

# **City & Borough of Juneau Bartlett Regional Hospital**

9001303, 9001328  
July 1, 2016

## **Important Telephone Numbers**

### **For Questions Regarding Your Medical, Dental, and Vision Benefits and Claims:**

- **Premiera Blue Cross Blue Shield of Alaska**  
Local and toll-free number: 1-800-508-4722  
Local and toll-free TTY number  
for the hearing impaired: 1-800-842-5357  
Monday - Friday, 8:00 a.m. – 5:00 p.m.  
Pacific Standard Time

### **For Questions Regarding Your Prescription Drug Program or to Locate an In-Network Pharmacy:**

- **Express Scripts**  
1-800-391-9701  
**[www.express-scripts.com](http://www.express-scripts.com)**  
Sunday -Saturday, 24 hours a day

### **For Care Facilitation:**

- **Care Management**  
1-800-722-4714  
Monday - Friday, 8:00 a.m. - 4:30 p.m.  
Pacific Standard Time

### **For Questions Regarding Eligibility for Enrollment:**

- **City & Borough of Juneau Division of Risk Management**  
1-907-586-0321  
Monday - Friday, 8:00 a.m. - 4:30 p.m.  
Alaska Time Zone

### **To Contact Your Confidential Employee Assistance Program:**

- 1-800--295-9059
- 1-800-697-0353

### **To Contact Your Plan's Consultant:**

- **AON Consulting Inc - Seattle**  
1-206-467-4600  
Monday - Friday, 8:00 a.m. - 5:00 p.m.  
Pacific Standard Time

**City & Borough of Juneau/ Bartlett Regional Hospital**  
**Health Benefit Plan**  
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## INTRODUCTION

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Welcome to the City & Borough of Juneau/Bartlett Regional Hospital Health Benefit Plan. Our program is designed to provide comprehensive protection for our employees and their covered family members. At the same time, the program has been designed to encourage the careful use of health care services.

We sincerely wish that you and your family enjoy good health, but in the event you need to use the Health Benefit Plan, the benefits are excellent. We believe it is one of the best programs available anywhere.

The City & Borough of Juneau/Bartlett Regional Hospital Health Benefit Plan is an "in-network provider arrangement"; it is based on agreements that certain providers have made with Premera Blue Cross Blue Shield of Alaska. The agreements with In-Network Providers mean lower fees charged for hospital and medical services furnished by In-Network Providers to our enrollees.

The In-Network Provider program is designed to lower your out-of-pocket expense. Therefore, you are encouraged to use In-Network Providers.

Please take time to become familiar with the benefits the program offers. Many terms have specific meanings as used throughout the book. Please refer to the "Definitions" section at the end of the booklet for clarification. **We suggest you review this booklet carefully.**

Our program is administered by Premera Blue Cross Blue Shield of Alaska. If you have questions regarding your coverage or how benefits have been paid, Premera Blue Cross Blue Shield of Alaska encourages you to contact their Customer Service Department at:

Local and toll-free number: 1-800-508-4722  
Local and toll-free TTY number for the  
hearing impaired: 1-800-842-5357  
Monday - Friday, 8:00 a.m. – 5:00 p.m.  
Pacific Standard Time

Your claims correspondence can be sent to:

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

If at any time you have questions concerning your eligibility, please contact the CBJ Risk Management at (907) 586-0321.

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

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## SUMMARY OF BENEFITS

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

All benefits are based on the "allowable" amount.

<b>Annual Plan Maximum:</b>	No Annual Plan Maximum
<b>Deductible (per plan year):</b> <b>Economy Plan:</b> <b>Standard Plan:</b> <b>Premium Plan:</b>	\$500 per enrollee; \$1,000 per family. \$250 per enrollee; \$500 per family. \$150 per enrollee; \$300 per family. (Any expenses applied to the deductible during the last 3 months of the plan year will be carried over to meet the deductible requirement for the next plan year.)
<b>Reimbursement Percentages:</b>	80% of the allowable 100% after Out of Pocket Maximum is reached. Constant 80% for Hearing Aid Benefit
<b>Out-of-Pocket Maximum:</b> <b>Economy Plan:</b> <b>Standard Plan:</b> <b>Premium Plan:</b>	\$2,500 per enrollee; \$7,000 per family, per plan year. \$1,750 per enrollee; \$5,000 per family, per plan year. \$1,150 per enrollee; \$3,300 per family, per plan year. Once the individual out-of-pocket maximum has been satisfied the benefits for that individual will be provided at 100% of allowable charges for the remainder of the plan year for covered services.

*Note: Some services have limited benefits and do not apply to the Out of Pocket Maximum.*

<b><u>Hospital Services</u> (preauthorization requested)</b>	
<b>Inpatient</b>	
<ul style="list-style-type: none"> <li>Room and Board:</li> <li>Covered Ancillary Services:</li> </ul>	80% of the allowable amount. Subject to the deductible. 80% of the allowable amount. Subject to the deductible.
<b>Outpatient</b>	
<ul style="list-style-type: none"> <li>Same Day Surgery, including physician services billed by hospital:</li> <li>Emergency Room Services (including physician services billed by hospital):</li> </ul>	80% of the allowable amount. Subject to the deductible. \$100 copay per enrollee then 80% of the allowable amount. Subject to the deductible. The Emergency Room co-pay is waived if admitted.

<b><u>Professional Services</u></b>	
<ul style="list-style-type: none"> <li>Hospital and Office Visits, Surgery, Anesthesiology:</li> </ul>	80% of the allowable amount. Subject to the deductible.
<ul style="list-style-type: none"> <li>Diagnostic X-ray and Laboratory:</li> </ul>	80% of the allowable amount. Subject to the deductible.
<ul style="list-style-type: none"> <li>Maternity Care:</li> </ul>	80% of the allowable amount. Subject to the deductible.
<ul style="list-style-type: none"> <li>Preventive Diagnostic and Laboratory:</li> </ul>	100% of allowable. Not subject to the deductible.
<ul style="list-style-type: none"> <li>Telehealth Services with vendor</li> </ul>	80% of the allowable amount. Subject to the deductible.

### **Limited Benefits and Services**

The following have limited benefits and services that do apply toward the out of pocket.

<ul style="list-style-type: none"> <li>Obesity Treatment (Please see benefit for details)</li> </ul>	80% of the allowable amount, up to a lifetime maximum of \$25,000. Subject to the deductible.
<ul style="list-style-type: none"> <li>Organ/Bone Marrow Transplants:</li> </ul>	80% of the allowable amount. Subject to the deductible.
<ul style="list-style-type: none"> <li>Home Health Care:</li> </ul>	80% of the allowable amount, up to a maximum of 130 visits per plan year. Subject to the deductible.
<ul style="list-style-type: none"> <li>Hospice Care:</li> </ul>	80% of the allowable amount. Subject to the deductible. Lifetime maximum of 10 inpatient days and 6 months outpatient benefit.
<ul style="list-style-type: none"> <li>Skilled Nursing Facility:</li> </ul>	80% of the allowable amount up to a maximum of 60 days per plan year. Subject to the deductible.
<ul style="list-style-type: none"> <li>Acute Nursing Services:</li> </ul>	80% of the allowable amount, up to a maximum of \$2,500 per plan year. Subject to the deductible.
<ul style="list-style-type: none"> <li>Rehabilitation Services: <ul style="list-style-type: none"> <li>Inpatient:</li> <li>Outpatient:</li> </ul> </li> </ul>	80% of the allowable amount, up to a maximum of 30 days per plan year. Subject to the deductible. 80% of the allowable amount, up to a maximum of 45 visits per plan year. Subject to the deductible.
<ul style="list-style-type: none"> <li>Neurodevelopmental Therapy: <ul style="list-style-type: none"> <li>Inpatient:</li> <li>Outpatient:</li> </ul> </li> </ul>	80% of the allowable amount, up to a maximum of 30 days per plan year. Subject to the deductible. 80% of the allowable amount, up to a maximum of 45 visits per plan year. Subject to the deductible.
<ul style="list-style-type: none"> <li>Routine Mammogram</li> </ul>	100% of the allowable amount. Not subject to the deductible.
<ul style="list-style-type: none"> <li>Preventive Care (Please see benefit for details)</li> </ul>	100% of the allowable amount.



### **Additional Covered Services and Supplies**

• Acupuncture:	80% of the allowable amount, up to a maximum of 12 visits per plan year. Subject to the deductible.
• Chiropractic Treatment:	80% of the allowable amount. Subject to the deductible.
• Diabetes Health Education:	100% of the allowable amount.
• Dialysis due to End Stage Renal Disease (ESRD)	80% of the allowable amount. Subject to the deductible
• Durable Medical Equipment and Medical Supplies:	80% of the allowable amount. Subject to the deductible.
• Emergency Round Trip Commercial Air Transportation:	80% of the allowable amount. Subject to the deductible.
• Hearing Aid Benefit:	Constant 80% of the allowable amount, up to a maximum of \$400 per plan year, shared with Hearing Exam benefit. Subject to the deductible.
• Intravenous Therapy Drugs and Supplies:	80% of the allowable amount. Subject to the deductible.
• Licensed Ambulance Service:	\$100 copay, then 80% of the allowable amount. Subject to the deductible.
• Mental Health Care	
• Inpatient:	80% of the allowable amount. Subject to the deductible.
• Outpatient:	80% of the allowable amount. Subject to the deductible
• Routine Newborn Care:	80% of the allowable amount. Subject to the deductible.
• Special Transportation, Commercial Air Transportation:	80% of the allowable amount subject to the criteria. Subject to deductible.
• Sterilization:	100% of the allowable amount.
• Substance Abuse (Drug Dependency and Alcoholism):	80% of the allowable amount. Subject to the deductible.

## **PRESCRIPTION DRUGS**

Prescription drug deductibles, coinsurance, and copays do not apply toward the medical plan out of pocket maximum or deductibles.

<b>In-Network Pharmacies and Non-Network Pharmacies:</b>	
<ul style="list-style-type: none"> <li>Prescription Deductible and out-of-pocket:</li> <li>Economy</li> <li>Standard</li> <li>Premium</li> </ul>	<p>\$50 deductible / \$1,500 out-of-pocket per enrollee*.</p> <p>\$50 deductible / \$1,000 out-of-pocket per enrollee*.</p> <p>\$50 deductible / \$500 out-of-pocket per enrollee*.</p>
<ul style="list-style-type: none"> <li>Legend Drugs (up to 30 day supply):</li> <li>Economy</li> </ul>	<p>\$10 copayment per prescription or refill for generic.</p> <p>40% copayment for non-preferred or brand name.</p> <p>When generic equivalent is available you must also pay the difference in cost between the generic and the brand name drug.</p>
<ul style="list-style-type: none"> <li>Standard</li> </ul>	<p>\$10 copayment per prescription or refill for generic.</p> <p>30% copayment for non-preferred or brand name.</p> <p>When generic equivalent is available you must also pay the difference in cost between the generic and the brand name drug.</p>
<ul style="list-style-type: none"> <li>Premium</li> </ul>	<p>\$10 copayment per prescription or refill for generic.</p> <p>20% copayment for non-preferred or brand name.</p> <p>When generic equivalent is available you must also pay the difference in cost between the generic and the brand name drug.</p>
<ul style="list-style-type: none"> <li>Mail Order Pharmacy Program (up to 90 day supply):</li> <li>Economy</li> </ul>	<p>\$10 copayment per prescription or refill for generic.</p> <p>\$35 copayment prescription or refill for non-preferred or brand name.</p> <p>When generic equivalent is available, you must also pay the difference in cost between the generic and the brand name drug.</p>
<ul style="list-style-type: none"> <li>Standard</li> </ul>	<p>\$10 copayment per prescription or refill for generic.</p> <p>\$30 copayment prescription or refill for non-preferred or brand name.</p> <p>When generic equivalent is available you must also pay the difference in cost between the generic and the brand name drug.</p>
<ul style="list-style-type: none"> <li>Premium</li> </ul>	<p>\$10 copayment per prescription or refill for generic.</p> <p>\$25 copayment prescription or refill for non-preferred or brand name.</p> <p>When generic equivalent is available you must also pay the difference in cost between the generic and the brand name drug.</p>
<ul style="list-style-type: none"> <li>Specialty Pharmacy (up to 30 day supply):</li> <li>Economy</li> <li>Standard</li> <li>Premium</li> </ul>	<p>\$100 copayment per prescription</p> <p>\$100 copayment per prescription</p> <p>\$100 copayment per prescription</p>

## DENTAL BENEFITS

<b>Maximum Plan Year Benefit:</b>	\$2,000
<b>Deductibles (apply to Class II and Class III services only)</b> These deductibles are separate from your medical deductibles. Any expenses applied to the deductible during the last three months of the plan year will <u>not</u> be carried over to meet the deductible requirement for the next year. <ul style="list-style-type: none"> <li>• Per enrollee:</li> <li>• Maximum per family:</li> </ul>	          \$50 per plan year. \$150 per plan year.

### Reimbursement Percentage:

<b>Class I - Diagnostic and Preventive</b> <ul style="list-style-type: none"> <li>• <b>Economy Plan:</b></li> <li>• <b>Standard Plan:</b></li> <li>• <b>Premium Plan:</b></li> </ul>	100% of the allowable amount. Not subject to the deductible. 100% of the allowable amount. Not subject to the deductible. 100% of the allowable amount. Not subject to the deductible.
<b>Class II – Basic</b> <ul style="list-style-type: none"> <li>• <b>Economy Plan:</b></li> <li>• <b>Standard Plan:</b></li> <li>• <b>Premium Plan:</b></li> </ul>	80% of the allowable amount. Subject to the deductible. 80% of the allowable amount. Subject to the deductible. 80% of the allowable amount. Subject to the deductible.
<b>Class III – Major</b> <ul style="list-style-type: none"> <li>• <b>Economy Plan:</b></li> <li>• <b>Standard Plan:</b></li> <li>• <b>Premium Plan:</b></li> </ul>	50% of the allowable amount. Subject to the deductible. 50% of the allowable amount. Subject to the deductible. 50% of the allowable amount. Subject to the deductible.

**VISION BENEFITS** - (No deductible required)

Benefits are provided for **Standard and Premiums Plans ONLY**. No benefits are provided under the **Economy Plan**.

<p>Examination:</p> <ul style="list-style-type: none"><li>• 19 years of age and older</li><li>• Children under the age of 19</li></ul> <p>Lenses:</p> <ul style="list-style-type: none"><li>• 19 years of age and older</li><li>• Children under the age of 19</li></ul>	<p>100% of allowable amount. Limited to 1 exam per plan year.</p> <p>100% of allowable amount, deductible waived. Limited to 1 exam per plan year.</p> <p>100% of allowable amount. Limited to 1 pair per plan year. Allowed amount does not accrue to the Hardware benefit limit.</p> <p>Covered in full. Limited to 1 pair per plan year.</p>
<p>Hardware (Frames and Contact Lenses):</p> <ul style="list-style-type: none"><li>• 19 years of age and older<ul style="list-style-type: none"><li>• Standard Plan:</li><li>• Premium Plan:</li></ul></li><li>• Children under the age of 19</li></ul>	<p>Up to \$200 per plan year.</p> <p>Up to \$225 per plan year.</p> <p>Covered in full. Limited to 1 pair per plan year or 12 month supply of contact lenses in lieu of glasses.</p>

## **SPECIAL ENROLLMENT QUALIFYING EVENTS**

### **Involuntary Loss of Other Coverage – *See Late Enrollment Section***

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

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

**Note:** *Employees that do not enroll or waive coverage (with proof of other coverage) within 30 days of the date the applicant becomes eligible to enroll, will automatically be enrolled on the Economy Plan with employee only coverage.*

### **Subscriber And Dependent Special Enrollment – *See Subscriber and Dependent Special Enrollment Section***

- Marriage
- Birth
- Adoption
- Placement for adoption

### **State Medical Assistance and Children's Health Insurance Program – *See Subscriber and Dependent Special Enrollment Section***

- The person is eligible for state medical assistance, and the Alaska Department of Health and Social Services (DHSS) determines that it is cost-effective to enroll the person in this plan.
- The person qualifies for premium assistance under the state's medical assistance program or Children's Health Insurance Program (CHIP).
- The person no longer qualifies for health coverage under the state's medical assistance program or CHIP.

# STARTING OUT IN THE PROGRAM

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## Who May Be Covered?

