PPO $750 Deductible – Alaska

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Highlights of your Health Care Coverage

Bering Straits Native Corporation

Group Number: 4000231

Effective Date: 01/01/2017

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MEDICAL PLAN	2017 BUY-UP AK - $750/20%/$5,000/$25	
	IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 2X Individual)	$750 PCY	Shared with In-Network
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	Hospital and Hospital-Based CD Programs: 20%; Other Facilities and Professionals: Same as In-Network
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$5,000 PCY	Shared with In-Network
Office Visit Cost Share	$25 Copay, applies to the Out of Pocket Maximum	$25 Copay, applies to the Out of Pocket Maximum
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited)	Covered In Full[1]	Covered In Full[1]
Immunizations (Unlimited)	Covered In Full‡	Deductible, then Hospital and Hospital-Based CD Programs: 20%; Other Facilities and Professionals: Same as In-Network‡
Health Education (HE) (Unlimited)	Covered In Full[1]	Covered In Full[1]
Diabetes Health Education (DE) (Unlimited)	Covered In Full[1]	Covered In Full[1]
PROFESSIONAL CARE		
Professional Office Visit Including Urgent Care	$25 Copay, applies to the Out of Pocket Maximum	$25 Copay, applies to the Out of Pocket Maximum
Inpatient Professional Services	Deductible, then 20%	Deductible, then 20%
Contraceptive Management Services (Unlimited)	Covered In Full[1]	Covered In Full[1]
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full[1]	Covered In Full[1]
Other Professional Diagnostic Imaging	Deductible, then 20%	Deductible, then Hospital and Hospital-Based CD Programs: 20%; Other Facilities and Professionals: Same as In-Network
Other Professional Diagnostic Laboratory/Pathology	Deductible, then 20%	Deductible, then Hospital and Hospital-Based CD Programs: 20%; Other Facilities and Professionals: Same as In-Network
Diagnostic Mammography	Covered In Full[1]	Covered In Full[1]

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FACILITY CARE OPTIONS		
Inpatient Facility	Deductible, 20% Preferred/20% Participating	Deductible, then Hospital and Hospital-Based CD Programs: 20%; Other Facilities: Same as In-Network
Outpatient Surgery Facility	Deductible, then 20% Preferred/20% Participating	Deductible, then 20%
Hospice Inpatient Facility (Inpatient: Unlimited; Respite: 240 hours; 6 month limit)	Deductible, 20% Preferred/20% Participating	Deductible, then Hospital and Hospital-Based CD Programs: 20%; Other Facilities: Same as In-Network
EMERGENCY CARE AND TRANSPORTATION OPTIONS		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$100 copay applies to the Out of Pocket Maximum, then deductible, waive coinsurance	$100 copay applies to the Out of Pocket Maximum, then deductible, waive coinsurance
Emergency Room Physician	Deductible, then 20%	Deductible, then 20%
Ambulance Transportation (Unlimited)	$100 copay applies to the Out of Pocket Maximum, then deductible, waive coinsurance	$100 copay applies to the Out of Pocket Maximum, then deductible, waive coinsurance
Non-Emergent Ground Ambulance (Unlimited)	$100 copay applies to the Out of Pocket Maximum, then deductible, waive coinsurance	$100 copay applies to the Out of Pocket Maximum, then deductible, waive coinsurance
Air Ambulance (Unlimited)	$100 copay applies to the Out of Pocket Maximum, then deductible, waive coinsurance	$100 copay applies to the Out of Pocket Maximum, then deductible, waive coinsurance
Non-Emergent Air Ambulance (Unlimited)	Deductible, then 20%	Deductible, then 60%
Air Or Surface Transportation (3 round trips PCY for patient (includes 3 round trips PCY for parent or guardian if pt. under 18 yrs of age))	Deductible, then 20%	Deductible, then 20%
Medical Travel Support (Prior Authorization Required: Member & Companion - Air: 1 round-trip per episode; Surface Transportation & Parking: $35/day; Ferry Transportation $50 per person each way; Lodging $50/day per person)	Travel: Covered In Full; Medical Procedures: covered as any other service	Travel: Covered In Full; Medical Procedures: covered as any other service
OTHER SERVICES		
Allergy/Therapeutic Injections	$25 Copay, applies to the Out of Pocket Maximum	$25 Copay, applies to the Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	Deductible, 20% Preferred†	Deductible, then Hospital and Hospital-Based CD Programs: 20%; Other Facilities: Same as In-Network†
Mental Health Outpatient Professional Care (Unlimited)	$25 Copay, applies to the Out of Pocket Maximum†	$25 Copay, applies to the Out of Pocket Maximum†
Chemical Dependency Inpatient Facility Care (Unlimited)	Deductible, 20% Preferred	Deductible, then Hospital and Hospital-Based CD Programs: 20%; Other Facilities: Same as In-Network
Chemical Dependency Outpatient Professional Care (Unlimited)	$25 Copay, applies to the Out of Pocket Maximum	$25 Copay, applies to the Out of Pocket Maximum

