Health plans that come with trust

INDIVIDUALS AND FAMILIES | 1.1.2014

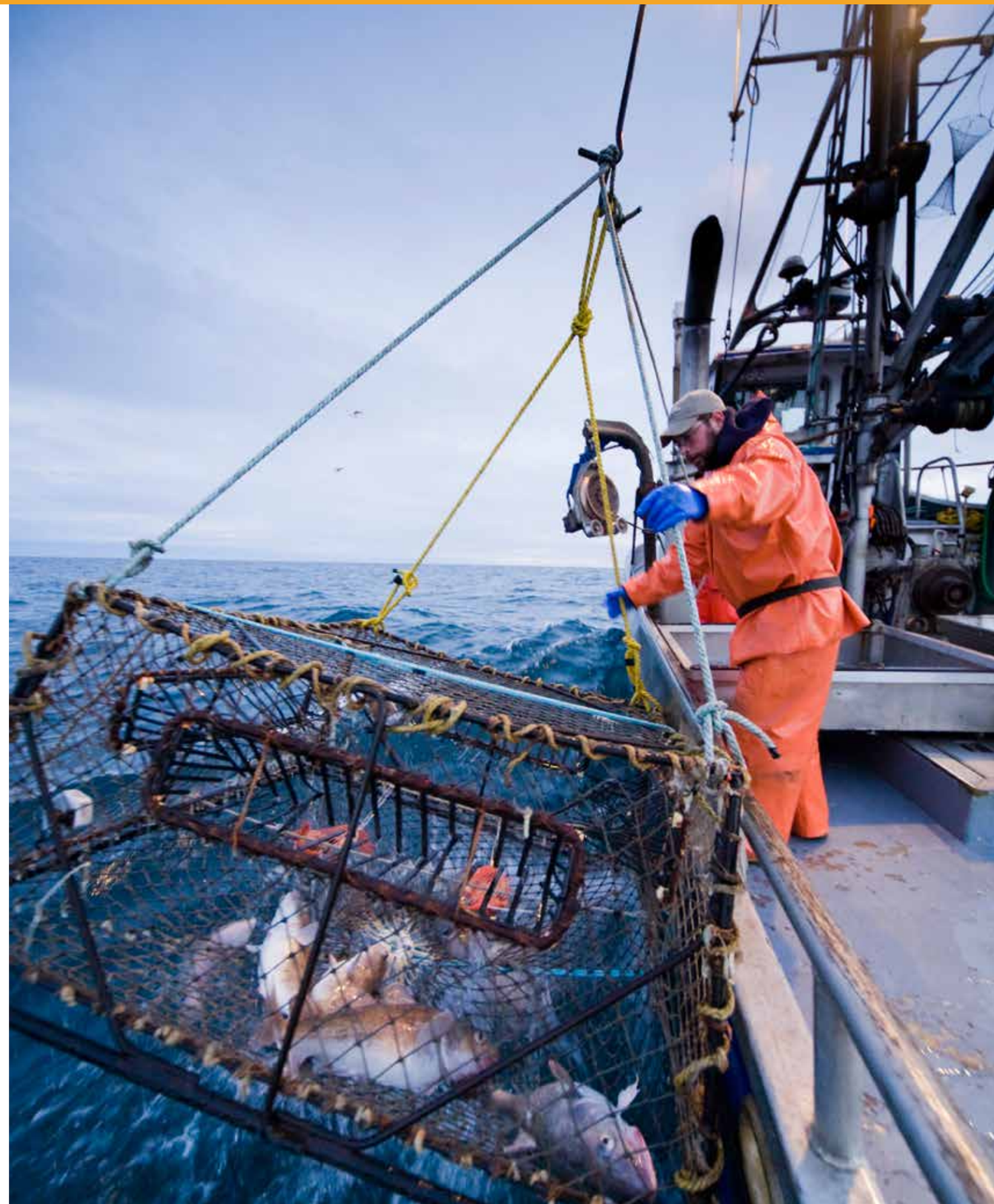
PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

We know the territory.

Why Premera Blue Cross Blue Shield of Alaska?

We're here. We're with you. Premera has been serving Alaskans since before Alaska was a state. The Premera network of doctors and hospitals is the largest in Alaska, which means you can choose the providers you trust at a price you can afford. Plus your membership provides access to quality care and coverage nationwide.

We provide peace of mind by offering affordable, effective coverage, programs, and services.



Coverage

Our range of metallic plans offers you plenty of options to find the right balance between your budget and your healthcare needs. And to learn more about our qualified high-deductible plans that can be paired with tax-advantaged health savings accounts (HSAs), see page 8 in this brochure.

With Premera Blue Cross Blue Shield of Alaska:

- Reduce your office visit copays by choosing a primary care provider in our Plus network.
- If you get your preventive care—including office visits, screenings, and immunizations—from providers in our network, the plan pays 100% of the cost.
- Most outpatient prescriptions are covered as part of your plan.
- Get 24-hour coverage for all enrolled family members for occupational conditions not covered by workers' compensation.

Health support programs

Your Premera membership comes with programs and tools to support you in staying as healthy as possible.

Our programs support pregnant moms and newborns.

If you have a complex or chronic illness such as asthma or diabetes, we can help you manage your care. We can also help smokers who want to quit and members who are ready to tackle substance abuse issues.

If you're on the fitness path, you'll appreciate our discounts on fitness clubs, weight loss programs, and more.

Personalized service and online tools

Premera members are one click or phone call away from a rich array of online and personal tools. We can help you manage your health and your family healthcare budget.

The **Find a Doctor tool** makes it simple to find and compare providers in our network. Learn about their qualifications and read user reviews.

The **24-Hour NurseLine** is always there when you need to talk to a registered nurse about a health issue that won't wait. The nurses can help you decide what to do about it.

Premera **customer service** staff know what you're calling about is important, and so is your time. That's why they're trained to guide you to the resources and knowledge you need to resolve your issue—in just one phone call.