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### CBJ Employees

Start effective on the date of hire when an employee is eligible to enroll in the Plan, and chooses to “enroll” in the Plan, if they satisfy the following:

- They become an active full-time employee, including a new seasonal employee, who regularly works a minimum of 37 1/2 hours per week;
- They become an active permanent/probationary: part-time employee, seasonal employee, or exempt employee working less than full time and who regularly works a minimum of 780 hours per year and a minimum of 15 hours per week, and they agree to pay their portion of the premium, which will be pro-rated depending on the number of hours worked per pay period;
- They become an Assembly Member.

### Bartlett Regional Hospital Employees

Start effective on the date of hire when an employee is eligible to enroll in the Plan, and chooses to “enroll” in the Plan, if they satisfy the following:

- They become an active-full-time employee, including a new seasonal employee, who regularly works a minimum of 72 hours per pay period;
- They become an active permanent/probationary: part-time employee, or exempt employee working less than full time and who regularly works a minimum of 832 hours per year and a minimum of 16 hours per week, and they agree to pay their portion of the premium, which will be pro-rated depending on the number of hours worked per pay period.

### Dependent Eligibility

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To be eligible for coverage as a dependent under this Plan, the family member must be:

- The employee's lawful spouse, unless legally separated;
- A “child” under 26 years of age. An eligible child is one of the following:
- A natural offspring of either or both the employee or spouse;
- A legally adopted child of either or both the employee or spouse; or
- A child “placed” with the employee for the purpose of legal adoption in accordance with state law. “Placed” for adoption means assumption and retention by the employee of a legal obligation for total or partial support of a child in anticipation of adoption of such child.
- A minor for whom the subscriber or spouse has a legal guardianship. There must be a court order signed by a judge, which grants guardianship of the child to the subscriber or spouse as of a specific date. When the court order terminates or expires, the child is no longer an eligible child.

If a dependent, other than a child covered from birth, or a legally adopted child covered from date of placement with the employee, is confined for medical care or treatment in any institution or at home when coverage would normally start, the dependent will not be covered until given a final release by the doctor from all such confinement.

## **Continued Eligibility for a Disabled Child**

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

- The child became disabled before reaching the limiting age;
- The child is incapable of self-sustaining employment by reason of developmental disability or physical handicap and is chiefly dependent upon the employee for support and maintenance;
- The employee remains covered under this program;
- The child's required contributions, if any, continue to be paid;
- Within 31 days of the child reaching the limiting age, the employee furnishes the Claims Administrator with a "Request for Certification of Handicapped Dependent" form. The Plan Administrator must approve the request for certification for coverage to continue; and
- The employee provides the Claims Administrator with proof of the child's disability and dependent status when requested. The Claims Administrator 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.

## **Enrollment**

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When the employee becomes eligible to enroll, they **must** complete an enrollment form or waive form (with proof of other coverage) and if necessary an affidavit of marriage for themselves and any eligible dependents within 30 days.

You or your eligible dependents may become eligible to enroll in this program on the following dates or may enroll once annually unless additional family status changes occur during the plan year:

- For the employee and existing eligible family members, the date the employee meets the employee eligibility requirements.
- For a spouse and eligible children that they meet the criteria outlined in the affidavit of marriage.
- For a natural newborn child born on or after the employee's effective date, the child's birth date.
- For an adoptive child, the date the child is placed with the employee for the purpose of legal adoption.

We must receive completed enrollment applications and required subscription charges within 30 days of the date the applicant becomes eligible to enroll, or in the case of a spouse and eligible children acquired through marriage, adoptive and natural newborn children, 30 days from the date they become eligible to enroll as explained above.

CBJ and Bartlett employees that do not enroll or waive coverage (with proof of other coverage) within 30 days of the date the applicant becomes eligible to enroll, will automatically be enrolled on the Economy Plan with employee only coverage.

## **When Coverage Begins**

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Provided timely application is made as explained above, coverage for the employee and their eligible dependents will become effective on their eligibility date. CBJ and Bartlett employees are eligible on their date of hire.

Newly acquired eligible dependent's coverage will begin as follows:

- **Completion of affidavit of marriage** - You must complete and return an enrollment form and affidavit of marriage within 30 days of change of status;
- **Birth** - Newborns are automatically covered for medical benefits. You must complete and return an enrollment form within 30 days after the birth of such child.
- **Adoption** - An adopted child or a child for which you are appointed as legal guardian is eligible and may have coverage on the date the child is placed for legal adoption or the date you are appointed as legal guardian. You must complete and sign an enrollment form within 30 days of the placement or appointment.

## **Children Covered Under Medical Child Support Orders Or Legal Guardianship**

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When we receive the completed enrollment application within 30 days of the date of the medical child support order or legal guardianship, coverage for an otherwise eligible child that is required under the order (by the court) 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 application for coverage. The enrollment application may be submitted by the subscriber, the child's custodial parent, a state agency administering Medicaid, or the state child support enforcement 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 your Group for detailed procedures.

## **Family and Medical Leave/Alaska Family Leave**

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The City & Borough of Juneau and Bartlett Regional Hospital adheres to the provisions of the Family and Medical Leave Act (FMLA) and the Alaska Family Leave Act (AFLA) for all Employees that meet eligibility requirements.

Eligible Employees on Family Medical Leave Act who go into a leave without pay status will continue to receive health insurance benefits as if they were continuing to work; including an obligation to pay their share of the premium. Eligible Employees who have exhausted benefits under the FMLA but remain eligible for benefits under the AFLA and are in a leave without pay status are eligible for continuing health insurance benefits but are obligated to pay the full premium.

You have a right under the Family and Medical Leave Act (FMLA) for up to 18 weeks of unpaid leave in a 12-month period for the reasons listed below.

- For the birth of the employee's child or for the placement of a child with the employee through adoption or foster care.
- When an employee is needed to care for the employee's child, spouse or parent who had a serious health condition;
- When an employee is unable to perform the functions of his or her job due to a serious health condition.
- Due to a qualifying exigency or for care of an injured covered service member under the National Defense Authorization Act.

Employees who have worked for CBJ or Bartlett long enough to be eligible for coverage under the FMLA policy can, if absent for one of the reasons listed above, continue to receive health insurance benefits even if they run out of personal leave and go into Leave Without Pay. The employees'



obligation to pay their share of the contribution continues, just the same as if they were working, but the employer will continue to pay its contribution towards the health benefits. When the FMLA is over, the employee will be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment unless the position has been laid off.

If an employee chooses not to return to work following FMLA, the employee may be required to reimburse CBJ/Bartlett for health benefit contributions it made during the entire period of FMLA. Reimbursement may not be required if the failure to return to work is due to: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA; or 2) other circumstances beyond the employee's control.

For more information about the Family/Medical Leave Policy, please contact your Human Resources Department.

- **Bartlett Regional Hospital employees:** 907-796-8418
- **City and Borough employees:** 907-586-5250

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### **Donation of Leave**

**CBJ Employees** – Refer to your Personnel Policies or contact the Human Resources Department at 907-586-5250 for more information.

**Bartlett Employees** – Refer to your Human Resources Department at 907-796-8418.

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### **Re-Enrollment**

If an employee terminates coverage during the plan year, and returns to work within that same plan year, all credits and deductibles previously satisfied will be reinstated.

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### **Late Enrollment**

If you decline enrollment for your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends.

When we receive the employee and/or dependent's completed enrollment application and any required subscription charges within 30 days of the date such other coverage ended, coverage under this plan will become effective on the first of the month following receipt of the employee and/or dependent's enrollment application.

When we don't receive the employee and/or dependent's completed enrollment application within 30 days of the date prior coverage ended, refer to "Enrollment".

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. Please contact your Plan Administrator for instructions on other special enrollments.

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### **Subscriber And Dependent Special Enrollment**

An eligible employee and otherwise eligible dependents who previously elected not to enroll in any of the employer's group health plans when such coverage was previously offered, may enroll in this plan at the same time a newly acquired dependent is enrolled under "Enrollment" in the case of marriage, birth, adoption, or placement for adoption. The eligible employee may choose to enroll without enrolling any eligible dependents.

If a qualifying event occurs while an eligible employee and dependent are currently on the group's plan, they may elect to change plans due to that qualifying event during the plan year.

## **Medicaid or Children's Health Insurance Program (CHIP)**

A Special Enrollment Period will apply to you or your dependent if:

- Your Medicaid or Children's Health Insurance Program (CHIP) terminates as a result of loss of eligibility and your request for enrollment is made within 30 days after the date of termination; or
- You become eligible for premium assistance subsidy under Medicaid or CHIP and your request for enrollment is made within 30 days after the date you become eligible for the premium assistance.

Coverage under this plan will become effective on the first of the month following receipt of your enrollment application.

## **Changes in Coverage**

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No rights are vested under this program. Its terms, benefits, and limitations may be changed at any time. All changes to this program will apply as of the date the change becomes effective.

## **Program Replacement**

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When this program replaces another program with no lapse in the coverage, any waiting period required by this program will be reduced by the length of time you were continuously covered under the other program. Amounts credited toward your plan year deductible, out of pocket maximum, benefit maximums or annual maximums under the other program will also apply to this program's applicable plan year deductible, out of pocket maximum, benefit maximums or annual maximums.

If, on or after the effective date of the contract, the waiting period provision of this Program Replacement section is in conflict with any state law or regulation, this section will be deemed amended to conform with the minimum requirements of such statute or regulation on the date prescribed therein.

The Plan Administrator reserves the final discretionary authority to determine eligibility for benefits and to construe the terms of this program.

## **WHEN COVERAGE ENDS**

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### **Termination Of Coverage**

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Except as stated under specific benefits and "Continuation of Coverage Under This Program-COBRA," coverage will terminate on the day after the date the following occurs. Coverage will terminate for the employee and dependents when:

- The Plan terminates.
- The date on which the employee fails to meet the minimum eligibility requirements.
- The next monthly required contribution is not paid when due or within the grace period.
- The employee dies or is no longer eligible as an employee.
- In the event of an employee's death, the surviving dependents are covered through the end of the month.
- On the date the employee is no longer actively employed.
- For a spouse when the marriage to the employee is annulled or they become legally separated or divorced from the employee.

**Notice: The employee must notify the Plan Administrator when an enrolled family member is no longer eligible to be enrolled as a dependent under this program. Employee is liable for all claims paid if not notified.**

## **Termination Of The Plan**

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The Plan Administrator has established the Health Benefit Plan with the intention and expectation that it will continue indefinitely, but will have no obligation to maintain the Plan for any length of time. The Plan Administrator reserves the right to amend or terminate, in whole or part, this Plan at any time without liability. Termination and Plan amendments affecting enrollees will be communicated to them. Upon termination of the Plan, the rights of enrollees to benefits are limited to claims incurred up to the date of termination.

## **Extended Benefits**

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

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

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

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

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

## **Continuation Of Coverage Under This Program-COBRA**

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Under certain circumstances, you and your enrolled dependents may have the right to continue coverage at your own expense beyond the time coverage would ordinarily have ended.

You have the right to elect continuation of coverage if you would otherwise lose coverage for one of the following qualifying events:

- Termination of employment (for reasons other than gross misconduct),
- Reduction in hours of employment,
- Retirement, or
- Leave of absence.

Your spouse has the right to choose continuation of coverage if they would otherwise lose coverage for any of the following events:

- Death of your spouse (employee).
- Termination of your spouse's (employee's) employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment.
- Divorce or legal separation from the employee.

- Spouse's (employee's) retirement.
- The employee becomes entitled to Medicare.
- Spouse's (employee's) leave of absence.

Your enrolled dependent child has the right to continuation of coverage if coverage would otherwise be lost for any of the following qualifying events:

- Death of parent.
- Parents' divorce or legal separation.
- Termination of parent's enrollment (for reasons other than gross misconduct) or a reduction in a parent's hours or employment.
- A parent (employee) becomes entitled to Medicare benefits; or
- The dependent child ceases to be eligible as a dependent under the Plan.

**Qualified Beneficiary:** The term Qualified Beneficiary refers to individuals who are covered under the employer's group health plan the day before a COBRA qualifying event takes place. According to the COBRA statute, a Qualified Beneficiary is the covered employee, covered spouse of the employee, covered dependent child of the employee, or any child born to, or placed for adoption or legal guardianship with the covered employee during the period of continuation coverage.

**Whom to Notify:** The enrolled employee or enrolled dependent has the responsibility of informing the Plan Administrator of a divorce, legal separation, a Social Security determination that a qualified beneficiary was disabled at the time of the employee's termination or reduction in hours, or a child's loss of dependent status within 30 days of the date of the event or Social Security determination of disability. The Plan Administrator has the responsibility of notifying the Claims Administrator of an employee's death, termination of employment, or reduction in hours.

**Once Notification is Given:** When the Plan Administrator is notified that one of these events has occurred, they will notify the employee or enrolled dependent that they have the right to elect continuation of coverage. Under this provision, that person has 30 days from the date coverage would otherwise be lost because of one of the events described previously or 30 days from the date of notification from the Plan Administrator, whichever is later, to elect continuation. Failure to elect continuation within that period will cause health plan coverage to end as it normally would under the terms of this Plan.

If you choose continuation coverage, your employer is required to give you coverage that is identical to the coverage provided under the Plan to similarly situated employees or family members. The opportunity to maintain coverage will continue for three years unless you lost coverage because of a termination of employment or reduction in hours. In that case, the continuation coverage period is 18 months, unless the Social Security Administration determines that you or a covered family member were disabled at the time of, or within 30 days following termination or reduction of hours. You must inform your employer of a qualifying disability before the end of the 18-month period, in which case your coverage and that of your covered family members may be extended for up to a total of 29 months from the date your coverage terminated. If, during that 18 months another event takes place that also entitles you or another qualified beneficiary to an extension, coverage may be extended. In no case will the coverage be continued for more than 36 months.

**Making Monthly Payments:** The employee or enrolled dependent is responsible for the full cost of coverage during the continuation. Premium for continuation of coverage must be paid to the group on a timely basis within 30 days of the group's premium due date. The only exception is the premium payment for the period preceding the election that may be made up to 45 days from the date of election.

**How Long Continued Coverage Lasts:** When loss of coverage is due to termination of employment or reduction in hours, continuation of coverage may last for up to 18 months. For all other qualifying events, continuation under this policy will end on the last day of the month for which premiums have been paid, when any one of the following occurs:

- Premium for a person on continuation is not paid on a timely basis.
- The Plan Administrator receives written notice that a person on continuation wishes to terminate their coverage.
- A person on continuation becomes covered by Medicare.
- A person becomes covered under another group health plan that does not restrict coverage for pre-existing conditions.

In addition, continuation will end on the day the group policy is terminated. Continued coverage will still be available under a succeeding plan unless the group no longer provides a group health plan for any of its employees.

## EXPLANATION OF YOUR MEDICAL BENEFITS

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This program is an "in-network provider arrangement;" it is based on agreements that certain providers have made with Premier Blue Cross Blue Shield of Alaska. The agreements with In-Network Providers mean lower fees charged for hospital and medical services furnished by In-Network Providers to City & Borough of Juneau/ Bartlett Regional Hospital Health Benefit Plan enrollees.

The In-Network Provider program is designed to lower your out-of-pocket cost. Therefore, you are encouraged to use In-Network Providers.

When you receive covered services from an In-Network Provider, that provider will accept the benefit payment, plus your payment of any applicable deductible, copayment, coinsurance, charges in excess of stated benefit maximums, and charges for services or supplies not covered by this Plan, as payment in full. Therefore, it is to your advantage to obtain hospital and medical services from In-Network Providers.

However, if you elect to obtain care from a Non-Network Provider, your out-of-pocket cost may increase because you will be responsible for any amounts over the allowable amount.

This plan does not require the use or selection of a primary care provider.

The example below shows how you can decrease your out-of-pocket costs by using an In-Network Provider.

### Out of Area Provider

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An out of area provider is a provider who renders services outside of Alaska and Washington. Benefits are paid differently for out of area hospitals than they are for out of area professional services. Out of area hospital charges are covered at 80% of the billed charges and out of area professional charges are covered at 80% of Usual Customary and Reasonable (UCR)\* charges. Please see the *example* below.

