

# Premera Blue Cross Standard Silver 1800 CSR3

Alaska plan for individuals and families

Start date January 1, 2024



**BLUE CROSS BLUE SHIELD OF ALASKA**

An Independent Licensee of the Blue Cross Blue Shield Association

		IN NETWORK		OUT OF NETWORK	
		Legacy and Dental Select network Preferred providers	Non-preferred providers	Non-participating providers	
<b>Annual deductible</b>	Per calendar year (PCY) Family = 2x individual	\$0	\$0	\$0	
	Amount you pay after your deductible is met	25%	25%	60%	
<b>Out-of-pocket maximum</b>	Includes deductible, copays Family = 2x individual (in-network only)	\$1,800	\$1,800	Not covered	
<b>10 essential health benefits</b>					
<b>1 Ambulatory patient services</b>	Outpatient services	25% coinsurance	25% coinsurance	60% coinsurance	
<b>Professional visits and services</b>	Designated PCP office visit	Covered in full	25% coinsurance	60% coinsurance	
	Specialist office visit	\$10 copay	25% coinsurance	60% coinsurance	
	Urgent care	\$5 copay	25% coinsurance	60% coinsurance	
	Spinal manipulation: 12 visits PCY; Acupuncture: 12 visits PCY	Covered in full	25% coinsurance	60% coinsurance	
<b>2 Emergency services</b>	Emergency care	25% coinsurance	25% coinsurance	25% coinsurance	
	Ambulance transportation (air and ground)	25% coinsurance	25% coinsurance	25% coinsurance	
<b>3 Hospitalization</b>	Inpatient services	25% coinsurance	25% coinsurance	60% coinsurance	
	Organ and tissue transplants, inpatient	25% coinsurance	Not covered	Not covered	
<b>4 Maternity and newborn care</b>	Prenatal and postnatal care	25% coinsurance	25% coinsurance	60% coinsurance	
	Inpatient delivery and services	25% coinsurance	25% coinsurance	60% coinsurance	
<b>5 Mental health and substance use disorder services, including behavioral health treatment</b>	Office visit	Covered in full	25% coinsurance	60% coinsurance	
	Inpatient hospital: mental/behavioral health	Deductible, then 25%	25% coinsurance	60% coinsurance	
	Outpatient services	Deductible, then 25%	25% coinsurance	60% coinsurance	
<b>6 Prescription drugs</b>	Preferred generic	Covered in full	Covered in full	Covered in full	
	Retail/Specialty: 30-day supply	Preferred brand	\$15 copay	\$15 copay	
	(Mail order: 90-day supply)	Non-preferred drugs	\$50 copay	\$50 copay	\$50 copay
		Specialty	\$150 copay	\$150 copay	\$150 copay
		Drug list	<b>M4</b>		
<b>7 Rehabilitative and habilitative services and devices</b>	Inpatient rehabilitation: 30 days PCY	25% coinsurance	25% coinsurance	60% coinsurance	
	Physical, speech, occupational, massage therapy: 25 visits combined PCY	Covered in full	25% coinsurance	60% coinsurance	
	Durable medical equipment	25% coinsurance	25% coinsurance	60% coinsurance	
<b>8 Laboratory services</b>	Includes x-ray, pathology, imaging and diagnostic, standard ultrasound	25% coinsurance	25% coinsurance	60% coinsurance	
	Major imaging, including MRI, CT, PET (preapproval required for certain services)	25% coinsurance	25% coinsurance	60% coinsurance	
<b>9 Preventive/wellness services</b>	Screenings	Covered in full	25% coinsurance	60% coinsurance	
	Exams and vaccinations	Covered in full	25% coinsurance	60% coinsurance	
<b>10 Pediatric services, including vision and dental</b> under 19 years of age	Eye exam: 1 PCY	\$30 copay	\$30 copay	\$30 copay	
	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	Covered in full	Covered in full	
	Dental: preventive/basic/major	Covered in full/deductible, then 20%/50%	Not applicable	Deductible, then 30%/40%/50%	
	Orthodontia (medically necessary only)	50% coinsurance	Not applicable	Deductible, then 50%	
<b>Adult routine dental</b>	Cleanings 2 PCY; Bitewing x-rays 1 PCY; subject to \$750 maximum per person PCY	10% coinsurance	Not applicable	30% coinsurance	
<b>Virtual care</b>	Doctor On Demand: general medicine	See professional visits and services	See professional visits and services	Not covered	
	Boulder Care or Workit Health: mental health including substance use disorder	See professional visits and services	See professional visits and services	Not covered	
	All other virtual providers	See professional visits and services	See professional visits and services	See professional visits and services	

## Important plan and network information

Premiera Preferred plans are preferred provider organization (PPO) plans. You have access to the Premiera [Legacy and Dental Select Network](#) and the national Blue Cross Blue Shield BlueCard® provider network. Premiera 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. Cost-sharing for essential health benefit services provided by preferred and non-preferred providers accumulate toward meeting the annual in-network out-of-pocket maximum.

## 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 them to perform
- Services received when you are Unlimited 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 (preapproval), visit [premera.com](#).

## Contact Us

For enrollment information or if you have questions about Premiera Blue Cross:

- Visit [premera.com](#).
- Call **877-Premiera** (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.

Visit [premera.com/visitor/summary-benefits-coverage](#) for a Summary of Benefits and medical glossary.

**Discrimination is against the law.** Premiera Blue Cross Blue Shield of Alaska (Premiera) 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. Premiera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premiera 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). Premiera 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 Premiera 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, P.O. Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email [AppealsDepartmentInquiries@Premiera.com](mailto:AppealsDepartmentInquiries@Premiera.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 le tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se tologi, mo oe, Telefoni mai: 800-809-9361 (TTY: 711).

ໄປອຊາວ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໄດຍບໍ່ຄ່າຈ່າຍ, ຕ້ອງມີພ້ອມໃຫ້ທ່ານ. ໂທສ 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 kenyan. 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 تماس بگیرید.