City & Borough of Juneau
Bartlett Regional Hospital
Juneau School District

9001303, 9001328, 9002890
July 1, 2020

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Important Telephone Numbers

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

- Premera 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, 5:00 a.m. – 8:00 p.m.
  Pacific 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
  Sunday -Saturday, 24 hours a day

For Care Management:

- Prior Authorization and Emergency Notification
  1-800-722-4714
  Monday - Friday, 8:00 a.m. - 4:30 p.m.
  Pacific Time

For Questions Regarding Eligibility for Enrollment:

- City & Borough of Juneau Division of Risk Management
  1-907-586-0323
  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 Time

Discrimination is Against the Law

Premera Blue Cross Blue Shield of Alaska complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Premera:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:
Civil Rights Coordinator - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592, TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross Blue Shield of Alaska. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-508-4722 (TTY: 800-842-5357).

አማርኛ (Amharic):
ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Premera Blue Cross Blue Shield of Alaska ሽፋን አስፈላጊ መረጃ ሊኖረው ይችላል። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖች ሊኖሩ ይችላሉ። የጤናን ሽፋንዎን ለመጠበቅና በአከፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ከፍያ በሚነጋገሯ እርዳታ እንዲያገኙ መብት አለዎት።በስልክ ቁጥር 800-508-4722 (TTY: 800-842-5357) ይደውሉ።

العربية (Arabic):
يحوي هذا الإشعار معلومات هامة. قد يحوي هذا الإشعار معلومات مهمة بخصوص طلبك أو التغطية التي تريد الحصول عليها من خلال Premera Blue Cross Blue Shield of Alaska. قد تكون هناك تواريخ مهمة في هذا الإشعار. وقد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون تكبد أية تكلفة. اتصل بـ800-508-4722 (TTY: 800-842-5357).

中文 (Chinese):
本通知有重要的訊息。本通知可能有關於您透過 Premera Blue Cross Blue Shield of Alaska 提交的申請或保險的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-508-4722 (TTY: 800-842-5357)。

Oromoo (Cushite):
Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa Premera Blue Cross Blue Shield of Alaska tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qabaachuu danda'a. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 800-508-4722 (TTY: 800-842-5357) tii bilbilaa.

Français (French):
Cet avis a d'importantes informations. Cet avis peut avoir d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Premera Blue Cross Blue Shield of Alaska. Le présent avis peut contenir des dates clés. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez le 800-508-4722 (TTY: 800-842-5357).

Kreyòl ayisyen (Creole):
Avi sila a gen Enfòmasyon Enpòtan ladann. Avi sila a kapab genyen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè Premera Blue Cross Blue Shield of Alaska. Kapab genyen dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk aksyon avan sèten dat limit pou ka kenbe kouvèti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resevwa enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 800-508-4722 (TTY: 800-842-5357).

Deutsche (German):
Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält unter Umständen wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Premera Blue Cross Blue Shield of Alaska. Suchen Sie nach eventuellen wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 800-508-4722 (TTY: 800-842-5357).

Hmoob (Hmong):
Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tej zaum tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm Premera Blue Cross Blue Shield of Alaska. Tej zaum muaj cov hnub tseem ceeb uas sau rau hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 800-508-4722 (TTY: 800-842-5357).

Iloko (Ilocano):
Daytoy a Pakdaar ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaar mabalin nga adda ket naglaon iti napateg nga impormasion maipanggep iti apliksayonyo wenno coverage babaen iti Premera Blue Cross Blue Shield of Alaska. Daytoy ket mabalin dagiti importante a petsa iti daytoy a pakdaar. Mabalin nga adda rumbeng nga aramidenyo nga addang sakbay dagiti partikular a naituding nga aldaw tapno mapagtalinaedyo ti coverage ti salun-atyo wenno tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong iti bukodyo a pagsasao nga awan ti bayadanyo. Tumawag iti numero nga 800-508-4722 (TTY: 800-842-5357).

Italiano (Italian):
Questo avviso contiene informazioni importanti. Questo avviso può contenere informazioni importanti sulla tua domanda o copertura attraverso Premera Blue Cross Blue Shield of Alaska. Potrebbero esserci date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama 800-508-4722 (TTY: 800-842-5357).

City & Borough of Juneau/ Bartlett Regional Hospital/Juneau School District
Health Benefit Plan
Table of Contents

INTRODUCTION

Welcome to the City & Borough of Juneau/Bartlett Regional Hospital/Juneau School District 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/Juneau School District 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 (TTY: 771)
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 91059
Seattle, WA 98111-9159

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

This plan will comply with the 2010 federal health care reform law, called the Affordable Care Act (see *Definitions*). If Congress, federal or state regulators, or the courts make further changes or clarifications regarding the Affordable Care Act and its implementing regulations, 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.

SUMMARY OF YOUR BENEFITS

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

- The **allowed amount**. This is the most this plan allows for a covered service. For providers that do not have agreements with us, you are responsible for any amounts over the allowable charge.
- The **coinsurance**. This is a defined percentage of allowable charges for covered services and supplies you receive. The benefit level provided by this plan and the remaining percentage you are responsible for, not including required copays, are both referred to as "coinsurance."
- The **copay**. This is a fixed up-front dollar amount that you're required to pay for each occurrence of certain covered services. Your provider of care may ask you to pay the copay at the time of service. Unless stated otherwise, benefits subject to a copay aren't subject to your deductible or coinsurance if any.
- The **deductible**. This is the amount you must pay in each plan year for covered services and supplies before this plan provides certain benefits. The amount credited toward the plan year deductible doesn't include any copays required by this plan, and won't exceed the "allowable charge" for any covered service or supply.
- The **out-of-pocket maximum**. This is the amount you could pay toward the plan year deductible and coinsurance, if any, for services listed under the ***Medical Benefits*** section.

Annual Plan Maximum:	No Annual Plan Maximum
Deductible (per plan year):	
Economy Plan:	$550 per enrollee; $1,100 per family.
Standard Plan:	$300 per enrollee; $600 per family.
Reimbursement Percentages:	80% of the allowed amount 100% after Out of Pocket Maximum is reached.
Out-of-Pocket Maximum:	
Economy Plan:	$2,550 per enrollee; $7,100 per family, per plan year.
Standard Plan:	$1,800 per enrollee; $5,100 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 allowed amount for the remainder of the plan year for covered services.

- **Prior Authorization.** Some services must be pre-approved before you get them, in order to be eligible for benefits. See ***Prior Authorization*** for details.
- **Conditions, time limits and maximum limits.** This plan has certain conditions, time limits and maximum limits that are described in this booklet. Some services have special rules. See ***Covered Services*** for details.

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

MEDICAL SERVICES	YOUR BENEFIT
Acupuncture Benefits are provided for up to 12 visits per member per plan year.	80% of the allowed amount. Subject to the deductible.
Allergy Testing and Injections – Outpatient Professional	80% of the allowed amount. Subject to the deductible.
Ambulance • Emergency surface transport • Emergency air transport • Non-emergent surface transport • Non-emergent air transport	$150 copay then 80% of the allowed amount, per trip. Subject to the deductible.
Blood Products and Services Benefits are provided for the cost of blood and blood derivatives.	80% of the allowed amount. Subject to the deductible.
Cellular Immunotherapy and Gene Therapy	80% of the allowed amount. Subject to the deductible.
Chemotherapy and Radiation Therapy See the ***Hospital Inpatient Care, Hospital Outpatient Care*** and ***Surgical Center Care – Outpatient*** for facility charges.	80% of the allowed amount. Subject to the deductible.
Clinical Trials Medically necessary care of a qualified clinical trial. • Transportation for **Cancer Clinical Trials** only	Covered as any other service depending where the service is performed 80% of the allowed amount. Subject to the deductible.
Contraception Management and Sterilization • Prescription contraceptives dispensed in a pharmacy **Dental Care**	100% of the allowed amount Prescription contraceptives including emergency contraception and prescription barrier devices or supplies that are dispensed by a licensed pharmacy are covered under the prescription drug benefit.
Dental Anesthesia Hospital or ambulatory surgical center care for dental procedures are provided for general anesthesia and related facility services that are medically necessary.	80% of the allowed amount. Subject to the deductible.
Dental Injury When services are related to an accidental injury, benefits are provided when such repair is performed within 12 months of the accidental injury.	Covered as any other service depending where the service is performed
Diagnostic and Preventive Mammography Services • Outpatient professional preventive mammography services • Outpatient professional non-preventive mammography services	 100% of the allowed amount 100% of the allowed amount
Diagnostic Lab, X-ray and Imaging **Please note:** For preventive diagnostic services see the ***Preventive Care*** benefit.	80% of the allowed amount. Subject to the deductible.

MEDICAL SERVICES	YOUR BENEFIT
Dialysis Benefits for end stage renal disease (ESRD). • During Medicare's waiting period • After Medicare's waiting period	 80% of the allowed amount. Subject to the deductible. 100% of the allowed amount
Emergency Room The copay is waived if you are admitted as an inpatient through the emergency room.	$150 copay then 80% of the allowed amount. Subject to the deductible.
Foot Care Routine medically necessary foot care.	80% of the allowed amount. Subject to the deductible.
Health Management • Health Education • Nicotine Dependency Programs • Diabetes Health Education	100% of the allowed amount
Hearing • Hearing exam Benefits are provided for one hearing examination (or screening) per member each plan year. Plan year limit: $400 • Hearing hardware Benefits are provided up to a maximum benefit of $3,000 per member in a period of 3 consecutive calendar years.	 100% of the allowed amount 100% of the allowed amount
Home Health Care **Professional Home Health** • Intermittent home health visits limited to 130 visits per member each plan year. • Private duty nursing Private duty nursing services are limited to a maximum of $2,500 per plan year, when services are ordered by a physician	80% of the allowed amount. Subject to the deductible. 80% of the allowed amount. Subject to the deductible.
Home Medical Equipment (HME), Orthotics, Prosthetics and Supplies	80% of the allowed amount. Subject to the deductible.
Hospice Care Lifetime limit for terminal illness: 6 months Inpatient stay limit: 10 days Home visits: Unlimited (not subject to Home Health Care visit limit) Respite care: 240 hours. • Inpatient hospice care • Professional in-home hospice care • Respite care	 80% of the allowed amount. Subject to the deductible. 80% of the allowed amount. Subject to the deductible. 80% of the allowed amount. Subject to the deductible.
Infusion Therapy – Outpatient Professional	80% of the allowed amount. Subject to the deductible.

MEDICAL SERVICES	YOUR BENEFIT
Mastectomy and Breast Reconstruction Mastectomy necessary due to disease, illness or accidental injury and for breast reconstruction needed in connection with a mastectomy.	80% of the allowed amount. Subject to the deductible.
Maternity Care Benefits for the hospital stay and related inpatient medical care following childbirth are provided up to: • 48 hours after a normal vaginal birth; or 96 hours after a normal cesarean birth.	80% of the allowed amount. Subject to the deductible.
Medical Foods	80% of the allowed amount. Subject to the deductible.
Medical Transportation Benefits **Medical Access Transportation** Benefits are limited to 3 round trip coach air or surface transports per plan year only for the ill or injured member. When transportation is for a child under the age of 19, this benefit will also cover a parent or guardian to accompany the child.	80% of the allowed amount. Subject to the deductible.
Mental Health Care	
• Professional outpatient office visits	80% of the allowed amount. Subject to the deductible.
• Outpatient facility services	80% of the allowed amount. Subject to the deductible.
• Inpatient professional	80% of the allowed amount. Subject to the deductible.
• Inpatient facility	80% of the allowed amount. Subject to the deductible.
Neurodevelopmental Therapy	
• Inpatient professional services	80% of the allowed amount. Subject to the deductible.
• Inpatient facility services Benefits for inpatient facility and professional care are provided up to 30 days per member each plan year.	80% of the allowed amount. Subject to the deductible.
• Professional outpatient therapy	80% of the allowed amount. Subject to the deductible.
• Outpatient facility services Benefits for outpatient care will be provided for physical, speech, and occupational therapy services, up to a combined maximum benefit of 45 visits per member each plan year.	80% of the allowed amount. Subject to the deductible.