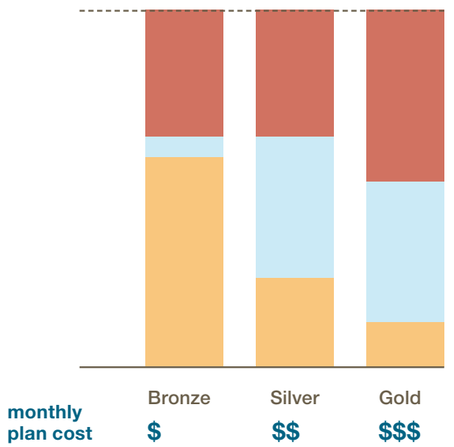
When you log in to **premera.com**, you'll find easy-to-use health assessments, a treatment cost estimator, and a tool to produce a report of your spending activity. You can also pay your monthly bill or manage a health savings account.

What will your Premera plan cover?

Premera offers a wide range of bronze, silver, and gold metallic plans, with options for every family's budget and healthcare needs.

Each metallic plan covers the 10 essential benefits, but with differences in rates and your cost sharing for benefits. (See rate sheets and plan summaries in this package.)

HOW A HEALTH PLAN WORKS



Your plan pays: after out-of-pocket maximum is met

We both pay: coinsurance

You pay: copays and deductible

Let's start with day one of your plan year. All the covered care you get up to a certain amount, your *deductible*, is paid by you. If your deductible is $2,000, you pay for all of your care that year until you have paid out $2,000. (But for covered preventive care, the plan pays 100% right away.)

After you *meet your deductible* (pay out $2,000, for example), you begin to pay *coinsurance*—a percentage, such as 20 percent of the cost of a treatment—for covered care. After you pay the coinsurance *annual out-of-pocket maximum* for your plan, the plan pays 100 percent.

The difference between metallic plans (gold, silver, and bronze) is the cost sharing (annual deductible, copays, coinsurance) and the amount of out-of-pocket costs on the covered services you pay when you get medical care. In general, bronze plans have the highest cost sharing levels, and the lowest monthly rates. Gold plans have the lowest cost shares and the highest monthly rates.

Call us at **888.334.0109** and we'll help you make sense of all your plan options.

The 10 essential benefits your plan covers:

1. **Ambulatory Patient Services**—such as office visits to your in-network PCP, non-PCP or specialist office visits, spinal manipulation, or acupuncture.
2. **Emergency Services**—for issues that could lead to death or disable you if do not treat them.
3. **Hospitalization**—covers room and board, tests, drugs, and care from doctors and nurses while admitted; includes organ and tissue transplants, and hospice and respite care.
4. **Maternity and Newborn Care**—covers prenatal and postnatal care, delivery and inpatient maternity services, plus newborn child care.
5. **Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment**—covers inpatient hospital and outpatient mental and behavioral health.
6. **Prescription Drugs**—covers retail, mail order, and specialty drugs.
7. **Rehabilitative and Habilitative Services and Devices**—to help gain or regain mental and physical skills in case of injury, disability, or chronic condition. Includes inpatient rehabilitation; physical, speech, and occupational therapy; durable medical equipment; or skilled nursing.
8. **Laboratory Services**—covers lab tests, X-ray services, and pathology, and imaging and diagnostics such as MRI, CT scan, and PET scan.
9. **Preventive/Wellness Services and Chronic Disease Management**—includes mammograms, colonoscopies, vaccines, and more. Covered in full if you use providers in our network for care such as routine physicals, screening, and immunizations. Disease management coordinates care for diabetes, asthma, and other conditions.
10. **Pediatric services**—including dental care (preventive, basic, major) and vision care (eye exam, lenses, and eyewear).

Tax-advantaged health savings accounts

A health savings account (HSA) combines healthcare coverage with a way to invest for your financial future.

Our qualified high-deductible health plans paired with HSA plans offer great basic coverage—and you also get the chance to save money and invest it for future healthcare expenses. These plans also allow you to reduce your taxable income.

And we make it easy to enroll in and then manage both the health plan and the savings account.

How does an HSA with a qualified high-deductible health plan work?

- Your plan pays 100% for covered preventive care and certain preventive prescription drugs from day one.
- You pay—either out of pocket or with your HSA funds—all medical and pharmacy expenses until you meet your annual deductible. Then the plan pays 100% of expenses for the rest of the year.
- Funds not spent from your HSA continue to accrue interest.

Why choose a qualified HSA health plan?

- HSAs offer you a triple tax advantage:
  1. Contributions are 100% tax deductible.
  2. Funds you withdraw to pay for qualified medical expenses are not taxed.
  3. Interest earnings accumulate tax-deferred and are tax-free when used to pay qualified medical expenses.
- Monthly rates are lower because of higher plan annual deductibles.
- Unused funds accrue interest over time.
- You can put funds into investment products and mutual funds—with no transaction fee.
- The HSA is yours to keep even if you change to another health plan.
- You can use HSA funds without penalty for nonmedical expenses if you are 65 or older or if you become permanently disabled. (You will still owe income tax on the funds you withdraw.)

Are you eligible for an HSA?

Before you can open an HSA, you must be covered by a qualified high-deductible health plan.

And you must also be able to answer "No" to these questions:

- Are you covered by any other health plan?
- Are you enrolled in Medicare?
- Are you another person's dependent?

Mutual funds include more than 100 options with no load and no transaction fees. This means when you choose your mutual fund, you will not pay a fee to invest in the fund nor will you pay a fee when you buy or sell your fund.

Strong regional and nationwide provider network

The Premera network of doctors, hospitals, and other healthcare providers is designed to offer you ready access to high-quality care at low out-of-pocket costs.

