By Mail/Mail-Order Pharmacy Program provides coverage for prescription drugs when prescribed by a physician.

BENEFITS

Generic Prescriptions or refills will be paid in full after a \$25 copayment per prescription or refill.

Name Brand Prescriptions will be paid in full after a \$75 copayment per prescription or refill.

DISPENSING LIMITATION

Up to a 90-day supply of covered medications may be purchased through the Mail-Order Pharmacy Program unless the drug maker's packaging limits the supply in some other way.

Please Note: The copayments and coinsurance of this benefit cannot be used to satisfy any deductible or coinsurance maximum of any other benefit under this program. The deductibles and coinsurance of the Medical Benefits of this program do not apply to this benefit.

How Do I Use This Program?

1. Ask your physician to prescribe needed medications for up to the maximum day supply stated earlier in this benefit, plus refills. If you are presently taking medication, ask your doctor 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 your mail service envelope.
2. Enclose your original prescription(s) in a mail service envelope and follow the instructions printed on the envelope.
3. Your prescription drug order will be processed and mailed to you via First Class Mail or UPS, along with instructions for future prescriptions and/or refills. **Please allow up to 14 days for delivery.**

To obtain additional details about the Medco By Mail's Pharmacy Program, call the Pharmacy Benefit Administrator's customer service department at the following toll-free number: 1-800-626-6080 or visit their Web site at www.medco.com.

VISION BENEFIT

You pay 20% coinsurance for vision exams and hardware.

This coinsurance doesn't count toward your out-of-pocket maximum. You must still pay it if you have exams or hardware after the out-of-pocket maximum is reached.

The calendar year deductible does not apply to the Vision benefit.

The Vision benefit covers the following:

- 1 eye exam per calendar year. Covered routine exam services include:
 - Examination of the outer and inner parts of the eye;
 - Evaluation of vision sharpness (refraction);
 - Binocular balance testing;
 - Routine tests of color vision, peripheral vision and intraocular pressure; and
 - Case history and recommendations.
- 1 pair of lenses per calendar year
- 1 pair of frames every 2 consecutive calendar years

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

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

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

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

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

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

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

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

under this benefit or plan ended.

DENTAL BENEFIT

Benefits are available for the services described in this section which are furnished for a covered dental condition. Such services must meet all of these requirements:

- They must be dentally necessary (see definition of "Dentally Necessary").
- They mustn't be excluded from coverage under this benefit.
- They must be furnished by a licensed dentist (D.M.D. or D.D.S.). Services may also be furnished by a dental hygienist or other individual performing within the scope of his or her license, as allowed by law. (These providers are referred to as "dental care providers.") Services must be rendered under the supervision and guidance of a dentist.

You are responsible for providing us with diagnostic materials (such as dental X rays, study models, and chart records), upon our request, that we may need to determine available benefits. Benefits will only be provided for dental services that can be verified as covered services based on the diagnostic materials we've been furnished. Benefits will not be provided for dental services that we are unable to verify as covered services when necessary diagnostic materials are not furnished upon our request.

ALTERNATIVE BENEFITS

To determine benefits available under this program, we consider alternative procedures or services with different fees which are consistent with acceptable standards of dental practice. In all cases where there is an alternative course of treatment that is less costly, we will only provide benefits for the treatment with the lesser fee. If you and your dentist choose a more costly treatment, then you are responsible for the additional charges beyond those for the less costly alternative treatment.

ESTIMATE OF DENTAL BENEFITS

Your dentist should submit an estimate of dental benefits request to us for any proposed dental service or series of dental services for which the total charge will exceed \$450. It is also important that any cast or porcelain restorations, prosthetic appliances, or periodontal surgeries be sent for an estimate of dental benefits. Within 72 hours after we receive the fully documented request, we will determine whether the service meets the standards for coverage under this program.

We strongly recommend that you request an estimate of dental benefits so that benefit questions are answered before your course of treatment begins. If your dentist makes a major change in the treatment plan, he or she should submit a revised plan.

The decision to deny, reduce, or end benefits for an otherwise covered service because that service is not dentally necessary will be made by a Premera Blue Cross Blue Shield of Alaska employee or consultant who is a licensed dental care provider.

BENEFITS

Calendar Year Dental Deductible

Covered dental services are classified as Type A, Type B, or Type C. Type A covered services are not subject to any calendar year deductible. However, a calendar year deductible does apply to Type B and Type C covered services. This is called the "Dental Deductible." The dental deductible is the amount of expense you must incur for Type B and Type C covered services each calendar year before benefits are payable under this program for those services. The amount credited toward the deductible will not exceed the allowable charge for the covered service. Any amount used to satisfy this deductible will not be used to satisfy any other deductible under this program.

For each member, this individual dental deductible is \$25.

This plan has an annual dollar maximum described below. We don't count allowable charges that apply to your individual dental deductible toward that annual dollar maximum. However, the plan also has limits on how often some Basic or Major procedures can be covered in a specific period of time. If you receive services or supplies covered by a benefit that has such a limit, we do count the procedures that apply to your individual dental deductible toward that limit.

Family Dental Deductible

We also keep track of the expenses applied to the individual dental deductible that are incurred by all enrolled family members combined. When the total equals \$75, we'll consider the individual deductible of every enrolled

family member to be met for the year. The \$75 is called the "family dental deductible." Only the amounts used to satisfy each enrolled family member's dental deductible will count toward the family dental deductible.

Dental Benefit Maximum

The maximum amount of Dental Benefits available to any one member in a calendar year is \$1,500.

Benefits for covered services with multiple treatment dates are subject to the Dental Benefit maximum of the calendar year in which the services are started.

Please Note: Copays, calendar year deductibles, coinsurance and/or out-of-pocket maximums that may be required for other benefits of this plan don't apply to this benefit. This benefit's deductible and coinsurance don't count toward other out-of-pocket maximums of this plan and are still required when those other limits are reached.

Benefit Payment Percentages

After you satisfy the required deductible, Dental Benefits are provided at the following percentages of allowable charges each calendar year, up to the Dental Benefit maximum.

Type Of Covered Service	Percentage Of Allowable Charge
• Type A - Diagnostic And Preventive	100%
• Type B - Basic	85%
• Type C - Major	50%

The Dental Benefits of this program are based on allowable charges for dentally necessary covered services. The percentage of an allowable charge that you are responsible for is called coinsurance.

Please refer to the "Definitions" section for a detailed explanation of allowable charge.

The Dental Benefits available under this section will be provided prior to any Dental Benefits which may be available under other provisions of this program.

COVERED SERVICES

Type A - Diagnostic And Preventive

- Routine oral examinations, limited to two each calendar year. Initial consultations, second opinion consultations and office visits count toward the limit for oral examinations.
- Emergency oral examinations. Services that are determined to be routine will be limited to 2 per calendar year.
- Prophylaxis (cleaning, scaling, and polishing of teeth), limited to two each calendar year.
- Topical application of fluoride, for members under age 20, limited to two treatments each calendar year.
- Dental X rays. Benefits are available for either a complete series or panoramic X ray once in any 36 consecutive months, but not both. X rays taken for root canal therapy are limited to one periapical X ray per tooth.
- Space maintainers, for members under age 20.
- Sealants, for members under age 14, limited to use on permanent teeth.

Type B - Basic

- Simple extractions.
- Oral surgery consisting of surgical extractions, fracture and dislocation treatment, and diagnosis and treatment of cysts and abscesses.
- Dentally necessary injectable drugs administered in a dental office
- Fillings, consisting of silver amalgam, silicate, and composite resins. For other types of fillings, such as gold foils, the allowance will be limited to what would have otherwise been allowed for amalgam fillings. A filling on any given tooth surface is a benefit only once in any 24 consecutive months.
- Treatment of periodontal and other diseases of the gums and tissues of the mouth. Periodontal scaling and root planing and subgingival curettage are limited to a total of two full-mouth treatments in any 12 consecutive months. Periodontal maintenance, as a follow-up to active periodontal treatment, including removal of bacterial flora, sub-gingival scaling, polishing, periodontal evaluation and review of oral hygiene, is limited to 1 visit every 3 consecutive months.
- Endodontic (root canal) treatment.
 - Benefits for root canals performed in conjunction with overdentures are limited to 2 per arch

- Open and drain (open and broach) (open and medicate) procedures may be limited to a combined allowance based on our review of the services rendered
- X-rays done in conjunction with a root canal. The primary periapical x-ray for diagnostic purposes is covered. Additional x-rays are limited to the allowance for the root canal therapy.
- Repair and recementing of crowns, inlays, bridgework, and dentures.
- Emergency palliative treatment. We require a written description and/or office records of services provided.
- General anesthesia in a dental care provider's office, when dentally necessary. This includes members who are under the age of 7 or are disabled physically or developmentally.

