Preferred Silver 3000 HSA

Alaska plan for individuals and families

Start date January 1, 2021

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

An Independent Licensee of the Blue Cross Blue Shield Association

You have access to the Legacy and Dental Select Network and the national Blue Cross Blue Shield BlueCard® provider network. Please refer to the next page for important plan and network information.

			Preferred Silver 3000 HSA		
			Legacy and Dental Select network	Non-preferred providers	Non-participating providers
	Annual deductible	Per calendar year (PCY) Family = 2x individual	$3,000	2x individual deductible	2x individual deductible
	Coinsurance	Amount you pay after your deductible is met	30%	40%	60%
	Out-of-pocket maximum	Includes deductible, coinsurance, copays Family = 2x individual (in-network only)	$6,600	Unlimited	Unlimited
	10 essential health benefits				
1	**Ambulatory patient services**	Outpatient services	30%*	40%*	60%*
	Office visits	Designated PCP office visit	30%*	40%*	60%*
		Specialist office visit	30%*	40%*	60%*
		Urgent care	30%*	40%*	60%*
		Spinal manipulation: 10 visits PCY; Acupuncture: 12 visits PCY	30%*	40%*	60%*
2	**Emergency services**	Emergency care	30%*	Same as in-network	Same as in-network
		Ambulance transportation (air and ground)	30%*	Emergent: Same as in-network Non-emergent: Air - 40%* Ground - Same as in-network	Emergent: Same as in-network Non-emergent: Air - 60%* Ground - Same as in-network
3	**Hospitalization**	Inpatient services	30%*	40%*	60%*
		Organ and tissue transplants, inpatient	30%*	Not covered	Not covered
4	**Maternity and newborn care**	Prenatal and postnatal care	30%*	40%*	60%*
		Inpatient delivery and services	30%*	40%*	60%*
5	**Mental health and substance use disorder services, including behavioral health treatment**	Office visit	30%*	40%*	60%*
		Inpatient hospital: mental/behavioral health	30%*	40%*	60%*
		Outpatient services	30%*	40%*	60%*
6	**Prescription drugs**	Preferred generic	30%*	Retail: Same as in-network Mail order: not covered	Retail: Same as in-network Mail order: not covered
	Retail/Specialty: 30-day supply	Preferred brand	30%*	Retail: Same as in-network Mail order: not covered	Retail: Same as in-network Mail order: not covered
	Mail order: 90-day supply	Non-preferred drugs	30%*	Retail: Same as in-network Mail order: not covered	Retail: Same as in-network Mail order: not covered
		Specialty	40%*	Retail: Same as in-network Mail order: not covered	Retail: Same as in-network Mail order: not covered
		Drug list	M2		
7	**Rehabilitative and habilitative services and devices**	Inpatient rehabilitation: 30 days PCY	30%*	40%*	60%*
		Physical, speech, occupational, massage therapy: 45 visits combined PCY	30%*	40%*	60%*
		Durable medical equipment	30%*	40%*	60%*
8	**Laboratory services**	Includes x-ray, pathology, imaging and diagnostic, standard ultrasound	30%*	40%*	60%*
		Major imaging, including MRI, CT, PET (preapproval required for certain services)	30%*	40%*	60%*
9	**Preventive/wellness services**	Screenings	Covered in full	40%*	60%*
		Exams and vaccinations	Covered in full	40%*	60%*
10	**Pediatric services, including vision and dental** under 19 years of age	Eye exam: 1 PCY	Deductible waived, then 30%	Same as in-network	Same as in-network
		Eyewear: 1 pair of glasses PCY (frames and lenses); 12-month supply of contacts PCY, in lieu of glasses (frames and 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%*
	Virtual Care	Doctor On Demand: general medicine, behavioral health	30%	40%*	60%*
		Boulder Care or Workit Health: Substance use disorder	30%	40%*	60%*
		All other virtual providers	Subject to standard cost shares	Subject to standard cost shares	Subject to standard cost shares

* The deductible applies unless otherwise noted

Important network information

You have access to the Premera Legacy and Dental Select Network and the national Blue Cross Blue Shield BlueCard® provider network. 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 receive from any state-licensed or certified provider outside of 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.

Understanding your health plan should be simple and easy.

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%, you pay 30% of the allowed amount and your plan pays the other 70%.

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 of drugs, sometimes called a formulary, that are 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. These subsidies 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 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.

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% 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. The 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 and coordinate your care. You can choose a different primary care provider for each family member. Your PCP can be a family practice physician, general practice provider, geriatric practice provider, gynecologist, internist, nurse practitioner, obstetrician, pediatrician, or physician assistant.

Urgent care: Conditions that need treatment right away but are not severe or life threatening. For urgent conditions, care from an out-of-network provider is not covered.

Virtual care: Talk with a doctor by phone or online video—usually for the same cost as an in-person office visit.

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:

- Services that are not medically necessary
- Cosmetic surgery or reconstructive surgery (except as specifically provided)
- 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 such as property insurance, liability insurance, or motor vehicle insurance
- Services that the provider's license or certification does not allow him or her to perform
- Services received when you are not covered by this plan
- Sexual dysfunction
- Sterilization reversal

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:

- 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.

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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, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities 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 services to people whose primary language is not English, such as qualified interpreters and 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, sex, gender identity, or sexual orientation, 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: 711, 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 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.

Language Assistance

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-809-9361 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-809-9361 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-809-9361 (TTY: 711) 번으로 전화해 주십시오.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 800-809-9361 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-809-9361 (телетайп: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-809-9361 (TTY：711）。

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 800-809-9361 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-809-9361 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-809-9361 （TTY:711）まで、お電話にてご連絡ください。

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 800-809-9361 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-809-9361 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.

Телефонуйте за номером 800-809-9361 (телетайп: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-809-9361 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-809-9361 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-809-9361 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-809-9361 (رقم هاتف الصم والبكم: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-809-9361 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-809-9361 (ATS : 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-809-9361 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-809-9361 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-809-9361 (TTY: 711) تماس بگیرید.