# Premera Blue Cross Standard Bronze II 7500

## Alaska plan for individuals and families

Start date January 1, 2024

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.

| | | | IN NETWORK | | OUT OF NETWORK |
|---|---|---|---|---|---|
| | | | Legacy and Dental Select network Preferred providers | Non-preferred providers | Non-participating providers |
| | **Annual deductible** | Per calendar year (PCY)<br>Family = 2x individual | $7,500 | $7,500 | $15,000 |
| | | Amount you pay after your deductible is met | 50% | 50% | 60% |
| | **Out-of-pocket maximum** | Includes deductible, copays<br>Family = 2x individual (in-network only) | $9,400 | $9,400 | Not covered |
| | **10 essential health benefits** | | | | |
| 1 | **Ambulatory patient services** | Outpatient services | Deductible, then 50% | Deductible, then 50% | Deductible, then 60% |
| | **Professional visits and services** | Designated PCP office visit | $50 copay | Deductible, then 50% | Deductible, then 60% |
| | | Specialist office visit | $100 copay | Deductible, then 50% | Deductible, then 60% |
| | | Urgent care | $75 copay | Deductible, then 50% | Deductible, then 60% |
| | | Spinal manipulation: 12 visits PCY;<br>Acupuncture: 12 visits PCY | $50 copay | Deductible, then 50% | Deductible, then 60% |
| 2 | **Emergency services** | Emergency care | Deductible, then 50% | Deductible, then 50% | Deductible, then 50% |
| | | Ambulance transportation (air and ground) | Deductible, then 50% | Deductible, then 50% | Deductible, then 50% |
| 3 | **Hospitalization** | Inpatient services | Deductible, then 50% | Deductible, then 50% | Deductible, then 60% |
| | | Organ and tissue transplants, inpatient | Deductible, then 50% | Deductible, then 50% | Not covered |
| 4 | **Maternity and newborn care** | Prenatal and postnatal care | Deductible, then 50% | Deductible, then 50% | Deductible, then 60% |
| | | Inpatient delivery and services | Deductible, then 50% | Deductible, then 50% | Deductible, then 60% |
| 5 | **Mental health and substance use disorder services, including behavioral health treatment** | Office visit | $50 copay | Deductible, then 50% | Deductible, then 60% |
| | | Inpatient hospital: mental/behavioral health | Deductible, then 50% | Deductible, then 50% | Deductible, then 60% |
| | | Outpatient services | Deductible, then 50% | Deductible, then 50% | Deductible, then 60% |
| 6 | **Prescription drugs** | Preferred generic | $25 copay | $25 copay | $25 copay |
| | Retail/Specialty: 30-day supply | Preferred brand | Deductible, then $50 copay | Deductible, then $50 copay | Deductible, then $50 copay |
| | (Mail order: 90-day supply) | Non-preferred drugs | Deductible, then $100 copay | Deductible, then $100 copay | Deductible, then $100 copay |
| | | Specialty | Deductible, then $500 copay | Deductible, then $500 copay | Deductible, then $500 copay |
| | | Drug list | M4 | | |
| 7 | **Rehabilitative and habilitative services and devices** | Inpatient rehabilitation: 30 days PCY | Deductible, then 50% | Deductible, then 50% | Deductible, then 60% |
| | | Physical, speech, occupational, massage therapy: 45 visits combined PCY | $50 copay | Deductible, then 50% | Deductible, then 60% |
| | | Durable medical equipment | Deductible, then 50% | Deductible, then 50% | Deductible, then 60% |
| 8 | **Laboratory services** | Includes x-ray, pathology, imaging and diagnostic, standard ultrasound | Deductible, then 50% | Deductible, then 50% | Deductible, then 60% |
| | | Major imaging, including MRI, CT, PET (preapproval required for certain services) | Deductible, then 50% | Deductible, then 50% | Deductible, then 60% |
| 9 | **Preventive/wellness services** | Screenings | Covered in full | Deductible, then 50% | Deductible, then 60% |
| | | Exams and vaccinations | Covered in full | Deductible, then 50% | Deductible, then 60% |
| 10 | **Pediatric services, including vision and dental** 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) | Deductible, then 50% | Not applicable | Deductible, then 50% |
| | **Adult routine dental** | Cleanings 2 PCY; Bitewing x-rays 1 PCY; subject to $750 maximum per person PCY | 10% coinsurance | Not applicable | Deductible, then 30% |
| | **Virtual care** | 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

Premera Preferred plans are preferred provider organization (PPO) plans. 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. 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 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.

Visit premera.com/visitor/summary-benefits-coverage for a Summary of Benefits and medical glossary.

**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.