Type C - Major

- Initial placement of inlays, onlays, laboratory-processed labial veneers, and crowns for decayed or fractured teeth when amalgam or composite resin fillings would not adequately restore the teeth.
- Replacement inlays, onlays, laboratory-processed labial veneers, and crowns, but only when:
 - The existing restoration was seated at least five years prior to replacement; or
 - Repreparation of the natural tooth structure is required as a result of an accidental injury to that structure, and such repair is performed within 12 months of the accidental injury.
- Initial installation of partial and complete dentures.
- Initial installation of fixed bridgework (including inlays, onlays, and crowns to form abutments).
- Replacement of partial and complete dentures and fixed bridgework, but only when:
 - The existing denture or bridgework was installed at least five years prior to replacement;
 - The replacement or addition of teeth is required to replace one or more additional teeth extracted after initial placement; or
 - Repreparation of the natural tooth structure under the existing fixed bridgework is required as a result of an accidental injury to that structure, and such repair is performed within 12 months of the accidental injury.
- Relining and rebasing of partial and complete dentures when performed six or more months after denture installation. Charges for relines, rebases, and adjustments performed during the first six months following denture installation are limited to the allowance for the denture.
- Tooth build-ups for covered inlays, onlays, and crowns, including bridge abutments.
- Implants and implant related services, subject to our review for dental necessity

Note: Covered services including implant abutment and/or crowns over the implants are covered only once in a 5 consecutive year period (5 years from the date of the installation of the prosthetic service).
- Precision attachments subject to our review for dental necessity

Please Note: An accidental injury does not include damage incurred in the act of biting or chewing.

LIMITATIONS

In addition to "General Limitations And Exclusions," we will not provide this benefit for:

- Services or supplies:
 - Received or ordered when this benefit is not in effect, or when you are not covered under this benefit (including services and supplies started before your effective date or after the date coverage ends), except for Type C services and root canals which:
 - Were started after your effective date and prior to the date your coverage ended under this benefit; and
 - Were completed within 90 days after the date your coverage ended under this benefit.
- The following are deemed service start dates:
- For root canals, the date the canal is opened.
 - For inlays, onlays, laboratory-processed labial veneers, crowns, and bridges, the preparation date.
 - For partial and complete dentures, the impression date.
- The following are deemed service completion dates:
- For root canals, the date the canal is filled.
 - For inlays, onlays, laboratory-processed labial veneers, crowns, and bridges, the seat date.

- For partial and complete dentures, the seat or delivery date.
- To increase or alter the vertical dimension.
- Provided by more than one dentist for the same dental procedure.
- Which are not customary and accepted by the dental profession in the State of Alaska or Washington.
- For orthodontics, including casts, models, X rays, photographs, examinations, appliances, braces, and retainers. However, this exclusion does not apply to extractions incidental to orthodontic services.
- To treat congenital malformations, except when the patient is a dependent child.
- For cosmetic or aesthetic purposes, including endodontic tooth bleaching.
- Which are for mercury sensitivity or are allergy-related.
- Which are normally intended for home use (including toothbrushes, floss, and toothpaste).
- Counseling, education, or training services. This includes dietary planning for the control of dental caries, oral hygiene instruction, and training in preventive dental care.
- Charges for incomplete treatment, broken appointments, patient management, or duplicate X rays.
- Extra dentures or other appliances, including replacements due to loss or theft.
- Nonstandard techniques used to make restorations or prosthetic appliances, such as personalized restorations, precision attachments, and denture labeling.
- Any drugs or medicines. This includes vitamins, food supplements, and patient management drugs, such as premedication, sedation, and nitrous oxide.
- Dental services received from a:
 - Dental or medical department maintained for employees by or on behalf of an employer; or
 - Mutual benefit association, labor union, trustee, or similar person or group.
- Separate charges for records or reports, polishing or margination of restorations, supplies or materials, temporary crowns, acid etch, indirect pulp caps or bases for restorations, local anesthesia, occlusal analysis or bite registration, or supplies for infection and bacteria control, such as gloves or masks.
- Hospital and ambulatory surgical center care for dental procedures.

HEARING BENEFIT

Hearing Exams

You pay a \$25 professional visit copay for hearing exams.

Benefits are provided for one hearing examination (or screening) per member every 2 consecutive calendar years. 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

Benefits for hearing hardware aren't subject to the deductible or coinsurance. Benefits are provided up to a maximum benefit of \$3,000 per member in a period of 3 consecutive calendar years.

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

- You must be examined by a licensed physician 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
- Hearing aid rental while the primary unit is being repaired
- The initial batteries, cords and other necessary ancillary equipment
- A warranty
- A follow-up consultation within 30 days following delivery of the hearing aid with either the prescribing physician or audiologist
- Repairs, servicing and alteration of hearing aid equipment

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

- 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.

GENERAL LIMITATIONS AND EXCLUSIONS

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

WAITING PERIOD FOR PRE-EXISTING CONDITIONS

A **pre-existing condition** is a condition, regardless of cause, for which medical advice, diagnosis, care, or treatment was recommended or received in the 6 months prior to your "enrollment date."

The waiting period for pre-existing conditions is 12 months from your enrollment date. This waiting period may be reduced by prior periods of creditable coverage as explained below. Except as stated below, no benefits will be provided until:

- after your coverage becomes effective; and
- your 12-month waiting period for pre-existing conditions has been met.

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

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

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

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

"Creditable" coverage does not include coverage under a limited policy such as accident only coverage; disability income insurance; workers' compensation; limited scope dental or vision plans; liability insurance; automobile medical insurance; specified disease coverage; Medicare supplement policy; or long-term care policy.

The waiting period for pre-existing conditions **does not apply** to:

- Pregnancy
- Newborn children born after the subscriber's effective date of coverage under this program, provided they are covered from birth as explained under "Special Enrollment."
- Newborn children covered under creditable coverage at any time during the 30-day period beginning with their date of birth. However, the waiting period for pre-existing conditions will apply if, after such initial period of creditable coverage, there is a break in coverage exceeding 90 days.
- Adoptive children who are adopted or placed for adoption after the subscriber's effective date of coverage under this program, provided they are covered from the date of their adoption or placement for adoption as

explained under "Special Enrollment."

- Adoptive children, who before age 18, were covered under creditable coverage at any time during the 30-day period beginning with their date of adoption or placement for adoption. However, the waiting period for pre-existing conditions will apply if, after such initial period of creditable coverage, there is a break in coverage exceeding 90 days.
- Coverage for PKU formula for members with Phenylketonuria.
- Genetic information in absence of a diagnosis

WHAT YOUR PROGRAM DOES NOT COVER

In addition to the specific limitations stated elsewhere in this program, we will not provide benefits for:

- Services and supplies:
 - Directly related to any condition, service, or supply that is not covered under this program.
 - Received or ordered when this program is not in effect, or when you are not covered under this program, except as stated under specific benefits and under "Extended Benefits."
 - For which no charge is made, or for which none would have been made if this program were not in effect.
 - For which you do not legally have to pay, except as required by law in the case of federally qualified health center services.
 - That are not listed as covered in this program.
 - That are outside the scope of the provider's license or certification, or that are furnished by a provider that is not licensed or certified by the jurisdiction in which the services or supplies were received.
 - That you furnish to yourself or that are furnished to you by a provider who lives in your home or is related to you by blood, marriage, or adoption. Examples of such providers are your spouse, parent, or child.
 - That are not medically necessary even if they are court-ordered. This also includes places of service, such as inpatient hospital care.
 - That are for your convenience or that of your family; services of a personal nature, such as meals for guests, long-distance telephone charges, radio or television charges, or barber or beautician charges.
- Any direct complications, consequences, or aftereffects, whether immediate or delayed, that arise from any condition, service, or supply that is not covered under this program, except as specifically stated in this program.
- Amounts that exceed the allowable charge or maximum benefit for a covered service.
- Separate charges from providers for records or reports, except those we request for utilization review.
- Custodial care, except as provided under the "Home And Hospice Care" benefit.
- Any service or supply which Premera Blue Cross Blue Shield of Alaska determines is experimental or investigational on the date it is furnished. Our determination is based on the criteria stated in the definition of "Experimental/Investigational Services."

If we determine that a service is experimental or investigational, and therefore not covered, you may appeal our decision. Please refer to "Your Ideas, Questions, Complaints And Appeals" for an explanation of the appeals process.

Note: This exclusion does not apply to certain experimental or investigational services provided as part of oncology clinical trials. Benefit determination is based on the criteria specified in the definition of "Oncology Clinical Trials" in the definitions section in this booklet.

