Preferred Silver 3500

Alaska plan for individuals and families

Start date January 1, 2020

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

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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.

			Preferred Silver 3500		
			Legacy and Dental Select network	Non-preferred providers	Non-participating providers
	Annual deductible	Per calendar year (PCY) Family = 2x individual (in-network only)	$3,500	2x individual deductible	2x individual deductible
	Coinsurance	Amount you pay after your deductible is met	30%	40%	60%
	Out-of-pocket maximum	Includes deductible, coinsurance, copays Family = 2x individual (in-network only)	$7,800	Unlimited	Unlimited
	10 essential health benefits				
1	**Ambulatory patient services**	Outpatient services	30%*	40%*	60%*
	Office visits	Designated PCP office visit	$30 copay, first 2 PCP visits covered in full	40%*	60%*
		Specialist office visit	$60 copay	40%*	60%*
		Urgent care	$60 copay	40%*	60%*
		Virtual care	$15 copay	40%*	60%*
		Spinal manipulation: 10 visits PCY; Acupuncture: 12 visits PCY	$30 copay	40%*	60%*
2	**Emergency services**	Emergency care	30%*	Same as in-network	Same as in-network
		Ambulance transportation (air and ground)	30%*	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 c
3	**Hospitalization**	Inpatient services	30%*	40%*	60%*
		Organ and tissue transplants, inpatient	30%*	Not covered	Not covered
4	**Maternity and newborn care**	Prenatal and postnatal care	30%*	40%*	60%*
		Inpatient delivery and services	30%*	40%*	60%*
5	**Mental health and substance use disorder services, including behavioral health treatment**	Office visit	$60 copay	40%*	60%*
		Inpatient hospital: mental/behavioral health	30%*	40%*	60%*
		Outpatient services	30%*	40%*	60%*
6	**Prescription drugs**	Preferred generic	$20 copay	Retail: Same as in-network Mail order: not covered	Retail: Same as in-network Mail order: not covered
	Retail/Specialty: 30-day supply	Preferred brand	$60 copay	Retail: Same as in-network Mail order: not covered	Retail: Same as in-network Mail order: not covered
	Mail order: 90-day supply (copay x3)	Non-preferred drugs	50%*	Retail: Same as in-network Mail order: not covered	Retail: Same as in-network Mail order: not covered
		Specialty	40%*	Retail: Same as in-network Mail order: not covered	Retail: Same as in-network Mail order: not covered
		Drug list	M4		
7	**Rehabilitative and habilitative services and devices**	Inpatient rehabilitation: 30 days PCY	30%*	40%*	60%*
		Physical, speech, occupational, massage therapy: 45 visits combined PCY	Deductible, then $60 copay	40%*	60%*
		Durable medical equipment	30%*	40%*	60%*
8	**Laboratory services**	Includes x-ray, pathology, imaging and diagnostic, standard ultrasound	30%*	40%*	60%*
		Major imaging, including MRI, CT, PET (preapproval required for certain services)	30%*	40%*	60%*
9	**Preventive/wellness services**	Screenings	Covered in full	40%*	60%*
		Exams and vaccinations	Covered in full	40%*	60%*
10	**Pediatric services, including vision and dental** under 19 years of age	Eye exam: 1 PCY	$30 copay	Same as in-network	Same as in-network
		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	Same as in-network	Same as in-network
		Dental: preventive/basic/major	Deductible waived, then 10%/20%*/50%*	30%*/40%*/50%*	30%*/40%*/50%*
		Orthodontia (medically necessary only)	50%*	50%*	50%*
	Adult routine dental	Cleanings 2 PCY; Bitewing x-rays 1 PCY; subject to $750 maximum per person PCY	Deductible waived, then 10%	Deductible, then 30%	Deductible, then 30%

* The deductible applies unless otherwise noted

Important network information

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.

Understanding your health plan should be simple and easy.

Allowed amount: The amount we pay for healthcare services. When you receive services from in-network providers, you'll be responsible only for cost shares (deductibles, copays, and coinsurance) and charges for services not covered by the health plan. In-network providers will not bill you for charges over the allowed amount. If you receive services from out-of-network providers, you are responsible for all amounts not paid by us.

Coinsurance: Your percentage of the cost for a service. You pay 100% until your deductible is paid for the calendar year. After that, if your plan's coinsurance is 30%, you pay 30% of the allowed amount and your plan pays the other 70%.

Copay: This is a flat fee you pay for a specific service (such as an office visit) at the time you receive the service.

Covered in full: A benefit that does not require cost shares. You do not pay deductibles, coinsurance, or copays for services that are covered in full.

Deductible: The amount you pay in medical costs before your health plan begins to pay.

Drug list: A list of drugs, sometimes called a formulary, that are covered by the plan. Not all drugs are included in every drug list.

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

In-network: Doctors, dentists, pharmacies, 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 met your out-of-pocket maximum, the plan pays 100% for in-network services for the rest of the year.

Preferred plan: This preferred provider organization (PPO) plan is designed for the unique needs of Alaska residents. The plan provides benefits for both in-network and out-of-network providers. When you receive services from in-network providers, you will usually have lower out-of-pocket costs. The plan includes Alaska Medical Transportation benefits and access to the national Blue Cross Blue Shield BlueCard® network of providers.

Primary care provider (PCP): The doctor or other healthcare provider you designate to provide and coordinate your care. 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, or physician assistant.

Urgent care: Conditions that need treatment right away but are not severe or life threatening. For urgent conditions, care from an out-of-network provider is not covered.

Virtual care: Talk with a doctor by phone or online video—usually for the same cost as an in-person office visit.

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 plan member booklet.

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 him or her to perform
- Services received when you are not covered 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 (pre-approval), 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.