MEDICAL SERVICES	YOUR BENEFIT
Newborn Care Benefits for routine hospital nursery charges and related inpatient well-baby care for an eligible newborn are provided up to: • 48 hours after a normal vaginal birth; or • 96 hours after a normal cesarean birth. • Any deductible or coinsurance required for the newborn is separate from that of the mother.	80% of the allowed amount. Subject to the deductible.
Newborn Hearing Exams and Testing This benefit provides for one screening hearing exam for covered newborns up to 30 days after birth. Benefits are also provided for diagnostic hearing tests, including administration and interpretation, for covered children up to age 24 months if the newborn hearing screening exam indicates a hearing impairment.	80% of the allowed amount. Subject to the deductible.
Preventive Care Preventive exams, screenings and immunizations (including seasonal immunizations in a provider's office) are limited in how often you can get them based on your age and gender • Preventive Diagnostic services • Seasonal and travel immunizations provided by a pharmacy or other mass immunizer	100% of the allowed amount. 100% of the allowed amount. 100% of the allowed amount.
Professional Visits and Services You may have additional costs for other services like x-rays, lab, and facility charges if incurred. *Coverage for office visits throughout this plan includes real-time visits using online and telephonic methods with your doctor or other provider (telemedicine) when appropriate.* • Professional office visit. Covered services include professional office and home visits • Inpatient and other outpatient professional visits	80% of the allowed amount. Subject to the deductible. 80% of the allowed amount. Subject to the deductible.
Psychological and Neuropsychological Testing	80% of the allowed amount. Subject to the deductible.

MEDICAL SERVICES	YOUR BENEFIT
Rehabilitation Services • Outpatient professional services • Outpatient facility services • Physical, speech, occupational and massage therapy services, including cardiac and pulmonary rehabilitation, up to a combined maximum benefit of 45 visits per member each plan year. • Inpatient professional services • Inpatient facility Benefits for inpatient facility and professional care are available up to 30 days per member each plan year. This benefit covers Inpatient care you receive within 24 months from the onset of the injury or illness or from the date of the surgery that made rehabilitation necessary. This limitation does not apply to chronic pain care. See ***Mental Health*** and ***Substance Abuse*** for therapies provided for mental health conditions such as autism.	 80% of the allowed amount. Subject to the deductible. 80% of the allowed amount. Subject to the deductible. 80% of the allowed amount. Subject to the deductible. 80% of the allowed amount. Subject to the deductible.
Skilled Nursing Facility Care Benefits are provided up to 60 days per member each plan year.	80% of the allowed amount. Subject to the deductible.
Spinal and Other Manipulations Services must be medically necessary to treat a covered illness, injury or condition.	80% of the allowed amount. Subject to the deductible.
Substance Abuse Treatment • Outpatient office visit • Outpatient facility services • Inpatient professional • Inpatient facility	 80% of the allowed amount. Subject to the deductible. 80% of the allowed amount. Subject to the deductible. 80% of the allowed amount. Subject to the deductible. 80% of the allowed amount. Subject to the deductible.
Surgery This benefit covers surgical services that are not covered under other benefits when performed on an inpatient or outpatient basis, in such locations as a hospital, ambulatory surgical facility, surgical suite or provider's office For organ, bone marrow or stem cell transplant procedure benefit information, please see the ***Transplants*** benefit. You may have additional costs for hospital facility charges if incurred	 80% of the allowed amount. Subject to the deductible.
Surgical Center – Free Standing Facility	80% of the allowed amount. Subject to the deductible.
Therapeutic Injections – Outpatient Professional	80% of the allowed amount. Subject to the deductible.

MEDICAL SERVICES	YOUR BENEFIT
Transplants - This benefit covers medical services only if provided by "Approved Transplant Centers."	
• Outpatient professional visits	80% of the allowed amount. Subject to the deductible.
• Outpatient facility services	80% of the allowed amount. Subject to the deductible.
• Inpatient professional	80% of the allowed amount. Subject to the deductible.
• Inpatient facility	80% of the allowed amount. Subject to the deductible.
Donor Costs: Procurement expenses are limited to $75,000 per transplant. All covered donor costs accrue towards the $75,000 maximum, no matter when the donor receives them.	
Travel and Lodging for Transplant Services Covered transportation and lodging incurred by the transplant recipient and companions are limited to $7,500 per transplant. Reimbursement rates: • **Travel:** Travel is reimbursed between the patient's home and the approved transplant center for round trip (air, train, or bus) coach class transportation costs. • Mileage expenses are reimbursed at 18 cents per mile per trip • Surface transportation and parking are limited up to $35 per day • Ferry transportation expenses are limited up to $50 per person each way • **Lodging:** Expenses incurred by a transplant patient and companion for hotel lodging away from home. Lodging expenses are limited up to $50 per day per person • **Please note:** Reimbursement rates are based on IRS guidelines and are subject to change due to IRS regulations.	100% of the allowed amount. Subject to the deductible.
Urgent Care • You may have additional costs for other services like x-rays, lab, and hospital services if incurred.	
• Freestanding urgent care center	80% of the allowed amount. Subject to the deductible.
• Urgent care (Hospital facility)	See ***Emergency Room*** for cost shares
Virtual Care – On Demand • Access to medical care for low level conditions using virtual methods like secure chat, text, voice or video chat.	Covered in full
Weight Management Treatment Weight management covered up to a lifetime maximum of $25,000. • See ***Prescription Drugs*** for coverage of prescription weight management drugs.	80% of the allowed amount. Subject to the deductible.

PRESCRIPTION DRUGS	YOUR COST-SHARE	
	Economy Plan	**Standard Plan**
Prescription Deductible and out-of-pocket Prescription drug deductibles, coinsurance, and copays do not apply toward the medical plan out of pocket maximum or deductibles.	$50 deductible / $1,750 out-of-pocket per enrollee.	$50 deductible / $1,250 out-of-pocket per enrollee.
Prescription Drugs – Retail Pharmacy	**Economy Plan**	**Standard Plan**
Dispensing Limit Benefits are provided for up to a 90-day supply of covered medication. For prescriptions that require copays, you pay 1 copay for each 30-day supply.		
• Preferred Generic Drugs	$10 copay	$10 copay
• Preferred Brand Name Drugs	$35 copay	$25 copay
• Preferred Specialty Drugs	$55 copay	$45 copay
• All Non-Preferred Drugs	$150 copay	$100 copay
Prescription Drugs – Mail-Order	**Economy Plan**	**Standard Plan**
Must use a participating pharmacy **Dispensing Limit:** Benefits are provided for up to a 90-day supply of covered medication. **Dispensing Limit for Specialty Drugs:** Benefits for specialty drugs dispensed through a specialty pharmacy program via mail-order are limited to a 30-day supply and are subject to the specialty drug cost-share for each prescription drug purchase.		
• Preferred Generic Drugs	$10 copay	$10 copay
• Preferred Brand Name Drugs	$35 copay	$25 copay
• Preferred Specialty Drugs	$55 copay	$45 copay
• All Non-Preferred Drugs	$150 copay	$100 copay
Prescription Drugs – Anti-Cancer Medication This benefit covers self-administered anti-cancer drugs when the medication is dispensed by a pharmacy. This benefit is covered under this plans medical cost share.	Same as above cost-shares	

VISION SERVICES	YOUR BENEFIT
Benefits are provided for the **Standard Plan ONLY. No benefits are provided under the Economy Plan.**	
Adult Vision Benefits Vision services are provided for covered members 19 years of age or older. For vision benefits provided for members under age 19, see the ***Pediatric Vision*** Benefit. **Vision exams** This benefit provides one routine vision exam per member each plan year. **Vision hardware** The plan pays allowable charges including any applicable sales tax, shipping and handling costs up to a maximum benefit of $200 per member each plan year. 2 glass lenses per plan year are allowed and do not accrue to the $200 maximum.	100% of the allowed amount 100% of the allowed amount
Pediatric Vision Benefit This benefit covers vision services for covered children under the age of 19. **Vision Exam** Benefits are provided for one routine eye exam per plan year. **Vision Hardware** Benefits are provided for: • 1 pair of frames and lenses per plan year, or • 1 pair of hard contact lenses per plan year, or 12-month supply of disposable contact lenses per plan year	100% of the allowed amount No cost-shares

STARTING OUT IN THE PROGRAM

Who Is Eligible For Coverage?

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

Juneau School District Employees

For school district employees refer to your individual union contract

Dependent Eligibility

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

- The lawful spouse of the employee, unless legally separated.
- An eligible 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

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

- The child became disabled before reaching the limiting age
- The child is incapable of self-sustaining employment by reason of developmental disability or physical handicap and is chiefly dependent upon the 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.

WHEN DOES COVERAGE BEGIN?

Enrollment

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, 30 days from the date they become eligible to enroll as explained above. If we don't receive the enrollment application within 30 days of the date you became eligible, none of the dates above will apply. Please see ***Special Enrollment*** below.

For adoptive and natural newborn children we must receive completed enrollment applications and required subscription charges within 60 days of the date the applicant becomes eligible to enroll.

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

Children Covered Under Medical Child Support Orders Or Legal Guardianship

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

The City & Borough of Juneau and Bartlett Regional Hospital/Juneau School District 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) and Alaska Family Leave Act (AFLA) 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, Bartlett or Juneau School District 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 or Juneau School District 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
- **Junea School District employees**: 907-523-1781

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.

Juneau School District – Refer to your Payroll Department at 907-823-1781

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.

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.

Special Enrollment

Involuntary Loss Of Other Coverage

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

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

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

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

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

Subscriber And Dependent Special Enrollment

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

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

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

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

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

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

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

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

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

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

Changes in Coverage

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

Plan Transfers

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

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

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

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

WHEN COVERAGE ENDS

Termination Of Coverage

Coverage will end without notice, except as specified under ***Extended Benefits***, on the date on which one of these events occurs:

Coverage will end without notice on the date on which one of these events occurs:

- For the subscriber and dependents when any of the following occur:
  - The next required monthly charge for coverage isn't paid when due or within the grace period
  - The subscriber dies or is otherwise no longer eligible as a subscriber. If the subscriber dies, coverage for spouse and dependents will continue through the end of the month of the employee's death. After the expiration of the coverage, the spouse and/or dependents are eligible for COBRA coverage. See ***COBRA*** for details.
  - In the case of a collectively bargained program, the employer fails to meet the terms of an applicable collective bargaining agreement or to employ employees covered by a collective bargaining agreement
- For a spouse when his or her marriage to the subscriber is annulled, or when he or she becomes legally separated or divorced from the subscriber
- For a child when he or she no longer meets the requirements for dependent coverage shown in ***Who Is Eligible For Coverage?***
- For fraud or intentional misrepresentation of material fact under the terms of the coverage by the subscriber or the subscriber's dependents

The subscriber must promptly notify the Group when an enrolled family member is no longer eligible to be enrolled as a dependent under this plan.

Plan Termination

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

Extended Benefits

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

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

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

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

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

COBRA

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

The plan will provide qualified members with COBRA coverage when COBRA's enrollment and payment requirements are met. But, coverage is provided only to the extent that COBRA requires and is subject to the other terms and limitations of this plan. The Group, **not us**, is responsible for all notifications and other duties assigned by COBRA to the "plan administrator" within COBRA's time limits.

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

Qualifying Events and Length of Coverage

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

Please note: Covered grandchildren have the same rights to COBRA coverage as covered children.

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

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

However, if one of the events listed above follows the covered employee's entitlement to Medicare by less than 18 months, the Group must offer the covered spouse and children an election to continue coverage for up to 36 months starting from the date of the Medicare entitlement.

- COBRA coverage can be extended if a member who lost coverage due to a reduction in hours or termination of employment is determined to be disabled under Title II (OASDI) or Title XVI (SSI) of the Social Security Act at any time during the first 60 days of COBRA coverage. In such cases, all family members who elected COBRA may continue coverage for up to a total of 29 consecutive months from the date of the reduction in hours or termination.

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

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

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

Conditions of COBRA Coverage

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

You Must Give Notice Of Some Qualifying Events

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

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

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

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

  Note: The subscriber or affected dependent must also notify the Group if a qualified member is deemed by the Social Security Administration to no longer be disabled. Please see the ***When COBRA Coverage Ends*** section for details.
- For the other events above, the 60-day notice period starts on the **later** of: 1) the date of the qualifying event, or 2) the date the qualified member would lose coverage as a result of the event.