- Care rendered by any nonparticipating medical facility that is owned or operated by a government agency, except when:
 - We refer you to the facility;
 - You are receiving care for a medical emergency (see "Definitions.")
 - We must provide available benefits for covered services as required by law or regulation.
- Counseling, education, or training services, except as stated under the "Diabetes Health Education" benefit, the "Mental Health Care" benefit and for the support services stated in the "Chemical Dependency Treatment" benefit. This includes vocational assistance and outreach; nicotine dependency programs; and family, marital, social, sexual, lifestyle, nutritional, and fitness counseling.
- Habilitative, education, or training services or supplies for dyslexia, for attention deficit disorders, and for

disorders or delays in the development of a child's language, cognitive, motor, or social skills, including evaluations thereof. However, this exclusion does not apply to treatment of neurodevelopmental disabilities in children under the age of 7 as stated under the "Rehabilitation and Neurodevelopmental Therapy" benefit.

- Therapy designed to provide a changed or controlled environment.
- Cosmetic services and supplies (including drugs), except that benefits will be provided for:
 - All stages of the initial repair of a defect which is the direct result of an accidental injury, providing such repair is performed within 12 months of the date of the accident.
 - All stages of the initial repair of a dependent child's congenital anomaly.
 - Reconstructive breast surgery in connection with a mastectomy as provided under the "Mastectomy And Breast Reconstruction Services" benefit.
 - Correction of functional disorders upon our review and approval.
- Hair prostheses, such as wigs or hair weaves, transplants, and implants. Drugs, supplies, equipment, or procedures to replace hair, slow hair loss, or stimulate hair growth.
- Private duty nursing.
- Treatment of obesity or morbid obesity, including surgery and its complications, services and supplies connected with weight loss or weight control. This exclusion applies even if you also have an illness or injury which might be helped by weight loss.
- Routine or palliative foot care, including hygienic care; impression casting for prosthetics or appliances and prescriptions therefor; fallen arches, flat feet, care of corns, bunions (except for bone surgery), calluses, and toenails (except for ingrown toenail surgery), and other symptomatic foot problems. This includes foot-support supplies, devices, and shoes.
- Diagnosis and treatment of sexual disorders and defects, regardless of origin or cause; surgical or medical treatment of impotence, including drugs or medications or penile or other implants; and, any direct or indirect complications and aftereffects thereof.
- Testing, diagnosis and treatment of infertility, including procedures, supplies and drugs
- Assisted fertilization techniques, including but not limited to, artificial insemination, in-vitro fertilization, and gamete intra-fallopian transplant (GIFT).
- Reversal of surgical sterilization.
- Treatment or surgery to change gender.
- Jaw augmentation or reduction (orthognathic or maxillofacial surgery), regardless of origin of the condition that makes the procedure necessary.
- Any method of care connected with the diagnosis or treatment of temporomandibular joint (TMJ) disorders or similar conditions of or affecting the joints linking the lower jawbone and skull, including the complex of muscles, nerves, and other tissues related to those joints.
- Conditions caused by or arising from:
 - Acts of war (declared or undeclared) or armed invasion or aggression.
 - Service in the armed forces of any country, including the air force, army, coast guard, marines, national guard, navy, or civilian forces or units auxiliary thereto.
 - Voluntary participation in a riot or insurrection.
 - An member's commission of a felony or act of terrorism.
- Treatment of caffeine dependence.
- 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; or
 - Any legislative act providing compensation for work-related illness or injury.
- Services and supplies to the extent that benefits are payable under the terms of any contract or insurance offering:
 - Motor vehicle medical, motor vehicle no-fault, or personal injury protection (PIP) coverage;
 - Commercial premises or homeowner's medical premises coverage, or other similar type of contract or

insurance; or,

- Workers Compensation or similar coverage.
- Services and supplies that are not directly related to an illness, accidental injury, or distinct physical symptoms. Examples are routine tests or screenings and physical examinations. However, this exclusion does not apply to the routine services and supplies specifically stated as covered under the "Routine Newborn Care," "Preventive Medical Care," "Professional Visits," "Diagnostic Services," and "Diabetes Health Education" benefits.
- Well-baby care, except as specifically stated as covered under the "Routine Newborn Care" and "Preventive Medical Care" benefits.
- Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), and pleoptics. Also not covered are treatment or surgeries to improve the refractive character of the cornea, including the treatment of any results of such treatment. Routine vision services and supplies, including services of an optician, are not covered except as specified in the "Vision Benefit."
- Routine hearing care, including hearing examinations, diagnostic screenings, and tests; services and supplies for or related to hearing aids or other devices to improve hearing sharpness except as specified in the "Hearing Benefit" and the "Newborn Hearing Exams and Testing" benefit.
- Over-the-counter drugs, supplies, food supplements and vitamins.
- Dental services, except as specified under the "Dental Benefit," and except those performed in conjunction with treatment that is the direct result of an accidental injury to natural teeth, gums, or jaw, but only when all of the following requirements are met:
 - The services are within the scope of the provider's license;
 - The injury is not caused by biting or chewing, even if due to a foreign object in food;
 - The services are received within 12 months of the accident causing the injury;
 - For services provided for a natural tooth, the tooth must be the member's natural, living tooth that was free from decay and otherwise functionally sound at the time of the injury. "Functionally sound" means that the affected teeth:
 - Do not have extensive restoration, veneers, crowns or splints;
 - Do not have periodontal disease or other condition that would cause the tooth to be in a weakened state prior to the injury.
 - The services are essential and appropriate to the repair of the accidental injury. Treatment plan review will be performed by a dentist licensed to practice dentistry in the State of Alaska; and
 - The maximum benefits available under the "Dental Benefit" for the accidental injury have been provided.
- Orthodontics, including casts, models, X rays, photographs, examinations, appliances, braces, and retainers.
- Hospital care for dental procedures, unless adequate treatment cannot be provided without the use of hospital facilities, **and** you have a medical condition besides the one requiring treatment that makes hospital care medically necessary.
- Treatment of psychiatric conditions and eating disorders, such as anorexia nervosa, bulimia, or any similar conditions, except as specified under the "Mental Health Care" benefit.
- Electronic, on-line or internet medical consultations or evaluations.
- Benefits for human growth hormone are only provided under the Pharmacy Drug benefit.

COORDINATION OF BENEFITS

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

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

If you have other coverage besides this plan, we recommend that you submit your claim to the primary carrier first, 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 any of the medical plans involved. 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.
- **Claim Determination Period** means a calendar year.
- **Medical Plan** means all of the following health care coverages, even if they don't have their own coordination provisions:
 - Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization group or individual agreements issued by insurers, health care service contractors, and health maintenance organizations
 - Labor-management trustee plans, labor organization plans, employer organization plans or employee benefit organization plans
 - Government programs that provide benefits for their own civilian employees or their dependents
 - Group coverage required or provided by any law, including Medicare. This doesn't include workers' compensation.
 - Group student coverage that's sponsored by a school or other educational institution and includes medical benefits for illness or disease
- **Dental Plan** means all of the following dental care coverages, even if they don't have their own coordination provisions:
 - Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization group or individual agreements issued by insurers, health care service contractors, and health maintenance organizations
 - Labor-management trustee 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.

COORDINATING BENEFITS WITH MEDICARE

If you're also covered under Medicare, federal law may require this plan to be primary over Medicare.

When this plan isn't primary, we'll coordinate benefits with Medicare.

SUBROGATION AND REIMBURSEMENT

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

Definitions The following terms have specific meanings in this contract:

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

To the fullest extent permitted by law, we're entitled to the proceeds of any settlement or judgment that results in a recovery from a third party, up to the amount of benefits paid by us for the condition. Our right to recover exists regardless of whether it is based on subrogation, reimbursement or restitution. Such recoveries will not be sought more than 365 days after we receive notice of the settlement or judgment. In recovering benefits provided, we may at our election hire our own attorney or be represented by your attorney. We will not pay for any legal costs incurred by you or on your behalf, and you will not be required to pay any portion of the costs incurred by us or on our behalf.

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

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

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

To the fullest extent permitted by law, we're entitled to the proceeds of any settlement or judgment that results in a recovery from a third party, up to the amount of benefits paid by us for the condition. Our right to recover exists regardless of whether it is based on subrogation, reimbursement or restitution. Such recoveries will not be sought more than 365 days after we receive notice of the settlement or judgment. In recovering benefits provided, we may at our election hire our own attorney or be represented by your attorney. We will not pay for any legal costs incurred by you or on your behalf, and you will not be required to pay any portion of the costs incurred by us or on our behalf.

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

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

UNINSURED AND UNDERINSURED MOTORIST/PERSONAL INJURY PROTECTION COVERAGE

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

GENERAL PROVISIONS

CONFORMITY WITH THE LAW

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

ENTIRE CONTRACT

The entire contract between the Trust and us consists of all of the following:

- The contract face page and "Standard Provisions";
- The benefit booklet(s);
- The Trust's signed application which is kept on file with us (a copy is available upon request);
- The Funding Arrangement Agreement between the Trust and us; and
- All attachments, endorsements, and riders included or issued hereafter.

