Premera BCBS of AK: Preferred Gold 1500 AI/AN 300%

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-809-9361 (TTY: 711) or visit us at https://www.premera.com/ak/SBC. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, Provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-809-9361 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: $1,500 Individual / $3,000 Family. Out-of-network: $3,000 Individual.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Does not apply to copayments, certain prescription drugs and services listed below as "No charge."	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/ preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $6,300 Individual / $12,600 Family. Out-of-network: Not Applicable	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, penalties for failure to obtain pre-authorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See Legacy and Dental Select medical network. For a list of in-network providers, see https://www.premera.com or call 1-800-809-9361.	You pay the least if you use a provider in our preferred network. You pay more if you use a provider in our non-preferred network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	AI AN In-Network Provider	What you will Pay: Network Provider (You will pay the least)	What you will Pay: Out-Of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	$30 copayment	Non-Preferred: 40% coinsurance Non-Participating: 60% coinsurance	Deductible does not apply in-network. Deductible applies out-of-network. No charge for first 2 visits per calendar year from designated primary care physician.
	Specialist visit	No charge	$60 copayment	Non-Preferred: 40% coinsurance Non-Participating: 60% coinsurance	Deductible does not apply in-network. Deductible applies out-of-network.
	Preventive care / screening / immunization	No charge	No charge	Non-Preferred: 40% coinsurance Non-Participating: 60% coinsurance	Deductible does not apply in-network. Deductible applies out-of-network. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	Non-Preferred: 40% coinsurance Non-Participating: 60% coinsurance	Deductible applies.
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	Non-Preferred: 40% coinsurance Non-Participating: 60% coinsurance	Deductible applies. Prior authorization required for some outpatient imaging tests. The penalty is: 50% of the allowable charge up to a maximum of $1,500 per occurrence.
If you need drugs to treat your illness or condition More information	Preferred Generic drugs	No charge	$15 copayment (retail) $45 copayment (mail)	$15 copayment (retail) Not covered (mail)	Deductible does not apply. Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). No charge for specific preventive drugs. Prior authorization required for some drugs.

Common Medical Event	Services You May Need	What you will Pay			Limitations, Exceptions, & Other Important Information
		AI AN In-Network Provider	Network Provider (You will pay the least)	Out-Of-Network Provider (You will pay the most)	
about **prescription drug coverage** is available at https://www.premera.com/documents/052166_2022.pdf.	Preferred brand drugs	No charge	$45 copayment (retail) $135 copayment (mail)	$45 copayment (retail) Not covered (mail)	Deductible does not apply. Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). Prior authorization required for some drugs.
	Non-preferred brand drugs	No charge	50% coinsurance	50% coinsurance (retail) Not covered (mail)	Deductible applies. Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). Prior authorization required for some drugs.
	Specialty drugs	No charge	40% coinsurance	40% coinsurance	Deductible applies. Covers up to a 30 day supply. Only covered at specific contracted specialty pharmacies. Prior authorization required for some drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	Non-Preferred: 40% coinsurance Non-Participating: 60% coinsurance	Deductible applies. Prior authorization required for some services. The penalty is: 50% of the allowable charge up to a maximum of $1,500 per occurrence.
	Physician/surgeon fees	No charge	30% coinsurance	Non-Preferred: 40% coinsurance Non-Participating: 60% coinsurance	Deductible applies.
If you need immediate medical attention	Emergency room care	No charge	30% coinsurance	30% coinsurance	Deductible applies.
	Emergency medical transportation	No charge	30% coinsurance	30% coinsurance	Deductible applies.
	Urgent care	No charge	Hospital-based: 30% coinsurance Freestanding center: $60 copayment	Hospital-based: 30% coinsurance Freestanding center: Non-Preferred: 40% coinsurance Non-Participating: 60% coinsurance	Hospital based: Deductible applies. Freestanding center: Deductible does not apply in-network. Deductible applies out-of-network.

