BLUE CROSS BLUE SHIELD PLUS 5250 HSA HIGH, A MULTI-STATE PLAN

BLUE CROSS BLUE SHIELD OF ALASKA

An Independent Licensee of the Blue Cross Blue Shield Association

In Exchange Alaska plan for individuals & families

Beginning January 1, 2016

***The deductible applies, unless otherwise noted.**

			BLUE CROSS BLUE SHIELD PLUS 5250 HSA HIGH, A MULTI-STATE PLAN		
			Heritage Plus network providers	**Non-preferred providers**	**Non-participating providers**
	Annual Deductible	Per Calendar Year (PCY) Family = 2x individual	$5,250	2x individual deductible	2x individual deductible
	Coinsurance	Amount you pay after your deductible is met	20%	40%	60%
	Out-of-Pocket Maximum	Includes deductible, coinsurance, and copays Family = 2x individual *(in-network)*	$6,100	Unlimited	Unlimited
	10 Essential Benefits Covered Services				
1	**Ambulatory Patient Services Office Visits**	Outpatient services	20%*	40%*	60%*
		PCP office visit	20%*	40%*	60%*
		Non-designated PCP & specialist office visit	20%*	40%*	60%*
		Urgent care	20%*	40%*	60%*
		Virtual care	20%*	40%*	60%*
		Spinal manipulation: 12 visits PCY; Acupuncture: 12 visits PCY	20%*	40%*	60%*
2	**Emergency Services**	Emergency care	20%*	Same as in-network	Same as in-network
		Ambulance transportation (air & ground)	20%*	Emergent: Same as in-network Non-emergent: Air - 40%* Ground - Same as in-network	Emergent: Same as in-network Non-emergent: Air - 60%* Ground - Same as in-network
3	**Hospitalization**	Inpatient services	20%*	40%*	60%*
		Organ and tissue transplants, inpatient	20%*	Not covered	Not covered
4	**Maternity & Newborn Care**	Prenatal, delivery, postnatal care	20%*	40%*	60%*
5	**Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment**	Office visit	20%*	40%*	60%*
		Inpatient hospital	20%*	40%*	60%*
		Outpatient services	20%*	40%*	60%*
6	**Prescription Drugs** *Retail: up to 90-day supply* *Mail Order: 90-day supply*	Generic	20%*	Retail: Same as in-network Mail order: not covered	Retail: Same as in-network Mail order: not covered
		Preferred brand	20%*		
		Non-preferred brand	20%*		
		Specialty *(30 day supply)*	20%*	Not covered	Not covered
		Drug formulary	X1		
7	**Rehabilitative & Habilitative Services & Devices**	Inpatient rehabilitation: 30 days PCY	20%*	40%*	60%*
		Physical, speech, occupational, massage therapy: 45 visits combined PCY	20%*	40%*	60%*
		Durable medical equipment	20%*	40%*	60%*
8	**Laboratory Services**	Includes x-ray, pathology, imaging/diagnostic, ultrasound	20%*	40%*	60%*
		Major imaging including MRI, CT, PET *(prior authorization required for certain services)*	20%*	40%*	60%*
9	**Preventive/Wellness Services**	Screenings	Covered in full	40%*	60%*
		Exams and immunizations	Covered in full	40%*	60%*
10	**Pediatric Services, including Vision & Dental** *Under 19 years of age*	Eye exam: 1 PCY	Deductible waived, then 10%	Same as in-network	Same as in-network
		Eyewear: 1 pair of glasses PCY (frames & lenses); 12-month supply of contacts PCY, in lieu of glasses (frames & lenses)	Covered in full	Same as in-network	Same as in-network
		Dental: preventive/basic/major	10%* / 20%* / 50%*	30%* / 40%* / 50%*	30%* / 40%* / 50%*
		Orthodontia (medically necessary only)	50%*	50%*	50%*

Premera Blue Cross Blue Shield of Alaska does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment & benefit determinations.