In-Network Provider		Non-Network Provider		Out of Area Hospital		Out of Area Professional	
Billed charge:	\$500	Billed charge	\$500	Billed charge:	\$500	Billed charge	\$500
Contracted fee:	\$450	Allowable amount:	\$450	Plan pays 80% of billed charges:	\$400	UCR amount:	\$400
Plan pays 80%:	\$360	Plan pays 80%:	\$360			Plan pays 80% of UCR:	\$320
<b>You pay:</b>		<b>You pay:</b>		<b>You pay:</b>		<b>You pay:</b>	
Coinsurance:	\$90	Coinsurance:	\$90	Coinsurance:	\$100	Coinsurance:	\$ 80
Amount over contract	-0-	Amount over allowable:	\$50			Amount over UCR:	\$100
<b>TOTAL YOU PAY:</b>	<b>\$90</b>	<b>TOTAL YOU PAY:</b>	<b>\$140</b>	<b>TOTAL YOU PAY:</b>	<b>\$100</b>	<b>TOTAL YOU PAY:</b>	<b>\$180</b>

\* UCR (Usual Customary and Reasonable) Fee

The amount commonly charged for a particular medical service by physicians within a particular geographic region. UCR fees are used by traditional health insurance companies as the basis for physician reimbursement.

To gain maximum benefit of this Plan and avoid unnecessary financial liability, it is very important for you and your dependents to know how the program works and what your responsibilities are.

## Deductibles

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A deductible is the amount of expense you must incur for covered services and supplies before benefits can be provided under this Plan. The amount credited will not exceed the allowable amount for the covered service or supply. Your plan has separate medical and dental deductibles.

Each plan year you must satisfy a deductible before your medical benefits are payable.

### **Deductible (per plan year):**

- **Economy Plan:** \$500 per enrollee; \$1,000 per family
  - **Standard Plan:** \$250 per enrollee; \$500 per family
  - **Premium Plan:** \$150 per enrollee; \$300 per family
- (Any expenses applied to the deductible during the last 3 months of a plan year will be carried over to meet the deductible requirement for the next year.)

## Emergency Room Copay

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Each time you receive services in an emergency room you pay a \$100 copay per visit. The services you receive in an emergency room are also subject to your plan year in-network deductible and in-network coinsurance which are explained below.

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

## Allowable Amount

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The benefits of this Plan are based on allowable amount for covered services and supplies. These allowable amounts are determined by the status and location of the provider; please see the definition of an "allowable amount" in this booklet.

## Reimbursement Percentages, Per Tier

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Your Plan's benefit level is 80% of the allowable. The 20% that each enrollee is responsible for is called coinsurance. After an enrollee reaches the out of pocket maximum, benefits will be paid at 100% of the allowable amount for covered services or supplies received by that enrollee during the remainder of the plan year.

**Please note:** Services and supplies provided under the Hearing Aid Benefit do not apply to the out of pocket maximum and are paid at a constant 80%.

In-Network Providers will seek payment solely from the Plan for the provision of covered services, and accept such payment as full and final payment for such services. In-Network Providers may seek payment from City & Borough of Juneau/Bartlett Regional Hospital employees only for the following:

- Deductibles and coinsurance amounts;
- Services not covered by this program; and
- Amounts in excess of stated benefit maximums.

Non-Network or Noncontracting providers may seek payment from City & Borough of Juneau/ Bartlett Regional Hospital employees for the following:

- Deductibles and coinsurance amounts;
- Services not covered by this program;
- Amounts in excess of stated benefit maximums; and
- Services over usual and customary fees.

## MEDICAL COVERAGE

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### Covered Services and Supplies

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This section 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 prevention, diagnosis or treatment of a covered illness or injury;
- It must be medically necessary and must be furnished in a medically necessary setting;
- It must be prescribed by a physician, except that mammography services may be recommended by a physician's assistant;
- It must not be excluded from coverage under this Plan;
- The expense for it must be incurred while you are covered under this Plan and after any applicable waiting period required under this Plan is satisfied; and
- It must be furnished by a provider that is covered under the applicable benefit.
- It must meet the standard set in our medical and payment policies.
- Some services must be authorized in writing.

### Hospital Inpatient Care

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Benefits will be provided at 80% of the allowable amount for covered hospital inpatient services, unless stated elsewhere. Subject to the deductible.

Hospital Inpatient Care includes room, intensive and coronary care units; ancillary services and supplies, such as diagnostic x-ray and laboratory services; surgical dressings and drugs, furnished by and used while confined in a hospital.

In addition to "General Limitations and Exclusions" the Plan 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 determined as medically necessary to treat your condition;
- Personal convenience items such as admission kits, etc.;
- Take-home drugs dispensed and billed by a hospital or skilled nursing facility.
- Treatment of substance abuse. Coverage for the treatment of substance abuse is available under the Substance Abuse benefit. 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

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Benefits will be provided at 80% of the allowable amount for covered hospital outpatient services, unless stated elsewhere. Subject to the deductible.

Hospital Outpatient Care includes operating, recovery, procedure and emergency rooms; ancillary services and supplies, such as diagnostic x-ray and laboratory services; surgical dressings and drugs, furnished by and used while at the hospital.

**Hospital** means a lawfully operated institution for the care and treatment of sick and injured persons with organized facilities for diagnosis and treatment, medical supervision, and 24-hour nursing service and is accredited by the Joint Commission on Accreditation of Hospitals (JCAH).



Hospital includes a licensed ambulatory surgical center; a licensed or accredited health facility or a residential facility which is set, maintained, contracted with or operated by the Mental Health Division.

## **Professional Services**

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Benefits will be provided at 80% of the allowable amount for covered professional services performed in the office, home, or hospital unless stated elsewhere. Subject to the deductible.

Professional services include home, office, emergency room and inpatient visits; surgery; anesthesia administration; x-ray and laboratory services. Benefits are only paid for services of an assistant surgeon when medically necessary and will not exceed 20% of the primary surgeon's allowable.

When a physician performs more than one surgical procedure during a single operative session, benefits will be provided based on the allowable amount for the first or major procedure and one-half of the allowable amount for each additional procedure.

Professional services also include services rendered by a dentist for repair of an accidental injury to functionally sound natural teeth if the enrollee is covered at the time of the accident and services are rendered within 12 months of the accident. This benefit does not provide benefits for injuries caused by biting or chewing.

## **Telehealth Virtual Care Services**

This benefit includes access to care via online and telephonic methods when medically appropriate, and is real-time communication between your doctor and you. Eligible services must be medically necessary to treat a covered illness, injury or condition.

## **Electronic visits**

This benefit includes electronic visits (e-visits). E-visits are structured, secure online messaging protocol (email) consultations between an approved doctor and you. They are not real-time visits. Your approved doctor will determine which conditions and circumstances are appropriate for e-visits in their practice. E-visits are covered when provided by an approved provider and all of the following are true:

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

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

## **Diagnostic Services**

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**Preventive Screening Services** - Benefits will be provided at 100% of the allowable amount for preventive screening services, including administration and interpretation.

**Non-Preventive Diagnostic Services** – Benefits will be provided at 80% of the allowable amount. Subject to the deductible.

Some examples of what's covered are:

- Diagnostic imaging and scans (including x-rays and EKGs)
- Laboratory services
- Pathology

**Please Note:**

- Diagnostic surgeries and scope insertion procedures, such as colonoscopy or endoscopy, can only be covered under the Surgical Services benefit, unless they meet the standards for preventive services described in the Preventive Care benefit. Full anesthesia delivered by an anesthesiologist is covered only if there are specific risk factors or significant medical conditions that increase the likelihood of complications or intolerance to moderate sedation anesthesia.
- BRCA genetic testing for women at risk for certain breast cancers
- Allergy testing is covered only under the Professional Services benefit.
- 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.
- For mammography services, please see the Diagnostic and Screening Mammography benefit.
- Preventive lab covered in full (plan year deductible waived) Preventive diagnostic services are laboratory and imaging services that meet the standards for preventive services as stated in the Preventive Care benefit. (A list of these services are available at [premera.com](http://premera.com) or by contacting us.)

**Surgical Services**

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

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

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

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

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

## Limited Benefits and Services

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Some of the following limited benefits and services do not apply toward the out of pocket maximum.

### Acupuncture

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Benefits will be provided at 80% of the allowable amount for acupuncture services when medically necessary to relieve pain, induce surgical anesthesia, or to treat a covered illness, injury. Benefits are provided up to a maximum of 12 visits per plan year. Subject to the deductible.

### Hearing Aid Benefit

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Benefits will be provided at a constant 80% of the allowable amount for covered services and supplies, up to a maximum of \$400 per plan year. Subject to the deductible.

The enrollee must be examined by a physician (M.D. or D.O.) before obtaining a hearing aid. The enrollee must also provide the Plan with a written certificate from the examining physician stating that the enrollee is suffering from a hearing loss that may be lessened by the use of a hearing aid. Such written certificate must be obtained within a 3 month period prior to purchase of a hearing aid. The physician certification and your claim for the hearing aid device must be submitted together. Benefits will not be provided without this certification. (This requirement will be waived if the enrollee replaces a hearing aid that was originally provided while covered under this benefit).

Covered services and supplies include only the following:

- One otological (ear) examination by a physician licensed as a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.);
- One audiological (hearing) examination and hearing evaluation by a certified or licensed audiologist.
- The audio device/hearing aid (monaural or binaural) prescribed as a result of an examination, as specified above, including:
  - Ear mold(s);
  - Hearing aid instrument;
  - Initial batteries, cords, and other necessary ancillary equipment;
  - Warranty;
- A follow-up consultation within 30 days following delivery of the hearing aid with either the prescribing physician or audiologist.

*Your coinsurance for covered services for audio benefits does not accrue toward this Plan's out of pocket maximum.*

In addition to "General Limitation and Exclusions," the Plan will not provide this benefit for:

- Batteries or other ancillary equipment other than that obtained upon purchase of the hearing aid;
- Repairs, servicing, or alteration of hearing aid equipment;
- A hearing aid which exceeds the specifications prescribed for correction of hearing loss;
- Expenses incurred after coverage ends under this program unless a hearing aid was ordered prior to that date and was obtained within 45 days after the day coverage ended;
- Hearing aid charges in excess of the hearing aid benefit are not eligible for the major medical benefit;
- Hearing aids purchased or ordered prior to the enrollee's effective date of coverage under this program.

## Transplants

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

You pay the same share of the allowable charges for covered transplants and transplant-related medical services that you would pay for any other surgery and related services. What you pay depends on where the service is performed. For example, if you receive inpatient care in a hospital, you pay the share of allowable charges shown under the Hospital Inpatient benefit. For office visits, you pay the share of allowable charges shown under the Professional Visits and Services benefit.

This benefit is subject to a 12 month waiting period. Refer to the Transplant Waiting Period in the “Starting Out In The Program” section earlier in this booklet for details.

This benefit is subject to the plan year deductible and coinsurance. However, transportation and lodging expenses are subject to the plan year deductible, but not your coinsurance.

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

### Covered Transplants

Organ transplants and bone marrow/stem cell reinfusion procedures must not be considered experimental or investigational for the treatment of your condition. (Please see the Definitions section in this booklet for the definition of “Experimental/ Investigational Services.”) We reserve the right to base coverage on all of the following:

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

**Please Note:** For the purposes of this plan, the term “transplant” doesn’t include cornea transplantation, skin grafts or the transplant of blood or blood derivatives (except for bone marrow or stem cells). Benefits for such services are provided under other benefits of this plan.

- Your medical condition must meet our written standards, which are found by referring to our website at [premera.com](http://premera.com) or by contacting Customer Service.

- The transplant or reinfusion must be furnished in an approved transplant center. (“Approved transplant center” is a hospital or other provider that’s developed expertise in performing solid organ transplants, or bone marrow or stem cell reinfusion.) Premiera Blue Cross Blue Shield of Alaska has agreements with approved transplant centers in Washington and Alaska, and Premiera Blue Cross Blue Shield of Alaska has access to a special network of approved transplant centers around the country. Whenever medically possible, you’ll be directed to an approved, contracted transplant center for transplant services.

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

### **Donor Costs**

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

### **Transportation and Lodging Expenses**

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

- The transplant recipient must reside more than 50 miles from the approved transplant center, unless medically necessary treatment protocols require the member to remain closer to the transplant center.
- The transportation must be to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure, or necessary post-discharge follow-up.
- Covered transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) are limited to \$7,500 per transplant. When the recipient is a dependent minor child, expenses for the child and two companions are included. If not a dependent minor child, lodging and meal expenses are limited to the recipient and one companion.

### **In addition to “What’s Not Covered?” this benefit doesn’t cover the following:**

- Services and supplies that are payable by any government, foundation or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers.
- Donor costs for an organ transplant or bone marrow or stem cell reinfusion that isn’t covered under this benefit, or for a recipient who isn’t a member.
- Donor costs for which benefits are available under other group or individual coverage.
- Non-human or mechanical organs, unless they aren’t “experimental or investigational services” (please see the “Definitions” section in this booklet).
- Personal care items.
- Anti-rejection drugs, except those administered by the transplant center during the inpatient or outpatient stay in which the transplant was performed.
- Take-home prescription drugs dispensed by a licensed pharmacy. See the “Prescription Drug Benefit” section for benefit information.

## Home Health and Hospice Care

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Benefits will be provided as follows for covered home health and hospice care services:

- Home Health Care: 80% of the allowable amount, up to a maximum of 130 visits per plan year. Subject to the deductible.
- Hospice Care: 80% of the allowable amount. Subject to the deductible. Lifetime maximum of 10 inpatient days and 6 months outpatient benefit.

Benefits for home health care and hospice care services are provided 80% of allowable amount, subject to deductible for covered services furnished and billed by a home health agency or hospice that is Medicare-certified as such or is licensed or certified as such by the state in which it operates.

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

Covered employees of a home health agency and hospice are; a licensed practical nurse; a licensed or registered 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 who is directly supervised by one of the above providers (providing services prescribed in the plan of care to achieve the desired medical results); and a master of social work (Hospice Care Benefit only).

**Home Health Care:** Benefits are limited to a maximum of 130 intermittent home visits per enrollee each plan year by one or more of the home health agency providers above. Each visit by a home health agency representative shall be considered 1 visit.

Home Health Care furnished and billed by a home health care agency

- In-home visits by one or more registered nurses, not to exceed two hours per day, for skilled care:
- Intravenous therapy by an intravenous therapy company.
- Respiratory therapy by a certified respiratory therapist for therapeutic treatment of lung disease.
- Phototherapy by a registered nurse for treatment of jaundice of a newborn child.

**Hospice Care:** Benefits shall not exceed 6 months of covered hospice care. Benefits will not be available beyond 6 months from the initial date of hospice care covered under this program. However, at the end of the 6-month period, the enrollee may apply to the Plan for an extension if hospice care benefits have not been exhausted.

- Covered hospice services are:
- In-home intermittent hospice visits by one or more of the hospice providers 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. Covers inpatient services and supplies used while the enrollee is 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.
- Palliative care for members facing serious, life-threatening conditions but who are not in imminent danger of death, including expanded access to home based care and care coordination. Participation in palliative care is usually approved for 12 months at a time and may be extended based on the member's specific condition.

**Prescription Drugs and Insulin:** Furnished and billed by a covered home health agency or hospice during a period of covered home health or hospice care. The drugs must be prescribed in the written plan of care.

**Home Health and Hospice Care Benefit For Home Intravenous Therapy:** Includes professional services furnished and billed by one of the following providers:

- A home health agency or hospice that is Medicare-certified as such or licensed or certified as such by the state in which it operates.
- An intravenous therapy provider that is state-licensed or state certified as both a home health agency and a pharmacy.

In addition to "General Limitations and Exclusions," the Plan will not provide the Home Health and Hospice Care 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 enrollee.
- Social services, except under the Hospice Care Benefit.
- 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.

### **Skilled Nursing Facility**

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Benefits will be provided at 80% of the allowable amount for covered skilled nursing facility services, up to 60 days per member each plan year. Subject to the deductible.

Skilled nursing facilities include room, ancillary services and supplies furnished by and used while confined in an in-network or Medicare-approved skilled nursing facility in Alaska or Washington or a Medicare-approved skilled nursing facility outside Alaska or Washington.

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," the Plan will not provide this benefit for:

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

### **Acute Nursing Services**

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Benefits will be provided at 80% of the allowable amount, up to a maximum of \$2,500 per plan year for covered acute nursing services. Subject to the deductible.

Acute nursing services of a registered nurse in the home when such services are ordered by a physician.

## Rehabilitation Services

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Benefits will be provided as follows for covered rehabilitation services.