This contract is delivered in the State of Alaska and governed by the laws of that State, except to the extent preempted by federal law.

No change to this contract, including any change made by an agent or broker of the Trust, will be binding upon us unless it is in writing and approved over the signature of an officer of ours.

EVIDENCE OF MEDICAL NECESSITY

We have the right to require proof of medical necessity from you or your provider when you are receiving benefits under this program. No benefits will be available under this program if the proof is not provided or not acceptable to us.

TRUST AS THE AGENT

The Trust is the agent of the members for all purposes under this program and not the agent of Premera Blue Cross Blue Shield of Alaska. Any action taken by the Trust will be binding on you.

INTENTIONALLY FALSE OR MISLEADING STATEMENTS

If this program's benefits are paid in error due to any intentionally false or misleading statements of material fact under the terms of the coverage, we will be entitled to recover these amounts. See "Right Of Recovery" below.

And, if you make any intentionally false or misleading statements of material fact under the terms of the coverage on any application for enrollment under this program, or any forms required for enrollment, that affect your acceptability for coverage, we may, at our option, deny your claim, reduce the amount of benefits provided for your claim, or terminate your coverage under this program.

Finally, intentionally false or misleading statements of material fact under the terms of the coverage which are made on any Trust form required by us which affect the acceptability of the Trust or the risks to be assumed by us may cause the contract for this program to be terminated. Such recoveries will not be sought more than 365 days from the date we discovered, or could have reasonably discovered the intentionally false or misleading statements.

LIMITATIONS OF LIABILITY

We 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 program'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

All members are under a duty to cooperate in a timely and appropriate manner with us in our administration of benefits or 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 health information, or personal data such as your address, telephone number or Social Security Number. We may receive this information from, or release it to, health 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;
- Coordinating benefits with other health care plans;
- Conducting care management, case management, or quality reviews; and,
- Fulfilling other legal obligations that are specified under the Trust Contract.

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

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

If a disclosure of PPI is not 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 request form be mailed to you.

NOTICE OF OTHER COVERAGE

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

- Any legal action or claim against another party for a condition or injury for which we paid 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, uninsured motorist, or any other insurance under which you are or may be entitled to recover compensation.
- The name of any other group insurance plan(s) under which you are covered.

NOTICES

Any notice we are required to submit to the Trust or subscriber will be considered to be delivered if mailed to the Trust or subscriber, at the most recent address appearing on our records. We will use the date of postmark in determining the date of our notification. If the Trust or subscriber is required to submit notice to us, we will determine our receipt of such notice based on the earlier of postmark or date received at our offices.

RIGHT OF RECOVERY

We have the right to recover amounts we paid that exceed the amount for which we are liable. Such amounts may be recovered from the subscriber or any other payee, including a provider. Or, such amounts may be deducted from future benefits of the subscriber or any of his or her dependents (even if the original payment was not made on that member's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a provider that does not have a contract with us.

In addition, if the contract for this program is terminated as described in "Intentionally False Or Misleading Statements," we have the right to recover the amount of any claims we paid under this program and any administrative costs we incurred to pay those claims.

RIGHT TO AND PAYMENT OF BENEFITS

All rights to the benefits of this program are available only to members. However, we will honor subscribers' requests to assign benefit payments to the provider who furnished the care when such requests do not conflict

with our obligations under our provider agreements. We will also honor such assignments when they are made by a third party to whom the right to make such assignments has been clearly designated in a valid qualified domestic relations order. To find out how to make assignments, please call Customer Service. The phone numbers are shown in "Your Ideas, Questions, Complaints, And Appeals" section of this booklet.

We will not honor any other attempted assignment, garnishment, attachment or transfer of any right of this program.

At our option and in accordance with this provision and federal and state law, we may pay the benefits of this program to the subscriber, provider, member, other carrier, or other party legally entitled to such payment under federal or state medical child support laws, or jointly to any of these. Such payment will discharge our obligation to the extent of the amount paid so that we will not be liable to anyone aggrieved by our choice of payee.

VENUE

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

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

WORKERS' COMPENSATION INSURANCE

This contract does not replace, affect, or supplement any state or federal requirement for the Trust to provide workers' compensation insurance, employer's liability insurance, or other similar insurance. When an employer is required by law to provide or has the option to provide workers' compensation insurance, employer's liability insurance, or other similar insurance and does not provide such coverage for its employees, the benefits available under this program will not be provided for illnesses and/or injuries arising out of the course of employment which are or would be covered by such insurance, unless otherwise excepted under "General Limitations And Exclusions."

STARTING OUT IN THE PROGRAM

WHO IS ELIGIBLE FOR COVERAGE

Employee Eligibility

Under this large employer health benefit plan, to be an "eligible employee" you must:

- be a regular and active employee of an employer participating in the PUBLIC SAFETY EMPLOYEES ASSOCIATION HEALTH & WELFARE TRUST.
- regularly work a minimum of 25 hours per week if you are a salaried employee or 20 hours per week if you are a part-time employee; and
- under the terms of your employment, have the applicable monthly contribution made by your employer and received by the Trust.

Employees Performing Employment Services In Hawaii

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

Dependent Eligibility

An "eligible dependent" is defined as:

- The lawful spouse of the subscriber, unless legally separated.
- The same sex domestic partner of the subscriber. If all requirements are met, as stated in the signed "Affidavit of Domestic Partnership," all rights and benefits afforded to a "spouse" under this plan will also be afforded to an eligible same sex domestic partner. In determining benefits for same sex domestic partners and their children under this plan, the term "establishment of the domestic partnership" shall be used in place of "marriage"; the term "termination of the domestic partnership" shall be used in place of "legal separation" and "divorce."
- An eligible child under 25 years of age who is unmarried and primarily dependent upon the subscriber for support. However, if the child is an employee who meets the requirements in "Employee Eligibility" earlier in the section, the child can only enroll as a subscriber. An "eligible child" is:
 - a natural offspring of either or both the subscriber or spouse;
 - a legally adopted child of either or both the subscriber or spouse;
 - a child "placed" with the subscriber for the purpose of legal adoption in accordance with state law. "Placed" for adoption means assumption and retention by the subscriber of a legal obligation for total or partial support of a child in anticipation of adoption of such child; or
 - a minor for whom the subscriber or spouse has a legal guardianship.

Foster children are not eligible.

ENROLLMENT

When we receive the completed enrollment application and required subscription charges, coverage for the employee and enrolled dependents will become effective on the first day of the month for which your employer has made the required contribution.

SPECIAL ENROLLMENT

We are obligated under the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to inform you of special enrollment situations, as stated below. However, this will not apply to the Public Safety Employees Association Health & Welfare Trust group plan because members and dependents are automatically covered when they become eligible.

Involuntary Loss Of Other Coverage

If you don't enroll in this plan or another plan sponsored by the Group when you are eligible because you aren't required to do so, you may later enroll in this plan outside of the annual open enrollment period if each of the following requirements is met:

- You were covered under group health coverage or a health insurance program at the time coverage under the Group's plan is offered
- your coverage under the other health care program ended as a result of one of the following:
 - loss of eligibility for the coverage (including but not limited to, the result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, or reaching a health care plan's overall lifetime benefit maximum),
 - termination of employer contributions toward such coverage
 - you were covered under COBRA at the time coverage under this program was previously offered and COBRA coverage has been exhausted.

In addition, if you were covered under another health plan sponsored by the Group, and you reach that plan's lifetime maximum, you also have the right enroll in this plan if one of two things is true:

- The lifetime maximum of this plan is higher than that of the other plan
- The benefits paid under the other plan could not be credited toward this plan's lifetime maximum. (See "Plan Transfers" later in this section for credits applied for transfers between two Premera Blue Cross Blue Shield of Alaska plans.

Please Note: For the purposes of special enrollment, federal law defines "Group health coverage" or "health insurance programs" to **exclude** Medicaid, medical care provided for current or former members of the U.S. military, a state health benefits pool, coverage provided through the Federal Employee Health Benefit Program, a medical program of the Indian Health Service or a tribal organization, or a public health program.

When you qualify as stated above, you may also enroll all eligible dependents. When only an eligible dependent qualifies for special enrollment, but you are not enrolled in any of the Group's plans or are enrolled in a different plan sponsored by the Group, you are also allowed to enroll in this plan in order for the dependent to enroll.

When we receive your completed enrollment application and any required subscription charges within 60 days of the date such other coverage ended, coverage under this program will become effective on the first of the month following receipt of your enrollment application.