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

The Group must notify qualified members of their rights under COBRA. If the Group has named a third party as its plan administrator, the plan administrator is responsible to notify members on behalf of the

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

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

You Must Enroll And Pay On Time

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

  Each qualified member will have an independent right to elect COBRA coverage. Subscribers may elect COBRA coverage on behalf of their spouses, and parents may elect COBRA coverage on behalf of their children.
- You must send your first payment to the Group no more than 45 days after the date you elected COBRA coverage
- Subsequent monthly payments must be paid to the Group

Adding Family Members

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

Keep The Group Informed Of Address Changes

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

When COBRA Coverage Ends

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

- The applicable continuation period expires
- The next monthly payment isn't paid when due or within the 30-day COBRA grace period
- When coverage is extended from 18 to 29 months due to disability (please see ***Qualifying Events And Lengths Of Coverage*** in this section), COBRA coverage beyond 18 months ends if there's a final determination that a qualified member is no longer disabled under the Social Security Act. However, coverage won't end on the date shown above, but on the last day for which subscription charges have been paid in the first month that begins more than 30 days after the date of the determination. The subscriber or affected dependent must provide the Group with a copy of the Social Security Administration's determination within 30 days after the **later** of: 1) the date of the determination, or 2) the date on which the subscriber or affected dependent was informed that this notice should be provided and given procedures to follow.

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

If You Have Questions

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

Other Continued Coverage Options

Continuation Under USERRA

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

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

Medicare Supplement Coverage

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

HOW DOES SELECTING A PROVIDER AFFECT MY BENEFITS?

This program 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 City & Borough of Juneau/ Bartlett Regional Hospital/Juneau School District 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 an out-of-network provider, your out-of-pocket cost may increase because you will be responsible for any amounts over the allowed 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.

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

Provider Status

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

Continuity of Care

You may be able to continue to receive covered services from a provider for a limited period of time at the in-network benefit level after the provider ends his/her contract with Premera. To be eligible for continuity of care you must be covered under this plan, in an active treatment plan and receiving covered services from an in-network provider at the time the provider ends his/her contract with Premera. The treatment must be medically necessary, and you and this provider agree that it is necessary for you to maintain continuity of care.

We will not provide continuity of care if your provider:

- Died
- Goes on sabbatical
- Is prevented from continuing to care for patients because of other circumstances
- No longer holds an active license
- Relocates out of the service area
- Retired
- Terminates the contractual relationship in accordance with provisions of contract relating to quality of care and exhausts his/her contractual appeal rights
- Will not accept the reimbursement rate applicable at the time the provider contract terminates

We will not provide continuity of care if you are no longer covered under this plan.

We will notify you no later than 10 days after your provider's Premera contract ends if we reasonably know that you are under an active treatment plan. If we learn that you are under an active treatment plan after your provider's contract termination date, we will notify you no later than the 10th day after we become aware of this fact.

You can call or send your request to receive continuity of care to Care Management at the address or fax number listed in this booklet. See ***How To Contact Us*** for additional information.

Duration of Continuity of Care

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

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

When continuity of care terminates, you may continue to receive services from this same provider, however, we will pay benefits at the out-of-network benefit level subject to the allowed amount. See ***How Providers Affect Your Costs*** for an illustration about benefit payments. If we deny your request for continuity of care, you may request an appeal of the denial, see ***Complaints and Appeals*** for information on how to submit a complaint review request.

Emergency Services

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

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

WHAT DO I NEED TO KNOW BEFORE I GET CARE?

Coinsurance

Your Plan's benefit level is 80% of the allowed amount. 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 allowed 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/Juneau School District employees only for the following:

- Deductibles and coinsurance amounts

Out-of-network or non-contracting providers may seek payment from City & Borough of Juneau/Bartlett Regional Hospital/Juneau School District employees for the following:

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

Plan Year Deductible

A deductible is the amount you must pay in each plan year for covered services and supplies before this plan provides certain benefits. The amount credited toward the plan year deductible won't exceed the "allowed amount" for any covered service or supply. Your plan has separate medical and dental deductibles.

Your plan year deductible amount for this plan is shown on the ***Summary of Your Benefits***.

Individual Deductible

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

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

Family Deductible

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

Fourth Quarter Carryover

Expenses you incur for covered services and supplies in the last 3 months of a plan year which are used to satisfy all or part of the plan year deductible will also be used to satisfy all or part of the next year's deductible. If your plan also includes an out-of-pocket maximum, however, the expenses carried over to satisfy the next year's deductible will not be applied to the next year's out-of-pocket maximum.

What Doesn't Apply To The Plan Year Deductible?

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

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

- Amounts that exceed the allowable charge
- Charges for excluded services
- Copays
- The plan year deductible and coinsurance required in the **Prescription Drugs** benefit on the ***Summary of Your Benefits***

COVERED SERVICES

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 these requirements:

- It must be furnished in connection with the prevention, diagnosis or treatment of a covered illness, disease or accidental injury;
- It must be medically necessary and must be furnished in a medically necessary setting. Inpatient care is only covered when you require care that couldn't be provided in an outpatient setting without adversely affecting your condition or the quality of care you would receive.
- It 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
- It must be furnished by a provider who is performing services within the scope of his or her license or certification. See the ***Definitions*** section for a definition of "provider."
- Some services or supplies must be approved in writing by us before you receive them. Please see the ***Prior Authorization*** section for details.
- Medical and Payment policies are used to administer the terms of the plan. Medical policies are generally used to further define medical necessity or investigation status for specific procedures, drugs, biologic agents, devices, level of care or services. Payment policies define our provider billing and payment rules. Our policies are based on accepted clinical practice guidelines and industry standards accepted by organizations like the American Medical Association (AMA), other professional societies and the Center for Medicare and Medicaid Services (CMS). Our policies are available to you and your provider at **premera.com** or by calling Customer Service.

Benefits for some types of services and supplies may be limited or excluded under this plan. Please refer to the actual benefit provisions below and the ***Exclusions*** section for a complete description of covered services and supplies, limitations and exclusions.

Acupuncture

This benefit covers acupuncture to:

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

Allergy Testing and Treatment

This benefit covers:

- Testing

- Allergy shots
- Serums

Ambulance

This benefit covers:

- Transport to the nearest facility that can treat your condition
- Medical care you get during the trip
- Transport from one medical facility to another as needed for your condition
- Transport to your home when medically necessary

These services are only covered when:

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

Air or sea emergency medical ambulance transportation is covered when:

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

Ambulance services that are not for an emergency need to be pre-approved. See ***Prior Authorization*** for details.

Blood Products and Services

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

Cellular Immunotherapy and Gene Therapy

Benefits are provided for medically necessary immunotherapy and gene therapy, such as CAR-T immunotherapy. The plan will cover designated providers outside the service area when there are no in-network providers within the service area.

Services must meet Premera's medical policy. You can access our medical policies by contacting Customer Service or going to **premera.com**. Services also require prior authorization. See ***Prior Authorization***.

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

Chemotherapy and Radiation Therapy

This benefit covers:

- Outpatient chemotherapy and radiation therapy
- Supplies, solutions and drugs
- Extractions to prepare the jaw for radiation treatment

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

Clinical Trials

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

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

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

Cancer Clinical Trials

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

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

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

This benefit doesn't cover:

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

Contraceptive and Sterilization Management

Benefits include the following services and supplies:

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

Prescription Contraceptives Dispensed by a Pharmacy

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

This benefit doesn't cover:

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

Dental Care

Dental Anesthesia

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

This benefit covers:

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

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

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

Dental Injury

Treatment of dental injuries to teeth, gum and jaw.

This benefit covers:

- Exams
- Consultations
- Dental treatment
- Oral surgery

This benefit is covered on sound and natural teeth that:

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

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

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

Diagnostic and Preventive Mammography

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

Diagnostic Lab, X-ray, and Imaging

Diagnostic lab, x-ray, and imaging services are basic and major medical tests that help find or identify diseases.

This benefit covers:

- Bone density screening for osteoporosis
- Cardiac testing
- Pulmonary function testing
- Diagnostic imaging and scans such as x-rays
- Lab services
- Mammograms (including 3-D mammograms) for a medical condition
- Neurological and neuromuscular tests
- Pathology tests
- Echocardiograms
- Ultrasounds

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

For additional details, see the following benefits:

- ***Preventive Care***
- ***Hospital***
- ***Emergency Room***

Some tests need to be approved before you receive them. See ***Prior Authorization*** for details.

Dialysis

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

Medicare has a waiting period, generally the first 90 days after dialysis starts. Benefits are different for dialysis during Medicare's waiting period than after the waiting period ends, see ***Summary of Your Benefits*** for details. Network providers are paid according to their provider contracts. The amount the plan allows out-of-network providers for dialysis after Medicare's waiting period is 125% of the Medicare-approved amount, even if you do not enroll in Medicare.

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

Emergency Room

This benefit covers:

- Emergency room and doctor services
- Equipment, supplies and drugs used in the emergency room
- Services and exams used for stabilizing an emergency medical condition
- Diagnostic tests performed with other emergency services
- Medically necessary detoxification

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

You may need to pay charges over the allowed amount if you get care from a provider not in your network. See ***How Does Selecting A Provider Affect My Benefits*** for details.

Foot Care

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

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

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

Health Management

Health Education

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

Nicotine Dependency Programs

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

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

Hearing

Hearing Exams

Hearing exam services include:

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

Hearing Hardware

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

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

Benefits are provided for the following:

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

This benefit does not cover:

- Hearing aids purchased before your effective date of coverage under this plan
- Batteries or other ancillary equipment other than that obtained upon purchase of hearing aids
- Hearing aids that exceed the specifications prescribed for correction of hearing loss
- Expenses incurred after your coverage ends under this plan unless hearing aids were ordered before that date and were delivered within 90 days after the date your coverage ended

Charges in excess of this benefit. These expenses are also not eligible for coverage under other benefits of this plan.

Home Health Care

Care is covered when a doctor states in writing that care is needed in your home. The care needs to be done by staff who works for a home health agency that is state-licensed or Medicare-certified.

Home health care provided as an alternative to hospitalization must have a written plan of care from your doctor. This type of care is not subject to any visit limit shown in the ***Summary of Your Benefits***. Medically intensive care in the home, or skilled hourly care provided as an alternative to facility-based care must be ***Pre-Approved*** by the plan.

This benefit covers:

- Home visits and short-term nursing care
- Home medical equipment, supplies and devices
- Prescription drugs given by the home health care agency
- Therapy, such as physical, occupational or speech therapy to help regain function
- Private duty or 24-hour nursing care. Private duty nursing is the independent hiring of a nurse by a family or member to provide care without oversight by a home health agency. The care may be skilled, supportive or respite in nature. See ***Summary of Your Benefits*** for benefit limits.

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

- A registered nurse
- A licensed practical nurse
- A licensed physical or occupational therapist
- A certified speech therapist
- A home health aide directly supervised by one of the above listed providers
- A person with a master's degree in social work

This benefit does not cover:

- Over-the-counter drugs, solutions and nutritional supplements
- Non-medical services, such as housekeeping
- Services that bring you food, such as Meals on Wheels, or advice about food

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

This benefit covers:

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

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

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

Covered items include:

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

Medical Supplies such as:

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

Medical Vision Hardware to correct vision due to medical eye conditions such as:

- Corneal ulcer
- Bullous keratopathy

- Recurrent erosion of cornea
- Tear film insufficiency
- Aphakia
- Sjogren's disease
- Congenital cataract
- Corneal abrasion
- Keratoconus

External Prosthetics and Orthotic Devices used to:

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

Orthopedic Shoes and Shoe Inserts

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

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

This benefit does not cover:

- Hypodermic needles, syringes, lancets, test strips, testing agents and alcohol swabs. These services are covered under the ***Prescription Drugs*** benefit.
- Supplies or equipment not primarily intended for medical use
- Special or extra-cost convenience features
- Items such as exercise equipment and weights
- Over bed tables, elevators, vision aids and telephone alert systems
- Over the counter orthotic braces and or cranial banding
- Non wearable defibrillator, trusses and ultrasonic nebulizers
- Blood pressure cuff/monitor (even if prescribed by a physician)
- Enuresis alarm
- Compression stockings which do not require a prescription
- Physical changes to your house and/or personal vehicle
- Orthopedic shoes used for sport, recreation or similar activity
- Penile prostheses
- Routine eye care
- Prosthetics, intraocular lenses, equipment or devices which require surgery. These items are covered under the ***Surgery*** benefit.