Common Medical Event	Services You May Need	What you will Pay			Limitations, Exceptions, & Other Important Information
		AI AN In-Network Provider	Network Provider (You will pay the least)	Out-Of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% coinsurance	Non-Preferred: 40% coinsurance Non-Participating: 60% coinsurance	Deductible applies. Prior authorization required for all planned inpatient stays. The penalty is: 50% of the allowable charge up to a maximum of $1,500 per occurrence.
	Physician/surgeon fees	No charge	30% coinsurance	Non-Preferred: 40% coinsurance Non-Participating: 60% coinsurance	Deductible applies.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Office Visit: $60 copayment Facility: 30% coinsurance	Non-Preferred: 40% coinsurance Non-Participating: 60% coinsurance	Office visit: Deductible does not apply in-network. Deductible applies out-of-network. Facility: Deductible applies to in-network and out-of-network.
	Inpatient services	No charge	30% coinsurance	Non-Preferred: 40% coinsurance Non-Participating: 60% coinsurance	Deductible applies. Prior authorization required for all planned inpatient stays. The penalty is: 50% of the allowable charge up to a maximum of $1,500 per occurrence.
If you are pregnant	Office visits	No charge	30% coinsurance	Non-Preferred: 40% coinsurance Non-Participating: 60% coinsurance	Deductible applies. Cost-sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).
	Childbirth/delivery professional services	No charge	30% coinsurance	Non-Preferred: 40% coinsurance Non-Participating: 60% coinsurance	Deductible applies. Prior authorization is not required. Cost-sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).

Common Medical Event	Services You May Need	What you will Pay		Limitations, Exceptions, & Other Important Information
		AI AN In-Network Provider	Network Provider (You will pay the least)	Out-Of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	No charge	30% coinsurance	Non-Preferred: 40% coinsurance Non-Participating: 60% coinsurance	Deductible applies. Cost-sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound). Prior authorization is not required. However, you should notify the carrier of your admission for delivery as soon as reasonably possible.
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	Non-Preferred: 40% coinsurance Non-Participating: 60% coinsurance	Deductible applies. Limited to 130 visits per calendar year
	Rehabilitation services	No charge	Office Visit: $60 copayment Facility: 30% coinsurance	Non-Preferred: 40% coinsurance Non-Participating: 60% coinsurance	Deductible applies. Limited to 45 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Prior authorization required for all planned inpatient stays. The penalty is: 50% of the allowable charge up to a maximum of $1,500 per occurrence.
	Habilitation services	No charge	Office Visit: $60 copayment Facility: 30% coinsurance	Non-Preferred: 40% coinsurance Non-Participating: 60% coinsurance	Deductible applies. Limited to 45 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Prior authorization required for all planned inpatient stays. The penalty is: 50% of the allowable charge up to a maximum of $1,500 per occurrence.

Common Medical Event	Services You May Need	What you will Pay			Limitations, Exceptions, & Other Important Information
		AI AN In-Network Provider	Network Provider (You will pay the least)	Out-Of-Network Provider (You will pay the most)	
	Skilled nursing care	No charge	30% coinsurance	Non-Preferred: 40% coinsurance Non-Participating: 60% coinsurance	Deductible applies. Limited to 60 days per calendar year. Prior authorization required for all planned inpatient stays. The penalty is: 50% of the allowable charge up to a maximum of $1,500 per occurrence.
	Durable medical equipment	No charge	30% coinsurance	Non-Preferred: 40% coinsurance Non-Participating: 60% coinsurance	Deductible applies. Prior authorization required to buy some medical equipment over $750. The penalty is: 50% of the allowable charge up to a maximum of $1,500 per occurrence.
	Hospice service	No charge	30% coinsurance	Non-Preferred: 40% coinsurance Non-Participating: 60% coinsurance	Deductible applies. Limited to 240 respite hours, limited to 10 inpatient days – 6 months overall lifetime benefit limit.
If your child needs dental or eye care	Children's eye exam	No charge	$30 copayment	$30 copayment	Deductible does not apply. Limited to one exam per calendar year (under age 19).
	Children's glasses	No charge	No charge	No charge	Deductible does not apply. Frames and lenses limited to 1 pair per calendar year.
	Children's dental check-up	No charge	No charge	30% coinsurance	Deductible does not apply in-network. Deductible applies out-of-network.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Assisted fertility treatment
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Acupuncture
- Chiropractic care or other spinal manipulations
- Foot care
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-907-269-7900 or 1-800-467-8725 for the state insurance department, or the insurer at 1-800-809-9361 or TTY 711. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your plan at 1-800-809-9361, or the state insurance department at 1-907-269-7900 or 1-800-467-8725.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Not Applicable.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-809-9361 or TTY 711.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-809-9361 or TTY 711.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-809-9361 or TTY 711.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-809-9361 or TTY 711.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist copayment	$60
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$3,300
What isn't covered	
Limits or exclusions	$60
The Total Peg would pay is	**$4,870**

Managing Joe's type 2 diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist copayment	$60
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The Total Joe would pay is	**$1,820**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist copayment	$60
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The Total Mia would pay is	**$2,000**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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.