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Rehab Inpatient Facility (Unlimited)	Deductible, 20% Preferred/20% Participating	Deductible, then Hospital and Hospital-Based CD Programs: 20%; Other Facilities: Same as In-Network
Rehab Outpatient Care, Including Physical, Occupational, Speech & Pulmonary Rehab. and Chronic Pain (20 visits PCY. Cardiac rehab is limited to 36 separate visits PCY. Massage therapy is not covered)	$25 Copay, applies to the Out of Pocket Maximum*	$25 Copay, applies to the Out of Pocket Maximum*
Medical Supplies, Equipment, Prosthetics (MS: Unlimited; ME: Unlimited; Pro: Unlimited)	Deductible, then 20%	Deductible, then Hospital and Hospital-Based CD Programs: 20%; Other Facilities and Professionals: Same as In-Network
Foot Orthotics, Orthopedic Shoes and Accessories (Unlimited)	Deductible, then 20%	Deductible, then Hospital and Hospital-Based CD Programs: 20%; Other Facilities and Professionals: Same as In-Network
Home Health Visits (120 Visits PCY)	Deductible, then 20%	Deductible, then Hospital and Hospital-Based CD Programs: 20%; Other Facilities and Professionals: Same as In-Network
Hospice Care (Home Health and Respite) (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	Deductible, then 20%	Deductible, then Hospital and Hospital-Based CD Programs: 20%; Other Facilities and Professionals: Same as In-Network
TMJ (Temporomandibular Joint Disorders) (Non-Surgical $1,250 lifetime maximum; surgical is not covered)	Covered as any other service	Covered as any other service
Transplants (Unlimited; $75,000 donor and $10,000 travel and lodging limits)	Covered as any other service	Not Covered
ALTERNATIVE CARE		
Manipulations (Spinal and other) (Unlimited)	$25 Copay, applies to the Out of Pocket Maximum	$25 Copay, applies to the Out of Pocket Maximum
Acupuncture (12 visits PCY)	$25 Copay, applies to the Out of Pocket Maximum	$25 Copay, applies to the Out of Pocket Maximum
Nutritional Therapy (Unlimited)	Covered In Full[1]	Covered In Full[1]
SUPPLEMENTAL BENEFITS		
Pediatric Vision Exam (1 PCY Under age 19)	Covered In Full[1]	Covered In Full[1]
Pediatric Vision Hardware (Under age 19: One pair of glasses PCY (frames & lenses). 12 month supply of contacts PCY, in lieu of glasses (frames & lenses).)	Covered In Full[1]	Covered In Full[1]
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited

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	IN-NETWORK	OUT-OF-NETWORK

[1]Benefits provided at 100% of allowable charges; not subject to deductible or coinsurance.

‡Seasonal immunizations provided at a pharmacy will be covered in full up to maximum allowable amount.

*Massage therapy must be billed by a licensed physician.

†Autism: Mental Health, Psychological & Neuropsychological Testing, Outpatient Professional & Facility Care covered as any other service.

Copays are not subject to the deductible unless otherwise noted.

Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross Blue Shield of Alaska. Members are responsible for amounts in excess of the allowable charge.

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms under which the program may be continued in force. This benefit highlight is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.

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Pharmacy Benefits

Tier 1 = Generic
Tier 2 = Brand Name

Below is a brief overview of what you can expect to pay for a generic prescription drug when using an In-Network Pharmacy. For more information on your pharmacy benefits, including Out-of-Network benefits, see your benefit booklet. To locate an In-Network Pharmacy, go to www.premera.com.

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PHARMACY PLAN	**2017 RX PLAN $10/$25**
	Cost Share Category Tier1/Tier2
PRESCRIPTION DRUGS	
Retail Cost Shares	$10/$25
Mail Cost Shares	$20/$50
Day Supply	Retail: 30 days; Mail: 90 days; Specialty: 30 days
Individual Deductible PCY	$0
(Non-participating retail pharmacies)	Member pays 30%, plan pays 70%
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Annual Benefit Maximum	Unlimited
Drug List	Preferred A2
Specialty Pharmacy	Mandatory

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