Hospice Care

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

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

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

This benefit covers:

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

This benefit does not cover:

- Over-the-counter drugs, solutions and nutritional supplements
- Services provided to someone other than the ill or injured member
- Services of family members or volunteers
- Services, supplies or providers not in the written plan of care or not named as covered in this benefit
- Non-medical services, such as spiritual, bereavement, legal or financial counseling
- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care; and transportation services

Hospital

This benefit covers:

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

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

Even though you stay at an in-network hospital, you may get care from doctors or other providers who do not have a network contract at all. In that case, you will have to pay any amounts over the allowed amount.

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

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

This benefit does not cover:

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

Infusion Therapy

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

Infusion examples include:

- Drug therapy
- Pain management

- Total or partial parenteral nutrition (TPN or PPN)

This benefit covers:

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

This benefit does not cover over-the-counter:

- Drugs and solutions
- Nutritional supplements

Mastectomy and Breast Reconstruction Services

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

This benefit covers:

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

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

Maternity Care

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

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

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

Maternity care benefits cover the following.

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

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

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

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

Medical Foods

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

This benefit covers:

- Dietary replacement to treat inborn errors of metabolism (example phenylketonuria (PKU))
- Dietary replacement when you have a severe allergy to most foods based on white blood cells in the stomach and intestine that cause inflammation (eosinophilic gastrointestinal associated disorder)

- Other severe conditions when your body cannot take in nutrient from food in the small intestine (malabsorption) disorder
- Disorders where you cannot swallow due to a blockage or a muscular problem and need to be fed through a tube

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

This benefit does not cover:

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

Medical Transportation Benefits (Non-emergent)

Medical Access Transportation

Round trip coach air or ground transportation to the closest in-network provider for a serious medical condition that can't be treated locally. Prior authorization not required.

This benefit covers transportation via commercial carrier when you have a serious medical condition that cannot be treated locally. Round-trip coach air or surface transportation by a licensed commercial carrier is provided only for the ill or injured member. The trip must begin where you became ill or injured and end at the in-network provider equipped to provide treatment not available in a local facility. Benefits are limited to 3 round-trip transports per plan year.

When transportation is for a child under the age of 19, this benefit will also cover a parent or guardian to accompany the child.

To submit a claim for these services:

- Complete a Travel Claim Form. A separate Travel Claim Form is needed for each patient and each commercial carrier or transportation service used. You can get a Travel Claim Form on our website at **premera.com**. You can also call us for a copy of the form.
- A statement or letter from your physician attesting to the medical necessity of the services you received that required the air or service travel.

Attach one of the following forms of documentation:

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

Travel for a Procedure Available Locally

- If traveling for a procedure that is available locally, but the cost is lower outside of Alaska, in addition to the documentation described above, you must also provide a cost comparison for the procedure locally and the procedure at your facility of choice outside of Alaska. The cost of the procedure outside of Alaska combined with the cost of the travel must be less than have the procedure done locally.

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

This benefit does not cover:

- Meals and lodging
- First class airline fees
- Transport by taxi, bus, private car or rental car
- Transportation for routine dental, vision and hearing services

Mental Health Care

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

Covered services include all the following:

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

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

This benefit does not cover:

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

Neurodevelopmental Therapy

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

Inpatient Care Inpatient facility services must be furnished and billed by a hospital or by a rehabilitation facility, and will only be covered when services can't be done in a less intensive setting.

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

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

When the above criteria are met, benefits will be provided for physical, speech, and occupational therapy services. This benefit includes physical, speech, and occupational therapy assessments and evaluations related to treatment of covered neurodevelopmental therapy.

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

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

This benefit does not cover:

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

Newborn Care

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

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

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

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

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

Benefits are also provided for routine circumcision.

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

Newborn Hearing Exams and Testing

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

Prescription Drugs

This benefit provides coverage for medically necessary prescription drugs, prescriptive oral agents for controlling blood sugar levels, glucagon emergency kits, allergy emergency kits and insulin when prescribed for your use outside of a medical facility and dispensed by a licensed pharmacist in a pharmacy licensed by the state in which the pharmacy is located. Also covered in this benefit are diabetic injectable supplies. However, when a brand name drug is prescribed, and that drug has equally safe and effective generic alternatives, only the generic alternative will be covered. Generic alternatives are FDA-approved as safe and effective as brand name drugs but are more cost effective. Additionally, coverage will not be provided for prescribed drugs that have ample availability/variety of over the counter comparables will be limited in coverage. These contain drugs included in, but not limited to, therapeutic classes for heartburn, allergy and cough/cold remedies. For the purposes of this plan, a prescription drug is any medical substance that, under federal law, must be labeled as follows: "Caution: Federal law prohibits dispensing without a prescription." In no case will the member's out-of-pocket expense exceed the cost of the drug or supply.

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

Individual Prescription Drug Deductible

Prescription drug and supply purchases shown under ***What's Covered?*** later in this section apply to the prescription drug deductible. This deductible applies to prescription drugs and supplies dispensed by a licensed retail pharmacy, and through the mail-order pharmacy program.

Please note: The prescription drug deductible is separate from this plan's plan year deductible described earlier in this booklet. Amounts credited toward the prescription drug deductible don't accrue toward this plan's plan year deductible. Also, amounts credited toward this plan's plan year deductible don't accrue toward the prescription drug deductible.

Retail Pharmacy Prescriptions

Participating Pharmacies

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

Non-participating Pharmacies

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

If the pharmacy does not submit your claim for you, you will have to pay the full cost for new prescriptions and refills purchased at these pharmacies. You will also need to fill out a prescription drug claim form, attach your prescription drug receipts and submit the information to the address shown on the claim form.

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

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

Mail-Order Pharmacy Program

How To Use The Mail-Order Pharmacy Program

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

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

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

You may also call the mail-order pharmacy's benefit manager's Customer Service department or visit their website at:

1-800-391-9701

www.express-scripts.com

You can mail your prescription drug claims to:

Express Scripts
Attn: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

Diabetic Injectable Supplies and Drugs

When insulin needles and syringes are purchased along with insulin, only the prescription drug deductible, if any, and the copay or coinsurance for the insulin will apply. When insulin needles and syringes are purchased separately, the prescription drug deductible, if any, and the Preferred List Brand Name Drug copay or coinsurance will apply for each item purchased. The prescription drug deductible, if any, and the Preferred List Brand Name Drug copay or coinsurance will also apply to purchases for alcohol swabs, test strips, testing agents and lancets.

What's Covered?

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

- Prescription drugs and vitamins (federal legend and state restricted drugs as prescribed by a licensed provider). This benefit covers off-label use of FDA-approved drugs as provided under this plan's definition of "Prescription Drug." See ***Definitions*** for details.
- Prescriptive oral agents for controlling blood sugar levels
- Prescribed injectable medications for self-administration (such as insulin)
- Glucagon and allergy emergency kits
- Compounded medications of which at least one ingredient is a covered prescription drug
- Hypodermic needles, syringes and alcohol swabs used for self-administered injectable prescription medications. Also covered are the following disposable diabetic testing supplies: test strips, testing agents and lancets.
- Inhalation spacer devices and peak flow meters
- Drugs for the treatment of nicotine dependency, including over the counter (OTC) nicotine patches, gum or lozenges purchased through a participating retail pharmacy. Over the counter nicotine products are subject to the generic drug cost-share. Your normal cost-share for drugs received from a participating pharmacy is waived for certain prescription nicotine dependency drugs that meet the guidelines for preventive services described in the ***Preventive Care*** benefit.
- Prescription drugs for the treatment of autism
- Prescription contraceptive drugs and devices (e.g. oral drugs, diaphragms and cervical caps). See ***Contraceptive Management and Sterilization*** for details.
- Weight management drugs

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

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

Additional Information About Your Prescription Drug Benefit

Generic Drugs

This plan requires the use of appropriate "generic drugs." When available a generic drug will be dispensed in place of a brand name drug. If you or the prescriber request a brand name drug instead of a generic when a generic equivalent is available, you'll be required to pay the difference in price between the brand name drug and the generic equivalent, in addition to paying the applicable brand name copay. Please consult with your pharmacist on the higher costs you'll pay if you select a brand name drug.

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

Refills

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

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

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

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

Prescription Drug Formulary

This benefit uses our Essentials drug list, 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 on our drug lists. The drug lists are updated quarterly based on the Committee's recommendations.

The Essentials drug list includes preferred generic drugs, preferred brand name drugs, preferred specialty drugs, and non-preferred generic, brand name and specialty drugs. Preferred brand name drugs are brand-name drugs that are only made by one drug company. Consult the RX Search tool on our website or contact Customer Service for a complete list of covered prescription drugs.

It's important to note that this plan provides benefits for non-preferred generic, brand name, and specialty drugs, but at a higher cost to you

Generic Substitution This plan requires the use of appropriate "generic drugs" (as defined below). When available, a generic drug will be dispensed in place of a brand name drug. You or the prescriber may request a brand name drug instead of a generic, but if a generic equivalent is available, you'll have to pay the difference in price between the brand name drug and the generic equivalent, in addition to paying the applicable brand name drug cost-share. Please consult with your pharmacist on the higher costs you'll pay if you select a brand name drug.

A "generic drug" is a prescription drug manufactured and distributed after the brand name drug patent of the innovator company has expired. Generic drugs have an AB rating from the U.S. Food and Drug Administration (FDA). The FDA considers them 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.

Right to a Review

- If you cannot tolerate the generic equivalent drug or the prescriber determines that it is not effective in treating your condition, the prescriber can request a medical necessity review. If approved, you'll only have to pay the applicable brand-name cost-share.
- Your prescriber can also ask for a medical necessity review of a drug not on the Essentials drug list if you cannot tolerate the drugs or dosages included on the list. If approved, the drug or dosage will be covered. You will pay the cost-share above for the non-preferred drug.

Specialty Pharmacy Program

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

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

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

Pharmacy Management

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

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

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

Anti-Cancer Medication

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

Drug Discount Programs

Pharmacy Benefit Drug Program For pharmacy benefit claims, Premera Blue Cross Blue Shield of Alaska will pay Plan Sponsor a prescription drug rebate payment equal to a specific amount per paid brand-name prescription drug claim. Prescription drug rebates Premera Blue Cross Blue Shield of Alaska receives from its pharmacy benefit manager in connection with Premera Blue Cross Blue Shield of Alaska's overall pharmacy benefit utilization may be more or less than the Plan Sponsor's rebate payment. The Plan Sponsor's rebate payment shall be made to the Plan Sponsor on a plan year quarterly basis unless agreed upon otherwise.

The allowable charge for prescription drugs may be higher than the price paid to the pharmacy benefit manager for those prescription drugs.

Premera Blue Cross Blue Shield of Alaska and the Group agree that the difference between the allowable charge for prescription drugs and the price paid to the pharmacy benefit manager or other vendors, and the prescription drug payments received by Premera Blue Cross Blue Shield of Alaska from its pharmacy benefit manager or other vendors, constitutes Premera Blue Cross Blue Shield of Alaska property, and not part of the compensation payable under Premera Blue Cross Blue Shield of Alaska's contract with the Group, and that Premera Blue Cross Blue Shield of Alaska is entitled to retain and shall retain such amounts and may apply them to the cost of its operations and the pharmacy drug benefit.

Medical Benefit Drug Program The medical benefit drug program is separate from the pharmacy program. It includes claims for drugs delivered as part of medical services. For medical benefit drug claims, Premera Blue Cross Blue Shield of Alaska may contract with subcontractors that have rebate contracts with various manufacturers. Rebate subcontractors retain a portion of rebates collected as a rebate administration fees. Premera Blue Cross Blue Shield of Alaska retains a portion of the rebate and describes the medical benefit drug rebate in the Group's annual accounting report. The Group's medical benefit drug rebate payment shall be made to the Group on a plan year annual basis if the rebate is $500 or more. If less than $500, Premera will retain the medical benefit drug rebates.