- Inpatient: 80% of the allowable amount, up to a maximum of 30 days per plan year. Subject to the deductible.
- Outpatient: 80% of the allowable amount, up to a maximum of 45 visits per plan year. Subject to the deductible.

**Inpatient Care:** Inpatient care benefits are provided when:

- Services cannot be done in a less intensive setting;
- They are part of a continuous inpatient stay following acute treatment. Admissions solely for rehabilitative care are not included;
- The services are medically necessary to restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an injury, illness, or surgery;
- Services are rendered in and furnished and billed by a specialized rehabilitative unit of a hospital or by another approved rehabilitation facility;
- The therapy must be appropriate to the condition being treated; and
- The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physician.

**Outpatient Care:** Outpatient rehabilitation services, when furnished and billed by a hospital, by another approved rehabilitation facility, by a physician (M.D. or D.O.), a licensed massage therapist, or by a registered physical, occupational, or speech therapist, including: physical; speech; and occupational therapy, including cardiac rehabilitation. Outpatient care benefits are provided when:

- Services are medically necessary to restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an injury, illness, or surgery;
- The enrollee is not confined in the hospital; and
- The care starts within one year of the date the condition being treated began.

In addition, it is recommended, but not required, that the physical therapist provide a written treatment plan for the benefit of the patient.

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

### Chronic Pain Care

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

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

In addition to "General Limitations and Exclusions," the Plan will not provide this benefit for:

- Care to halt or slow further physical deterioration.
- Nonmedical self-help, such as "Outward Bound" or "Wilderness Survival;" recreational, vocational, or educational therapy; work hardening, exercise, or maintenance-level programs.



- Learning disabilities, such as dyslexia; tongue thrust; stuttering, or stammering; speech and articulation disorders.
- Social or cultural rehabilitation.
- Acupressure.
- Treatment that is not actively engaged in by the ill, injured, or impaired enrollee.
- Gym or swim therapy
- Custodial care
- Inpatient rehabilitation received more than 24 months from the date of onset of the member's accidental injury or illness or from the date of the member's surgery that made rehabilitation necessary
- Services to treat a psychiatric condition; see the Mental Health Care benefits.

### **Psychological and Neuropsychological Testing**

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The following services are subject to your plan year deductible and coinsurance.

Covered services include testing related to mental health, rehabilitation and neurodevelopmental therapy, and evaluations, including interpretation, necessary to prescribe an appropriate treatment plan. This includes later re-evaluations to make sure the treatment is achieving the desired medical results.

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

### **Neurodevelopmental Therapy (for enrollees under age 7)**

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Benefits will be provided as follows for covered neurodevelopmental therapy services for enrollees under age 7.

Physical, speech and occupational therapy provided for treatment of psychiatric conditions, such as autism spectrum disorders, are covered as described under the Mental Health Care benefit.

- Inpatient: 80% of the allowable amount. Subject to the deductible.
- Outpatient: 80% of the allowable amount. Subject to the deductible.

**Inpatient:** Services must be furnished and billed by a hospital, by a physician (M.D. or D.O.) or with a physician's referral, by a registered physical, occupational, or speech therapist.

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

Benefits will be provided for inpatient neurodevelopmental therapy services if all of the following requirements are met:

- The enrollee is under age 7;
- The services cannot be rendered in a lesser care facility;
- The therapy is appropriate to the condition being treated; and
- The treatment is part of a formal written program of treatment prescribed by the physician.

**Outpatient:** Outpatient neurodevelopmental therapy services, when furnished and billed by a hospital, a physician (M.D. or D.O.), or with a physician's referral, by a registered physical, occupational, or speech therapist. Inpatient neurodevelopmental therapy must be medically necessary to restore and improve function, or to maintain function where significant physical deterioration would occur without the services.

Benefits will be provided for outpatient neurodevelopmental therapy services if all of the following requirements are met:

- The enrollee is under age 7;
- The enrollee is not confined in a hospital; and
- The treatment is part of a formal written treatment program prescribed by a physician.

**Please Note:** Physical, speech and occupational therapy provided for treatment of psychiatric conditions, such as autism spectrum disorders, are covered under the Mental Health Care benefit.

In addition to "General Limitations and Exclusions," the Plan will not provide this benefit for:

- Neurodevelopmental therapy and related evaluations for enrollees age 7, or older.
- Nonmedical self-help, such as "Outward Bound," "Wilderness Survival," recreational or educational therapy.
- Social, cultural, or vocational therapy.
- Acupressure or services of a massage therapist.
- Gym or swim therapy
- Custodial care

**Please Note:** Benefits will not be provided for rehabilitation services and neurodevelopmental therapy services for the same condition. Once the plan year maximum has been exhausted under one of these benefits, no further coverage is available for the same conditions under the other.

### **Contraceptive and Sterilization Management**

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Benefits will be provided at 100% of the allowable amount for covered contraceptive management. Not subject to the deductible.

This benefit covers:

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

In addition to "General Limitations and Exclusions," the Plan will not provide this benefit for:

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

## **Diagnostic and Preventive Screening Mammography**

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Diagnostic and Screening mammography will be covered 100% of the allowable amount. Not subject to the deductible.

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.

## **Preventive Care**

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### **What Are Preventive Services?**

Preventive services are now defined to include:

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

You can get a complete list of the preventive care services with the limits on our website at **premera.com** or call us for a list. This list may be changed as required by state and federal preventive guidelines change. The list will include website addresses where you can see current federal preventive guidelines. Services designated as preventive care when they meet the federal guidelines include periodic exams, routine immunizations described below, and laboratory and imaging services that are covered as preventive under the Diagnostic Services benefit and the Diagnostic and Preventive Screening Mammography benefit.

### **Preventive Exams**

Your plan year deductible and coinsurance, if any, don't apply to benefits for preventive exams.

Preventive care services are covered 100% and are not subject to the deductible.

The following exam services are covered:

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

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

### **Preventive Immunizations**

Your plan year deductible, coinsurance and copay, if any, don't apply to benefits for preventive immunizations.

## **Seasonal Immunizations and Other Immunizations**

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

## **Nutritional Counseling**

Healthy eating assessments and dietary counseling.

## **Fall Prevention**

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

## **Women's Preventive Care**

Benefits for women's preventive care, when they meet the federal guidelines as defined for women's health.

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

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

### **This Preventive Care benefit doesn't cover:**

- Services not named above as covered
- Charges for preventive services that exceed what's covered under this benefit
- Inpatient routine newborn exams while the child is in the hospital following birth (These services are covered under the Newborn benefit)
- Routine or other dental care (These services are covered under the Dental benefit)
- Routine vision and hearing exams (These services are covered under the Vision benefit)
- 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
- Facility charges when preventive care is received at a hospital-based clinic or hospital-based physician's office. See the hospital OP care benefit for your cost share
- Breast pumps. See Medical Equipment and Supplies.
- Contraceptive services, drugs or devices. Benefits for these services and supplies are provided under the Contraceptive Management and Prescription Drugs benefits

**Please Note:** For outpatient routine or preventive diagnostic services (including x-ray and laboratory) please see the Diagnostic Services benefit.

## **Obesity Treatment**

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### **Non-Surgical Weight Management**

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

Non-Surgical Weight Management benefits include, but aren't limited to, coverage of the following outpatient medical services:

- Behavioral health visits
- Nutritional/dietician visits
- Physical therapy visits
- Physician visits
- Prescription drugs
- Related lab and diagnostic services

For specific benefit information, please see the Mental Health Care, Nutritional Therapy, Rehabilitation Therapy and Chronic Pain Care, Professional Visits, Prescription Drug, and Diagnostic Services benefits.

### **Surgical Treatment of Morbid Obesity**

Benefits for surgical treatment of morbid obesity are covered the same as any other covered condition subject to the criteria listed below, applicable benefits, limitations and exclusions. Prior authorization is required.

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

To qualify for the surgical treatment for morbid obesity benefit, the member must meet the following criteria:

- Diagnosed as morbidly obese with a Body Mass Index (BMI) greater than or equal to 40; or
- Overweight with a BMI greater than 35 with co morbidities, including but not limited to:
- Congestive heart failure disease (CHF)
- Coronary Heart Disease
- Diabetes
- Hyperlipidemia
- Hypertension
- Sleep Apnea

For specific surgical treatment benefit information, please see the Hospital Inpatient Care, Hospital Outpatient Care and Surgical Services benefits.

### **Surgical Treatment of Morbid Obesity Maximum**

The Surgical Treatment of Morbid Obesity benefit is subject to a **lifetime maximum** benefit of \$25,000 for covered services, including but not limited to surgery, anesthesia, facility and other charges directly related to surgical care. Medically necessary treatment of surgical complications do not accrue toward this benefit maximum.

**The Obesity Treatment benefit doesn't cover:**

Expenses beyond the lifetime maximum for eligible surgical service

- Procedures or treatments that Premiera Blue Cross and its affiliates deem are experimental and investigational (please see the "Definitions" section in this booklet)
- Surgical removal of excess abdominal, arm or other skin or liposuction unless medically necessary
- Over-the-counter medications for weight loss
- Liquid diet or fasting programs
- Other food replacement and nutritional supplements
- Membership in diet programs
- Health clubs
- Wiring of the jaw
- Weight management drugs
- Exercise equipment, whole body calorimeter studies
- Vitamin injections

**Additional Covered Services and Supplies**

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The following services and supplies are covered.

**Blood Transfusions**

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Benefits will be provided at 80% of the allowable amount for blood transfusion services. Subject to the deductible.

Blood transfusion services include transfusions and the cost of blood and blood derivatives that are not replaced by voluntary donors. The donation and storage of the enrollee's blood for their own planned surgery is also allowed.

**Breast Reconstruction Following Mastectomy**

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Benefits will be provided at 80% of the allowable amount for breast reconstruction following a mastectomy, subject to the deductible. Coverage includes:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

**Chiropractic Treatment**

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Benefits will be provided at 80% of the allowable amount for covered chiropractic treatment, subject to the deductible. Services must be performed by a chiropractor (D.C.), operating within the scope of their license.

**Diabetes Health Education**

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These services are provided at 100% of allowable charges. Outpatient self-management training and education for diabetes, including medical nutritional therapy is not subject to a benefit limit, when performed by a covered provider. This benefit does not include weight loss or weight management programs.

## Dialysis

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Benefits will be provided at 80% of the allowable amount dialysis services. Subject to the deductible.

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

## Durable Medical Equipment, Medical Supplies, and Prosthetic Devices

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Benefits will be provided at 80% of the allowable amount for covered durable medical equipment, medical supplies, and prosthetic devices. Subject to the deductible except as otherwise stated below.

### Breast Pumps

This benefit covers the purchase of standard electric breast pumps at 100% of allowable charges. Rental of hospital grade breast pumps is also covered when medically necessary. Purchase of hospital-grade pumps is not covered.

**Durable medical equipment** includes rental, but not to exceed the purchase price, when prescribed by a physician and required for therapeutic use in direct treatment of a covered illness or injury. The Plan may also provide benefits for the initial purchase of equipment, in place of rental.

Examples of durable medical equipment are a wheelchair, a hospital-type bed, traction equipment, and an intermittent positive pressure breathing apparatus. In cases where there is an alternative type of equipment that is less costly and serves the same medical purpose, the Plan will provide benefits only up to the lesser amount.

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

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

**Medical supplies and orthopedic appliances** directly required for the appropriate treatment of illness or accidental injury, include items such as braces, splints, casts, rib belts, crutches and orthopedic shoes.

### Medical Vision Hardware

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

**PKU Dietary Formula** Benefits will be provided at 80% of the allowable amount for covered PKU Dietary Formula. Subject to the deductible.

**Prosthetic devices** 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, except that only the initial charge for the first such prosthetic device will be included. Benefits will not be provided for the replacement of prosthetic devices, except when the existing device cannot be repaired and replacement is recommended by a physician due to a change in your physical condition (growth or physical deterioration). Covered prosthetic devices include, but are not limited to artificial limbs or eyes.

**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 Plan will not provide this benefit for:

- Special or extra-cost convenience features.

- Items such as corrective shoes, exercise equipment or weights, whirlpools, whirlpool baths, portable whirlpool pumps, sauna baths, and massage devices.
- Orthopedic appliances prescribed primarily for use during participation in sports, recreation, or similar activities.
- Used equipment, unless approved by the Plan prior to purchase.
- Supplies or equipment not primarily intended for medical use
- Penile prostheses
- Over bed tables, elevators, vision aids and telephone alert systems
- Structural modifications to your home and/or personal vehicle
- Hypodermic needles, syringes, lancets, test strips, testing agents and alcohol swabs used for self-administered medications, except as specified in the "What Are My Prescription Drug Benefits?" section
- Eyeglasses, contact lenses and other vision hardware for conditions not listed as a covered medical condition, including routine eye care

### **Emergency Round Trip Air Transportation**

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Benefits will be provided at 80% of the allowable amount for emergency round trip air transportation. Subject to the deductible.

Charges for round trip air transportation, for the ill or injured enrollee, by a licensed commercial carrier. The trip must begin at the location in Alaska where the enrollee became ill or injured and end at the site of the nearest hospital in Alaska or within the continental limits of the United States equipped to provide treatment not available in a local facility. Transportation south will be limited to Seattle, Washington.

#### **Benefits will only be provided if all of the following apply:**

- The illness or accidental injury occurred suddenly, unexpectedly, and was life-endangering;
- The enrollee was admitted at the end of the trip;
- Medically necessary covered surgery could not be performed locally

If the patient is a child under 19 years of age, the transportation charges of a parent or legal guardian accompanying the child will be allowed if the attending physician certifies the need for such attendance.

**Please note:** charges are only covered for the parent or legal guardian if they are a covered member under this plan.

Transportation Benefits are not provided for services that are covered under the vision, dental, or hearing aid benefits.

### **Health Management**

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These services are provided at 100% of allowable charges.

#### **Health Education**

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

#### **Nicotine Dependency Programs**

Benefits are provided for nicotine dependency programs. You pay for the cost of the program and send us proof of payment along with a reimbursement form. When we receive these items, the plan will



provide benefits as stated above in this benefit. Please contact Customer Service department for a reimbursement form.

### **Nutritional Therapy**

Benefits are provided for outpatient nutritional therapy services to manage your covered condition, illness or injury including services to manage diabetes or eating disorders. This benefit isn't subject to a plan year benefit limit.

### **Community Wellness**

This benefit allows you to participate in classes and programs that promote positive health and lifestyle choices. Examples of these classes and programs are adult, child, and infant CPR; safety; babysitting skills; back pain prevention; stress management; bicycle safety; and parenting skills.

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

### **Intravenous Therapy Drugs and Supplies**

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Benefits will be provided at 80% of the allowable amount for intravenous therapy drugs and supplies. Subject to the deductible.

### **Licensed Ambulance Service**

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For covered licensed ambulance services, you pay a \$100 copay per trip, then benefits will be provided at 80% of the allowable amount, subject to the deductible. For transportation, for the patient only, to the nearest medical facility equipped to treat the enrollee's condition. Ambulance service is only covered when any other mode of transport would endanger the patient's health or safety. This benefit is not available for private automobiles, or taxi services.

### **Maternity Care**

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Benefits will be provided at 80% of the allowable amount, subject to the deductible.

Pregnancy, childbirth, and related conditions are covered the same as any other condition. Covered services include screening and diagnostic procedures during pregnancy, and related genetic counseling, when medically necessary for prenatal diagnosis of congenital disorders, and elective abortion. This benefit is available to enrolled employees and their eligible dependents (eligible spouses and children).

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. ***However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).*** In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for a length of stay less than 48 hours (or 96 hours as applicable).

### **Mental Health Care**

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Benefits will be provided as follows for covered mental health care services:

- Inpatient: 80% of the allowable amount. Subject to the deductible.
- Outpatient: 80% of the allowable amount. Subject to the deductible.

Inpatient and outpatient treatment of mental and nervous conditions, including treatment of eating disorders such as anorexia nervosa, bulimia, or any similar condition. Covered services must be

furnished by a hospital, physician, psychologist, psychological associate, licensed clinical social worker, Licensed Marital and Family Therapist (L.M.F.T.), Master of Nursing Registered Nurse (M.N.R.N.), Certified Registered Nurse (C.R.N.), Master of Social Work (M.S.W.), or a Community Mental Health Clinic (C.M.H.C.). Services may also be rendered by a Master of Science Counseling (M.S.C.), Master of Arts (M.A.), or Master of Science (M.S.) with the supervision of a physician or licensed psychologist. A "mental and nervous condition" is a condition classified as such by the current edition of the International Classification of Diseases manual.