Our strong relationships with our provider partners help you get the most out of your healthcare dollar by:

- Focusing on quality and cost-effective care
- Helping control rising medical costs
- Providing resources for improved healthcare

Premera members who need care outside Alaska and Washington also have access to the nationwide BlueCard® network of preferred providers.

For more information, visit **premera.com** and use the Find a Doctor tool.

Choose a primary care provider right away

Your first step as a Premera member should be to choose a primary care provider (PCP) for you and your covered family members. Then record your choice with us online or by calling customer service. This is a good idea for a couple of reasons.

If you choose and visit a PCP in our Plus network, your out-of-pocket costs for doctor visit copays are lower.

Also, a primary care provider gets to know you and your health history, which makes it easier to catch a developing problem early or help you manage an ongoing one.

You can choose a different primary care provider for each family member from:

- General practitioner or internist
- Obstretrician, gynecologist, or women's health specialist
- Pediatrician
- Geriatric specialist
- Naturopath
- Nurse practitioner
- Family physician
- General preventive medicine
- ARNP/Physician Assistant

Use the Find a Doctor tool on **premera.com** to find and compare providers in our network.

CAN I GET HELP WITH MY MONTHLY RATE?

You might qualify for help with your monthly payments. To get more information including how to take advantage of a subsidy if you are eligible for one, call us at **888.334.0109**, call your producer, or go to **premera.com** and click the Health Care Basics tab.

How do I enroll?

It's easy to become a Premera member.

First, call us at **888.334.0109** or call a producer. We help you make sense of all the Premera health plans and options offered to you; how to get help with your payment if you're eligible; and how and when to apply.

We'll make sure to share what you need to know to help you decide what's best for you and your family before you enroll. Then you can enroll in one of two ways:

- Apply at **premera.com.**
- Complete and mail us the Premera enrollment application in the addressed envelope. (You'll find both in this package.)

Are you eligible for coverage?

To be eligible to enroll:

- You must reside in the state of Alaska.
- You must not be eligible for Medicare A or B, including entitlement due to a disability.
- You must not be covered under any other health plan.

To review additional eligibility requirements, please refer to the enrollment application.

What will your monthly rate be?

The monthly rate for the metallic plan you choose depends on your answer to these questions:

- What is your zip code?
- How old is each person who will be on the plan?
- Do you use tobacco products?

Use the rate sheet included in this packet to help you figure out your monthly rate. For more information about the monthly rate to expect for plans you are interested in, call customer service at **888.334.0109**.

Choose from a range of plans

Find the right balance between your budget and your family's healthcare needs.

Preferred Plus plans

The Preferred Plus plans offer members savings on health plan costs and give the highest benefit level to members when they use preferred providers and hospitals. Nonpreferred and nonparticipating or out-of-network facilities and providers are also covered, but at a lower benefit level.*

Preferred Select plans

The Preferred Select plans give members the same benefit whether their doctor is in the Premera network or not:

- Members have the flexibility to see the doctor of their choice and receive the highest benefit levels.*
- When a member needs care in a hospital setting, they will get the highest benefit levels in preferred facilities.
- Nonpreferred and non-participating or out-of-network facilities are also covered, but at a lower benefit level.*

Vision and hearing care plans

You can choose plans that include coverage for:

- **Adult vision** – exams and eyewear
- **Hearing** – exams, and hearing aids and hardware

* Balance billing may still apply if a provider is not contracted with Premera Blue Cross Blue Shield of Alaska. For more information about providers, visit **premera.com** and use the Find a Doctor tool.

Preferred Plus HSA

The deductible applies whenever there is a coinsurance listed, unless otherwise noted.

PCY = per calendar year
Network = HeritagePlus

			PREFERRED PLUS HSA		
			In-network	**Non-Preferred**	**Non-Participating**
	Aggregate Individual Deductible	PCY (choose one) Family = 2x individual (aggregate)	Silver $2,500 / Bronze $5,250	2x Individual deductible	
	Coinsurance	Amount you pay after your deductible is met	20% / 0%	40%	60%
	Out-of-Pocket Maximum	Includes deductible, coinsurance, and copays Family = 2x individual (aggregate)	$4,500 / $5,250	Unlimited	
	Office visits		20% / 0%	40%	60%
	10 Essential Benefits *Covered Services*				
1	**Ambulatory Patient Services**	Outpatient	20% / 0%	40%	60%
		Spinal manipulation (12 visits PCY); Acupuncture (12 visits PCY)			
2	**Emergency Services**	Emergency care	Deductible, then in-network coinsurance		
		Ambulance transportation (air & ground)	Deductible, then in-network coinsurance	Emergent: Same as in-network Non-emergent: Air – 40% / 60%; Ground – Same as in-network	
3	**Hospitalization**	Inpatient	20% / 0%	40%	60%
		Organ and tissue transplants, inpatient unlimited, except $75,000 donor coverage limit and $7,500 travel and lodging per transplant		Not covered	
		Hospice: 10 days inpatient Respite care: 240 hours lifetime		40%	60%
4	**Maternity & Newborn Care**	Prenatal, delivery, postnatal care	20% / 0%	40%	60%
5	**Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment**	Office visit	20% / 0%	40%	60%
		Inpatient hospital: mental/behavioral health			
		Outpatient services			
6	**Prescription Drugs** *4-Tier: Generic/Preferred Brand/ Non-Preferred Brand/Specialty*	**Retail** up to 90-day supply (3x 30 day supply cost) **Mail Order** 90-day supply; 3x retail supply cost **Specialty Rx** 30-day supply **Drug List** See X1 formulary	20% / 0%	Retail: Same as in-network; Mail order & specialty: not covered	
7	**Rehabilitative & Habilitative Services & Devices** *Therapy* *Rehabilitative and habilitative benefits have the same number of visits, but are counted separately*	Inpatient rehabilitation: 30 days PCY	20% / 0%	40%	60%
		Physical, speech, occupational, massage therapy: 45 visits PCY			
		Durable medical equipment			
		Skilled nursing facility: 60 days PCY			
8	**Laboratory Services**	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET	20% / 0%	40%	60%
9	**Preventive/Wellness Services & Chronic Disease Management**	Screenings	Covered in full	40%	60%
		Exams and immunizations			
10	**Pediatric Services, including Vision Care** *Under 19 years of age*	Eye exam: 1 PCY	Deductible waived, then 10%		
		Eyewear: 1 pair lenses/contacts PCY; 1 pair frames every 2 calendar years	Covered in full		
		Dental: preventive/basic/major	2500 plan – 10% / 20% / 50%; 5250 plan – 0% / 0% / 0%		
		Orthodontia (medically necessary only)	2500 plan – 50%; 5250 plan – 0%		