Dependents Acquired Through Marriage After The Subscriber's Effective Date

When we receive the completed enrollment application and any required subscription charges within 60 days after the marriage, coverage will become effective on the first of the month following the date of marriage.

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. However, if payment of additional subscription charges is required to provide coverage for a newborn child, and the subscriber desires coverage of the newborn child to extend beyond the 31-day period following the newborn child's date of birth, we must receive a completed enrollment application and the required additional subscription charges within the 60-day period following the date of birth.

Adoptive dependent children who are adopted or placed for adoption on or after the subscriber's effective date will be covered from their date of adoption or placement for adoption. However, if payment of additional subscription charges is required to provide coverage for an adoptive dependent child, and the subscriber desires coverage of the adoptive child to extend beyond the 31-day period following the dependent child's date of adoption or placement for adoption, we must receive a completed enrollment application and the required additional subscription charges within the 60-day period following the date of adoption or placement for adoption.

If we do not receive the completed enrollment application and the required additional subscription charges within the 60-day period, initial coverage will be limited to the 31-day period referenced above.

Children Acquired Through Legal Guardianship

When we receive the completed enrollment application, any required subscription charges, and a copy of the guardianship papers within 60 days of the date legal guardianship began with the subscriber, coverage for an otherwise eligible child will begin on the first of the month following the date legal guardianship began.

Children Covered Under Medical Child Support Orders

When we receive the completed enrollment application within 60 days of the date of the medical child support

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

Court-Ordered Dependent Coverage

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

Subscriber And Dependent Special Enrollment

An eligible employee and otherwise eligible dependents who previously elected not to enroll in any of the employer's group health plans when such coverage was previously offered, may enroll in this program at the same time a newly acquired dependent is enrolled under "Special Enrollment" in the case of marriage, birth, adoption, or placement for adoption.

CHANGES IN COVERAGE

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

The exception is inpatient confinements described in "Extended Benefits" under "Continued Coverage Under This Program." Changes to this program will not apply to inpatient stays which are covered under that provision.

PROGRAM TRANSFERS

Subscribers (with their enrolled dependents) may be allowed to transfer to this program from another program with us offered by the Trust. Transfers also occur if the Trust replaces another program (with us) with this program. Also, we may replace the Trust's current contract for this program with an updated one from time to time. All transfers to this program must occur during "open enrollment" or on another date agreed upon by us and the Trust.

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

- waiting period for pre-existing conditions;
- calendar year deductible;
- coinsurance maximum;
- benefit maximums; and
- lifetime maximums.

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

This provision does not apply to transfers from programs not offered by us.

WHEN COVERAGE ENDS

EVENTS THAT END COVERAGE

Coverage will end without notice, except as specified under "Extended Benefits," on the last day of the monthly period for which subscription charges have been paid in which one of these events occurs:

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

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

CERTIFICATE OF HEALTH COVERAGE

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

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

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

CONTRACT TERMINATION

No rights are vested under this program. Termination of the Trust Contract for this program completely ends all members' coverage and all our obligations, except as provided under "Extended Benefits" in "Continued Coverage Under This Program."

The Trust Contract will automatically be terminated if subscription charges or contributions are not paid when due; coverage will end on the last day for which payment was made. This program may also terminate as indicated below.

The Trust may terminate the Trust Contract:

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

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

- the Trust has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage;
- the Trust has failed to comply with a material plan provision relating to minimum participation or employer contribution requirements;

- in the case of a network plan, the Trust no longer has any members who reside or work in Alaska or Washington;
- in the case of a plan that is made available only through a bona fide association, the employer's membership in the association ceases and coverage is terminated uniformly without regard to a member's health;
- we discontinue offering a particular type of health care plan in the group market providing:
 - we furnish written notice of the decision to discontinue coverage to all affected groups, members, and to the insurance regulatory official in each state in which an affected member is known to reside. Such notice must be given at least 180 days before we decide to discontinue the health care plan;
 - we furnish written notice of the decision to discontinue coverage to the director and to the insurance regulatory official in each state in which we are licensed at least 30 days before notice is given to the affected groups and members as described above;
 - we offer each group who is provided the particular type of health care plan the option to purchase another health care plan currently being offered by us to groups in the same market in that state; and
 - we act uniformly without regard to the claims experience of those groups, or to any health status factor of a member or a prospective member who may become eligible for coverage;
- we discontinue offering and renewing all health care plans in the group market providing:
 - we furnish written notice of the decision to discontinue coverage to all affected groups, members, and to the insurance regulatory official in each state in which an affected member is known to reside. Such notice must be given at least 180 days before we decide to discontinue the health care plans;
 - we furnish written notice of the decision to discontinue coverage to the director and to the insurance regulatory official in each state in which we are licensed at least 30 days before the notice is given to the affected groups and members as described above; and
 - we do not issue a health care plan in the group market in the applicable states for five (5) years from the date the last group health care plan was discontinued.

CONVERTING TO A NONGROUP PROGRAM

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

You can apply for a Conversion Program if:

- you are not entitled to services or benefits for medical and hospital care under another group program
- you are entitled to other coverage, but that coverage contains exclusions or waiting periods for any pre-existing conditions you have
- you are not eligible for Medicare coverage

For more information about our Conversion Programs, contact our Customer Service Department.

We also offer other types of nongroup medical programs, including Medicare supplement coverage (if you are eligible for and enrolled in Parts A and B of Medicare). For more information, contact your agent or our Customer Service Department.

Please Note: The rates, coverage and eligibility requirements of the above nongroup programs differ from those of your current Trust program.

MEDICARE SUPPLEMENT COVERAGE

We also offer Medicare supplement coverage for those who are eligible for and enrolled in Parts A and B of Medicare. Also, you **may** be eligible for guarantee-issued coverage under certain Medicare supplement plans if you apply within 63 days of losing coverage under this program. For more information, contact your agent or our Customer Service Department.

CONTINUED COVERAGE UNDER THIS PROGRAM

CONTINUED ELIGIBILITY FOR A DISABLED CHILD

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

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

The 90-day leave of absence period counts toward the maximum COBRA continuation period, except as prohibited by the Family and Medical Leave Act of 1993 (Public Law 1033).

CONTINUATION OF GROUP COVERAGE - COBRA

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

At the Trust's request, we will provide qualified members with continued coverage under this program 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 program. Members' rights to this coverage may be affected by the Trust's failure to abide by the terms of its contract with us. The Trust, **not us**, must also perform all notifications and other duties assigned by COBRA to the "plan administrator" within COBRA's time limits.

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

Qualifying Events And Length Of Coverage

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

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

- The Trust 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 one of two qualifying events:
 - **The subscriber's work hours are reduced.**
 - **The subscriber's employment terminates, except for discharge due to actions defined by the Trust as gross misconduct.**

However, if one of the events listed above follows the covered employee's entitlement to Medicare by less than 18 months, the Trust 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. To be eligible for the extended continuation period, you must give the Trust a copy of the determination of disability during the 18-month continuation period and no later than 60 days after you receive the determination.

- The Trust 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 one of four 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. The extended period will end no later than 36 months from the date of the first qualifying event.

The subscriber or qualified beneficiary must notify the Trust no more than 60 days after either the qualifying event date or the date the dependent's coverage ends, whichever is later.

Conditions of COBRA Coverage

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

You Must Give Notice Of Some Qualifying Events

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

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

If the required notice is not given or is late, the qualified member loses the right to COBRA coverage.

Except as described below for disability notices, the subscriber or affected dependent has 60 days in which to give notice to the Trust. The notice period starts on the date shown below.

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

Note: The subscriber or affected dependent must also notify the Trust if a qualified member is deemed by the Social Security Administration to no longer be disabled. See "When COBRA Coverage Ends."

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

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

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

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

14-day notice time limit applies.

You Must Enroll And Pay On Time

- You must elect COBRA coverage no more than 60 days after the later of 1) the date coverage was to end because of the qualifying event, or 2) the date you were notified of your right to elect COBRA coverage.

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

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

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

Adding Family Members

Eligible family members may be added after the continuation period begins, but only as allowed under "Special Enrollment." With one exception, family members added after COBRA begins are not 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." 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. Continued coverage is subject to all other terms and limitations of this program.

Keep The Trust Informed Of Address Changes

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

When COBRA Coverage Ends

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

- The applicable continuation period expires.
- The next monthly subscription charge isn't paid when due or within the 30-day COBRA grace period.
- When coverage is extended from 18 to 29 months due to disability (see "Qualifying Events And Lengths Of Coverage" in this section), COBRA coverage beyond 18 months ends if there's a final determination that a qualified member is no longer disabled under the Social Security Act. However, coverage won't end on the date shown above, but on the last day for which subscription charges have been paid in the first month that begins more than 30 days after the date of the determination. The subscriber or affected dependent must provide the Trust with a copy of the 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. If, however, the new plan contains an exclusion or limitation for a pre-existing condition, coverage doesn't end for this reason until the exclusion or limitation no longer applies.
- You become entitled to Medicare after the date you elect COBRA coverage.
- The Trust ceases to offer group health care coverage to any employee.