**Please note:** Benefits will only be provided for a Licensed Marital and Family Therapist for covered diagnosis under the Mental Health Care benefit.

In addition to "General Limitations and Exclusions," the Plan will not provide this benefit for:

- Outpatient milieu therapy (treatment intended to provide a change in environment or a controlled environment);
- Treatment of disorders and delays in a child's language, motor, cognitive, or social skills;
- Sexual dysfunctions and sleep disorders;
- Services furnished by a hospital owned or operated by a government agency, except as required by law;
- Services or supplies related to an inpatient eating disorder program, except as stated above.
- Conditions of substance abuse (see Substance Abuse Benefit).
- Outward bound, wilderness, camping or tall ship programs or activities
- EEG biofeedback or neurofeedback services
- Mental health evaluations for purposes other than evaluating the presence of or planning treatment for covered mental health disorders, including, but not limited to, custody evaluations, competency evaluations, forensic evaluations, vocational, educational or academic placement evaluations.

### **Routine Newborn Care**

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Benefits will be provided at 80% of the allowable amount for covered routine newborn care. Subject to the deductible.

Hospital routine newborn care is covered for an eligible dependent child during the child's initial hospital confinement at birth. Covered services include hospital nursery services as long as it is medically necessary for the mother to be confined. Well Child physician visits are covered while the newborn is confined in the hospital. Routine newborn care terminates and major medical begins for the child upon the mother's release from the hospital. Circumcisions are covered.

**Please Note:** Benefits for routine newborn care and for care of an ill baby are provided under the child's coverage, subject to their own deductible and coinsurance requirements.

### **Newborn Hearing Exams and Testing**

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

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

## **Special Transportation**

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- Benefits will be provided at 80% of the allowable amount for round trip air transportation; subject to deductible. Charges for round trip air transportation, limited to commercial coach fare only, for the ill or injured employee by a licensed commercial carrier.

Travel will be covered for services that are not available locally, with the following restrictions:

- The enrollee must see a physician within 3 working days of arrival.
- Services provided must be covered through the current health plan.

**Upon completion of travel, you will be required to send in a subscriber claim form along with your travel information to complete your claim. This includes:**

- **Written certification and documentation of medical necessity is submitted by a covered provider.**
- **Your ticket/boarding pass**
- **Copy of Travel Itinerary**

**Please note:** Tickets must be purchased by a covered member in order to be eligible for reimbursement. If air miles are purchased for air travel, the dollar amount must be listed on the ticket for it to be reimbursable. Frequent flyer miles that have been "earned" are not reimbursed.

For services that are available locally, but can be obtained less expensively out of town, the cost of travel will be covered subject to the following restrictions:

- The amount of travel cost paid cannot exceed the difference between the cost of covered services in your location and the cost of those same services in the location you choose; and
- Services provided must be covered through current health plan.

**Submit procedural cost documentation and receipts for the cost of travel, for both local and out-of-town procedure, to the claims department administrator, the amount of reimbursement, if any will be determined when the claim is processed.**

**Please submit your claim with documentation to the following address for determination:**

**Alaska Providers send claims to:**

Premiera Blue Cross Blue Shield of Alaska  
PO Box 240609  
Anchorage, AK 99524-0609

**All other Providers send claims to:**

Premiera Blue Cross  
PO Box 91080  
Seattle, WA 98111

**Please allow 30 days to respond to your request.**

If a patient is a child under the age of 19, the transportation charges of a parent or legal guardian accompanying the child will be allowed if the attending physician certified the need for such attendance.

Transportation benefits are not provided for services that are covered under the vision, dental or hearing aid benefits.

**\*REIMBURSEMENTS, IF APPLICABLE ARE BASED ON DATES OF TRAVEL.**

## **Sterilization**

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Services and supplies related to a sterilization procedure will be covered at 100% of the allowable amount.

In addition to "General Limitations and Exclusions," the program will not provide this benefit for:

- Charges to reverse a sterilization procedure.

## **Substance Abuse**

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Benefits will be provided at 80% of the allowable amount for covered inpatient and outpatient treatment of substance abuse and supporting services, subject to the deductible.

Covered services must be furnished by a state-approved treatment program.

Benefits for therapeutic and supporting services provided to enrolled family members to assist in the chemically dependent enrollee's diagnosis and treatment.

In addition to "General Limitations and Exclusions," the Plan will not provide this benefit for:

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

## Prescription Drug Benefit

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

### Prescription Drug Deductible and Copayments

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Each covered prescription or refill purchased at an in-network pharmacy or non-network pharmacy is subject to the deductible and a copayment. Prescription drug deductibles, coinsurance, and copays do not apply toward the medical plan out of pocket maximum or deductibles.

**Please Note:** Out-of-network Mail Order pharmacies are not covered.

For preferred and non-preferred brand name drugs or supplies, each member must pay coinsurance for each separate new prescription or refill. “Coinsurance” is defined as the percentage of the allowable charge that you’re required to pay to the retail pharmacy or the in-network home delivery pharmacy for each prescription drug purchase.

After the deductible has been met, the enrollee pays a specified amount for each prescription or refill, and the Plan pays the remaining balance, unless stated otherwise. The deductible and copayments are as follows:

#### Retail Pharmacy Prescriptions

<b>In-Network and Non-Network Pharmacies:</b> <ul style="list-style-type: none"><li>Prescription Deductible and out-of-pocket:<ul style="list-style-type: none"><li>Economy</li><li>Standard</li><li>Premium</li></ul></li></ul>	<ul style="list-style-type: none"><li>\$50 deductible / \$1,500 out-of-pocket per enrollee</li><li>\$50 deductible / \$1,000 out-of-pocket per enrollee</li><li>\$50 deductible / \$500 out-of-pocket per enrollee</li></ul>
<ul style="list-style-type: none"><li>Legend Drugs (up to 30 day supply):<ul style="list-style-type: none"><li>Economy</li></ul></li></ul>	<ul style="list-style-type: none"><li>\$10 copayment per prescription or refill for generic.</li><li>40% copayment for non-preferred or brand name</li><li>When generic equivalent is available you must also pay the difference in cost between the generic and the brand name drug after you have paid the \$10 copayment for the generic.</li></ul>
<ul style="list-style-type: none"><li>Standard</li></ul>	<ul style="list-style-type: none"><li>\$10 copayment per prescription or refill for generic.</li><li>30% copayment for non-preferred or brand name</li><li>When generic equivalent is available you must also pay the difference in cost between the generic and the brand name drug after you have paid the \$10 copayment for the generic.</li></ul>
<ul style="list-style-type: none"><li>Premium</li></ul>	<ul style="list-style-type: none"><li>\$10 copayment per prescription or refill for generic.</li><li>20% copayment for non-preferred or brand name</li><li>When generic equivalent is available you must also pay the difference in cost between the generic and the brand name drug after you have paid the \$10 copayment for the generic.</li></ul>

## Home Delivery Pharmacy

<ul style="list-style-type: none"> <li>Mail Order Pharmacy Program (up to 90 day supply):             <ul style="list-style-type: none"> <li>Economy</li> </ul> </li> </ul>	\$10 copayment per prescription or refill for generic. \$35 copayment prescription or refill for non-preferred or brand name When generic equivalent is available, you must also pay the difference in cost between the generic and the brand name drug after you have paid the \$10 copayment for the generic.
<ul style="list-style-type: none"> <li>Standard</li> </ul>	\$10 copayment per prescription or refill for generic. \$30 copayment prescription or refill for non-preferred or brand name When generic equivalent is available you must also pay the difference in cost between the generic and the brand name drug after you have paid the \$10 copayment for the generic.
<ul style="list-style-type: none"> <li>Premium</li> </ul>	\$10 copayment per prescription or refill for generic. \$25 copayment prescription or refill for non-preferred or brand name When generic equivalent is available you must also pay the difference in cost between the generic and the brand name drug after you have paid the \$10 copayment.

## Specialty Pharmacy – Up to 30 day Supply

<ul style="list-style-type: none"> <li>Economy</li> </ul>	\$100 copayment per prescription
<ul style="list-style-type: none"> <li>Standard</li> </ul>	\$100 copayment per prescription
<ul style="list-style-type: none"> <li>Premium</li> </ul>	\$100 copayment per prescription

"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. The plan makes use of our contracted 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.

Benefits for certain drugs which require special handling, storage, administration or patient monitoring may be limited to specific in-network pharmacies, and to a 30-day supply for initial dispensing at a Retail Pharmacy. Benefits for up to a 90-day supply of these drugs will be allowed under the Mail Order Pharmacy Program benefit.

Contact Customer Service for details on which drugs are included in the Specialty Pharmacy Program, or visit our website at [premera.com](http://premera.com).

Specialty pharmacies are pharmacies that focus on the delivery and clinical management of specialty drugs. You and your health care provider must work with a network specialty pharmacy to arrange ordering and delivery of these drugs.

**Please note:** This plan will only cover specialty drugs that are dispensed by a network specialty pharmacy. Contact Customer Service for details on which drugs are included in the specialty pharmacy program, or visit our website, which is shown on the inside cover of this booklet.

## **How To Use The Home Delivery Pharmacy Program**

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

To obtain additional details about the Home Delivery Pharmacy program, you may go to [premera.com/MyPharmacyPlus](http://premera.com/MyPharmacyPlus), call the Pharmacy Benefit Administrator's customer service department or visit their website at:

1-800-391-9701

**[express-scripts.com](http://express-scripts.com)**

For more information on the Home Delivery Pharmacy program, or to obtain mail service envelopes, please contact the Customer Service department at the number listed inside the front cover of this booklet.

### **Injectable Supplies**

When hypodermic needles and syringes are purchased along with the medication to be injected, only the copay for the medication will apply.

When hypodermic needles and syringes are purchased separately from the medication to be injected, the brand name drug copay will apply for each item purchased, providing you have a written prescription from your health care provider for each item.

The prescription drug deductible, if any, and the brand name drug copay will apply to purchases for alcohol swabs, test strips, testing agents and lancets, providing you have a written prescription from your health care provider for each item. A separate copay will apply to each item purchased.

### **What's Covered?**

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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)
- Inhalation spacer devices and peak flow meters
- Prescription contraceptives
- Prescription vitamins
- Drugs for the treatment of nicotine dependency, including over the counter (OTC) nicotine patches, gum or lozenges purchased through a retail in-network pharmacy
- 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.
- Prescription drugs for the treatment of autism

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

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

### **Additional Information About Your Prescription Drug Benefit**

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**Generic Drugs** When available and indicated by the prescriber, a generic drug will be dispensed in place of a brand name drug. In the event a generic equivalent isn't manufactured, the applicable brand name copay will apply. If you or the prescriber request a brand name drug 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.

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

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

### **Prescription Drug Formulary**

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

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

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

- There is no formulary drug or alternative available
- You cannot tolerate the formulary drug
- The formulary drug or dose is not safe or effective for your condition

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

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



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

### **Clinical Pharmacy Management**

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

### **Prescription Drug Volume Discount Program**

Your prescription drug program includes per-claim rebates that are received by Premera Blue Cross Blue Shield of Alaska from its pharmacy benefit manager. These rebates are paid or credited to 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 retains the difference and applies it to the cost of our operations and the prescription drug benefit program. If your prescription drug benefit includes a copay, coinsurance calculated on a percentage basis, or a deductible, the amount you pay and your account calculations are based on the allowable charge.

### **What's Not Covered?**

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In addition to "General Limitations and Exclusions," the Plan will not provide this benefit for:

- Drugs and medicines that may be lawfully obtained over the counter (OTC) without a prescription, except as required by law. OTC drugs are excluded even if prescribed by a practitioner, unless otherwise stated in this benefit. Examples of such excluded items include, but aren't limited to, non-prescription drugs and vitamins, food and dietary supplements, herbal or naturopathic medicines and nutritional and dietary supplements (e.g. infant formulas or protein supplements).
- Therapeutic devices or appliances, regardless of their intended use, including:
- Support garments.
- Any other nonmedical substances.
- Services other than prescription drugs, including their administration.
- Drugs to treat infertility, including fertility enhancement medications.
- Norplant.
- Food supplements (except for certain medical conditions).
- Non-prescription contraceptive methods (e.g. jellies, creams, foams or devices).
- Non-prescription vitamins
- Non FDA approved legend drugs other than insulin.
- Drugs used for cosmetic purposes or to promote or stimulate hair growth (e.g. wrinkles or hair loss).
- Drugs intended for use in a physician's office or setting other than home.
- Take-home drugs dispensed and billed by a medical facility.
- Prescription drugs used while you are an inpatient in 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.
- Any drug prescribed or dispensed in a manner contrary to normal medical or pharmaceutical practice.
- Investigation or experimental drugs including compounded medications for non-FDA use.

- Prescriptions which an eligible person is entitled to receive without charge under any worker compensation law or any municipal, state, or federal program.
- Any drug that does not require a physician's prescription.
- Infusion therapy drugs or solutions and drugs requiring parenteral administration or use, and injectable medications. (The exception is injectable drugs for self-administration, such as insulin and glucagon).
- Immunization agents, biological sera, such as rabies serum, blood or blood plasma.
- Impotency drugs.
- Biologicals, blood or blood derivatives.
- Any prescription refilled in excess of the number of refills specified by the prescribing provider, or any refill dispensed after one year from the prescribing provider's original order.
- Weight management drugs.
- Replacement of lost or stolen medication
- Drugs to treat sexual dysfunction.

## DENTAL COVERAGE

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Covered dental services will be paid up to the allowable amount for enrollees. The covered services and supplies must be provided by a dentist, a dental hygienist under the supervision of a dentist, or a denturist, each operating within the scope of their license. No dental benefits will be paid for any dental service which is incomplete or temporary, or which is not on the following list of covered dental expenses.

### Plan Year Maximum

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A \$2,000 plan year maximum benefit is applied for all preventive, diagnostic, basic and major services per plan year per enrollee.

### Deductible

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A plan year deductible of \$50 per enrollee applies to all basic and major services. There is no deductible for preventive and diagnostic services. The maximum plan year deductible per family is \$150. The deductible does not carry over to the next plan year.

### Estimate of Benefits

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You are advised to request an estimate of the benefits that will be payable from the Claims Administrator for any proposed dental services or series of dental services for which the total charge will exceed \$450. The Claims Administrator will then review the request to determine the estimated dental benefit under this program and notify both you and your dentist of the amount to be paid by this program.

If the dentist submits a treatment plan for an estimate of benefits and then changes the treatment, benefits allowed will be adjusted accordingly. If the dentist makes a major change in the treatment plan, you should ask the dentist to submit a revised plan.

An estimate of benefits is not a guarantee of coverage or payment. Benefits provided to you will be subject to the specific benefits, limitations, and eligibility provisions set forth by the program in effect at the time the services are rendered.

### Alternate Benefits

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The Claims Administrator will determine benefits available under this program, taking into account alternate procedures or services carrying different fees which are consistent with acceptable standards of dental practice. In all cases where there are alternate courses of treatment carrying different fees, the Plan only provides benefits for the treatment carrying the lesser fee. If you and your dentist decide upon a more costly treatment, then you are responsible for the additional charges beyond those for the less-costly alternate treatment and for which benefits have been provided.

### Reimbursement Percentage

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The dental program pays the following percentages of allowable amounts for covered services and supplies per plan year to a maximum of \$2,000 per enrollee:

Class I - Diagnostic and Preventive	
• <b>Economy Plan:</b>	100% of the allowable amount. Not subject to the deductible.
• <b>Standard Plan:</b>	100% of the allowable amount. Not subject to the deductible.
• <b>Premium Plan:</b>	100% of the allowable amount. Not subject to the deductible.

<b>Class II – Basic</b> <ul style="list-style-type: none"> <li>• <b>Economy Plan:</b></li> <li>• <b>Standard Plan:</b></li> <li>• <b>Premium Plan:</b></li> </ul>	80% of the allowable amount. Subject to the deductible. 80% of the allowable amount. Subject to the deductible. 80% of the allowable amount. Subject to the deductible.
<b>Class III – Major</b> <ul style="list-style-type: none"> <li>• <b>Economy Plan:</b></li> <li>• <b>Standard Plan:</b></li> <li>• <b>Premium Plan:</b></li> </ul>	50% of the allowable amount. Subject to the deductible. 50% of the allowable amount. Subject to the deductible. 50% of the allowable amount. Subject to the deductible.