A full list of all services is available on **premera.com/ak/member**

Preferred Plus Bronze

The deductible applies whenever there is a coinsurance listed, unless otherwise noted.

PCY = per calendar year
Network = HeritagePlus

			PREFERRED PLUS BRONZE		
			In-network	**Non-Preferred**	**Non-Participating**
	Individual Deductible	PCY (choose one) Family = 2x individual (In-network only)	$5,500 / $6,350	2x Individual deductible	
	Coinsurance	Amount you pay after your deductible is met	20% / 0%	40%	60%
	Out-of-Pocket Maximum	Includes deductible, coinsurance, and copays Family = 2x individual (In-network only)	$6,350	Unlimited	
	Office visits	Designated PCP office visit	$15 / $25	40%	60%
		Non-designated PCP or specialist office visit	$45 / $50		
	10 Essential Benefits *Covered Services*				
1	**Ambulatory Patient Services**	Outpatient	20% / 0%	40%	60%
		Spinal manipulation (12 visits PCY); Acupuncture (12 visits PCY)	$15 / $25		
2	**Emergency Services**	Emergency care	Deductible, then in-network coinsurance		
		Ambulance transportation (air & ground)	Deductible, then in-network coinsurance	Emergent: Same as in-network Non-emergent: Air – 40% / 60%; Ground – Same as in-network	
3	**Hospitalization**	Inpatient	20% / 0%	40%	60%
		Organ and tissue transplants, inpatient unlimited, except $75,000 donor coverage limit and $7,500 travel and lodging per transplant		Not covered	
		Hospice: 10 days inpatient Respite care: 240 hours lifetime		40%	60%
4	**Maternity & Newborn Care**	Prenatal, delivery, postnatal care	20% / 0%	40%	60%
5	**Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment**	Office visit	$45 / $50	40%	60%
		Inpatient hospital: mental/behavioral health	20% / 0%		
		Outpatient services	20% / 0%		
6	**Prescription Drugs** *4-Tier: Generic/Preferred Brand/ Non-Preferred Brand/Specialty*	**Retail** up to 90-day supply (3x 30 day supply cost) **Mail Order** 90-day supply; 3x retail supply cost (5500 plan) **Specialty Rx** 30-day supply **Drug List** See X4 – 5500 plan or X1 – 6350 plan formulary	5,500 plan – $25 / Deductible, then 50% / Deductible, then 50% / Deductible, then 20%; 6,350 plan – Deductible, then 0%	Retail: Same as in-network; Mail order & specialty: not covered	
7	**Rehabilitative & Habilitative Services & Devices** *Therapy* *Rehabilitative and habilitative benefits have the same number of visits, but are counted separately*	Inpatient rehabilitation: 30 days PCY	20% / 0%	40%	60%
		Physical, speech, occupational, massage therapy: 45 visits PCY			
		Durable medical equipment			
		Skilled nursing facility: 60 days PCY			
8	**Laboratory Services**	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET	20% / 0%	40%	60%
9	**Preventive/Wellness Services & Chronic Disease Management**	Screenings	Covered in full	40%	60%
		Exams and immunizations			
10	**Pediatric Services, including Vision Care** *Under 19 years of age*	Eye exam: 1 PCY	$45		
		Eyewear: 1 pair lenses/contacts PCY; 1 pair frames every 2 calendar years	Covered in full		
		Dental: preventive/basic/major	5500 plan – 10% / 20% / 50%; 6350 plan – 0% / 0% / 0%		
		Orthodontia (medically necessary only)	5500 plan – 50%; 6350 plan – 0%		
	Additional benefits included only if enrolled in Preferred Plus Bronze 6350 Package VH plan				
	Adult Vision	Vision exam: 1 PCY	$45 / $50		
		Eyewear: 1 pair lenses PCY; 1 pair frames every 2 calendar years ($90 retail max); contacts $170 retail max PCY; $350 annual max shared with vision exam	Covered in full		
	Hearing	Hearing exam: 1 per 2 calendar years	$45 / $50		
		Hearing aids and hardware: $1,000/3 cal. yrs	Deductible waived, then 20%		