This Prescription Drug benefit doesn't cover:

- Drugs and medicines that may be lawfully obtained over the counter (OTC) without a prescription, except as required by law. OTC drugs are excluded even if prescribed by a practitioner, unless otherwise stated in this benefit. Examples of such excluded items include, but aren't limited to, non-prescription drugs and vitamins, food and dietary supplements, herbal or naturopathic medicines and nutritional and dietary supplements (e.g. infant formulas or protein supplements).
- Non-prescription contraceptive methods (e.g. jellies, creams, foams or devices)

- Drugs for the purpose of cosmetic use, or to promote or stimulate hair growth (e.g. wrinkles or hair loss)
- Drugs for experimental or investigational use
- Biologicals, blood or blood derivatives
- Any prescription refilled in excess of the number of refills specified by the prescribing provider, or any refill dispensed after one year from the prescribing provider's original order
- Drugs dispensed for use or administration in a health care facility or provider's office, or take-home drugs dispensed and billed by a medical facility
- Replacement of lost or stolen medication
- Infusion therapy drugs or solutions and drugs requiring parenteral administration or use, and injectable medications. (The exception is injectable drugs for self-administration, such as insulin and glucagon). See ***Infusion Therapy*** for details.
- Drugs to treat infertility, including assisted reproduction medications
- Drugs to treat sexual dysfunction
- The plan does not cover some of the drugs in certain drug classes. An example is proton pump inhibitors. However, at least 1 drug in every drug class is covered. (A drug class is a group of drugs that may work in the same way, have a similar chemical structure, or may be used to treat the same conditions or group of conditions.) Please call Customer Service or visit our website for more information or to find out if a certain drug is covered. If your drug is not covered, please work with your provider to find an alternative drug in that drug class that the plan does cover.

Preventive Care

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

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

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

The agencies above may also change their guidelines from time to time. If this happens, the plan will comply with the changes. Some preventive services and tests have limits on how often you should get them. The limits are often based on your age or gender.

This benefit covers:

- Routine physical exams
- Well-baby exams and well-child exams, including those provided by a qualified health aide
- Physical exams related to school, sports, and employment
- Screening for depression
- Cancer screening tests, to include at a minimum:
  - Annual tests for prostate cancer for high risk men under 40; all men over 40 years of age, or as recommended by a physician
  - Annual cervical cancer pap smears for women 18 years of age and older, or as recommended by a physician
  - Screening tests for colorectal cancer for high risk individuals under 50 years of age; all individuals over 50 years of age, or as recommended by a physician. Includes pre-colonoscopy consultations,

exams, colonoscopy, sigmoidoscopy and fecal occult blood tests. Removal and pathology (biopsy) related to polyps found during a screening procedure are covered as part of the preventive screening. Coverage for colonoscopy and sigmoidoscopy includes medically necessary sedation. Benefits include anesthesia services performed in connection with the preventive colonoscopy if the attending provider determines that anesthesia would be medically appropriate for the member.

  - BRCA genetic testing for women at risk for certain breast cancers
- Preventive immunizations
- Seasonal and certain other immunizations provided by a pharmacy or other mass immunizer location. Covered services include flu shots, flu mist, pneumonia immunizations, whooping cough, adult shingles immunizations and travel immunizations.
- 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
  - Breastfeeding counseling
  - Purchase of standard electric breast pumps
  - Rental of hospital-grade breast pumps if medically necessary
  - Maternity diagnostic screening
  - Screening for gestational diabetes
  - Counseling for sexually transmitted infections
- Professional services to prevent falling for members who are 65 or older and have a history of falling or mobility issues.
- Healthy diet and eating habits for members at risk for health conditions that are affected by diet and nutrition
- Weight loss screening

This ***Preventive Care*** benefit does not cover:

- Charges that don't meet the federal guidelines for preventive services described at the start of this benefit. This includes services or items provided more often than as stated in the guidelines.
- Inpatient routine newborn exams while the child is in the hospital following birth. These services are covered under the ***Newborn Care*** benefit.
- Services not named above as covered
- Routine or other dental care
- Routine vision and hearing exams
- Services that are related to a specific illness, injury or definitive set of symptoms exhibited by the member. Please see the plan's non-preventive benefit for available coverage.
- Physical exams for basic life or disability insurance
- Work-related disability evaluations or medical disability evaluations
- Facility charges when preventive care is received at a hospital-based clinic or a hospital-based physician's office. See the ***Hospital*** benefit for details.
- Contraceptive services, drugs or devices
- Purchase of hospital-grade breast pumps.

Professional Visits and Services

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

Benefits are also provided for the following professional services:

- Biofeedback for migraines and other conditions for which biofeedback is not deemed experimental or investigational when provided by a qualified provider. See ***Definitions*** for a definition of "experimental/ investigational."

- Consultations and treatment for nicotine dependency
- 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 the following are true:
  - Premera 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.
- Real time visits via online and telephonic methods with your doctor or other provider (telemedicine)
- Prostate, colorectal, and cervical cancer screening exams, unless they meet the guidelines for preventive medical services described in the ***Preventive Care*** benefit
- Second opinions for any covered medical diagnosis or treatment plan when provided by a qualified provider

This benefit does not cover:

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

Psychological and Neuropsychological Testing

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

Rehabilitation Therapy and Chronic Pain Care

Rehabilitation Therapy

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

- Restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an accidental injury, illness or surgery; or

- Treat disorders caused by physical congenital anomalies. See ***Neurodevelopmental Therapy*** for coverage of disorders caused by neurological congenital anomalies.

Covered services include all the following:

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

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

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

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

When the above criteria are met, benefits will be provided for physical, speech and occupational therapy services, including cardiac and pulmonary rehabilitation. Benefits are also included for physical, speech, and occupational assessments and evaluations related to rehabilitation.

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

Chronic Pain Care

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

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

This benefit does not cover:

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

Skilled Nursing Facility

This benefit includes:

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

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

This benefit does not cover:

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

Spinal and Other Manipulations

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

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

Substance Abuse Treatment

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

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

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

This benefit does not cover:

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

Surgery

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

- Anesthesia or sedation and postoperative care as medically necessary. Benefits include anesthesia performed in connection with the preventive colonoscopy that your provider determines would be medically appropriate for you.

- Cornea transplantation, skin grafts, and the transfusion of blood or blood derivatives
- Sexual reassignment surgery if medically necessary and not for cosmetic purposes
- Colonoscopy and other scope insertion procedures are also covered under this benefit unless they qualify as preventive services described in the ***Preventive Care*** benefit.
- Surgical services that are considered medically necessary to correct the cause of infertility

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, see the ***Transplants*** benefit.

Transgender Surgical Services Criteria

Surgical gender reassignment services will be considered medically necessary if the following criteria are met. For all surgical procedures approved in the most current Standards of Care published by the World Professional Association for Transgender Health (WPATH), transgender benefits are available if:

1. You are at least 18 years old and diagnosed as having gender identity disorder.
2. For breast surgery (mastectomy, chest reconstruction or augmentation mammoplasty) you must also have one letter of recommendation for surgery from a mental health professional.
3. For genital surgery (examples include: orchiectomy, penectomy, vaginoplasty, clitoroplasty, labiaplasty, hysterectomy, salpingo-oophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, testicular prosthesis placement, and phalloplasty) the first criteria listed above and all the following criteria must be met:

- You have been an active participant in a recognized gender identity treatment program and have successfully lived and worked within the desired gender role full time for at least 12 months.
- You have received recommendations for surgery from two separate mental health professionals, at least one of which includes an extensive report. One master's degree level professional is acceptable if the second letter is from a psychiatrist or Ph.D. clinical psychologist.
- The surgery is recognized as medically necessary within the most current Standards of Care published by the World Professional Association for Transgender Health WPATH).

Please Note: Coverage of prescription drugs, lab, x-ray and other non-surgical services and mental health treatment associated with the treatment of gender dysphoria is eligible under the general plan provisions subject to the applicable copay, deductible or coinsurance and plan limitations and exclusions.

Obtaining a Prior Authorization

To check on your benefit eligibility, the physician who is the most knowledgeable about your history may submit a prior authorization request to Premera Blue Cross on your behalf. The request should include:

- The surgical procedure(s) for which coverage is being requested
- The date the surgery will be performed
- Information supporting that criteria listed above has been met, based on the surgery being requested

Surgical Center – Outpatient

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

Therapeutic Injections

This benefit covers:

- Shots given in the doctor’s office

- Supplies used during visit, such as serums, needles and syringes
- Three teaching doses for self-injectable specialty drugs

This benefit does not cover:

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

Transplants

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

Covered Transplants

Solid organ transplants and bone marrow/stem cell reinfusion procedures mustn't be considered experimental or investigational for the treatment of your condition. See ***Definitions*** for a definition of "experimental/ investigational."

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

- Solid organ transplants and bone marrow/stem cell reinfusion procedures must be medically necessary and meet the plan's criteria for coverage. The medical indications for the transplant, documented effectiveness of the procedure to treat the condition and failure of medical alternatives are all reviewed.
- The types of solid organ transplants and bone marrow/stem cell reinfusion procedures that currently meet the plan's criteria for coverage are:

  Heart

  Heart/double lung

  Single lung

  Double lung

  Liver

  Kidney

  Pancreas

  Pancreas with kidney

  Bone marrow (autologous and allogeneic)

  Stem cell (autologous and allogeneic)

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

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

Recipient Costs

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

Donor Costs

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

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

Travel and Lodging

The transplant recipient must reside more than 50 miles from the approved transplant center, unless medically necessary treatment protocols require the member to remain closer to the transplant center. Travel and lodging expenses will be based on current IRS guidelines on the date(s) the expenses were incurred. Please see the ***Summary of Your Benefits*** to find out what the reimbursement rates are.

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

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

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

This benefit does not cover:

- Services and supplies that are payable by any government, foundation or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers.
- Donor costs for a solid organ transplant or bone marrow or stem cell reinfusion that isn't covered under this benefit, or for a recipient who isn't a member
- Donor costs for which benefits are available under other group or individual coverage
- Non-human or mechanical organs, unless they aren't experimental or investigational services. See ***Definitions*** for a definition of "experimental/ investigational."
- Anti-rejection drugs, except those administered by the transplant center during the inpatient or outpatient stay in which the transplant was performed
- Planned storage of blood for more than 12 months against the possibility it might be used at some point in the future
- Meals
- Alcohol or tobacco
- Car rentals
- Personal care items, such as shampoo or a toothbrush
- Souvenirs or other tourist items such as T-shirts, sweatshirts, or toys
- Entertainment such as movies, visits to museums or mileage for sightseeing
- Phone calls

- Costs for people other than you and your covered companion(s)
- Take-home prescription drugs dispensed by a licensed pharmacy. See ***Prescription Drugs*** for benefit information.

Urgent Care

This benefit covers:

Exams and treatment of:

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

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

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

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

Virtual Care – On Demand

On demand virtual care provides ease, convenience and immediate access to medical care for limited low-level acute medical conditions such as a urinary tract infection or strep throat using several technology solutions. This benefit covers on demand virtual care using secure chat, text, voice or audio messaging, and video chat.

This benefit does not cover real-time office visits between you and your doctor via online and telephonic methods (telemedicine). See the ***Professional Visits and Services*** and ***Mental Health Care*** benefit.

Vision Benefits

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

Vision Exams

Covered routine exam services include:

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

Vision Hardware

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

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

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

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

- Prescription safety glasses
- Prescription sunglasses
- Special features, such as tinting or coating
- Fitting of eyeglass lenses to frames
- Fitting of contact lenses to the eyes

Important note: Prescribed vision hardware necessitated by surgery, injury or disease is covered under ***Medical Vision Hardware***.

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

This benefit does not cover:

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

Pediatric Vision Benefit

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

Vision Exam

Covered routine exam services include:

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

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

Vision Hardware

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

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

Weight Management Treatment

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 for Weight Management

Benefits for surgical weight management services 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 coverage under this benefit, the member must meet all of the following criteria:

- The member must be diagnosed as one of the following:
  - A Body Mass Index (BMI) greater than or equal to 40; or
  - Overweight with a BMI greater than 35 with severe co-morbidities, including but not limited to:
    - Congestive heart failure disease (CHF)
    - Established coronary Heart Disease
    - Other atherosclerotic disease
    - Type 2 diabetes that is not controlled by drug therapy
    - High blood pressure that is not controlled by medical management
    - Sleep apnea documented as severe
- During the 2 years immediately before the surgery, the member has actively taken part in a weight-loss program that is supervised by a physician and that lasted at least 6 months in a row. The program must be documented in the patient's medical records.
- Member has been evaluated by a licensed mental health provider to establish emotional stability and ability to cope with surgical limitations?