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

When COBRA coverage under this plan ends, you may be eligible for benefits as described in "Extended Benefits" later in this section. You may also be eligible to apply for one of our Conversion plans as explained in "Converting To A Non-Group Plan" in the "When Will My Coverage End?" section.

If You Have Questions

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

EXTENDED BENEFITS

Under the following circumstances, certain benefits of this program may be extended after your coverage ends. If the contract between the Trust and us is terminated while you are receiving the extended benefits below, your right to those benefits will not be affected.

Extended Inpatient Benefits

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

- Your coverage had been in effect for more than 31 days;
- Your coverage did not end because of fraud or an intentional misrepresentation of material fact under the terms of the coverage by you or the Trust;
- 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 are covered under a health plan or contract that provides benefits for your confinement or would provide benefits for your confinement if coverage under this program did not exist;
- You are discharged from that facility or from any other facility to which you were transferred;
- Inpatient care is no longer medically necessary;
- The maximum benefit for inpatient care in the medical facility has been provided. If the calendar year ends before a calendar year maximum has been reached, the balance is still available for covered inpatient care you receive in the next year. Once it is used up, however, a calendar year maximum benefit will not be renewed.
- This program's lifetime maximum has been provided.

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 (e.g. pre-existing condition exclusions) except for service-connected illnesses or injuries.

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

HOW TO SUBMIT A CLAIM

MEDICAL AND DENTAL CLAIMS

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

Step 1

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

Step 2

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

- Names of the subscriber and the member who incurred the expense.
- Identification numbers for both the subscriber and the Group (these are shown on the subscriber's identification card).
- Name, address, and IRS tax identification number of the provider.
- Information about other insurance coverage.
- Date of onset of the illness or injury.
- Diagnosis or ICD-9 code.
- Procedure codes (CPT-4, HCPCS, ADA, or UB-92) or descriptive English nomenclature 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 are 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 will not 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:

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

SUBMISSION OF PHARMACY DRUG CLAIMS

To make a claim for covered prescription drugs, please refer to the "Pharmacy Drug Benefit" on page 21 and the "Mail-Order Pharmacy Program" on page 25.

TIMELY FILING

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

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

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

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. If we do not receive the additional information, we will continue to notify you every 45 calendar days from our initial notice, until we make a decision about the claim.
- 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.

YOUR IDEAS, QUESTIONS, COMPLAINTS, AND APPEALS

As a Premera Blue Cross Blue Shield of Alaska member you have the right to offer your ideas, ask questions, voice complaints, and submit appeals. Our goal is to listen, resolve your problems, and improve our service to you.

WHEN YOU HAVE IDEAS

We would like to hear from you on ways we can continue to improve our service. If you have an idea, suggestion, or opinion, please let us know. You can call us at the numbers listed below or send your ideas and comments to:

Premera Blue Cross Blue Shield of Alaska
Customer Assessment Manager
P.O. Box 91059
Seattle, WA 98111-9159

WHEN YOU HAVE QUESTIONS

Call your provider of care when you have questions about the health care services you receive. Please call our Customer Service Department with any other questions regarding your Premera Blue Cross Blue Shield of Alaska program.

Seattle area: (425) 670-5900
Outside Seattle Area: 1-800-508-4722
Hearing-impaired TDD: 1-800-842-5357

If you need an interpreter to help with your question, please tell us when you call, and we will provide one for the call.

WHEN YOU HAVE A COMPLAINT

A **complaint** is an expression of dissatisfaction with an action or policy of ours, a claim for benefits, or with a provider of care or service. The complaint process lets Customer Service quickly and informally correct errors, clarify decisions or benefits, or take steps to improve our service. We recommend, but do not require, that you take advantage of this process when you have a concern about a benefit or coverage decision. If Customer Service finds that you need to submit your complaint as a formal appeal, they will tell you.

When you have a complaint, call or write our Customer Service Department. If your complaint is about the quality of care you receive, it will be given to our Clinical Quality Management staff for review. If the complaint is of a non-medical nature relating to a provider, it will be given to our Provider Network staff for review. We may request more information if needed. When we receive all needed information, we will review your complaint and respond as soon as possible, but in no case more than 30 days.

WHEN YOU HAVE AN APPEAL

An **appeal** is an expression of dissatisfaction which requires our review of any issue, including, but not limited to, claim appeal, dissatisfaction with a service, or benefit administration. We must receive your appeal in writing within 180 days of the date you received notice of the decision or issue you are appealing. If you are appealing a complaint decision, we must receive your appeal within 180 days of the date we gave you that decision.

You have the right to send us written comments, documents, or other information to support your appeal.

You may mail all appeals to:

Premera Blue Cross Blue Shield of Alaska
Appeals Coordinator
P.O. Box 91102
Seattle, WA 98111-9202

APPEALS PROCESS

Our standard appeals process has two levels of review. In both levels, a person who holds the same professional license as the provider who is treating you will decide appeals about services or supplies that we determined were not medically necessary, not appropriate or experimental or investigational. We'll give you our appeal decisions in writing.

Level I Level I appeal decisions will be given to you within 30 calendar days, with two exceptions as noted below.

Exceptions:

- Urgent appeals (see "Urgent Appeals" below)
- You're appealing a medical necessity, appropriateness, or quality of health care services and supplies decision. We'll decide these appeals no more than 18 business days after we receive them.

If you don't agree with the decision reached in our Level I review, you may ask us to perform a Level II review of your appeal. If you're appealing a quality of care issue, a decision that a service or supply was denied as not medically necessary or appropriate, is experimental or investigational, or otherwise denied based on our medical judgment, you have the option to request independent review instead of Level II review (see "Independent review" below). With any of the above options, you may also send us more information to support your appeal. **You must send us your written request for a Level II or independent review no more than 60 days after the date you receive our Level I decision.** At our discretion, an extension to the 60-day limit may be granted in the event the member needs to obtain additional medical documentation, physician consultations or opinions, if the member is hospitalized or traveling, or for other reasonable cause beyond the member's control.

Level II Your appeal will be reviewed by a Premera Blue Cross Blue Shield of Alaska panel that includes health care providers and is different from the Level I panel. You and/or your authorized representative may meet with the panel. Appeals involving complex medical issues will be referred for external review by independent medical consultants who, to the extent possible, are in your provider's locality. Unless your appeal is deemed urgent (see "Urgent appeals" below), we'll give you our decision within 30 days of the date we receive your request.

If you aren't satisfied with the Level II decision concerning medical necessity, appropriateness, experimental or investigational care, or quality of health care services and supplies, you may request independent review. We must receive your request within 60 days after the date you receive our Level II decision.

Independent review Independent reviews are conducted by an independent review organization (IRO), which is an organization of medical experts qualified to review your appeal. We'll submit your file to the IRO on your behalf and will pay the charges of the IRO. The IRO will make its decision within 21 days of receipt of the appeal (72 hours for urgent appeals) and give you its decision in writing. We'll implement the IRO's determination promptly. If you wish to appeal the IRO's decision, you must make your request within 6 months of the date of their decision.

Urgent appeals We deem your appeal urgent when your physician or other provider advises us that a delay will harm your health. Level I and Level II responses on urgent appeals will be given within 72 hours after the fully documented appeal is received.

Please call Customer Service if you have questions or need more information about our complaint or appeal process. The numbers are shown inside the front cover of this booklet.

DEFINITIONS

As used in this program, any term listed below has the meaning listed after it.

Accidental Injury

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

Allowable Charge

For Heritage providers, the allowable charge is the fee that the provider has agreed to accept as full payment for medically necessary covered services.

The amount that Heritage providers have agreed to accept as full payment for medically necessary covered services is determined by our agreements with the providers. Heritage providers will seek payment from us when they furnish covered services to you.

For providers who do not have agreements with us, the allowable charge will be no less than the 80th percentile for the geographical area.

You are responsible for any applicable deductibles, copayments, coinsurance, charges in excess of stated benefit maximums, and charges for services or supplies not covered under this program. These amounts will be reflected on the "Explanation of Benefits" we send you. We reserve the right to determine the amount allowed for any given service or supply.

Ambulatory Surgical Center

A facility that is licensed or certified as required by the state in which it operates, 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 does not provide inpatient services or accommodations.

