Alaska HSA 20 Plan

For plans effective May 1, 2009

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Deductible, coinsurance and copay represent **what you pay**. All coinsurance amounts are based on allowable charges. Benefits apply after calendar year deductible is met, unless otherwise noted as "no deductible," "copay" or "covered in full."

MEDICAL BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible PCY (choose one)	Individual: $1,700 *or* $2,500 Family: $3,400 *or* $5,000	
Annual Coinsurance Maximum PCY (once met, in-network providers covered in full)	Individual: $3,300 *or* $2,500 Family: $6,600 *or* $5,000	Unlimited for out-of-network hospital
Lifetime Benefit Maximum	$5 Million	
COVERED SERVICES		
PREVENTIVE CARE		
Preventive Care Exams (routine medical exam, men's and women's health exam, sports physical and well baby exam)	No deductible applies, you pay 20%	
Immunizations (unlimited)	Covered in full	
Preventive Screenings (includes PAP smear, PSA testing, home colon cancer screening, cholesterol screening and bone density test)	Covered in full	
PROFESSIONAL CARE		
Office Visit and Urgent Care (visits shared with Naturopathy)	Deductible applies first, then you pay 20%	
Outpatient and Inpatient Professional Services	Deductible applies first, then you pay 20%	
ALTERNATIVE CARE		
Spinal and Other Manipulations 12 visits PCY (visits shared with Acupuncture)	Deductible applies first, then you pay 20%	
Acupuncture 12 visits PCY (visits shared with Spinal and Other Manipulations)	Deductible applies first, then you pay 20%	
Naturopathy (visits shared with Office Visits)	Deductible applies first, then you pay 20%	
DIAGNOSTIC SERVICES		
Outpatient Diagnostic X-ray and Lab Services	Deductible applies first, then you pay 20%	
Mammography	No deductible applies, you pay 20%	
PHARMACY		
Retail and Mail Order	Not covered, discount program available*	
EMERGENCY CARE		
Emergency Care (copay waived if direct admit to an inpatient facility)	Deductible applies first, then you pay 20%	
Ambulance Transportation Air and Ground (unlimited)	Deductible applies first, then you pay 20%	
FACILITY CARE		
Inpatient Facility Care	Deductible applies first, then you pay 20%	You pay 50% for out-of-network hospital
Outpatient Facility Care	Deductible applies first, then you pay 20%	You pay 50% for out-of-network hospital
Skilled Nursing Facility 20 days PCY	Deductible applies first, then you pay 20%	You pay 50% for out-of-network hospital
MATERNITY		
Maternity Care (including prenatal care) $4,000 PCY 12-month benefit exclusion period**	Deductible applies first, then you pay 20%	
OTHER SERVICES		
Supplies, Equipment and Prosthetics $5,000 PCY	Deductible applies first, then you pay 20%	
Home Health Care 130 visits PCY	Deductible applies first, then you pay 20%	
Hospice Care Inpatient: 10 days, Respite: 240 hours PCY	Deductible applies first, then you pay 20%	
Rehabilitation (includes Physical, Occupational, Speech, Massage Therapy; Chronic Pain; Cardiac & Pulmonary Rehab) Outpatient: 15 visits PCY, Inpatient: 10 days PCY	Deductible applies first, then you pay 20%	
Transplants (Organ and Bone Marrow) $250,000 lifetime benefit max, 12-month benefit exclusion period**	Deductible applies first, then you pay 20%	Not covered

PCY = Per Calendar Year

* In order to validate current eligibility for this discount, the pharmacy will transmit your information to Premera, including the details of the prescription to be filled.

** Benefit exclusion period is a time period during which specified treatment or services are excluded from coverage under this plan. After the benefit exclusion period is satisfied, services may be eligible for benefits, subject to terms of contract.

Note: For services covered in full, benefits are provided at 100% of allowable charges; not subject to deductible or coinsurance.

This is only a summary of the major benefits provided by our plans. This is not a contract.

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015350 (01-2009)