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Preferred Plus Silver

			PREFERRED PLUS SILVER		
The deductible applies whenever there is a coinsurance listed, unless otherwise noted. **PCY = per calendar year** **Network = HeritagePlus**			**In-network**	**Non-Preferred**	**Non-Participating**
	Individual Deductible	PCY (choose one) Family = 2x individual (In-network only)	$2,000 / $3,000	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 only)	$6,350	Unlimited	
	Office visits	Designated PCP office visit	$15	40%	60%
		Non-designated PCP or specialist office visit	$45		
	10 Essential Benefits *Covered Services*				
1	**Ambulatory Patient Services**	Outpatient	20%	40%	60%
		Spinal manipulation (12 visits PCY); Acupuncture (12 visits PCY)	$15		
2	**Emergency Services**	Emergency care	Deductible, then in-network coinsurance		
		Ambulance transportation (air & ground)	Deductible, then in-network coinsurance	Emergent: Same as in-network Non-emergent: Air – 40% / 60%; Ground – Same as in-network	
3	**Hospitalization**	Inpatient	20%	40%	60%
		Organ and tissue transplants, inpatient unlimited, except $75,000 donor coverage limit and $7,500 travel and lodging per transplant		Not covered	
		Hospice: 10 days inpatient Respite care: 240 hours lifetime		40%	60%
4	**Maternity & Newborn Care**	Prenatal, delivery, postnatal care	20%	40%	60%
5	**Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment**	Office visit	$45	40%	60%
		Inpatient hospital: mental/behavioral health	20%		
		Outpatient services	Deductible waived, then 20%		
6	**Prescription Drugs** *4-Tier: Generic/Preferred Brand/ Non-Preferred Brand/Specialty*	**Retail** up to 90-day supply (3x 30 day supply cost) **Mail Order** 90-day supply; 3x retail supply cost **Specialty Rx** 30-day supply **Drug List** See X4 formulary	2000 plan – $15 / $50 / Deductible, then 50% / Deductible, then 20%; 3000 plan – $10 / $50 / Deductible, then 50% / Deductible, then 20%	Retail: Same as in-network; Mail order & specialty: not covered	
7	**Rehabilitative & Habilitative Services & Devices** *Therapy* *Rehabilitative and habilitative benefits have the same number of visits, but are counted separately*	Inpatient rehabilitation: 30 days PCY	20%	40%	60%
		Physical, speech, occupational, massage therapy: 45 visits PCY			
		Durable medical equipment			
		Skilled nursing facility: 60 days PCY			
8	**Laboratory Services**	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET	Deductible waived, except on major imaging, then 20%	40%	60%
9	**Preventive/Wellness Services & Chronic Disease Management**	Screenings	Covered in full	40%	60%
		Exams and immunizations			
10	**Pediatric Services, including Vision Care** *Under 19 years of age*	Eye exam: 1 PCY	$45		
		Eyewear: 1 pair lenses/contacts PCY; 1 pair frames every 2 calendar years	Covered in full		
		Dental: preventive/basic/major	10% / 20% / 50%		
		Orthodontia (medically necessary only)	50%		
	Additional benefits included only if enrolled in Preferred Plus Silver 3000 Package VH plan				
	Adult Vision	Vision exam: 1 PCY	$45		
		Eyewear: 1 pair lenses PCY; 1 pair frames every 2 calendar years ($90 retail max); contacts $170 retail max PCY; $350 annual max shared with vision exam	Covered in full		
	Hearing	Hearing exam: 1 per 2 calendar years	$45		
		Hearing aids and hardware: $1,000/3 cal. yrs	Deductible waived, then 20%		

A full list of all services is available on **premera.com/ak/member**

Preferred Plus Gold

			PREFERRED PLUS GOLD		
The deductible applies whenever there is a coinsurance listed, unless otherwise noted. **PCY = per calendar year** **Network = HeritagePlus**			**In-network**	**Non-Preferred**	**Non-Participating**
	Individual Deductible	PCY (choose one) Family = 2x individual (In-network only)	$1,000 / $1,500	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 only)	$4,500	Unlimited	
	Office visits	Designated PCP office visit	$10	40%	60%
		Non-designated PCP or specialist office visit	$40		
	10 Essential Benefits *Covered Services*				
1	**Ambulatory Patient Services**	Outpatient	20%	40%	60%
		Spinal manipulation (12 visits PCY); Acupuncture (12 visits PCY)	$10		
2	**Emergency Services**	Emergency care	Deductible, then in-network coinsurance		
		Ambulance transportation (air & ground)	Deductible, then in-network coinsurance	Emergent: Same as in-network Non-emergent: Air – 40% / 60%; Ground – Same as in-network	
3	**Hospitalization**	Inpatient	20%	40%	60%
		Organ and tissue transplants, inpatient unlimited, except $75,000 donor coverage limit and $7,500 travel and lodging per transplant		Not covered	
		Hospice: 10 days inpatient Respite care: 240 hours lifetime		40%	60%
4	**Maternity & Newborn Care**	Prenatal, delivery, postnatal care	20%	40%	60%
5	**Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment**	Office visit	$40	40%	60%
		Inpatient hospital: mental/behavioral health	20%		
		Outpatient services	Deductible waived, then 20%		
6	**Prescription Drugs** *4-Tier: Generic/Preferred Brand/ Non-Preferred Brand/Specialty*	**Retail** up to 90-day supply (3x 30 day supply cost) **Mail Order** 90-day supply; 3x retail supply cost **Specialty Rx** 30-day supply **Drug List** See X4 formulary	1000 plan – $10 / $40 / Deductible waived, then 50% / Deductible, then 20%; 1500 plan – $10 / $40 / Deductible waived, then 50% / Deductible waived, then 20%	Retail: Same as in-network; Mail order & specialty: not covered	
7	**Rehabilitative & Habilitative Services & Devices** *Therapy* *Rehabilitative and habilitative benefits have the same number of visits, but are counted separately*	Inpatient rehabilitation: 30 days PCY	20%	40%	60%
		Physical, speech, occupational, massage therapy: 45 visits PCY			
		Durable medical equipment			
		Skilled nursing facility: 60 days PCY			
8	**Laboratory Services**	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET	Deductible waived, except on major imaging, then 20%	40%	60%
9	**Preventive/Wellness Services & Chronic Disease Management**	Screenings	Covered in full	40%	60%
		Exams and immunizations			
10	**Pediatric Services, including Vision Care** *Under 19 years of age*	Eye exam: 1 PCY	$40		
		Eyewear: 1 pair lenses/contacts PCY; 1 pair frames every 2 calendar years	Covered in full		
		Dental: preventive/basic/major	10% / 20% / 50%		
		Orthodontia (medically necessary only)	50%		
	Additional benefits included only if enrolled in Preferred Plus Gold 1500 Package VH plan				
	Adult Vision	Vision exam: 1 PCY	$40		
		Eyewear: 1 pair lenses PCY; 1 pair frames every 2 calendar years ($90 retail max); contacts $170 retail max PCY; $350 annual max shared with vision exam	Covered in full		
	Hearing	Hearing exam: 1 per 2 calendar years	$40		
		Hearing aids and hardware: $1,000/3 cal. yrs	Deductible waived, then 20%		