Calendar Year

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

Chemical Dependency

An illness characterized by physiological or psychological dependency, or both, on alcohol or a state-regulated controlled substance. It's further characterized by a frequent or intense pattern of pathological use to the extent:

- The user exhibits a loss of self-control over the amount and circumstances of use.
- The user develops symptoms of tolerance, or psychological and/or physiological withdrawal if use is reduced or discontinued.
- The user's health is substantially impaired or endangered, or his or her social or economic function is substantially disrupted.

Complication Of Pregnancy

A condition which falls into one of the two categories listed below that requires covered, medically necessary services which are provided in addition to, and greater than, those usually provided for antepartum care, normal or cesarean delivery, and postpartum care, in order to treat the condition.

- Diseases of the mother which are not caused by pregnancy, but which coexist with and are adversely affected by pregnancy.
- Maternal conditions caused by the pregnancy which make its treatment more difficult. These conditions are limited to:
 - Ectopic pregnancy
 - Hydatidiform mole/molar pregnancy
 - Incompetent cervix requiring treatment
 - Complications of administration of anesthesia or sedation during labor or delivery
 - Obstetrical trauma uterine rupture before onset or during labor

- Ante- or postpartum hemorrhage requiring medical/surgical treatment
- Placental conditions which require surgical intervention
- Preterm labor and monitoring
- Toxemia
- Gestational diabetes
- Hyperemesis gravidarum
- Spontaneous miscarriage or missed abortion
- Fetal conditions requiring in utero surgical intervention.

Congenital Anomaly

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

Custodial Care

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

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

Dental Care Provider

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

Dentally Necessary

Those services and supplies that are determined to meet all of the following requirements. They must be:

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of a disease, accidental injury or condition harmful or threatening to the member's dental health, unless provided for preventive services when specified as covered under this plan.
- Appropriate and consistent with authoritative dental or scientific literature.
- Not primarily for research or data accumulation.
- Not primarily for the convenience of the member, the member's family, the member's physician or another provider.
- The least costly of the alternative levels of service which can safely be provided to the member.

The fact that covered services were furnished, prescribed or approved by a dental care provider doesn't in itself mean that the services are dentally necessary. When it is necessary to review the dentist's treatment plan or conduct a utilization review, the review will be performed by a dentist licensed to practice dentistry in the State of Alaska.

Effective Date

The date on which your coverage under this program begins. If you reenroll in this program after a lapse in coverage, the date that the coverage begins again will be your effective date.

Eligibility Waiting Period

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

Enrollment Date

For the subscriber and eligible dependents who enroll when the subscriber is first eligible, the enrollment date is the subscriber's date of hire. There's one exception to this rule. If the subscriber was hired into a class of employees to which the Group doesn't provide coverage under this plan, but was later transferred to a class of employees to which the group does provide coverage under this plan, the enrollment date is the date the subscriber enters the eligible class of employees. (For example, the enrollment date for a seasonal employee who was made permanent after six months would be the date the employee started work as a permanent employee.). For subscribers who don't enroll when first eligible and for dependents added after the subscriber's

coverage starts, the enrollment date is the effective date of coverage.

Expense Incurred

An expense is incurred on the date the service is received or the supply is ordered.

Experimental/Investigational Services

Experimental or investigational services include a treatment, procedure, equipment, drug, drug usage, medical device, or supply which meets one or more of the following criteria as determined by us:

- A drug or device which cannot be lawfully marketed without the approval of the United States Food and Drug Administration, and has not been granted such approval on the date the service is provided.
- The service is subject to oversight by an Institutional Review Board.
- Reliable evidence does not demonstrate efficacy of the service, nor does it define a specific role for the service in clinical evaluation, management, or treatment.
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety, or efficacy. However, services that meet the standards set in the definition of "Oncology Clinical Trials" below in this section, will not be deemed experimental or investigational.
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

Reliable evidence includes, but is not limited to, reports and articles published in authoritative medical and scientific literature, and assessments and coverage recommendations published by the Blue Cross Blue Shield Association Technical Evaluation Center (TEC).

Heritage Provider

A provider located in Alaska or Washington that, at the time services are rendered, has a Heritage provider agreement in effect with us.

Home Medical And Respiratory Equipment (Durable Medical Equipment)

Mechanical equipment that can stand repeated use and is used in connection with the direct treatment of an illness or accidental injury. It is of no use in the absence of illness or accidental injury.

Hospital

A facility legally operating as a hospital in the state in which it operates and that meets the following requirements:

- It has facilities for the inpatient diagnosis, treatment, and acute care of injured and ill persons by or under the supervision of a staff of physicians.
- It continuously provides 24-hour nursing services by or under the supervision of registered nurses.

In no event will a "hospital" be an institution which is run mainly:

- As a rest, nursing, or convalescent home; residential treatment center; or health resort.
- To provide hospice care for terminally ill patients.
- For the care of the elderly.
- For the treatment of chemical dependency or tuberculosis.

Illness

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

Inpatient

Confined in a medical facility as an overnight bed patient.

Large Employer

An employer, including a person, firm, corporation, partnership, association, or political subdivision, that is actively engaged in business, that employed an average of at least 51 employees on the business days during the preceding calendar year and that employs at least 2 employees on the first day of a health benefit year.

Medical Equipment

Mechanical equipment that can stand repeated use and is used in connection with the direct treatment of an illness or accidental injury. It's of no use in the absence of illness or accidental injury.

Medical Emergency

The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of

a bodily organ or part, or would place the person's health in serious jeopardy. (A "prudent layperson" is someone who has an average knowledge of health and medicine.)

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

Medical Facility (also called "Facility")

A hospital, skilled nursing facility, state-approved chemical dependency treatment facility, or hospice.

Medically Necessary

Those covered services and supplies that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Member

A person who is covered under this program as a subscriber or dependent; also called "you" and "your" in this booklet.

Obstetrical Care

Care furnished during pregnancy (antepartum, delivery, and postpartum) or any condition arising from pregnancy, except for complications of pregnancy. This includes the time during pregnancy and within 45 days following delivery.

Oncology Clinical Trials

Treatment that is part of a scientific study of therapy or intervention in the treatment of cancer being conducted at the phase 2 or phase 3 level in a national clinical trial sponsored by the National Cancer Institute or institution of similar stature, or trials conducted by established research institutions funded or sanctioned by private or public sources of similar stature. All approvable trials must have Institutional Review Board (IRB) approval by a qualified IRB.

The clinical trial must also be to treat cancer that is either life-threatening or severely and chronically disabling, has a poor chance of a positive outcome using current treatment, and the treatment subject to the clinical trial has shown promise of being effective.

An "oncology clinical trial" does not include expenses for:

- Costs for treatment that are not primarily for the care of the patient (such as lab services performed solely to collect data for the trial).
- Any drug or device provided as part of a phase I oncology clinical trial
- Services, supplies or pharmaceuticals that would not be charged to the member, were there no coverage.
- Services provided in a clinical trial that are fully funded by another source

The member for whom benefits are requested must be enrolled in the trial at the time of treatment for which coverage is being requested. We encourage you, your provider, or the medical facility to ask us for a benefit advisory to determine coverage before you enroll in the clinical trial.

Orthodontics

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

Outpatient

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

Participating Pharmacy

A licensed pharmacy which contracts with us or our Pharmacy Benefits Administrator to provide prescription drug benefits under this program.

Pharmacy Benefits Administrator

An entity which contracts with us to administer prescription drug benefits under this program.

Physician

A state-licensed:

- Doctor of Medicine and Surgery (M.D.)
- Doctor of Osteopathy and Surgery (D.O.)
- Podiatrist (D.P.M.)

Professional services provided by one of the following types of providers will be covered under this program 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 program, and when benefits would be payable if the services were provided by a "Physician" as defined above:

- an Advanced Nurse Practitioner (A.N.P.)
- a Certified Direct-Entry Midwife
- a Chiropractor (D.C.)
- a Dentist (D.D.S. or D.M.D.)
- a Licensed Clinical Social Worker (L.C.S.W.)
- a Licensed Marital and Family Therapist (L.M.F.T.)
- a Licensed Marriage and Family Counselor (L.M.F.C.)
- a Naturopath (N.D.)
- a Nurse Midwife
- an Occupational Therapist (O.T.)
- an Optometrist (O.D.)
- a Physical Therapist (P.T.)
- a Physician Assistant supervised by a collaborating M.D. or D.O.
- a Psychological Associate
- a Psychologist

Prescription Drug

A **prescription drug** is 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 program 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 which is other than that stated in its FDA-approved labeling.

Benefits are not 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.

Program, This

The benefits, terms, and limitations set forth in this booklet.

Provider

A physician or other health care professional or facility named in this program 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 edition of "Diagnostic and Statistical Manual of Mental Disorders."

Skilled Care

Care which is ordered by a physician and requires the medical knowledge and technical training of a licensed registered nurse.

