Preferred Bronze 5250 HSA

Alaska plan for individuals and families

Start date January 1, 2019

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

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You have access to the national Blue Cross Blue Shield BlueCard® network of providers. The plan's high deductible allows you to set up a savings account to pay for qualified healthcare costs. Premera plans include benefits that support you in traveling to get the medical care you need. Except for emergency care, you pay the Non-Participating cost-share for services you get from any state-licensed or certified provider outside the service area of Alaska or Washington. Your out-of-pocket costs will be lower if you use a BlueCard provider, as these providers accept our allowed amount as payment in full.

			Preferred Bronze 5250 HSA		
			Heritage network of providers	Non-preferred providers	Non-participating providers
	Annual Deductible	Per Calendar Year (PCY) Family = 2x individual	$5,250	2x individual deductible	2x individual deductible
	Coinsurance	Amount you pay after your deductible is met	35%	40%	60%
	Out-of-Pocket Maximum	Includes deductible, coinsurance, and copays Family = 2x individual *(in-network)*	$6,700	Unlimited	Unlimited
	10 Essential Health Benefits				
1	**Ambulatory Patient Services** **Office Visits**	Outpatient services	35%*	40%*	60%*
		PCP office visit	35%*	40%*	60%*
		Non-designated PCP & specialist office visit	35%*	40%*	60%*
		Urgent care	35%*	40%*	60%*
		Virtual care	35%*	40%*	60%*
		Spinal manipulation: 12 visits PCY; Acupuncture: 12 visits PCY	35%*	40%*	60%*
2	**Emergency Services**	Emergency care	35%*	Same as in-network	Same as in-network
		Ambulance transportation (air & ground)	35%*	Emergent: Same as in-network Non-emergent: Air - 40%* Ground - Same as in-network coverage	Emergent: Same as in-network Non-emergent: Air - 60%* Ground - Same as in-network coverage
3	**Hospitalization**	Inpatient services	35%*	40%*	60%*
		Organ and tissue transplants, inpatient	35%*	Not covered	Not covered
4	**Maternity & Newborn Care**	Prenatal, delivery, postnatal care	35%*	40%*	60%*
5	**Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment**	Office visit	35%*	40%*	60%*
		Inpatient hospital	35%*	40%*	60%*
		Outpatient services	35%*	40%*	60%*
6	**Prescription Drugs** *Retail: up to 90-day supply* *Mail Order: 90-day supply*	Preferred generic	35%*	Retail: Same as in-network Mail order: not covered	Retail: Same as in-network Mail order: not covered
		Preferred brand	35%*	Retail: Same as in-network Mail order: not covered	Retail: Same as in-network Mail order: not covered
		Non-preferred drugs	35%*	Retail: Same as in-network Mail order: not covered	Retail: Same as in-network Mail order: not covered
		Specialty *(30-day supply)*	40%*	Retail: Same as in-network Mail order: not covered	Retail: Same as in-network Mail order: not covered
		Drug list	M2		
7	**Rehabilitative & Habilitative Services & Devices**	Inpatient rehabilitation: 30 days PCY	35%*	40%*	60%*
		Physical, speech, occupational, massage therapy: 45 visits combined PCY	35%*	40%*	60%*
		Durable medical equipment	35%*	40%*	60%*
8	**Laboratory Services**	Includes x-ray, pathology, imaging/diagnostic, standard ultrasound	35%*	40%*	60%*
		Major imaging, including MRI, CT, PET *(pre-approval required for certain services)*	35%*	40%*	60%*
9	**Preventive/Wellness Services**	Screenings	Covered in full	40%*	60%*
		Exams and immunizations	Covered in full	40%*	60%*
10	**Pediatric Services, including Vision & Dental** *Under 19 years of age*	Eye exam: 1 PCY	Deductible waived, then 35%	Same as in-network	Same as in-network
		Eyewear: 1 pair of glasses PCY (frames & lenses); 12-month supply of contacts PCY, in lieu of glasses (frames & lenses)	Covered in full	Same as in-network	Same as in-network
		Dental: preventive/basic/major	10%* / 20%* / 50%*	30%* / 40%* / 50%*	30%* / 40%* / 50%*
		Orthodontia (medically necessary only)	50%*	50%*	50%*

*The deductible applies, unless otherwise noted.

We want to make it simple and easy for you to understand your health plan.

Allowed amount: The amount we pay for healthcare services. When you receive services from in-network providers, you'll be responsible only for cost shares (deductibles, copays, and coinsurance) and charges for services not covered by the health plan. In-network providers will not bill you for charges over the allowed amount. If you receive services from out-of-network providers, you are responsible for all amounts not paid by us.