This benefit is covered as any other surgery and is subject to a lifetime maximum benefit of $25,000 for covered services. Medically necessary treatments of surgical complications do not accrue toward this benefit maximum.

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

Surgical Treatment for Weight Management 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 ***Weight Management Treatment*** benefit doesn't cover:

- Expenses beyond the lifetime maximum for eligible surgical service

- Procedures or treatments that Premera 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

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

Out-of-Area Care

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

The BlueCard® Program is the Inter-Plan Arrangement that applies to most claims from Host Blues' network providers. The Host Blue is responsible for its network providers and handles all interactions with them. Other Inter-Plan Arrangements apply to providers that are not in the Host Blues' networks (out-of-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. See ***Prior Authorization*** for details.

In-Network Provider		**Out-of-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	Allowed 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
You pay:		**You pay:**		**You pay:**		**You pay:**	
Coinsurance:	$90	Coinsurance:	$90	Coinsurance:	$100	Coinsurance:	$ 80
Amount over contract	-0-	Amount over allowed:	$50			Amount over UCR:	$100
TOTAL YOU PAY:	**$90**	**TOTAL YOU PAY:**	**$140**	**TOTAL YOU PAY:**	**$100**	**TOTAL YOU PAY:**	**$180**

*** 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.

BlueCard Program

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

- The provider's billed charges for your covered services; or
- The allowed amount that the Host Blue made available to us. See ***Definitions*** for a definition of "allowed amount."

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

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

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

Value-Based Programs

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

Taxes, Surcharges and Fees

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

Out-of-Network Providers

It could happen that you receive covered services from providers outside 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 allowed amount for these providers or the pricing requirements under applicable law. See ***Definitions*** for a definition of "allowed amount."

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

Blue Cross Blue Shield Global Core® Program

If you are outside the United States, Puerto Rico, and the U.S. Virgin Islands (the "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core. Blue Cross Blue Shield Global Core is unlike the BlueCard Program in the BlueCard service area in some ways. For instance, although Blue Cross Blue Shield Global Core helps you access a provider network, you will most likely have to pay the provider and send us the claim yourself in order for the plan to reimburse you. See ***How Do I File A Claim?*** for more information on submitting claims. However, if you need hospital inpatient care, the Blue Cross Blue Shield Global Core 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 Blue Cross Blue Shield Global Core service area, need help submitting claims or have other questions, please call the Blue Cross Blue Shield

Global Core Service Center at 1-800-810-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 Blue Cross Blue Shield Global Core information by calling the toll-free phone number.

CARE MANAGEMENT

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

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

Prior Authorization

There are certain medical services and prescription drugs that requires prior authorization from us before you get them.

You must get Premera's approval for some services before the service is performed, or you may pay a penalty. This process is called prior authorization.

There are two different types of prior authorization required:

1. **Prior Authorization for Benefit Coverage** You must get prior authorization for certain types of medical services, equipment, and for most inpatient facility stays, as listed below. This is so that Premera can confirm that these services are medically necessary and covered by the plan.
2. **Prior Authorization for In-Network Cost Shares for Out-of-Network Providers** You must get prior authorization in order for the plan to:

   Cover an out-of-network provider in Alaska at the in-network benefit level.

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

   Cover a provider who is outside the service area at the in-network benefit level.

How Prior Authorization Works

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

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

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

1. Prior Authorization for Benefit Coverage

Prior Authorization for Medical Services, Supplies or Equipment

The plan has a list of services, equipment, and facility types that must have prior authorization before you receive the service or are admitted as an inpatient at the facility. Please contact your in-network provider or Premera Customer Service before you receive a service to confirm that your service requires prior authorization.

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

The following services require prior authorization:

- **Elective (non-emergent) Air or Ground Ambulance Transport**
- **Home Medical Equipment (HME) and Prosthetic Devices**

  HME rental for home use do not require prior authorization. However, rental beyond 3 months may be reviewed for ongoing medical necessity.
  - Bone growth stimulators – electronic and ultrasonic
  - Chest compression vests and devices
  - Cochlear devices
  - Custom-made knee braces
  - Electrical stimulation devices – includes bone growth stimulators
  - Electronic, mechanical or microprocessor-controlled artificial limb or joint
  - Equipment and supplies to treat obstructive sleep apnea: CPAP, BiPAP and APAP machines and related supplies
  - Hospital beds and accessories (no prior authorization needed for rental of standard beds for hospital to home transitions for less than 3 months)
  - Lymphedema pumps (pumps to reduce swelling)
  - Medical foods
  - Myoelectric upper limb prosthetic (externally powered artificial arm or hand)
  - Oral devices, appliances, surgical splints and impressions – includes preparation
  - Power-operated lifting devices
  - Standing frames
  - Vagal nerve stimulators other than TENS (implanted devices to stimulate a specific nerve)
  - Wheelchairs, power-operated vehicles and scooters (no prior authorization is needed for standard manual wheelchairs rented for less than 3 months)
- **Inpatient Facility Admissions**
  - All planned (elective) inpatient hospital care (surgical, non-surgical, behavioral health and/or substance abuse)

    Elective admissions must have prior authorization **before** admission

    For facilities only, if the service for which the member is admitted is not included in the list below, notification from the facility is required within 24 hours of the admission
  - Admission to skilled nursing facility, a long-term acute care hospital (LTACH) or a rehabilitation facility
  - Admission to all residential treatment program
- **Outpatient Imaging Tests**
  - Contrast enhanced computed tomography (CT) angiography of the heart
  - Computed tomography (CT) scans
  - Echocardiograms (ultrasound test of the heart)
  - Magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA)
  - Magnetic resonance spectroscopy (special imaging to look at the brain)
  - Nuclear cardiology (using special dyes to look at heart function)
  - Positron emission tomography (PET and PET/CT)

- **Surgical, Medical, Therapeutic, Diagnostic and Reconstructive Procedures (inpatient or outpatient)**
  - Ablation therapy (destruction of abnormal tissue)
  - Artificial intervertebral disc, any level (artificial disc between vertebrae in the spine)
  - Blepharoplasty (eyelid surgery)
  - Bone anchored and implantable hearing aids
  - Breast surgeries – selected: implant removal, mastectomy for gynecomastia (removal of breast tissue in males), prophylactic mastectomy (removal of breasts to prevent breast cancer), reduction mammoplasty (breast reduction)
  - Cardiac devices; including related services for implantation if applicable: ventricular assist devices for outpatient (a certain kind of device to help the heart pump), implanted and wearable defibrillators (a device to shock the heart into a normal rhythm); closure devices for septal defects (a hole in a specific part of the heart); transcatheter aortic valve replacement known as TAVR/TAVI (a specific procedure that replaces the heart's aortic valve)
  - Chemotherapy administration and radiation oncology
  - Cochlear implantation (stimulates the nerve in the inner ear)
  - Corneal remodeling/keratoprosthesis (reshaping the clear front layer of the eyeball/implanting an artificial cornea)
  - Cosmetic or reconstructive surgeries (usually done to change appearance) that are covered under this plan
  - Cryosurgical ablation/ablation of tumors (using extreme cold to destroy tumors)
  - Deep brain stimulation (electrical stimulation of the brain through implanted wires)
  - Esophageal sphincter procedures (anti-reflux surgery)
  - Extracorporeal photopheresis (collecting cells, treating them with special light, and then returning specific cells to the body)
  - Facet arthroscopy (replacing a specific part of a joint in the spine with an artificial support)
  - Facility based polysomnography (sleep studies done in a lab)
  - Foot surgery (some specific surgeries)
  - Genetic testing and analysis
  - Home-based polysomnography (sleep studies done at home)
  - Hyperbaric oxygen therapy (pressurized oxygen to treat certain kinds of wounds and illnesses
  - Implantation or application of electric stimulator devices – selected: gastric (stomach), spinal cord, sacral nerve (a specific nerve that affects bladder and bowel function), pelvic floor (muscles at the bottom of the pelvis), implanted bone stimulators, posterior tibial nerve (a nerve running down the back of the lower leg)
  - Interspinous distraction devices (spacers between the bone of the spine)
  - Major joint surgeries, arthroplasty/arthroscopy: knee, hip and shoulder
  - Mitral valve repair (repair of a specific heart valve)
  - Nasal/sinus surgery
  - Panniculectomy (removing an apron of fat and tissue that hangs far below the waist)
  - Radiation therapy – selected: stereotactic radiosurgery, gamma knife, proton beam, intensity modulated radiation therapy (IMRT), high dose rate electronic brachytherapy, and brachytherapy
  - Radiofrequency ablation of tumors and treatment of facet joints (using heat to destroy tumors and treat nerves at specific joints of the spine)
  - Skilled home health care services
  - Skilled hourly nursing care
  - Spine surgeries and treatments
  - Surgeries related to gender reassignment
  - Surgery to treat sleep apnea

- Surgical treatments for the temporomandibular joint (joint that connects the jaw to the rest of the skull)
- Therapeutic apheresis (removing certain components of the blood)
- Transcatheter occlusion or embolization for tumor destruction (closing off the blood supply to tumors)
- Transcranial magnetic stimulation, TMS (magnetic pulses to the brain)
- Upper gastrointestinal endoscopy (a viewing scope inserted through the mouth to examine the esophagus, stomach, and first part of the small intestine)
- Vascular embolization or occlusion for tumors, organ ischemia or infarction (closing off a blood vessel to treat a tumor or other tissue)
- Vertebroplasty, kyphoplasty, or sacroplasty (specific treatments for stabilizing compression fractures in the spine)
- Varicose veins and perforator veins – all procedures

- **Transplant (inpatient or outpatient)**
  - Autologous progenitor cell therapy (stem cell transplants)
  - Complex organ transplants (small bowel, lung, heart, liver, multi-organ, face, limb)
  - Transplant donor procedures and services (for all types of transplants)

Prior Authorization for Prescription Drugs

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

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

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

The list below includes examples of drug categories that require prior authorization. This list does not include specific drugs, and it may be changed from time to time.

- Adrenal hormones
- Adrenergics
- Androgens
- Angiotensin II receptor blockers & renin inhibitors
- Antiandrogens
- Anticholinergics and antispasmodics
- Anticonvulsants
- Antidiarrheals
- Antimalarials
- Antiplatelet drugs
- Antipsoriatic/Antiseborrheic
- Antivertigo and antiemetic agents
- Beta agonists inhalers
- Beta blockers
- Blood glucose monitoring devices & supplies
- Bowel evacuants
- Combination narcotic/analgesics

- Compounds
- Direct acting miotics
- Drugs with significant changes in product labeling
- Estrogen combinations
- Estrogens
- Fluoroquinolones
- Glucose elevating agents
- Gonadotropin & related agents
- Growth hormones
- Headache therapy
- Hemostatics
- HIV/AIDS therapy
- Hypnotic agents
- Inhaled corticosteroids
- Insulin therapy
- Interferons
- Interleukins
- Intranasal steroids
- Keratolytics
- Kits
- Lipid/Cholesterol lowering agents
- Long acting nitrates
- MAO inhibitors
- Miscellaneous agents
- Miscellaneous analgesics
- Miscellaneous antidepressants
- Miscellaneous antiinfectives
- Miscellaneous antineoplastic drugs
- Miscellaneous antipsychotics
- Miscellaneous antivirals
- Miscellaneous cardiovascular agents
- Miscellaneous coagulation agents
- Miscellaneous dermatologicals
- Miscellaneous gastrointestinal agents
- Miscellaneous neurological therapy drugs
- Miscellaneous ophthalmologics
- Miscellaneous psychotherapeutic agents
- Miscellaneous pulmonary agents
- Miscellaneous rheumatological agents
- Miscellaneous urologicals
- Muscle relaxants and antispasmodic agents
- Myeloid stimulants
- Narcotics
- Narcotics antagonists
- Newly FDA-approved drugs
- Non-insulin hypoglycemic agents

- NSAIDS/Cox II inhibitors
- Other glaucoma drugs
- Proton pump inhibitors
- Selective serotonin reuptake inhibitors
- Smoking deterrents
- Specialty drugs
- Steroids
- Tetracyclines
- Therapy for acne
- Thiazide and related diuretics
- Topical anesthetics
- Topical antibacterials
- Topical antifungals
- Topical corticosteroids

Exceptions to Prior Authorization for Benefit Coverage

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

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

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

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

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

Please notify us by calling Customer Service when you receive non-emergency covered services from an out-of-network provider so that we can apply your benefits correctly.