## Covered Procedures

Only the cost necessary for dental care provided by a licensed dentist (D.M.D. or D.D.S.) is covered.

### Class I Preventive and Diagnostic Services

- Routine oral examinations, limited to twice per plan year.
- Prophylaxis or periodontal prophylaxis (cleaning, scaling, and polishing of teeth), limited to twice per plan year.
- Dental x-rays, including cone beam images (i.e. panoramic x-ray).
- Topical application of fluoride solutions if under age 20, twice per plan year.
- Sealants for use on permanent teeth only.
- Space maintainers designed to preserve the space between teeth caused by the premature loss of a primary tooth. This does not include space maintainers used in orthodontics. Limited to primary teeth.

### Class II Basic Services

- Simple extractions.
- Oral surgery consisting of surgical extractions, fracture and dislocation treatment, alveolar ridge augmentation, and diagnosis and treatment of cysts or abscesses.
- Fillings consisting of amalgam and resin based composite. For resin-based composite fillings performed on second and third molars, the allowance would be limited to what would have otherwise been allowed for a corresponding amalgam filling.
- Gold foils will be limited to what would have otherwise been allowed for amalgam or resin-based composite fillings.
- Treatment of periodontal and other diseases of the gums and tissues of the mouth.
- Endodontic treatment.
- Repair and recementing of crowns, inlays, bridgework, and dentures.
- Emergency palliative treatment primarily for relief of dental pain, not cure.
- Pin retention of fillings.
- Pulpotomy and root canal therapy.
- Nightguards (for treatment of bruxism only).
- Nitrous oxide - provided in a dental provider's office are covered when administered in connection with a covered Class II or Class III dental service

### **Class III Major Services**

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Restorative services and supplies, as follows:

- Gold or porcelain inlays, onlays, and crowns (or veneers instead of one of these), but only when the tooth, as a result of extensive caries or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling material.
- Replacement of an existing inlay, onlay, or crown, or of a veneer placed instead of one of these, but only when:
  - It has been at least 5 years since the restoration was initially placed or last replaced; or
  - Repreparation of the natural teeth is required as a result of an accidental injury.
- Initial placement of full or partial dentures (including adjustments during the first 6-month period following installation) or fixed bridgework (including inlays and crowns to form abutments).
- Replacement of full or partial dentures or fixed bridgework which cannot be made serviceable, but only when:
  - It has been at least 5 years since the denture or bridgework was initially placed or last replaced;
  - The replacement or addition of teeth is required to replace one or more additional teeth extracted after the initial placement; or
  - Repreparation of natural teeth in the existing fixed bridgework is required as a result of an accidental injury.
- Relining and rebasing of dentures.
- Implants and implant related services, subject to 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).

### **General Provisions**

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Certain provisions of your health care program, including eligibility, limitations and exclusions (where applicable), review of rejected claims, coordination of benefits and third party liability may also apply to this dental program.

If the benefit for a service or supply is not specifically stated in this booklet, the Plan Administrator will determine the benefit, if any.

Benefits will be provided for the least costly procedure when optional techniques of treatment are available.

### **Extension of Dental Benefits**

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An expense incurred for a covered dental service that is completed after an enrollee's benefits cease will be deemed to be incurred while they are covered if:

- For fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while covered and the device is installed or delivered within 30 days after the coverage ceases.
- For a crown, inlay, onlay, or veneer, the tooth is prepared while covered and the crown, inlay, onlay, or veneer is installed within 30 days after coverage ceases.
- For root canal therapy, the pulp chamber of the tooth is opened while covered and the treatment is completed within 30 days after coverage ceases.

There is no extension for any dental service not shown above.

## **Limitations and Exclusions**

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No benefits will be provided for the following:

- Charges that would not have been made or that the patient would have no obligation to pay in the absence of this program.
- Dental treatment for which a government or governmental agency prohibits the payment of benefits.
- Dental treatment paid for or provided by the laws of any government, or treatment given in a government owned facility, unless the enrollee is legally required to pay.
- Charges for any service and/or supply in excess of the percentages and allowances listed in this booklet, except in the case of dual employees both covered by the City & Borough of Juneau.
- Dental treatment required as the result of war or as a result of engaging in a riot or insurrection.
- Failure to keep appointments or for the completion of health care reports required by the Employer.
- Replacement of lost or stolen items.
- Dental treatment rendered principally for cosmetic purposes.
- Dental treatment in excess of the \$2,000 plan year maximum benefit per enrollee.
- Dental treatment which is not yet approved by the Council of Dental Therapeutics of the American Dental Association and/or which is experimental in nature.
- Services rendered for dietary planning for the control of dental caries, for plaque control or for oral hygiene instructions.
- Dental treatment involving the use of gold if such treatment could have been rendered at a lower cost by means of a reasonable substitute consistent with generally accepted dental practice.
- Bridges, crowns, or other prosthetic devices, or the fitting thereof, if ordered prior to the patient's effective date, or installed or delivered more than 30 days after the patient's coverage has terminated.
- Charges by any person other than a licensed dentist, except for a licensed dental hygienist working under the supervision of a licensed dentist whose services are included in such dentist's charge.
- The replacement of dentures or bridgework if the denture or bridgework was installed or replaced within the past five years.
- Jaw augmentation or reduction (orthognathic surgery), except for dependents who have been continuously covered under this Plan from birth. Also not covered is any method of care connected with the diagnosis or treatment of jaw joint problems. This includes care of temporomandibular joint (TMJ) dysfunction or other conditions of the joints linking the lower jawbone or skull, including the complex muscles, nerves, and other tissues related to those joints.
- Orthodontics, including casts, models, x rays, photographs, examinations, appliances, braces, and retainers.
- Charges for general anesthesia, except when administered by a dentists in connection with oral surgery in a dentist's office.
- E-Visits or structured, secure online consultation between dental provider and member.

## VISION BENEFITS

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Benefits are provided for **Standard and Premiums Plans ONLY**. No benefits are provided under the Economy Plan.

### Reimbursement

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Examination: <ul style="list-style-type: none"><li>• 19 years of age and older</li><li>• Children under the age of 19</li></ul> Lenses: <ul style="list-style-type: none"><li>• 19 years of age and older</li><li>• Children under the age of 19</li></ul>	100% of allowable amount. Limited to 1 per plan year. 100% of allowable amount, deductible waived. Limited to 1 exam per plan year.  100% of allowable amount. Limited to 1 pair per plan year. Allowed amount does not accrue to the Hardware benefit limit. Covered in full. Limited to 1 pair per plan year.
Hardware (Frames and Contact Lenses): <ul style="list-style-type: none"><li>• 19 years of age and older<ul style="list-style-type: none"><li>• Standard Plan:</li><li>• Premium Plan:</li></ul></li><li>• Children under the age of 19</li></ul>	Up to \$200 per plan year. Up to \$225 per plan year. Covered in full. Limited to 1 pair per plan year or 12 month supply of contact lenses in lieu of glasses.

Benefits are available for the listed vision services and supplies when such services and supplies meet all of these requirements:

- They must be prescribed by an ophthalmologist or optometrist;
- They must be furnished by an ophthalmologist, optometrist, or optician;
- They must not be excluded from coverage under this program; and
- They must be named in this benefit as covered.

### Covered Procedures

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Covered routine examination services are:

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

Benefits for the following are included in the maximum benefit for the type of lens prescribed:

- Fitting of eyeglass lenses to frames.
- Fitting contact lenses to the eyes.
- Special features, such as tinting or coating.

Benefits for the following are included in the maximum benefit for frames:

- Parts of frames.
- Fitting the frames to the face.

Charges for vision services or supplies that exceed what is covered under this benefit are not covered under other benefits of this Plan.

### **Extension of Vision Benefits**

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This benefit is provided for services or supplies received after your coverage under this benefit has ended when all of the following requirements are met:

- You receive a covered routine vision examination, with a refraction, no more than 30 days before the date your coverage under this benefit ended;
- You ordered covered contact lenses, eyeglass lenses, or frames before the date your coverage under this benefit ended; and
- You received the contact lenses or glasses you ordered no more than 30 days after the date your coverage under this benefit ended.

### **Vision Limitations and Exclusions**

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In addition to "General Limitations and Exclusions," the Plan will not provide this benefit for:

- Services or supplies that are not named above as covered, or that are covered under other provisions of this program.
- Services or supplies that are not furnished by a licensed ophthalmologist, optometrist, or optician.
- Nonprescription glasses, or other special purpose vision aids (such as magnifying attachments), sunglasses or light sensitive lenses, even if prescribed.
- Medical and surgical diagnosis or treatment of illness or injury that affects vision. This includes contact lenses prescribed after cataract surgery or to replace a missing portion of the eye. Benefits for these services may be available under other provisions of this program.
- Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye.
- Supplies used for the maintenance of contact lenses.
- If continuous blend multifocal eyeglass lenses or specialty contact lenses (such as extended wear or astigmatic contacts) are purchased, benefits will be provided only up to the respective eyeglass lens or simple spheric contact lens allowance. You will be responsible for any difference, even if the provider is an Approved Provider.
- Radial keratotomy.



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

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## Out-of-Area Care

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

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

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

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

## BlueCard Program

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

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

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

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

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

## Value-Based Programs

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

## **Taxes, Surcharges and Fees**

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

## **Non-Network Providers**

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

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

## **BlueCard Worldwide® Program**

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

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

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

# **CARE FACILITATION**

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## **Care Management**

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

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

## **Prior Authorization**

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

A planned service is reviewed to make sure it is medically necessary and eligible for coverage under this plan. We will let you know in writing if the service is authorized. We will also let you know if the services are not authorized and the reasons why. If you disagree with the decision, you can request an appeal. Please see "When You Have An Appeal" in your booklet or call us.

There are three situations where prior authorization is required:

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

Each situation has different requirements.

### **How To Ask For Prior Authorization**

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

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

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

The following services require prior authorization:

- Planned admission into hospitals or skilled nursing facilities
- Planned admission to an inpatient rehabilitation facility
- Non-emergency ground air or ambulance transport
- Transplant and donor services
- Injectable medications you get in a healthcare provider's office
- Prosthetics and orthotics other than foot orthotics or orthopedic shoes
- Reconstructive surgery, including repairs of defects caused by injury and correction of functional disorders
- Home medical equipment costing \$500 or more
- Surgical, medical therapeutic, diagnostic and reconstructive procedures, including:
  - Abdominoplasty/Panniculectomy
  - Bone anchored and implantable hearing aids
  - Cardiac devices, including implantation
  - Cardiac percutaneous interventions
  - Corneal remodeling
  - Deep brain stimulation
  - Endoscopy upper gastrointestinal
  - Hysterectomy
  - Knee arthroplasty and arthroscopy
  - Implantation or application of electric stimulator
  - Radiation therapy such as gamma knife, proton beam, intensity modulated radiation therapy (IMRT), intraoperative radiation therapy
  - Spine surgery/treatments, such as cervical spinal fusion and lumbar spinal fusion

- Blepharoplasty (eyelid surgery), non-cosmetic
- Breast surgeries such as implant removal, mastectomy, prophylactic mastectomy, reduction mammoplasty
- Cochlear implantation
- Hyperbaric oxygen therapy
- Facility based sleep studies (polysomnography)
- Radiofrequency tumor ablation
- Outpatient imaging tests including:
  - Positron Emission Tomography (PET and PET/CT)
  - Contrast Enhanced Computed Tomography (CT) Angiography of the heart
  - Computed Tomography (CT) Scans
  - Magnetic Resonance Imaging (MRI)
  - Magnetic Resonance Angiography (MRA)
  - Magnetic Resonance Spectroscopy
  - Nuclear Cardiology
  - Echocardiograms

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

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

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

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

### **Exceptions:**

The following services are not subject to this prior authorization requirement, but they have separate requirements. The services below do not need prior authorization. Instead, you must tell us as soon as reasonably possible after you receive them:

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

- Childbirth admission to a hospital, or admissions for newborns who need medical care at birth. They do not require prior authorization, but you must notify us as soon as reasonably possible. Admissions to a non-network hospital will be covered at the non-network cost-share unless the admission was an emergency.

### **Prior Authorization For Prescription Drugs**

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

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

The categories of drugs that require prior authorization are:

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

- Proton pump inhibitors
- Smoking deterrents
- Specialty drugs
- Tetracyclines

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

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

### **Services from Non-Network Providers**

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

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

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

### **Clinical Review**

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

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

### **Personal Health Support Programs**

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

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

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

## GENERAL LIMITATIONS AND EXCLUSIONS

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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 the Care Management provisions and your eligibility. In addition, some benefits have their own limitations.

### What Your Program Does Not Cover

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In addition to the specific limitations stated elsewhere in this program, the Plan 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 "Continuation of Coverage Under This Program-COBRA." Inpatient care in a medical facility is also not covered if you were admitted before your effective date.
- 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, registration, or certification, or that are furnished by a provider that is not licensed, registered, 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.

#### In addition, the Plan will not provide benefits for:

- 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.
- Services, supplies and procedures relating to altering the refractive character of the cornea, and their results, both direct and indirect, including, but not limited to radial keratotomy, corneal modulation, keratomileusis, or refractive keratoplasty.
- Amounts that exceed the allowable amount or maximum benefit for a covered service; except coordination of benefits for dual covered employees.
- Any method of care connected with the diagnosis or treatment of jaw joint problems. This includes care of temporomandibular joint (TMJ) dysfunction or other conditions of the joints linking the lower jawbone and skull, including the complex of muscles, nerves, and other tissues related to these joints.
- Separate charges for records or reports.
- Custodial care, except as provided under the Hospice Benefit.

- Any service or supply that is determined to be experimental or investigational on the date it's furnished, and any direct or indirect complication and aftereffects thereof. The determination is based on the criteria stated in the definition of "experimental/investigation services" (please see the "Definitions" section in this booklet).
- If a service is experimental or investigational, and therefore not covered, you may appeal the decision. You can get a description of your appeal rights by calling us or by visiting our web page at [premera.com](http://premera.com).
- Care rendered by any non-network medical facility that is owned or operated by a government agency, except when:
  - The Plan refers you to the facility;
  - The facility's covered services are to treat a medical emergency; and
  - The Plan is required by law to provide available benefits for covered services rendered by the facility.
- Counseling, education or training services, except as stated under the Substance Abuse, Health Management, Nutritional Therapy, Mental Health Care, and Obesity Treatment benefits, or for services that meet the standards for preventive services in the Preventive Care benefit. This includes vocational assistance and outreach; social, sexual and fitness counseling.
- Non-medical services, such as spiritual, bereavement, legal or financial counseling
- Recreational, vocational or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Gym or swim therapy
- Therapy designed to provide a changed or controlled environment.
- Services, supplies (including drugs), or procedures for cosmetic, plastic and reconstructive purposes and their results, direct or indirect, 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, provided 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 if covered under the Plan since birth.
- All stages of the reconstruction of the involved breast after a mastectomy required by illness or accidental injury. And, for all stages of one reconstructive breast reduction on the other breast to make it equal in size to the breast reconstructed after mastectomy.
- Correction of functional disorders upon review and approval.
- Private duty nursing.
- Services of family members or volunteers.
- Routine or palliative foot care, including hygienic care; impression casting for prosthetics or appliances and prescriptions thereof, except as stated under the Professional Visits and Services benefit; fallen arches, flat feet, care of corns, bunions (except for bone surgery), calluses, toenails (except for ingrown toenail surgery) and other symptomatic foot problems. This includes foot-support supplies, devices and shoes, except as stated under the Medical Equipment and Supplies benefit.
- Exams to assess a work-related or medical disability
- Services and supplies that aren't directly related to your illness, accidental injury or distinct physical symptoms. However, this exclusion doesn't apply to services and supplies that meet the requirements for preventive services as described in the Preventive Care benefit



- Diagnosis and treatment of sexual disorders and defects, whether or not they are the consequence of illness or injury. Examples are impotence, frigidity, and infertility.
- Reversal of surgical sterilization, artificial insemination, in-vitro fertilization, and gamete intrafallopian transplant (GIFT). However, elective sterilization is covered under the plan.
- Treatment or surgery to change gender.
- Jaw augmentation or reduction (orthognathic surgery), regardless of origin of the condition that makes the procedure necessary.
- 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 enrollee's commission of a felony or act of terrorism (this exclusion does not apply to a victim of domestic violence).
- Treatment of caffeine dependence, except for services covered under the Health Management benefit.
- Any illness or injury arising out of or in the course of employment or self-employment for wages or profit. This exclusion applies even if the expense for the illness or injury is not paid by Workers' Compensation, industrial insurance, or any similar law, or by an employer's liability contract or insurance.
- 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; or;
  - Commercial premises or homeowner's medical premises coverage, or similar type of coverage or insurance.
- Routine vision examinations, except under the Vision Benefit.
- Over-the-counter drugs, supplies, food supplements
- 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.
- Human Growth Hormone. Benefits for human growth hormone are only provided under the Specialty Pharmacy Program (please see the "Prescription Drugs" benefit) and are not covered to treat idiopathic short stature without growth hormone deficiency.