Coinsurance: Your percentage of the cost for a service. You pay 100% until your deductible is paid for the calendar year. After that, if your plan's coinsurance is 30 percent, you pay 30 percent of the allowed amount and your plan pays the other 70 percent.

Copay: This is a flat fee you pay for a specific service (such as an office visit) at the time you receive the service.

Covered in full: A benefit that does not require cost shares. You do not pay deductibles, coinsurance, or copays for services that are covered in full.

Deductible: The amount you pay in medical costs before your health plan begins to pay.

Drug list: A list, sometimes called a formulary, of drugs covered by the plan. Not all drugs are included in every drug list.

Federal poverty level (FPL): A measure of household income, set by federal guidelines, used to determine if you are eligible for government subsidies to help pay for healthcare coverage purchased through the state or federal exchange.

Health savings account (HSA): A savings account through a bank that is available to individuals who are enrolled in a qualified high-deductible health plan. The funds contributed to a health savings account are used to pay qualified medical expenses not covered by the health plan.

High-deductible health plan: A health plan that meets IRS requirements for use with a health savings account. A high-deductible health plan requires you to meet the annual deductible before most services are covered.

In-network: Doctors, dentists, pharmacies, hospitals, and other healthcare providers that are contracted to provide services and supplies at negotiated amounts, called allowed amounts.

Out-of-pocket maximum: The maximum amount of money you will pay for covered services in a calendar year. After you've met your out-of-pocket maximum, the plan pays 100 percent for in-network services for the rest of the year.

Preferred Plan: This preferred provider organization (PPO) plan is designed for the unique needs of Alaska residents. This plan provides benefits for both in-network and out-of-network providers. When you receive services from in-network providers, you will usually have lower out-of-pocket costs. The plan includes Alaska Medical Transportation benefits and access to the national Blue Cross Blue Shield BlueCard® network of providers.

Primary care provider (PCP): The doctor or other healthcare provider you designate to provide most of your healthcare needs. You can choose a different primary care provider for each family member. Your primary care doctor can be a family practice physician, general practice provider, naturopath, geriatric practice provider, gynecologist, internist, nurse practitioner, obstetrician, pediatrician, or physician assistant.

Urgent care: Illnesses or injuries that require treatment right away but are not life threatening. Examples are high fevers; minor sprains and cuts; and ear, nose, and throat infections.

Virtual Care: Talk with a doctor by phone or online video.

If you see a non-participating provider, you will be responsible for the difference between the allowed amount and the provider's billed charges, in addition to the deductible, coinsurance, and any applicable copay. The allowed amount for a non-participating provider is determined by Premera as described in your plan member booklet.

General exclusions and limitations

Below is a list of some things that this health plan does not cover. A complete list of exclusions is available in the sample benefit booklets available on **premera.com**.

Benefits are not provided for treatment, surgery, services, drugs, or supplies for any of the following:

- Cosmetic surgery
- Experimental or investigative services
- Assisted reproduction
- Weight loss, including surgery, drugs, foods, and exercise programs
- Service in excess of specified benefit maximums
- Services payable by other types of insurance coverage
- Services received when you are not covered by this plan
- Sexual dysfunction
- Sterilization reversal
- Temporomandibular joint (TMJ) disorder

For a list of services and procedures that require approval for coverage from your plan before you receive them (pre-approval), visit **premera.com**.

Contact us

For enrollment information or if you have questions about Premera Blue Cross Blue Shield of Alaska:

- Visit **premera.com**.
- Call **877-Premera** (877-773-6372).
- Talk to a **producer**, a licensed professional also known as an agent.

This is only a summary of the major benefits provided by our plans. This is not a contract. On our website, you can find a supplemental guide with information about plan policies and procedures.

Notice of availability and nondiscrimination **800-508-4722 | TTY: 711**

Call for free language assistance services and appropriate auxiliary aids and services.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Hu thov kev pab txhais lus pub dawb thiab lwm yam khoom pab dawb thiab kev pab cuam ua tsim nyog.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Vala‘au mo auaunaga tau fesoasoani mo gagana e leai ni totogi ma fesoasoani fa‘aopo‘opo talafeagai ma auaunaga.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
Tumawag para kadagiti libre a serbisio iti tulong iti pagsasao ken dagiti nakanada nga aid ken serbisio iti komunikasion.
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
ติดต่อขอบริการช่วยเหลือด้านภาษาฟรีพร้อมความช่วยเหลือและบริการอื่น ๆ เพิ่มเติม
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d’assistance linguistique et des aides et services auxiliaires appropriés.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

Discrimination is against the law. Premera Blue Cross Blue Shield of Alaska (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our 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, TTY: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our 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 Ave 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.

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