A full list of all services is available on **premera.com/ak/member**

Preferred Select HSA

			PREFERRED SELECT HSA		
The deductible applies whenever there is a coinsurance listed, unless otherwise noted. **PCY = per calendar year** **Network = HeritageSelect**			**In-network**	**Non-Preferred**	**Non-Participating**
	Aggregate Individual Deductible	PCY (choose one) Family = 2x individual (aggregate)	Silver $2,500 / Bronze $5,250	2x Individual deductible	
	Coinsurance	Amount you pay after your deductible is met	20% / 0%	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
	Out-of-Pocket Maximum	Includes deductible, coinsurance, and copays Family = 2x individual (aggregate)	$4,500 / $5,250	Unlimited	
	Office visits		Deductible, then coinsurance	Same as in-network	
	10 Essential Benefits *Covered Services*				
1	**Ambulatory Patient Services**	Outpatient Spinal manipulation (12 visits PCY); Acupuncture (12 visits PCY)	20% / 0%	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
2	**Emergency Services**	Emergency care	Deductible, then in-network coinsurance	Deductible, then in-network coinsurance	
		Ambulance transportation (air & ground)		Emergent: Same as in-network Non-emergent: Air – 40% / 60%; Ground – Same as in-network	
3	**Hospitalization**	Inpatient	20% / 0%	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
		Organ and tissue transplants, inpatient unlimited, except $75,000 donor coverage limit and $7,500 travel and lodging per transplant		Not covered	
		Hospice: 10 days inpatient Respite care: 240 hours lifetime		Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
4	**Maternity & Newborn Care**	Prenatal, delivery, postnatal care	20% / 0%	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
5	**Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment**	Office visit Inpatient hospital: mental/behavioral health Outpatient services	20% / 0%	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
6	**Prescription Drugs** *4-Tier: Generic/Preferred Brand/ Non-Preferred Brand/Specialty*	**Retail** up to 90-day supply **Mail Order** 90-day supply; 3x retail supply cost **Specialty Rx** 30-day supply **Drug List** See X1 formulary	20% / 0%	Retail: Same as in-network; Mail order & specialty: not covered	
7	**Rehabilitative & Habilitative Services & Devices** *Therapy* *Rehabilitative and habilitative benefits have the same number of visits, but are counted separately*	Inpatient rehabilitation: 30 days PCY Physical, speech, occupational, massage therapy: 45 visits PCY Durable medical equipment Skilled nursing facility: 60 days PCY	20% / 0%	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
8	**Laboratory Services**	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET	20% / 0%	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
9	**Preventive/Wellness Services & Chronic Disease Management**	Screenings Exams and immunizations	Covered in full	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
10	**Pediatric Services, including Vision Care** *Under 19 years of age*	Eye exam: 1 PCY	Deductible waived, then 10%		
		Eyewear: 1 pair lenses/contacts PCY; 1 pair frames every 2 calendar years	Covered in full		
		Dental: preventive/basic/major	2500 plan – 10% / 20% / 50%; 5250 plan – 0% / 0% / 0%		
		Orthodontia (medically necessary only)	2500 plan – 50%; 5250 plan – 0%		

A full list of all services is available on **premera.com/ak/member**

Preferred Select Bronze

			PREFERRED SELECT BRONZE		
The deductible applies whenever there is a coinsurance listed, unless otherwise noted. **PCY = per calendar year** **Network = HeritageSelect**			**In-network**	**Non-Preferred**	**Non-Participating**
	Individual Deductible	PCY (choose one) Family = 2x individual (In-network only)	$5,500 / $6,350	2x Individual deductible	
	Coinsurance	Amount you pay after your deductible is met	20% / 0%	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
	Out-of-Pocket Maximum	Includes deductible, coinsurance, and copays Family = 2x individual (In-network only)	$6,350	Unlimited	
	Office visits		$35 copay	Same as in-network	
	10 Essential Benefits *Covered Services*				
1	**Ambulatory Patient Services**	Outpatient	20% / 0%	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
		Spinal manipulation (12 visits PCY); Acupuncture (12 visits PCY)	$35 Copay		
2	**Emergency Services**	Emergency care	Deductible, then in-network coinsurance		
		Ambulance transportation (air & ground)	Deductible, then in-network coinsurance	Emergent: Same as in-network Non-emergent: Air – 40% / 60%; Ground – Same as in-network	
3	**Hospitalization**	Inpatient	20% / 0%	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
		Organ and tissue transplants, inpatient unlimited, except $75,000 donor coverage limit and $7,500 travel and lodging per transplant		Not covered	
		Hospice: 10 days inpatient Respite care: 240 hours lifetime		Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
4	**Maternity & Newborn Care**	Prenatal, delivery, postnatal care	20% / 0%	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
5	**Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment**	Office visit	$35 Copay	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
		Inpatient hospital: mental/behavioral health	20% / 0%		
		Outpatient services	20% / 0%		
6	**Prescription Drugs** *4-Tier: Generic/Preferred Brand/ Non-Preferred Brand/Specialty*	**Retail** up to 90-day supply (3x 30 day supply cost) **Mail Order** 90-day supply; 3x retail supply cost (5500 plan) **Specialty Rx** 30-day supply **Drug List** See X4 – 5500 plan or X1 – 6350 plan formulary	5500 plan – $25 / Deductible, then 50% / Deductible, then 50% / Deductible, then 20%; 6350 plan– Deductible, then 0%	Retail: Same as in-network; Mail order & specialty: not covered	
7	**Rehabilitative & Habilitative Services & Devices** *Therapy* *Rehabilitative and habilitative benefits have the same number of visits, but are counted separately*	Inpatient rehabilitation: 30 days PCY Physical, speech, occupational, massage therapy: 45 visits PCY Durable medical equipment Skilled nursing facility: 60 days PCY	20% / 0%	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
8	**Laboratory Services**	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET	20% / 0%	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
9	**Preventive/Wellness Services & Chronic Disease Management**	Screenings Exams and immunizations	Covered in full	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
10	**Pediatric Services, including Vision Care** *Under 19 years of age*	Eye exam: 1 PCY	$35		
		Eyewear: 1 pair lenses/contacts PCY; 1 pair frames every 2 calendar years	Covered in full		
		Dental: preventive/basic/major	5500 plan – 10% / 20% / 50%; 6350 plan – 0% / 0% / 0%		
		Orthodontia (medically necessary only)	5500 plan – 50%; 6350 plan – 0%		
	Additional benefits included only if enrolled in Preferred Select Bronze 6350 Package VH plan				
	Adult Vision	Vision exam: 1 PCY	$35		
		Eyewear: 1 pair lenses PCY; 1 pair frames every 2 calendar years ($90 retail max); contacts $170 retail max PCY; $350 annual max shared with vision exam	Covered in full		
	Hearing	Hearing exam: 1 per 2 calendar years	$35		
		Hearing aids and hardware: $1,000/3 cal. yrs	Deductible waived, then 20%		