### **Serious Adverse Events and Never Events**

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

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

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

# GENERAL PROVISIONS

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## Coordination of Benefits (COB) - Medical / Dental and Vision Coverage

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"Coordination of Benefits" is a method for determining the amount that each program should pay when you are covered under two or more group or individual health care programs. It determines which program is primary and which program is secondary. The primary program pays benefits as if you had no other coverage, while the secondary program is allowed to reduce its benefit payment so that the benefits of both programs do not exceed 100% of the allowable expenses for the plan year.

If you have other coverage in addition to this program, it is recommended that you send your claims to the primary carrier first; then sent to secondary carrier with copy of the primary carrier's Explanation of Benefits.

Only "allowable expenses" are subject to coordination of benefits. An "allowable expense" is a health care expense, including any deductibles, coinsurance and copayments, that is covered at least in part by any of your programs. When a program provides benefits in the form of services, the reasonable cash value of each service is an allowable expense and a benefit paid. An amount that is not covered by any of your programs is not an allowable expense.

If the other program has no provision for Integration or Coordination of Benefits, that plan would be the primary plan, and therefore, would pay first. If both programs Integrate or Coordinate Benefits, the following rules apply:

- The program that covers the patient as an employee, and not as a dependent, is primary, and pays first;
- Benefits of the program which covers a dependent child(ren), will be paid first by the program of the parent whose birthday occurs first in the year. If the birthdays fall on the same day, then the program that has covered the dependent the longest becomes primary and pays benefits first;
- If the dependent child's parents are separated or divorced, benefits for the dependent child are determined as follows:
- If a court order requires one parent to provide health care coverage, that parent's coverage will pay first.
- If there is no court order, the program of the parent having custody pays first, followed by the program of the spouse of the parent with custody, and then by that of the parent without custody.

If the rules above do not apply, the program that has covered an enrollee for the longest time will be primary, except that benefits of a program which covers an enrollee as a laid-off or retired employee, or as the dependent of such an employee shall be determined after the benefits of any program which covers an enrollee as other than a laid-off or retired employee, or as the dependent of such an employee. This applies, however, only when other programs involved have this provision regarding laid-off or retired employees.

If none of the rules above determine the order of benefits, the program that has covered the employee or subscriber for the longest time will be primary.

Any amount by which a secondary program's benefits have been reduced in accord with this section shall be used by the secondary program to pay the enrollee's allowable expenses not otherwise paid. However, the enrollee must have incurred these expenses during the claim determination period. As each claim is submitted, the secondary program determines its obligation to pay for allowable expenses based on all claims that were submitted up to that time during the claim determination period.

If an enrollee is covered under this program as both an employee and a dependent, this does not act to double the program's benefit maximums (including vision hardware limits). We will coordinate benefits between the employee coverage and the dependent coverage as we would if they were under two

different employer's programs. The dependent coverage will be secondary to the employee coverage. So, when the program covers a service or supply at 80%, the secondary coverage can provide its benefits to reimburse the enrollee's 20% coinsurance under the primary coverage. In addition, amounts saved by the secondary program on prior claims can be used to reimburse expenses which are covered by the primary program but not the secondary program.

### **Effect of Medicare and Other Government Programs**

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This program provides primary coverage when both Medicare and this program cover you or your dependents. This means that this program pays benefits first and Medicare pays benefits second.

If the employee or spouse is under age 65, disabled and eligible for Medicare, this program is primary unless the disability is due to end-stage renal disease (ESRD). If the disability is due to ESRD, then this program is primary for the first 30 months of ESRD care. At the start of the thirty-first month, Medicare becomes primary.

When this program is not primary, it will coordinate benefits with Medicare. This will be done if you are entitled to Medicare, whether or not you choose to enroll or claim benefits to which you are entitled.

This program does not cover services or supplies for which you are entitled to receive benefits under any other government program, unless it is required to do so by law. This is true even if you do not apply for such government benefit or choose to give up your rights to them.

### **Third Party Liability (Subrogation)**

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The Plan has the right to be reimbursed for the amount of benefits it has provided because of a condition or injury for which you are not legally liable. As explained below, reimbursement may be sought by you or by the Plan from the party who is legally liable or from that party's insurance carrier.

### **Recovering Payment**

If you bring an action or claim against another person, you must also seek recovery of the benefits the Plan paid under this program. The Plan may, however, assert its right to recover benefits directly from the other person, or from you. If it does so, you do not need to take any action on behalf of the Plan. You must, however, do nothing to impair the Plan's right of recovery. Should the Plan assert its right of recovery directly, it has the right to join as a party in the action or claim you brought. You must promptly notify the Plan in writing in advance of any settlement you intend to make of your action or claims.

In recovering benefits the Plan has provided, it may either hire its own attorneys, or be represented by your attorney. If the Plan chooses to be represented by your attorney, it will pay, on a contingent basis, a reasonable portion of the attorney's fees which are necessary and which benefit the Plan's rights of recovery in the case. This portion will usually not be more than 20% of the amount the Plan seeks to recover. The Plan will not pay for any legal costs incurred by you as the enrollee, or for costs incurred on your behalf, and you will not be required to pay any portion of the costs incurred by or on behalf of the Plan.

If you obtain a settlement or recovery for less than the insurance policy limits or reachable assets of the liable party, you are obligated to reimburse the Plan for the full amount of benefits paid on your behalf. If, however, you obtain a settlement or recovery that is equal to or greater than the liable party's insurance policy limits or reachable assets, you are only obligated to reimburse the Plan in the amount that is left after you have been fully compensated.

Any person who is obligated to pay for the services or supplies for which benefits have been paid by the Plan must pay to it the amounts to which it is entitled.

## **Motor Vehicle Liability**

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Benefits paid under this program will be reduced by an amount equal to any benefits paid or to be paid to the enrollee by a motor vehicle insurance company. The Claims Administrator has the right to request information about payments and the right to recover duplicate payments.

## **Uninsured and Underinsured Motorist Coverage**

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The Plan has 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 or similar type of insurance or contract.

The amount of reimbursement that the Plan is entitled to receive under this provision is the amount in excess of the amount you receive from all insurance sources which fully compensate you for all damages arising from the accidental injury for which such benefits have been paid.

## **Notice of Other Coverage**

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As a condition of receiving benefits under this program, you must notify the Claims Administrator of:

- Any legal action or claim against another party for a condition or injury for which the Plan paid benefits; and the name and address of that party's insurance carrier.
- The name and address of any insurance carrier providing 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 under which you are covered.

## **Right To Receive and Release Information**

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Your enrollment application authorizes any provider to release information about you that is required to process applications or claims to the Claims Administrator when requested. The enrollment application also authorizes any person or organization, including an insurance company, to release to the Claims Administrator or receive from it any information regarding your claim for benefits under this program. Benefits of this program will not be provided if you do not allow access to records.

## **Limitations of Liability**

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Neither City & Borough of Juneau, Bartlett Regional Hospital, Care Management, Premera Blue Cross Blue Shield of Alaska, or the Claims Administrator shall be liable for any of the following:

- Situations such as epidemics, disasters, or other causes or conditions beyond their control, that prevent enrollees from obtaining the benefits of this contract.
- The quality of services or supplies received by enrollees, 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 an enrollee 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 breach of claim.
- General damages including, without limitation, alleged pain, suffering, or mental anguish or consequential damages.

## **Right To and Payment of Benefits**

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All rights to the benefits of this program are available only to enrollees. The Plan will not honor any attempted assignment, garnishment, attachment or transfer of any right of this program.

At its option and in accordance with the laws of the state in which the Plan Document was issued, the Plan may pay the benefits of this program to the employee, provider, other carrier, or other party legally entitled to such payment under federal or state medical child support laws, or jointly to any of these. Such payment will discharge the Plan's obligation to the extent of the amount paid so that the Plan will not be liable to anyone aggrieved by its choice of payee. In the case of joint custody, please contact your Plan Administrator.

## **Enrollee Cooperation**

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All enrollees are under a duty to cooperate in a timely and appropriate manner with the Claims Administrator in the administration of benefits or in the event of a lawsuit.

## **Evidence of Medical Necessity**

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

## **Intentionally False Or Misleading Statements**

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

If you make any intentionally false or misleading statements on any application or enrollment form that affects your acceptability for coverage, we may, as directed by the Group:

- Deny your claim;
- Reduce the amount of benefits provided for your claim; or
- Void your coverage under this plan. (void means to cancel coverage back to its effective date as if it had never existed at all.)

**Please Note:** Your coverage cannot be voided (in other words, cancel back to its effective date as if it had never existed at all) based on a misrepresentation you made unless you have performed an act or practice that constitutes fraud; or made an intentional misrepresentation of material fact that affects your acceptability for coverage.

## **Right of Recovery**

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The Plan has the right to recover amounts it paid that exceed the amount for which it was liable. Such amounts may be recovered from the employee or any other payee, including a provider. Or, such amounts may be deducted from future benefits of the employee or any of their dependents (even if the original payment was not made on that enrollee's behalf) when the future benefits would otherwise have been paid directly to the employee or to a provider that does not have a contract with the Plan.

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

## **Venue**

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All suits or legal proceedings brought against the Plan or the Claims Administrator by the employee or anyone claiming any right under this program must be filed:

- Within 15 months of the date the Plan denied, in writing, the rights or benefits claimed under this program; and,

- In a mutually agreed upon location.

All suits or legal proceedings brought by the Plan will be filed within the appropriate statutory period of limitation, and venue may lie, at its option, in King County, the State of Washington.

### **Conformity With Federal Regulations**

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In the event that any provision contained in the contract, benefit booklet, or any Addendum attached thereto, is found to be in conflict with applicable laws or regulations, the conditions and provisions described therein shall be construed and applied in compliance with such laws and regulations.

### **No Verbal Modifications**

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The enrollee shall not rely on any oral statement from an employee of the Plan Administrator or Claims Administrator including, but not limited to, a customer service representative to:

- Modify or otherwise affect the benefits, General Limitations and Exclusions, or other provisions of this Plan.
- Increase, reduce, waive or void any coverages or benefits under this Plan.

In addition, such oral statement shall not be used in the prosecution or defense of a claim under this Plan.

Any written or oral verification received from the Plan Administrator or Claims Administrator is based upon eligibility information and Plan benefits, which are subject to change. Therefore, any verification should not be interpreted as a guarantee of coverage or payment for any services rendered or otherwise provided to an enrollee.

## **HOW TO SUBMIT A CLAIM**

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Many providers in Alaska and Washington have agreements with the Claims Administrator and will submit their bills to the Claims Administrator directly.

When you receive services from a provider in Alaska or Washington that does not have an agreement with the Claims Administrator, or from a provider outside Alaska and Washington, you will need to submit these claims directly to the Claims Administrator. 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 the Claims Administrator.

**Please Note:** For information on how to submit a claim for international services, please see Care Received Outside the United States, under the Claims Procedure section below.

### **Step 2**

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

- Names of the subscriber and the enrollee who incurred the expense.
- Identification numbers for both the subscriber and the Plan Sponsor (these are shown on the subscriber's identification card).
- Name, address, and IRS tax identification number of the provider.
- Information about other insurance coverage.
- Date of onset of the illness or injury.
- Diagnosis (ICD) code. Will need to change next renewal.
- Procedure codes (CPT, HCPCS, ADA, or UB-92) for each service.

- Dates of service and itemized charges for each service rendered.
- If the services rendered are for treatment of an accidental injury, the date, time, location, and a brief description of the accident.

### **Step 3**

If you 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:

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

### **Timely Filing**

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You should submit all claims within 90 days of the start of service or within 30 days after the service is completed. The Claims Administrator 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 enrollees 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 the Claims Administrator received 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.

### **Prescription Drug Claims**

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

#### **In-Network Pharmacies**

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

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



## **Non-Network Pharmacies**

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

## **Claims Procedure**

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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.
- 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.

## **Care Received Outside the United States**

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

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

- For professional outpatient services and other care with single dates of service, we use the exchange rate on the date of service.
- For inpatient stays of more than one day, we use the exchange rate on the date of discharge.
- Claim forms can be found on the website, [premera.com](http://premera.com), or you can call Customer Service at 1-800-508-4722

## **YOUR QUESTIONS, COMPLAINTS AND APPEALS**

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Please call Customer Service when you have questions about a benefit or coverage decision or the quality or availability of a health care service. Customer Service can quickly and informally correct errors and clarify benefits. There may be times when Customer Service will ask you to submit your complaint for review through the formal appeals process outlined below.

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

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

### **WHEN YOU DISAGREE WITH A PAYMENT OR BENEFIT DECISION**

If payment or benefits were denied in whole or in part, and you disagree with that decision, you have the right to ask the plan to review that adverse benefit determination through a formal, internal appeals process.

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

#### **What is an adverse benefit determination?**

An adverse benefit determination means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in this plan, rescission of coverage, and including, with respect to this plan, a denial reduction, or termination of, or a failure to provide or make payment in whole or in part for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medical necessary or appropriate.

### **WHEN YOU HAVE AN APPEAL**

Your plan includes three levels of internal appeals.

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

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

Once the Level II review is complete, you will receive a written determination. If you are not satisfied with the appeal decision, you may be eligible to request a Level III Plan Administrator Final review, as described below.

#### **Who may file an internal appeal?**

You or your authorized representative, someone you have named to act on your behalf, may file an appeal. To appoint an authorized representative, you must sign an authorization form and mail or fax the

signed form to the address or phone number listed below. This release provides us with the authorization for this person to appeal on your behalf and allows our release of information, if any, to them.

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

### **How do I file an internal appeal?**

You or your authorized representative may file an appeal by writing to the address listed below. Your appeal request must be received as follows:

- For a Level I internal appeal, within 180 calendar days of the date you were notified of the adverse benefit determination. If you are hospitalized or travelling, or have other reasonable cause why you can't submit the appeal within the timeframe, it will be extended to 180 days from the end of the event (hospitalization, travel, or other circumstance).
- For a Level II internal appeal, within 60 calendar days of the date you were notified of the Level I determination. If you are hospitalized or traveling, or for other reasonable cause beyond your control, we will extend this timeline up to 180 calendar days to allow you to obtain additional medical documentation, physician consultations or opinions.

You may submit your written appeal request to:

Premiera Blue Cross Blue Shield of Alaska

Attn: Appeals Department, MS 123

P.O. Box 91102

Seattle, WA 98111-9202

Or, you may fax your request to:

Attn: Appeals Department

(425) 918-5592

If you need help filing an appeal, or would like a copy of the appeals process, please call Customer Service at the number listed on the inside front cover of this benefit booklet.

### **How will I know that you received my request for an appeal?**

A written notice acknowledging receipt of your appeal request will be sent to you.

### **What if my situation is clinically urgent?**

If your provider believes that your situation is clinically urgent under law, your appeal will be conducted on an expedited basis. A clinically urgent situation means one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. You may request an expedited internal appeal by calling Customer Service at the number listed on the inside front cover of this booklet.

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

### **Can I provide additional information for my appeal?**

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

### **Can I request copies of information relevant to my appeal?**

You can request copies of information relevant to the adverse benefit determination. This information will be provided as well as any new or additional information that was considered, relied upon or generated in connection to your appeal as soon as possible and free of charge. You will have the opportunity to review this information and respond before a decision is made.

### **What happens next?**

The adverse benefit determination will be reviewed and you will receive a written decision as stated below:

- Expedited appeals: as soon as possible, but no later than 72 hours after we received your request. You will be notified of the decision by phone, fax or email and will be followed by a written decision.
- Adverse benefit determinations made prior to you receiving services: 15 days of the date we received your request.
- All other appeals: within 30 days of the date we received your request.

