PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Highlights of your Health Care Coverage

Bering Straits Native Corporation

Group Number: 4000231

Effective Date: 01/01/2016

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.
Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

MEDICAL PLAN	**2016 BASE PLAN AK - $1,500/20%/$5,000**	
	IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family aggregate deductible)	$1,500 Individual / $3,000 Family	Shared with In-Network
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	Hospital/CD Facility: 20%; Other Facilities and All Professionals: Same as In-Network
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family aggregate OOP max)	$5,000 Individual / $6,850 Family	Not Applicable
Office Visit Cost Share	Deductible, then 20%	Deductible, then 20%
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/CD Facility: 20%; Other Facilities and All 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	Deductible, then 20%	Deductible, then 20%
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]	Deductible, then Hospital/CD Facility: 20%; Other Facilities and All Professionals: Same as In-Network
Other Professional Diagnostic Imaging	Deductible, then 20%	Deductible, then Hospital/CD Facility: 20%; Other Facilities and All Professionals: Same as In-Network
Other Professional Diagnostic Laboratory/Pathology	Deductible, then 20%	Deductible, then Hospital/CD Facility: 20%; Other Facilities and All Professionals: Same as In-Network
Diagnostic Mammography	Deductible, then 20%	Deductible, then Hospital/CD Facility: 20%; Other Facilities and All Professionals: Same as In-Network

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	IN-NETWORK	OUT-OF-NETWORK
FACILITY CARE OPTIONS		
Inpatient Facility	Deductible, then 20% preferred/20% participating	Deductible, then Hospital/CD Facility: 20%; Other Facilities and All Professionals: Same as In-Network
Outpatient Surgery Facility	Deductible, then 20% preferred/20% participating	Deductible, then Hospital/CD Facility: 20%; Other Facilities and All Professionals: Same as In-Network
Hospice Inpatient Facility (Unlimited, within the 6-month lifetime maximum)	Deductible, then 20% preferred/20% participating	Deductible, then Hospital/CD Facility: 20%; Other Facilities and All Professionals: Same as In-Network
EMERGENCY CARE AND TRANSPORTATION OPTIONS		
Emergency Care	Deductible, then 20%	Deductible, then 20%
Emergency Room Physician	Deductible, then 20%	Deductible, then 20%
Ambulance Transportation (Unlimited)	Deductible, then 20%	Deductible, then 20%
Non-Emergent Ground Ambulance (Unlimited)	Deductible, then 20%	Deductible, then 20%
Air Ambulance (Unlimited)	Deductible, then 20%	Deductible, then 20%
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: Deductible, then 0%; Medical Procedures: covered as any other service	Travel: Deductible, then 0%; Medical Procedures: covered as any other service
OTHER SERVICES		
Allergy/Therapeutic Injections	Deductible, then 20%	Deductible, then 20%
Mental Health Inpatient Facility Care (Unlimited)	Deductible, then 20% preferred†	Deductible, then Hospital/CD Facility: 20%; Other Facilities and All Professionals: Same as In-Network†
Mental Health Outpatient Professional Care (Unlimited)	Deductible, then 20%†	Deductible, then 20%†
Chemical Dependency Inpatient Facility Care (Unlimited)	Deductible, then 20% preferred	Deductible, then Hospital/CD Facility: 20%; Other Facilities and All Professionals: Same as In-Network
Chemical Dependency Outpatient Professional Care (Unlimited)	Deductible, then 20%	Deductible, then 20%

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	IN-NETWORK	OUT-OF-NETWORK
Rehab Inpatient Facility (Unlimited)	Deductible, then 20% preferred/20% participating	Deductible, then Hospital/CD Facility: 20%; Other Facilities and All Professionals: 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.)	Deductible, then 20%*	Deductible, then 20%*
Medical Supplies, Equipment, Prosthetics (Unlimited)	Deductible, then 20%	Deductible, then Hospital/CD Facility: 20%; Other Facilities and All Professionals: Same as In-Network
Foot Orthotics, Orthopedic Shoes and Accessories (Unlimited)	Deductible, then 20%	Deductible, then Hospital/CD Facility: 20%; Other Facilities and All Professionals: Same as In-Network
Home Health Visits (120 Visits PCY)	Deductible, then 20%	Deductible, then Hospital/CD Facility: 20%; Other Facilities and All Professionals: Same as In-Network
Hospice Care (Home Health and Respite) (240 Hours)	Deductible, then 20%	Deductible, then Hospital/CD Facility: 20%; Other Facilities and All Professionals: Same as In-Network
TMJ (Temporomandibular Joint Disorders) ($1,250 non-surgical lifetime maximum; surgical not covered)	Deductible, then 20%	Deductible, then Hospital/CD Facility: 20%; Other Facilities and All Professionals: Same as In-Network
Transplants (Unlimited; $75,000 donor and $10,000 travel and lodging limits)	Deductible, then 20%	Not Covered
Prescription Drugs - Retail (generic/preferred/non-preferred)	Deductible, then 20%	Deductible, then 20%
Prescription Drugs - Mail (generic/preferred/non-preferred) (Specific preventive drugs and legend Retail: 30 day supply/Mail: 90 day supply/Specialty: 30 day supply)	Deductible, then 20%	Not Covered
Specialty Pharmacy (Mandatory)	Deductible, then 20%	Not covered
ALTERNATIVE CARE		
Manipulations (Spinal and other) (Unlimited)	Deductible, then 20%	Deductible, then 20%
Acupuncture (12 visits PCY)	Deductible, then 20%	Deductible, then 20%
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.