A full list of all services is available on **premera.com/ak/member**

Preferred Select Silver

			PREFERRED SELECT SILVER		
The deductible applies whenever there is a coinsurance listed, unless otherwise noted. **PCY = per calendar year** **Network = HeritageSelect**			**In-network**	**Non-Preferred**	**Non-Participating**
	Individual Deductible	PCY (choose one) Family = 2x individual (In-network only)	$2,000 / $3,000	2x Individual deductible	
	Coinsurance	Amount you pay after your deductible is met	20%	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
	Out-of-Pocket Maximum	Includes deductible, coinsurance, and copays Family = 2x individual (In-network only)	$6,350	Unlimited	
	Office visits		$35 copay	Same as in-network	
	10 Essential Benefits *Covered Services*				
1	**Ambulatory Patient Services**	Outpatient Spinal manipulation (12 visits PCY); Acupuncture (12 visits PCY)	20% $35 Copay	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
2	**Emergency Services**	Emergency care Ambulance transportation (air & ground)	20%	20% Emergent: Same as in-network Non-emergent: Air – 40% / 60%; Ground – Same as in-network	
3	**Hospitalization**	Inpatient Organ and tissue transplants, inpatient unlimited, except $75,000 donor coverage limit and $7,500 travel and lodging per transplant Hospice: 10 days inpatient Respite care: 240 hours lifetime	20%	Hospital: 40% All other facilities & professional: Same as in-network Not covered Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60% Hospital: 60%
4	**Maternity & Newborn Care**	Prenatal, delivery, postnatal care	20%	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
5	**Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment**	Office visit Inpatient hospital: mental/behavioral health Outpatient services	$35 Copay 20% Deductible waived, then 20%	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
6	**Prescription Drugs** *4-Tier: Generic/Preferred Brand/ Non-Preferred Brand/Specialty*	**Retail** up to 90-day supply (3x 30 day supply cost) **Mail Order** 90-day supply; 3x retail supply cost **Specialty Rx** 30-day supply **Drug List** See X4 formulary	2000 plan – $15 / $50 / $100 / Deductible, then 30%; 3000 plan – $15 / $50 / $100 / Deductible, then 20%	Retail: Same as in-network; Mail order & specialty: not covered	
7	**Rehabilitative & Habilitative Services & Devices** *Therapy* *Rehabilitative and habilitative benefits have the same number of visits, but are counted separately*	Inpatient rehabilitation: 30 days PCY Physical, speech, occupational, massage therapy: 45 visits PCY Durable medical equipment Skilled nursing facility: 60 days PCY	20%	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
8	**Laboratory Services**	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET	Deductible waived, except on major imaging, then 20%	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
9	**Preventive/Wellness Services & Chronic Disease Management**	Screenings Exams and immunizations	Covered in full	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
10	**Pediatric Services, including Vision Care** *Under 19 years of age*	Eye exam: 1 PCY Eyewear: 1 pair lenses/contacts PCY; 1 pair frames every 2 calendar years Dental: preventive/basic/major Orthodontia (medically necessary only)	$35 Covered in full 10% / 20% / 50% 50%		
	Additional benefits included only if enrolled in Preferred Select Silver 3000 Package VH plan				
	Adult Vision	Vision exam: 1 PCY Eyewear: 1 pair lenses PCY; 1 pair frames every 2 calendar years ($90 retail max); contacts $170 retail max PCY; $350 annual max shared with vision exam	$35 Covered in full		
	Hearing	Hearing exam: 1 per 2 calendar years Hearing aids and hardware: $1,000/3 cal. yrs	$35 Deductible waived, then 20%		