If the adverse benefit determination is upheld, you will be provided information about your right to an a Level II internal appeal or your right to external review at the end of the internal appeals process.

### **Appeals Regarding Ongoing Care**

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

### **Plan Administrator Final Review**

If you're appealing a decision to deny, change, reduce or end payment, coverage or authorization of coverage, and you're not satisfied with the outcome of the Level II appeal, you may ask for a Level III appeal by contacting your Plan Administrator, at

City and Borough of Juneau  
Attention Human Resources / Risk Management  
155 So Seward  
Juneau, Alaska 99801

The plan administrator will bring the appeal to the health benefit plan appeals panel per Administrative Policy 05-02 and evaluate all the information within 45 calendar days of the date we receive your Level III request. The decision made in response to a written appeal is final and the Plan Administrator has the final discretionary authority to determine eligibility for benefits and to construe the terms of this plan.

### **OTHER RESOURCES TO HELP YOU**

If you have questions about understanding a denial of a claim or your appeal rights, you may contact Customer Service for assistance.

### **Estimated Quote for Out of Pocket Expense**

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Please use the following guidelines when requesting an *estimated* out of pocket expense for medical, dental or vision procedures.

This request should be done when a subscriber desires information regarding out of pocket expenses or to have written verification of an allowable benefit.

The following information should be sent to Premiera Blue Cross Blue Shield of Alaska prior to the procedure being performed:

- Providers are to complete the attached request;
- A letter from the provider of service stating the full treatment plan, including all CPT Codes, diagnosis codes pertinent to each CPT Code, and the total charge for each code;
- All chart notes from the patient's file that pertain to the condition;
- All patient back-up, in addition to the patient's chart notes, showing medical necessity of the procedures; and
- In certain cases it is helpful to include pictures for visual documentation of the condition. If these are part of the patient's charge, these should be included.

Patients must consider any deductibles that must be met prior to these benefits being paid. If the patient does not utilize an In-Network Provider, the subscriber's out of pocket expense will be increased by any amounts over the allowable charge.

**Any written or oral verification received from the Plan Administrator or Claims Administrator is based upon eligibility information and Plan benefits, which are subject to change. Therefore, any verification should not be interpreted as a guarantee of coverage or payment for any services rendered or otherwise provided to a subscriber. In addition, such statements shall not be used in the prosecution or defense of a claim under this Plan.**

## Estimated Quote Request Form

Quote for out of pocket expense request: From the listed information below, please advise the amount that will be paid by Premera Blue Cross Blue Shield of Alaska.

Name of Subscriber: \_\_\_\_\_

Subscriber Identification Number: \_\_\_\_\_

Name of Patient: \_\_\_\_\_

Patient's relationship to Subscriber: \_\_\_\_\_

Diagnosis/ICD-9 Code: \_\_\_\_\_

Date of Proposed Procedure: \_\_\_\_\_

Name of Provider and zip code of where services were provided: \_\_\_\_\_

Name of Assisting Provider and zip code of where services were provided:: \_\_\_\_\_

**Please identify CPT codes, including bilateral procedures, separately.**

Name of Procedure	CPT Procedure Code	Provider's Charge	Assist. Provider's Charge	Estimated Amount Premera Blue Cross Blue Shield of Alaska will pay*

**Any written or oral verification from the Plan Administrator or Claims Administrator is based upon eligibility information and Plan benefits, which are subject to change. Therefore, any verification should not be interpreted as a guarantee of coverage or payment for any services rendered or otherwise provided to a subscriber. In addition, such statements shall not be used in the prosecution or defense of a claim under this Plan.**

\*Actual payment will be based on submitted bill and eligibility at the time of service.

## DEFINITIONS

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The terms listed throughout this section have specific meanings under this plan. We have the discretionary authority to determine the terms used in this plan.

### **Accepted Rural Provider**

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

### **Accidental Injury**

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

### **Affordable Care Act**

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

### **Allowable Charge**

The allowable charge shall mean one of the following:

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

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

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

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

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

For covered services and supplies received outside Alaska and Washington, or in Clark County, Washington, allowable charges are determined as stated in the "The BlueCard Program" in this booklet.

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

The allowable charge shall be defined as indicated below. When you receive services from a provider who does not have an agreement with us or another Blue Cross Blue Shield Licensee, you are responsible for any amounts not paid by us, including amounts over the allowable charge.

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

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

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

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

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

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

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

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

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

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

The allowable charge is the amount explained above in this definition.

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

The amount we pay for dialysis will be no less than a comparable provider that has a contracting agreement with us or another Blue Cross Blue Shield Licensee and no more than 90% of billed charges.

- **Emergency Services**

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

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

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

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

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

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

**Alcoholism**

See "Substance Abuse"



## **Applied Behavior Analysis**

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

## **Ambulatory Surgical Center**

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

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

## **Autism Spectrum Disorders**

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

## **Autism Service Provider**

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

## **Caffeine Dependency**

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

## **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 "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.

**Claims Administrator**

Premiera Blue Cross Blue Shield of Alaska, the administrator to whom the City & Borough of Juneau/ Bartlett Regional Hospital has delegated the administrative duties and responsibilities of this program.

**Community Mental Health Agency**

An agency that is licensed as such by the State of Alaska and Washington to provide mental health treatment under the supervision of a physician or psychologist.

**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.
  - Obstetrical trauma uterine rupture before onset or during labor.
  - Spontaneous miscarriage or missed abortion.
  - Complications of administration of anesthesia or sedation 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.
  - Fetal conditions requiring in utero surgical intervention

**Congenital Anomaly Of A Dependent Child**

A marked difference from the normal structure of an infant's body part, that's present from birth and manifests during infancy.

**Cost-share**

Member's share of the allowable charge for covered services. Deductibles, copays, and coinsurance are all types of cost-shares.

**Current Procedural Terminology (CPT)**

Descriptive term and identifying code for reporting medical services and procedures reported by providers. The purpose of the terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services.

**Custodial Care**

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

- For ongoing maintenance of the member's health and not for its therapeutic value in the treatment of an illness or injury

- To assist the member in meeting the activities of daily living. Examples are help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication not requiring constant attention of trained medical personnel

### **Dental Care Provider**

A state-licensed:

- Doctor of Medical Dentistry (D.M.D.)
- Doctor of Dental Surgery (D.D.S.)

The benefits of this plan are available if professional services are provided by a state-licensed denturist, a dental hygienist under the supervision of a licensed dentist, or other individual performing within the scope of his or her license or certification, as allowed by law. This plan's benefits would be payable if the covered service were provided by a "dental care provider" as defined above.

### **Dental Emergency**

A condition requiring prompt or urgent attention due to trauma and/or pain caused by a sudden unexpected injury, acute infection or similar occurrence.

### **Dentally Necessary**

Those covered services and supplies that a dentist, 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 dental practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
- Not primarily for the convenience of the patient, dentist, or other dental 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 those purposes, "generally accepted standards of dental practice" means standards that are based on authoritative dental or scientific literature.

Decisions regarding dental necessity are based on the criteria stated above. If you disagree with a decision that has been made, you have the right to additional review. See the "What If I Have A Question or An Appeal" section in this booklet for an explanation of the appeals process.

### **Detoxification**

Detoxification is active medical management of medical conditions due to substance intoxication or substance withdrawal, which requires repeated physical examination appropriate to the substance, and use of medication. Observation alone is not active medical management.

### **Effective Date**

30 days from the date of hire your coverage begins under this program.

### **Employer**

City & Borough of Juneau/Bartlett Regional Hospital

### **Enrollee**

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

**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 that meets one or more of the following criteria:

- A drug or device that can't be lawfully marketed without the approval of the U.S. Food and Drug Administration, and hasn't been granted such approval on the date the service is provided
- The service is subject to oversight by an Institutional Review Board
- No reliable evidence demonstrates that the service is effective, in clinical diagnosis, evaluation, management or treatment of the condition
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy.
- 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 peer reviewed medical and scientific literature, and assessments and coverage recommendations published by the Blue Cross and Blue Shield Association Technical Evaluation Center (TEC).

**Family**

Two or more enrollees under the plan.

**Group**

The entity that sponsors this self-funded plan.

**Hospice**

A facility which:

- Meets the standards established by the National Hospice Organization; or
- If required by a state, is licensed, registered, or certified by that state;
- Provides a hospice care program;
- Is a free-standing facility; and
- Provides inpatient care for persons who:
  - Have no reasonable hope for cure, as determined by a physician; and
  - Have a life expectancy of six months or less.

**Hospital**

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

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

A "hospital" will never be an institution that's run mainly:

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

**Illness**

A sickness, disease, medical condition, complication of pregnancy, or pregnancy of an employee or dependent.

**In-Network Pharmacy (In-Network Retail Pharmacy)**

A licensed pharmacy which contracts with us or our Pharmacy Benefits Administrator to provide Prescription Drug benefits.

**Injury**

Physical harm or disability sustained by an enrollee which is the direct result of an accident, independent of disease or bodily infirmity or any other cause. The injury must have occurred at an identifiable time and place. Injury does not include illness or infection, except infection of a cut or wound resulting from an accident.

**Inpatient**

Confined in a qualified medical facility as an overnight bed patient.

**Legend Drug**

A Food and Drug Administration (FDA) approved drug which by federal or state law requires a prescription.

**Medical Equipment**

Mechanical equipment that can stand repeated use and is used in connection with the direct treatment of an illness or injury. It's of no use in the absence of illness or 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 facility for treatment of substance abuse, or hospice.

**Medically Necessary**

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

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

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

**Member (also called "You" and "Your")**

A person covered under this plan as a subscriber or dependent.

**Mental and Nervous Condition**

Any condition that is classified as a Mental Disorder in the current edition of "International Classification of Diseases", published by the U.S. Department of Health and Human Services or is listed in the current edition of the **Diagnosis and Statistical Manual (DSM)** published by the American Psychiatric Association, as amended or reissued from time to time.

**Non-Contracting Provider**

A provider that at the time services were rendered is in a category of providers which Premera Blue Cross Blue Shield of Alaska has not offered participating contracts.

**Non-Network Provider**

A provider that at the time services were rendered is in a category of providers which Premera Blue Cross Blue Shield of Alaska has offered a participating contract to, but has not signed such a contract.

**Obstetrical Care**

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

**Occupational Disease Or Injury**

A disease, injury or condition which is peculiar to the occupation or arises out of the individual's employment or self-employment.

**Orthodontics**

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

**Out of Area Provider**

An out of area provider is a provider who renders services outside of Alaska and Washington State.

**Orthotic**

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

**Outpatient**

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

**Pharmacy Benefits Administrator**

An entity that contracts with us to administer Prescription Drug benefits under this plan.

**Physician**

A state-licensed:

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

In addition, professional services provided by one of the following types of providers will be covered under this plan, but only when the provider is providing a service within the scope of his or her state license; providing a service or supply for which benefits are specified in this plan; and providing a service for which benefits would be payable if the service were provided by a physician as defined above:

- Advanced registered nurse practitioner (A.R.N.P.)
- Chiropractor (D.C.)
- Dentist (D.D.S. or D.M.D.)
- Licensed Clinical Social Worker (L.C.S.W.)
- Licensed Marital and Family Therapist; (L.M.F.T.)
- Licensed Marriage and Family Counselor (L.M.F.C.)
- Licensed Massage Practitioners (L.M.P.)
- Naturopath (N.D.)
- Nurse Midwife
- Occupational Therapist (O.T.)
- Optometrist (O.D.)
- Physical Therapist (P.T.)
- Physician Assistant supervised by a collaborating M.D. or D.O.
- Podiatrist (D.P.M.)
- Psychological Associate
- Psychologist (Ph.D.)
- Other health care professional or facility named in this Plan that is licensed, registered or certified as required by the state in which services were received to provide a medical service or supply, and who does so within the lawful scope of that license, registration, or certification.

#### **Plan (also called "This Plan")**

The Group's self-funded plan described in this booklet.

#### **Plan Administrator**

City & Borough of Juneau/ Bartlett Regional Hospital, also called "we" and "our" in this booklet.

#### **Plan Year**

The period of 12 consecutive months that starts each July 1 at 12:01 a.m. and ends on the next June 30 at midnight.

#### **Premiera Blue Cross Blue Shield of Alaska**

Selected by City & Borough of / Bartlett Regional Hospital as the Claims Administrator to administer the benefits of this Plan.

#### **Prescription Drug**

Any medical substance, including biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication or for the treatment of people with HIV or AIDS, the label of which, under the Federal Food, Drug and Cosmetic Act, as amended, is required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription."

Benefits available under this plan will be provided for "off-label" use, including administration, of prescription drugs for treatment of a covered condition when use of the drug is recognized as effective for treatment of such condition by:

- One of the following standard reference compendia:
- **The American Hospital Formulary Service-Drug Information**
- **The American Medical Association Drug Evaluation**
- **The United States Pharmacopoeia-Drug Information**

- 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)
- The Federal Secretary of Health and Human Services

"Off-label use" means the prescribed use of a drug that's other than that stated in its FDA-approved labeling.

Benefits aren't available for any drug when the U.S. Food and Drug Administration (FDA) has determined its use to be contra-indicated, or for experimental or investigational drugs not otherwise approved for any indication by the FDA.

### **Program**

The benefits, terms, and limitations set forth in this booklet. Also called "this Plan."

### **Provider**

A health care practitioner or facility that is in a licensed or certified provider category regulated by the state in which the practitioner or facility provides care, and that practices within the scope of such licensure or certification. Also included is an employee or agent of such practitioner or facility, acting in the course of and within the scope of his or her employment.

Health care facilities that are owned and operated by an agency of the U.S. government are included as required by federal law. Health care facilities owned by the political subdivision or instrumentality of a state are also covered.

### **Psychiatric Condition**

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

### **Psychologist**

A provider who is licensed as such by the state in which he or she practices; licensed psychologists must have a doctorate in psychology. A psychological associate or assistant or a provider who has just a masters in social work is not a psychologist under this program.

### **Service Area**

Service area means the state of Alaska and the state of Washington, except for Clark County Washington.

### **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's state-licensed, approved by Medicare or would qualify for Medicare approval if so requested.

### **Subscriber**

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



**Subscription Charges**

The monthly rates to be paid by the member that are set by the Group as a condition of the member's coverage under the plan.

**Substance Abuse**

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

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

**Temporomandibular Joint (TMJ) Disorders**

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

**We, Us and Our**

Means Premiera Blue Cross Blue Shield of Alaska

# SUMMARY PLAN DESCRIPTION

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## **Plan Administration**

**Name of Plan** - City & Borough of Juneau Employee Health Benefit Plan

**Name, Address and Phone of Employer -**

City & Borough of Juneau  
155 South Seward  
Juneau, AK 99801  
907-586-0323

**Plan Number** - 501

**Type of Plan** - Employee Welfare Benefit Plan providing medical, dental, and vision benefits

**Type of Administration** - Contract Administration

**Plan Effective Date** - January 1, 2005

**Anniversary Date** - July 1

**Name, Address, and Telephone Number of Plan Administrator** - Employer (see above)

**Name, Address, and Telephone Number of Agency where employees can seek information about the Health Reform Law -**

Department of Labor and Industries  
300 Fifth Avenue S, Suite 1110  
Seattle, Washington 98104-2607  
Telephone: (206) 553-4482  
Fax: (206) 553-2883

**Employer Identification Number** - 92-0038816

**Name and Address of Designated Legal Agent** - Employer (see above)

**Eligibility To Participate In The Plan** - Plan participants and their dependents are eligible for the benefits of the Plan when they meet the eligibility requirements in this booklet.

**Benefits** - The Plan provides benefits which are described in this benefit booklet. Notification is given of changes which may occur in the coverage from time to time. Replacements for lost or misplaced copies will be furnished by the Plan Administrator.

**Source of Contributions To The Plan** - The employer pays 95% of the cost of the active full-time employee's coverage and 83% of their eligible dependent's coverage. Active part-time employee contributions are subsidized by the employer based on an average number of hours worked per month. Total self-payments are also permitted as provided in "Continuation of Coverage Under This Program" in this booklet.



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# where to send claims

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**MAIL YOUR CLAIMS TO:**

Premera Blue Cross Blue Shield of Alaska

P.O. Box 240609

Anchorage, AK 99524-0609

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[www.premera.com](http://www.premera.com)