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

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

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

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

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

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

If you are admitted to an out-of-network or out-of-area hospital due to an emergency condition, those services are always covered at the in-network benefit level. The plan will continue to cover those services until you are medically stable and can safely transfer to an in-network hospital. **In addition to the plan's cost shares, you will be required to pay any amounts over the allowed amount if the provider does not have a contract with us or the local Blue Cross and/or Blue Shield Licensee. Any amounts you pay over the allowed amount do not count toward your plan deductible and out-of-pocket maximum.**

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

Clinical Review

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

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

You can find our medical policies at **premera.com**.

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

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

Personal Health Support Programs

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

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

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

EXCLUSIONS

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

Amounts Over the Allowable Charge

This plan does not cover amounts over the allowed amount as defined by this plan. If you get services from a non-contracted provider, you will have to pay any amounts for your services that are over the allowed amount.

Assisted Reproduction

This plan does not cover any assisted reproduction technologies, including but not limited to:

- Artificial insemination or in-vitro fertilization

- Services to make you more fertile or for multiple births
- Reversing sterilization surgery

Benefits from Other Sources

This plan does not cover services that are covered by liability insurance, motor vehicle insurance, excess coverage, no fault coverage, or workers compensation or similar coverage for work-related conditions. For details, see ***Third Party Recovery*** in the ***What If I Have Other Coverage?*** section of the booklet.

Benefits That Have Been Exhausted

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

Broken or Missed Appointments

Charges For Records or Reports

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

Clinical Trials

This plan does not cover:

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

Comfort or Convenience

This plan does not cover:

- Items that are mainly for your convenience or that of your family. For instance, this plan does not cover personal services or items like meals for guests while hospitalized, long-distance phone, radio or TV, personal grooming, and babysitting.
- Normal living needs, such as food, clothes, housekeeping and transport. This does not apply to chores done by a home health aide as prescribed in your treatment plan.
- Meal or dietary assistance, including “Meals on Wheels”

Community Wellness and Safety Programs

This plan does not cover community wellness classes or safety programs.

Complications

This plan does not cover complications of a non-covered service, including follow-up services or effects of those services, except services defined as emergency care. See ***Definitions***.

Cosmetic Services

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

- Reshaping normal structures of the body in order to improve or change your appearance and self-esteem and not primarily to restore an impaired function of the body

  The only exceptions to this exclusion are:

  - Repair of a defect that’s the direct result of an accidental injury, providing such repair is started within 12 months of the date of the accident
  - Repair of a dependent child’s congenital anomaly

- Reconstructive breast surgery in connection with a mastectomy as provided under the Mastectomy and Breast Reconstruction Services benefit
- Correction of functional disorders (not including removal of excess skin and/or fat related to weight loss surgery or the use of weight management drugs), upon our review and approval
- Genital or breast surgery that meets medical necessity criteria, or is medically necessary for the treatment of gender dysphoria diagnoses

Counseling, Educational Or Training Services

This plan does not cover counseling and training in the absence of illness. This includes, but is not limited to:

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

Court-Ordered Services

This plan does not cover services that you must get to avoid being tried, sentenced or losing the right to drive when they are not medically necessary.

Custodial Care

This plan does not cover custodial services, except when it is part of covered hospice care.

Dental Care

This plan does not cover dental care or supplies, except as covered under ***Dental Care***.

Donor Breast Milk

Environmental Therapy

Therapy designed to provide a changed or controlled environment.

Experimental Or Investigational Services

This plan does not cover any service that is experimental or investigative, see ***Definitions***. This plan also does not cover any complications or effects of such services.

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

Family Members Or Volunteers

This plan does not cover services that you give to yourself. It also does not cover a provider who is:

- Your spouse, mother, father, child, brother or sister
- Your mother, father, child, brother or sister by marriage
- Your stepmother, stepfather, stepchild, stepbrother or stepsister
- Your grandmother, grandfather, grandchild or the spouse of one of these people
- A volunteer, except as described in ***Home Health Care*** and ***Hospice Care***

Governmental Medical Facilities

This plan does not cover services provided by a state or federal hospital which is not a network facility, except for emergency care or other covered services as required by law or regulation.

Hair Analysis

Hair Loss

This plan does not cover:

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

Hearing Hardware

- Hearing aids (including batteries and related equipment) that exceed the maximum benefit of $400 per member each plan year. These expenses are also not eligible for coverage under other benefits of this plan.
- Batteries or other ancillary equipment other than that obtained upon purchase of hearing aids
- Hearing aids that exceed the specifications prescribed for correction of hearing loss
- Expenses incurred after your coverage under this plan ends unless hearing aids were ordered before that date and were delivered within 90 days after the date your coverage ended

Hospital Admission Limitations

This plan does not cover hospital stays solely for the diagnostic studies, physical examinations, checkups, medical evaluations or observations, unless:

- The service cannot be provided without the use of a hospital
- You have a medical condition that makes hospital care medically necessary

Illegal Acts and Terrorism

This plan does not cover illness or injury you get while committing a felony, an act of terrorism, or an act of riot or revolt.

Laser Therapy

Benefits are not provided for low-level laser therapy

Military And War-Related Conditions

This plan does not cover illness or injury that is caused by or arises from:

- Acts of war, such as armed invasion, no matter if war has been declared or not
- Services in the armed forces of any country. This includes the air force, army, coast guard, marines, National Guard or navy. It also includes any related civilian forces or units. However, this exclusion does not apply to members of the U.S. military (active or retired) or their dependents enrolled in the TRICARE program. This plan will be primary to TRICARE for these members when required by federal law.

Non-Covered Services

This plan does not cover services or supplies:

- Ordered when this plan is not in effect or when the person is not covered under this plan
- Provided to someone other than the ill or injured member, other than outpatient health education services covered under the ***Preventive Care*** benefit. This includes health care provider training or educational services.
- Directly related to any condition, or related to any other service or supply, that is not covered
- You are not required to pay or would not have been charged for if this plan were not in force
- That are not listed as covered under this plan

Non-Treatment Charges

- Charges for provider travel time
- Transporting a member in place of a parent or other family member or accompanying the member to appointments or other activities outside the home, such as medical appointments or shopping. Doing housework or chores for the member or helping the member do housework or chores.
- Arrangements in which the provider lives with the member

Non-Treatment Facilities, Institutions or Programs

Benefits are not provided for institutional care, housing, incarceration or programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions. Examples are prisons, nursing homes and juvenile detention facilities. Benefits are provided for medically necessary treatment received in these locations. See ***Covered Services*** for specific benefit information.

Not Medically Necessary

Services and places of service that are not medically necessary.

Orthodontia

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

Orthognathic Surgery

Procedures to lengthen or shorten the jaw (orthognathic surgery), regardless of the origin of the condition that makes the procedure necessary. The only exception to this exclusion is for repair of a dependent child's congenital anomaly. See ***Surgery*** for benefit information.

Provider's Licensing or Certification

This plan does not cover services that the provider's license or certification does not allow him or her to perform. It also does not cover a provider that does not have the license or certification that the state requires. The only exception is for applied behavior analysis providers covered under ***Mental Health Care and Substance Use Disorder***. See ***Definitions*** for provider details.

Recreational, Camp and Activity Programs

This plan does not cover recreational, camp and activity-based programs. These programs include:

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

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) website at www.cms.hhs.gov.

Services or Supplies for which You Do Not Legally Have to Pay

Services and supplies for which no charge is made, for which none would have been made if this plan were not in effect, or for which you are not legally required to pay.

Sexual Dysfunction

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

Skilled Nursing Facility Coverage Exceptions

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

Substance Abuse Coverage Exceptions

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

Temporomandibular Joint (TMJ) Disorders

This plan does not cover treatment of TMJ disorders. TMJ disorders are problems with the lower jaw joint that have one or more of the features below:

- Pain in the muscles near the TMJ
- Internal derangements of the parts of the TMJ
- Arthritic problems with the TMJ
- The TMJ has a limited range of motion, or its range of motion is not normal

Vision Hardware

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

Vision Therapy

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

Voluntary Support Groups

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

Work-Related Conditions

This plan does not cover any illness, condition or injury for which you get benefits by law or from separate coverage for illness or injury on the job. For details, see ***Third Party Recovery*** under ***What If I Have Other Coverage?*** section of the booklet.

WHAT IF I HAVE OTHER COVERAGE?

Coordinating of Benefits With Other Health Care (COB) - Medical / Dental and Vision Coverage

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

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

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

Definitions Applicable To Coordination Of Benefits

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

- **Allowable Medical Expense** means the usual, customary and reasonable charge for any medically necessary health care service or supply provided by a licensed medical professional when the service or supply is covered at least in part under this plan. When a plan provides benefits in the form of

services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense.

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

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

Effect On Benefits

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

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

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

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

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

Next: A plan that covers you as a dependent. For dependent children, the following rules apply:
When the parents **aren't** separated or divorced: The plan of the parent whose birthday falls earlier in the year will be primary, if that's in accord with the coordination of benefits provisions of both plans. Otherwise, the rule set forth in the plan that doesn't have this provision shall determine the order of benefits.

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

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

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

Right Of Recovery/Facility Of Payment

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

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

Coordinating Benefits With Medicare

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

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

Third Party Recovery (Subrogation)

General

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

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

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

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

Definitions The following definitions shall apply to this section:

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

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

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

Exclusions

- **Benefits From Other Sources** – Benefits are not available under this plan when coverage is available through:
  - Any type of excess coverage
  - Any type of liability insurance, such as home owner’s coverage or commercial liability coverage
  - Any type of no-fault coverage, such as Personal injury protection (PIP), Medical Payment coverage or Medical Premises coverage
  - Boat coverage
  - Motor vehicle medical or motor vehicle no-fault
  - School or athletic coverage
- **Work-Related Conditions –** Any illness, condition or injury arising out of or in the course of employment, for which the member is entitled to receive benefits, whether or not a proper and timely claim for such benefits has been made under:
  - Occupational coverage required of or voluntarily obtained by the employer
  - State or federal workers compensation acts
  - Any legislative act providing compensation for work-related illness or injury

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

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

Reimbursement and Subrogation Rights

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

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

- The plan’s right to reimbursement first and in full shall apply even if:
  - The recovery is not enough to make you whole for your injury.
  - The funds have been commingled with other assets. The plan may recover from any available funds without the need to trace the source of the funds.
  - The member has died as a result of the injury and a representative is asserting a wrongful death or survivor claim against the third party.
  - The member is a minor, disabled person, or is not able to understand or make decisions.
  - The member did not make a claim for medical expenses as part of any claim or demand
- Any party who distributes your recovery funds without regard to the plan’s rights will be personally liable to the plan for those funds.
- In any case where the plan has the right to be repaid, the plan also has the right of subrogation. This means that the Plan Administrator can choose to take over your right to receive payments from any responsible third party. For example, the plan can file its own lawsuit against a responsible third party. If this happens, you must co-operate with the plan as it pursues its claim.
- The plan shall also have the right to join or intervene in your suit or claim against a responsible third party.
- You cannot assign any rights or causes of action that you might have against a third party tortfeasor, person, or entity, which would grant you the right to any recovery without the express, prior written consent of the plan.

Your Responsibilities

- If any of the requirements below are not met, the plan shall:
  - Deny or delay claims related to your injury
  - Recoup directly from you all benefits the plan has provided for your injury
  - Deduct the benefits owed from any future claims
- You must notify Premera Blue Cross Blue Shield of Alaska of the existence of the injury immediately and no later than 30 days of any claim for the injury.
- You must notify the third parties of the plan's rights under this provision.
- You must cooperate fully with the plan in the recovery of the benefits advanced by the plan and the plan's exercise of its reimbursement and subrogation rights. You must take no action that would prejudice the plan's rights. You must also keep the plan advised of any changes in the status of your claim or lawsuit.
- If you hire a lawyer, you must tell Premera Blue Cross right away and provide the contact information.
- Neither the plan nor Premera Blue Cross Blue Shield of Alaska shall be liable for any costs or lawyer's fees you must pay in pursuing your suit or claim. You shall defend, indemnify and hold the plan and Premera Blue Cross Blue Shield of Alaska harmless from any claims from your lawyer for lawyer's fees or costs.
- You must complete and return to the plan an Incident Questionnaire and any other documents required by the plan.
- Claims for your injury shall not be paid until Premera Blue Cross Blue Shield of Alaska receives a completed copy of the Incident Questionnaire when one was sent.
- You must tell Premera Blue Cross Blue Shield of Alaska if you have received a recovery. If you have, the plan will not pay any more claims for the injury unless you and the plan agree otherwise.
- You must notify the plan at least 14 days prior to any settlement or any trial or other material hearing concerning the suit or claim.