A full list of all services is available on **premera.com/ak/member**

Preferred Select Gold

			PREFERRED SELECT GOLD		
The deductible applies whenever there is a coinsurance listed, unless otherwise noted. **PCY = per calendar year** **Network = HeritageSelect**			**In-network**	**Non-Preferred**	**Non-Participating**
	Individual Deductible	PCY (choose one) Family = 2x individual (In-network only)	$1,000 / $1,500	2x Individual deductible	
	Coinsurance	Amount you pay after your deductible is met	20%	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
	Out-of-Pocket Maximum	Includes deductible, coinsurance, and copays Family = 2x individual (In-network only)	$5,000	Unlimited	
	Office visits		$30 copay	Same as in-network	
	10 Essential Benefits *Covered Services*				
1	**Ambulatory Patient Services**	Outpatient Spinal manipulation (12 visits PCY); Acupuncture (12 visits PCY)	20% $30 Copay	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
2	**Emergency Services**	Emergency care Ambulance transportation (air & ground)	20%	20% Emergent: Same as in-network Non-emergent: Air – 40% / 60%; Ground – Same as in-network	
3	**Hospitalization**	Inpatient Organ and tissue transplants, inpatient unlimited, except $75,000 donor coverage limit and $7,500 travel and lodging per transplant Hospice: 10 days inpatient Respite care: 240 hours lifetime	20%	Hospital: 40% All other facilities & professional: Same as in-network Not covered Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60% Hospital: 60%
4	**Maternity & Newborn Care**	Prenatal, delivery, postnatal care	20%	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
5	**Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment**	Office visit Inpatient hospital: mental/behavioral health Outpatient services	$30 Copay 20% Deductible waived, then 20%	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
6	**Prescription Drugs** *4-Tier: Generic/Preferred Brand/ Non-Preferred Brand/Specialty*	**Retail** up to 90-day supply (3x 30 day supply cost) **Mail Order** 90-day supply; 3x retail supply cost **Specialty Rx** 30-day supply **Drug List** See X4 formulary	1000 plan – $10 / $40 / $80 / Deductible waived, then 20%; 1500 plan – $10 / $30 / $80 / Deductible waived, then 20%	Retail: Same as in-network; Mail order & specialty: not covered	
7	**Rehabilitative & Habilitative Services & Devices** *Therapy* *Rehabilitative and habilitative benefits have the same number of visits, but are counted separately*	Inpatient rehabilitation: 30 days PCY Physical, speech, occupational, massage therapy: 45 visits PCY Durable medical equipment Skilled nursing facility: 60 days PCY	20%	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
8	**Laboratory Services**	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET	Deductible waived, except on major imaging, then 20%	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
9	**Preventive/Wellness Services & Chronic Disease Management**	Screenings Exams and immunizations	Covered in full	Hospital: 40% All other facilities & professional: Same as in-network	Hospital: 60%
10	**Pediatric Services, including Vision Care** *Under 19 years of age*	Eye exam: 1 PCY Eyewear: 1 pair lenses/contacts PCY; 1 pair frames every 2 calendar years Dental: preventive/basic/major Orthodontia (medically necessary only)	$30 Covered in full 10% / 20% / 50% 50%		
	Additional benefits included only if enrolled in Preferred Select Gold 1500 Package VH plan				
	Adult Vision	Vision exam: 1 PCY Eyewear: 1 pair lenses PCY; 1 pair frames every 2 calendar years ($90 retail max); contacts $170 retail max PCY; $350 annual max shared with vision exam	$30 Covered in full		
	Hearing	Hearing exam: 1 per 2 calendar years Hearing aids and hardware: $1,000/3 cal. yrs	$30 Deductible waived, then 20%		

A full list of all services is available on **premera.com/ak/member**

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 privacy policies, provider organization, key utilization management procedures, and pharmaceutical management procedures.

DEFINITIONS

allowable charge*	The negotiated amount for which a provider in the network agrees to provide services or supplies.
coinsurance	Your share of the fee for a service. If the plan's coinsurance share is 20%, the member pays 20% of the allowable charge and your plan benefit pays the other 80% of the allowable charge.
coinsurance maximum	A preset limit after which your plan pays 100% of the allowable charge.
copay	A flat fee you pay for a specific service, such as an office visit, at the time a service is rendered. Copays apply toward out-of-pocket maximum.
covered in full	Services your plan pays for in full. Benefits provided at 100% of the allowable charge; not subject to deductible or coinsurance.
deductible	The amount of money you pay every year before the plan begins to pay for certain services.

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

General exclusions and limitations

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

- Cosmetic or reconstructive surgery (except as specifically provided)
- Experimental or investigative services
- Infertility
- Learning disorders
- Obesity/morbid obesity related surgery, drugs, foods, and supplements
- Orthognathic surgery
- Orthotics, up to $300 PCY; except for treatment of diabetes, unlimited
- Services 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 reversals

For a complete list of exclusions and limitations, log in to **premera.com** and consult your benefit booklet.

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

formulary	A list of drugs the plan covers for specific uses. To find the formulary for a specific plan, go to **premera.com** and select Pharmacy under the Member Services tab.
network	A group of doctors, dentists, hospitals, and other healthcare providers that contract with Premera to provide services and supplies at negotiated amounts called allowable charges.
out-of-pocket maximum	A preset limit after which your plan pays 100% of the allowable charge. All in-network essential benefits apply to the out-of-pocket maximum.
primary care provider	Your designated provider that helps coordinate your care. They must be contracted as part of the Premera network and designated by you to get the reduced copay for an office visit (when applicable). You can choose a different primary care provider for each family member from: physicians and internists, physician assistants, and nurse practitioners; ob/gyns and women's health specialists, pediatricians, and geriatric specialists; or naturopaths.
producer	Previously referred to as a broker or agent.

Need help? Get help.

- For help shopping for and enrolling in a health plan, call the Premera Sales Team, **888.334.0109**, or call your producer.
- Call Premera customer service at **800.508.4722** from 8 a.m. to 6 p.m. Pacific time, Monday–Friday.
- **24-Hour NurseLine 800.841.8343** is fast, free, confidential, and always there when you need it. Registered nurses ask you the right questions, then can direct you to the closest appropriate in-network provider or clinic.
- Visit **premera.com** for information about Premera Blue Cross Blue Shield of Alaska. After you enroll, you get access to online information and tools you can use to:
  - Pay your monthly bill online
  - Check the status of a claim
  - See how much of your annual deductible you've met
  - Manage and track your HSA saving and spending
  - Manage and order prescriptions, and compare costs
  - And much much more!
- **Premera app** for Apple, Android, and Windows smartphones provides one-touch access to customer service, 24-Hour NurseLine, and lists of providers in the network.

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