Definitions

Allowed Amount: The amount contracted providers have agreed to accept for services or supplies. You'll be responsible only for any applicable cost sharing, including deductibles, copays, coinsurance, charges in excess of the stated benefit maximums and charges for services and supplies not covered under this plan. In-network providers cannot bill you for charges over the allowed amount.

Coinsurance: Your share of the cost for a service. If your plan's coinsurance is 20%, you pay 20% of the allowed amount and your plan pays the other 80% of the allowed amount.

Copay: A flat fee you pay for a specific service, such as an office visit, at the time you receive service.

Covered in full: Services of which your plan pays the total cost, at 100% of the allowed amount. You do not pay deductibles, coinsurance or copays for these services.

Deductible: The amount of money you pay every year for covered services before the plan pays for certain benefits.

Federal Poverty Level (FPL): A measure of household income, set by federal guidelines, used to determine if you are eligible for government subsidies to help pay for healthcare coverage purchased through the state or federal exchange.

Formulary: A list of drugs covered by a health plan. Not all generic, brand-name and specialty drugs are included in every formulary.

Health Savings Account (HSA): A savings account through a bank that is available to individuals who are enrolled in a qualified high deductible health plan. The funds contributed to the account, as well as interest and investment earnings, aren't subject to federal income tax when used for qualified medical expenses.

In-network: Doctors, dentists, hospitals, and other healthcare providers that are contracted to provide services and supplies at negotiated amounts called allowed amounts.

Out-of-pocket maximum: The maximum amount of money you will pay for covered services in a calendar year. After you've paid this amount, your plan pays 100% of the allowed amount for services received from in-network providers.

Primary care provider (PCP): The doctor or other healthcare provider you see for most of your routine healthcare needs, often known as your "family doctor." You can choose a different primary care provider for each family member. Your PCP can be a family practice physician, general practice provider, geriatric practice provider, gynecologist, internist, nurse practitioner, obstetrician, pediatrician, physician assistant or naturopath.

Urgent Care: For conditions that require immediate medical attention when your doctor is not available, but are not severe or life-threatening. Your copay may be lower if care is received from an urgent care center that is affiliated with your PCP. (Use the emergency room only for life-threatening emergencies and trauma requiring immediate medical attention and treatment.).

Note that if you see a non-participating provider, you will be responsible for the difference between the allowed amount and the provider's billed charges, in addition to the deductible, coinsurance and any applicable copay. The allowed amount for a non-participating provider is determined by Premera as described in your forthcoming benefit book.

General exclusions and limitations

Benefits are not provided for treatment, surgery, services, drugs, or supplies for any of the following:

- Cosmetic surgery
- Experimental or investigative services
- Infertility
- Obesity/morbid obesity, including surgery, drugs, foods, and exercise programs
- Orthognathic surgery
- Service in excess of specified benefit maximums
- Services payable by other types of insurance coverage
- Services received when you are not covered by this program
- Sexual dysfunction
- Sterilization reversal
- Temporomandibular joint (TMJ) disorder

For a list of services and procedures that require approval for coverage from your plan before you receive them (prior authorization), visit **premera.com**.

Contact Us

For information about how a health plan works, see Health Plan Basics on **premera.com**. You'll find information about:

- Monthly healthcare rates for low-income members (government subsidies)
- Penalties for people who don't choose a health plan
- How to find an in-network doctor

For information or questions about Premera Blue Cross Blue Shield of Alaska:

- Visit **premera.com**
- Call Customer Service at **800-508-4722** from 8 a.m. to 6 p.m. Pacific time, Monday–Friday
- Talk to your producer

This is only a summary of the major benefits provided by our plans. This is not a contract. Please see **premera.com/SBC** for the Summary of Benefits and Coverage and Glossary. On our website, you can also find a Supplemental Guide with information about plan policies and procedures.

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