Reimbursement and Subrogation Procedures

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

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

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

OTHER INFORMATION ABOUT THIS PLAN

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

Conformity With The Law

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

Evidence Of Medical Necessity

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

Health Care Providers - Independent Contractors

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

Intentionally False Or Misleading Statements

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

If you make any intentionally false or misleading statements on any application or enrollment form that affects your acceptability for coverage, we may, as directed by 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.) Your coverage cannot be voided based on a misrepresentation you made unless you have performed an act or practice that constitutes fraud; or made an intentional misrepresentation of material fact that affects your acceptability for coverage.

Limitations Of Liability

The plan, the Group and Premera Blue Cross Blue Shield of Alaska are not liable for any of the following:

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

Member Cooperation

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

Notice Of Information Use And Disclosure

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

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

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

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

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

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

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

Notice Of Other Coverage

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

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

The name of any group or individual insurance plans that cover you

Notices

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

Recovery Of Claims Overpayments

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

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

Right To And Payment Of Benefits

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

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

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

Payment to any of the above satisfies the plan's obligation as to payment of benefits.

Venue

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

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

HOW DO I FILE A CLAIM?

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

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:

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

Timely Filing

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. Exceptions will be allowed when required by law or regulation.

Prescription Drug Claims

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

Participating Pharmacies

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

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

Non-Participating Pharmacies

If the pharmacy does not submit your claim for you, you will have to pay the full cost for new prescriptions and refills purchased at these pharmacies. You will also need to fill out a prescription drug claim form, attach your prescription drug receipts and submit the information to the address shown on the claim form.

Claims Procedure

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

- If the claim includes all 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.

If your provider requires a copay when you get medical services or supplies, it is not considered a claim for benefits. However, you always have the right to request and obtain from us a paper copy of your explanation of benefits in connection with such a medical service by calling Customer Service. The phone number is on the front cover of your booklet and on your Premera ID card. Or, you can visit our website, **premera.com**, for information and secure online access to claims information. To file a claim, please see the "How Do I File A Claim?" section for more detail. If your claim is denied in whole or in part, you may submit a complaint or appeal as outlined under ***Complaints and Appeals*** in this booklet.

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**) 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, or you can call Customer Service at
- 1-800-508-4722

COMPLAINTS AND APPEALS

We know healthcare doesn't always work perfectly. Our goal is to listen, take care of you, and make it simple. If it does not go the way you expect, you have two options:

- Complaints – you can contact customer service if you have a complaint, we may ask you to send the details in writing. We will send a written response within 30 days.
- Appeals – is a request to review specific decisions we have made

You can appeal the following adverse benefit determinations (see ***Definitions***):

- Benefits or charges were not applied correctly
- A decision regarding your eligibility to enroll or stay in the plan, including rescissions
- A decision by the plan that services were experimental, investigative, or not medically necessary

How To Submit An Appeal

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

- **Level I internal appeal** People who were not part of the initial decision will review your appeal. Medical review denials will be reviewed by a medical specialist. We must receive your internal appeal request within 180 days of the date you were notified of our initial decision. You can request an extension of the 180-day deadline by sending us a written request that includes the reason why you believe an extension should be granted.
- **Level II internal appeal** will be reviewed by a panel of people who were not part of the Level I internal appeal. Medical review denials will be reviewed by a medical specialist. You may take part in the level II panel meeting in person or by phone. Please call us for more details about this process.

WHO CAN APPEAL

You can appeal yourself or choose someone, including your doctor, to appeal on your behalf. If you choose someone else, complete an Authorization for Appeals form located on **premera.com**. We can't release your information without this form.

HOW TO APPEAL

You can call Customer Service or you can write to us at the address listed inside the front cover of this book. By sending your appeal in writing, you can provide more details about your appeal. This may include chart notes, medical records or a letter from your doctor. Within 3 working days, we will confirm in writing that we have your request.

If you need help filing an appeal, or would like a copy of the appeals process, please call Customer Service. You can also get a description of the appeals process by visiting our website.

If you would like to review the information used for your appeal, please contact Customer Service. The information will be sent as soon as possible and free of charge.

WHAT HAPPENS WHEN YOU HAVE ONGOING CARE

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

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

WHAT HAPPENS WHEN IT'S URGENT

If your condition is urgent, we will handle your appeal in an expedited (fast) manner. Examples of urgent situation are:

- Your life or 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 are inpatient or receiving emergency care

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

Urgent appeals are only available for services you are currently receiving or have not yet received.

WHAT HAPPENS NEXT

Your appeal is reviewed and a decision is provided within the time limits below

Type of appeal	When to expect notification of a decision
Expedited appeals	No later than 72 hours. We will call, fax, or email you with the decision, and follow up in writing.
Other Appeals	Within 30 days

If we stand by our first decision or we do not follow the process above you can request an external appeal. External appeal is available only for decisions involving a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the service or treatment you received.

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.

ESTIMATED QUOTE FOR OUT OF POCKET EXPENSE

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 allowed benefit.

The following information should be sent to Premera 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 pertains 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 allowed amount.

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 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

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 allowed amount.

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.

Adverse Benefit Determination

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

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

Affordable Care Act

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

Allowable Charge

The allowable charge shall mean one of the following:

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

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

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

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

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

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

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

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

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

  The allowed amount 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 allowed amount.

  For Services and Supplies Received Within Our Service Area:

  In determining the allowed amount, 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 allowed amount 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 allowed amount to no less than the equivalent of the 80th percentile or no lower than 250% of Medicare allowed amount for the same services or supplies, whichever is greater.

Services and Supplies from Professional Providers: The allowed amount 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 allowed amount 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 allowed amount will be no less than the 80th percentile of billed charges using the methodology described above.

Services from Hospitals (Acute Facilities): In determining the allowed amount, 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 allowed amount 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 allowed amount to no less than the equivalent of the 80th percentile or no lower than 250% of Medicare allowed amount for the same services or supplies, whichever is greater.

- **Providers Outside of Alaska Who Don't Have Agreements With Us or Another Blue Cross Blue Shield Licensee**

  The allowed amount for providers outside of Alaska is the least of the three amounts shown below.

  - An amount that is no less than the lowest amount the plan pays for the same or similar service from a comparable provider that has a contracting agreement with us
  - 125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), if available
  - The provider's billed charges. Note: Ambulances are always paid based on billed charges.

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

Please note: Ambulance providers that do not have agreements with us or another Blue Cross Blue Shield Licensee are always paid based on billed charges.

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

  - The amount the plan allows for dialysis during Medicare's waiting period will be no less than 80th percentile of billed charges
  - The amount the plan allows for dialysis after Medicare's waiting period is 125% of the Medicare-approved amount, even if you do not enroll in Medicare

  Providers Outside of Alaska Who Don't Have Agreements With Us Or Another Blue Cross Blue Shield Licensee

  - The amount the plan allows for dialysis during Medicare's waiting period will be the least of these three amounts:
    - An amount that is no less than the lowest amount the plan pays for the same or similar service from a comparable provider that has a contracting agreement with us
    - 125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), if available
    - The provider's billed charges. Note: Ambulances are always paid based on billed charges.

- The amount the plan allows for dialysis after Medicare's waiting period is 125% of the Medicare-approved amount, even if you do not enroll in Medicare

Please see the ***Dialysis*** benefit for more details.

- **Emergency Services**

  Consistent with the requirements of the Affordable Care Act, the allowed amount 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

  Please note: Ambulance providers that do not have agreements with us or another Blue Cross Blue Shield Licensee are always paid based on billed charges.

  When you get 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 allowed amount, and for your normal share of the allowed amount.

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

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

Ambulatory Surgical Center

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

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

Applied Behavior Analysis

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

Autism Spectrum Disorders

Pervasive developmental disorders or a group of conditions having substantially the same characteristics as pervasive developmental disorders, as defined in the current **Diagnostics 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.

Clinical Trials

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

- An institutional review board that complies with federal standards for protecting human research subjects and
- One or more of the following:
  - The United States Department of Health and Human Services, National Institutes of Health, or its institutes or centers
  - The United States Department of Health and Human Services, United States Food and Drug Administration (FDA)

- The United States Department of Defense
- The United States Department of Veterans' Affairs
- A nongovernmental research entity abiding by current National Institute of Health guidelines

Congenital Anomaly

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

Copay

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

Cost-share

Member's share of the allowed amount for covered services. Deductibles, copays, and coinsurance are all types of cost-shares. Please see the ***Summary of Your Benefits*** to find out what your cost-share is.

Custodial Care

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

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

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 ***Complaints and Appeals*** in this booklet for an explanation of the appeals process.

Dentist

One who is licensed to provide services in the state where the services are rendered as a:

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

Detoxification

Detoxification is active medical management of medical conditions due to substance intoxication or 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.

Emergency Care

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

Employer

City & Borough of Juneau/Bartlett Regional Hospital/Juneau School District

Enrollee

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

Eligibility Waiting Period

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

Enrollment Date

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

Expense Incurred

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

Experimental/Investigational Services

Experimental or investigational services include a treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the following criteria:

- A drug or device that can’t be lawfully marketed without the approval of the U.S. Food and Drug Administration, and hasn’t been granted such approval on the date the service is provided
- The service is subject to oversight by an Institutional Review Board
- No reliable evidence demonstrates that the service is effective, in clinical diagnosis, evaluation, management or treatment of the condition
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy. However, services that meet the standards outlined in the Clinical Trials benefit will not be deemed experimental or investigational.
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies

Reliable evidence includes but 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.

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, complications of pregnancy, or pregnancy of an employee or dependent.

Inpatient

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

Maternity 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.

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.

Network Provider

A provider that is in one of the networks.

Orthodontia

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

Orthotic

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

Out-of-Network Provider

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

Outpatient

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

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

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

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.)
- Podiatrist (D.P.M.)

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

- An Advanced registered nurse practitioner (A.R.N.P.)
- A Certified Direct Entry Midwife
- A Chiropractor (D.C.)
- A Dentist (D.D.S. or D.M.D.)
- A Licensed Clinical Social Worker (L.C.S.W.)
- A Licensed Marital and Family Therapist; (L.M.F.T.)
- A Licensed Marriage and Family Counselor (L.M.F.C.)
- A Licensed Massage Practitioners (L.M.P.)

- A Naturopath (N.D.)
- A Nurse Midwife
- An Occupational Therapist (O.T.)
- An Optometrist (O.D.)
- A Physical Therapist (P.T.)
- A Physician Assistant supervised by a collaborating M.D. or D.O.
- A Podiatrist (D.P.M.)
- A Psychological Associate
- A Psychologist (Ph.D.)

Plan (also called "This Plan")

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

Plan Administrator

City & Borough of Juneau/ Bartlett Regional Hospital/Juneau School District, 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.

Premera Blue Cross Blue Shield of Alaska

Selected by City & Borough of / Bartlett Regional Hospital/Juneau School District 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 (also called "Covered Provider")

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

Psychiatric Condition

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

Service Area

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

Skilled Care

Care that's ordered by a physician and requires the medical knowledge and technical training of a licensed registered nurse.

Skilled Nursing Facility

A medical facility providing services that require the direction of a physician and nursing supervised by a registered nurse and that's 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 Premera Blue Cross Blue Shield of Alaska

SUMMARY PLAN DESCRIPTION

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
315 Fifth Avenue S, Suite 200
Seattle, Washington 98104
Telephone: (206) 515-2800
Fax: (206) 515-2779
TTY: (800) 833-6388

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.

where to send claims

MAIL YOUR CLAIMS TO:

Premera Blue Cross Blue Shield of Alaska

P.O. Box 91059

Seattle, WA 98111-9159

MAIL PRESCRIPTION DRUG CLAIMS TO:

Express Scripts

ATTN: Commercial Claims

P.O. Box 14711

Lexington, KY 40512-4711

www.premera.com