Skilled Nursing Facility

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

Subscriber

An enrolled employee of the Group. Coverage under this program is established in the subscriber's name.

Subscription Charges

The monthly rates set by us as consideration for the benefits offered in this program.

Temporomandibular Joint (TMJ) Disorders

TMJ disorders shall include those disorders which have one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.

We, Us And Our

Means Premera Blue Cross Blue Shield of Alaska in the State of Alaska, and Premera Blue Cross in Washington State.

DEATH BENEFIT

To help protect your family from the financial burden that death could bring, the Public Safety Employees Association Health and Welfare Trust provides a death benefit for you at no cost. Death benefits are self-funded by the Trust and payable if you die for any reason while covered by the plan.

ELIGIBILITY

If you are under age 70 and are eligible for benefits under the Health and Welfare Trust (see "Starting Out in the Program" on page 43), you are eligible. No coverage is provided if you are age 70 or older, and no dependents are covered regardless of age.

AMOUNT OF COVERAGE

If you die while covered by this plan, your beneficiary will receive \$10,000.

BENEFICIARY

Payment for loss of your life is made to the beneficiary you designate in writing and file with the Public Safety Employees Association Health and Welfare Trust. If you do not name a beneficiary, or if your named beneficiary does not survive you, benefits will be paid in the following order of priority:

- To your spouse
- To your child or children, equally
- To your parent or parents, equally
- To your brothers and sisters, equally
- To your estate.

BUSINESS TRAVEL ACCIDENT INSURANCE

This plan pays a benefit if you have a covered accident while traveling on business and the accident results in death or dismemberment within one year. Payment for loss of life is made to the beneficiary you designate in writing and file with the Public Safety Employees Association Health and Welfare Trust. Payment for any other loss is made to you.

ELIGIBILITY

If you are under age 70 and are eligible for benefits under the Health and Welfare Trust (see "Starting Out in the Program" on page 43), you are eligible. No coverage is provided if you are age 70 or older, and no dependents are covered regardless of age.

WHEN YOU ARE COVERED

For your trip to be covered:

- You must be traveling on, and in the course of, business for your employer, the State of Alaska, the Trust, or the Public Safety Employees Association
- Your travel must be authorized
- You must be traveling to a point located away from your regular place of employment in the city of permanent assignment.

Coverage begins at the actual start of a trip (whether from home, place of work, or other point) and ends when you arrive at your home or place of work, whichever happens first. However, if you make a change in your route in order to perform a personal task that is not related to your business and not incidental to your business trip, you will not have coverage during that part of your trip.

The following travel is not covered:

- Normal, daily commuting to and from work
- Travel during vacations or leaves of absence
- Activities that are not reasonably related to your business, and not incidental to your business trip
- Travel during the performance of Highway Patrol activities.

If you travel to another city and are expected to remain there for more than 60 days, this is deemed a change in your city of permanent assignment, and daily travel there is not covered.

AMOUNT OF BENEFIT

Life Insurance Company of North America will pay the full principal amount of \$100,000 for the accidental loss of:

- Life
- Both hands
- Both feet
- Sight of both eyes
- One hand and sight of one eye
- One foot and sight of one eye
- One hand and one foot.

You will receive one-half of the principal amount (\$50,000) for your accidental loss of one hand, one foot, or sight of one eye.

You will receive one-quarter of the principal amount (\$25,000) for your accidental loss of the thumb and index finger of the same hand.

If you suffer more than one loss from a covered accident, you will be paid only for the loss with the largest benefit. The maximum amount paid for all your losses from any one accident is \$100,000. If an accident affects more than one person insured by Life Insurance Company of North America, the maximum amount payable to all persons is \$1,000,000. (This amount is prorated among all affected individuals.)

BENEFICIARY

Payment for loss of life is made to the beneficiary you designate in writing and file with the Public Safety Employees Association Health and Welfare Trust. If you do not name a beneficiary, or if your named beneficiary does not survive you, benefits will be paid in the following order of priority:

- To your spouse
- To your child or children, equally
- To your parent or parents, equally
- To your brothers and sisters, equally
- To your estate.

AIRCRAFT RESTRICTIONS

If an accident happens while you are riding in, boarding, or disembarking from an aircraft, benefits will only be paid if all of the following apply:

- You are a passenger only, not a pilot or other crew member
- The aircraft has a valid certificate of airworthiness
- The pilot has a valid license
- The aircraft is not being used for crop dusting, spraying, or seeding; firefighting; sky-writing; skydiving; hang gliding; pipeline or power line inspections; aerial photography or exploration; or racing, endurance tests, stunt or acrobatic flying
- The aircraft is not being used for any operation which requires a special FAA permit, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on)
- The Public Safety Employees Association (or any affiliate or subsidiary) does not own, lease, or control the aircraft. An aircraft is "controlled" if it is used for more than 10 straight days, or more than 15 nonconsecutive days, in any year.

EXCLUSIONS

Benefits will not be paid for loss caused by or resulting from:

- Suicide, attempted suicide, or whenever you injure yourself on purpose, while sane or insane
- War or act of war, whether declared or not
- Injury while on full-time active duty in any armed force
- Taking part in a felony
- Any bacterial infection that was not caused by an accidental cut, wound, or food poisoning
- Travel or flight in any spacecraft.

CONVERSION

Life Insurance Company of North America cannot terminate your Trust coverage as long as you remain eligible as described in this section and as long as the insurer and the Trust agree to continue the insurance policy. When your eligibility and coverage end (if under age 70), you may be eligible to convert your business travel accident insurance to an individual accidental death and dismemberment policy. Contact the administrative office for more information.

APPEALS

All participants and beneficiaries of the PSEA Health & Welfare Trust must adhere to the following procedure in seeking review of denied or partially paid claims, or eligibility determinations.

1. Request review according to the relevant insurance carrier's procedure. Premera Blue Cross Blue Shield of Alaska's procedure is described under "When You Have a Complaint" and "When You Have an Appeal" starting on page 54. If a business travel accident claim is denied, appeal procedures will be provided by Life Insurance Company of North America at the time of denial. If this review does not resolve your issue, you may appeal to the Board of Trustees. Note: You should skip this step if you are appealing a claim denial for the death benefit.
2. If you wish to appeal to the Board of Trustees, please submit the following to the Trust Administrator no later than 60 calendar days after the issue has been finally decided or unresolved by the insurance carrier.
 - A short, concise statement of the issue
 - A chronological list of your interactions with the insurance carrier and the Trust Administrator
 - Copies of all records, correspondence and other relevant documentation of the dispute (arranged in date order).

The Trust Administrator will submit the materials to the Trustees at the next regular meeting. (The materials must be received by the Trust Administrator no later than 14 calendar days before the meeting at which the matter will be reviewed.) The Trustees will review the submitted materials and decide the issues presented. The Trust Administrator will notify you of the Trustees' decision within 10 business days by certified mail with return receipt requested (or some other method that verifies your receipt).

3. If the matter is not resolved to your satisfaction, you may request a hearing before the Board of Trustees. You must make your request in writing to the Trust Administrator within 30 calendar days of your receipt of the Trustees' original decision. Your request must thoroughly explain what additional information (that was not originally submitted) you will present, such as testimony by experts or other witnesses. If your request is received more than 60 days in advance of the next Trustee meeting or less than 14 days in advance of the next Trustee meeting, your appeal hearing shall be heard by an appeals committee designated by, and made up of, Trustees. Otherwise, it will be heard at the next Trustee meeting. If you do not seek a further hearing before the Trustees by the deadline, or if the Trustees decline to hear a further appeal, the decision of the Trustees will be final.

If a hearing is granted, you will be given written notice by the Trust Administrator of the date, time and location. Appropriate hearing procedures will be adopted by the Trustees for each appeal. You may have counsel represent you at the hearing if the Trust Administrator receives written notice of your counsel's participation no later than 10 calendar days before the hearing.

At the end of the appeal hearing, the Trustees will convene in executive session and decide the issues presented. The Trust Administrator will notify you in writing of the Trustees' decision within 30 business days of the hearing.

Nothing in this appeal procedure will limit the authority of the Trustees or preclude the Trustees from exercising their full and complete discretion in the handling of any appeal. The decision of the Trustees after the hearing will be final. Further recourse will be through the courts of the State of Alaska.

**Arranged by
Mercer Health & Benefits
1301 Fifth Avenue, Suite 1900
Seattle, WA 98101**

where to send claims

MAIL YOUR CLAIMS TO:

Premera Blue Cross Blue Shield of Alaska

P.O. Box 240609

Anchorage, AK 99524-0609

MAIL PRESCRIPTION DRUG CLAIMS TO:

Medco Health Solutions, Inc.

P.O. Box 14711

Lexington, KY 40512

www.premera.com