



**Premera Blue Cross Blue Shield of Alaska : F3T HeritagePlus Coinsurance NGF**

Coverage for: Individual or Family | Plan Type: PPO

 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-508-4722 (TTY: 1-800-842-5357) or visit us at [www.premera.com](http://www.premera.com). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf](http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf) or call 1-800-508-4722 (TTY: 1-800-842-5357) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$5,000 Individual / \$10,000 Family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Does not apply to services listed below as "No charge"	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In-network: \$5,000 Individual / \$10,000 Family Out-of-network: Unlimited	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premium</u> , balance-billed charges, penalties for failure to obtain prior authorization for services, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.premera.com">www.premera.com</a> or call 1-800-508-4722 for a list of <u>network providers</u> .	You pay the least if you use a <u>provider</u> in the Preferred <u>network</u> . You pay more if you use a <u>provider</u> in the Participating <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	0% <u>coinsurance</u> for Preferred/20% <u>coinsurance</u> for Participating	40% <u>coinsurance</u>	<u>Deductible</u> applies.
	<u>Specialist</u> visit	0% <u>coinsurance</u> for Preferred/20% <u>coinsurance</u> for Participating	40% <u>coinsurance</u>	<u>Deductible</u> applies.
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u> for Preferred/20% <u>coinsurance</u> for Participating	40% <u>coinsurance</u>	<u>Deductible</u> applies.
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u> for Preferred/20% <u>coinsurance</u> for Participating	40% <u>coinsurance</u>	Prior authorization is required for some outpatient imaging tests. Penalty for non-contract provider: 50% of allowable charge to \$1,500 per occurrence. <u>Deductible</u> applies.
If you need drugs to treat your illness or condition	Generic drugs	0% coinsurance	0% coinsurance	Covers up to a 90 day supply. Out-of-network mail order is not covered. Prior authorization is required for certain drugs.
	Preferred brand drugs	0% coinsurance	0% coinsurance	
Non-preferred brand drugs	0% coinsurance	0% coinsurance		
More information about <u>prescription drug coverage</u> is available at <a href="http://client.formularynavigator.com/Search.aspx?siteCode=1214076976">http://client.formularynavigator.com/Search.aspx?siteCode=1214076976</a> .	<u>Specialty drugs</u>	0% coinsurance	0% coinsurance	Covers up to 30 day supply (retail), covers up to a 90 day supply (mail). Prior authorization is recommended for certain drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u> for Preferred/20% <u>coinsurance</u> for Participating	40% <u>coinsurance</u>	Prior authorization is required for some services. Penalty for non-contract provider: 50% of allowable charge to \$1,500 per occurrence. <u>Deductible</u> applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	0% <u>coinsurance</u> for Preferred/20% <u>coinsurance</u> for Participating	40% <u>coinsurance</u>	<u>Deductible</u> applies.
If you need immediate medical attention	<u>Emergency room care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	<u>Deductible</u> applies.
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	<u>Deductible</u> applies.
	<u>Urgent care</u>	Hospital-based: 0% <u>coinsurance</u> Freestanding center: 0% <u>coinsurance</u> for Preferred/20% <u>coinsurance</u> for Participating	Hospital-based: 0% <u>coinsurance</u> Freestanding center: 40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <u>coinsurance</u> for Preferred/20% <u>coinsurance</u> for Participating	40% <u>coinsurance</u>	Prior authorization is required for all planned inpatient stays. Penalty for non-contract provider: 50% of allowable charge to \$1,500 per occurrence. <u>Deductible</u> applies.
	Physician/surgeon fees	0% <u>coinsurance</u> for Preferred/20% <u>coinsurance</u> for Participating	40% <u>coinsurance</u>	<u>Deductible</u> applies.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Deductible</u> applies.
	Inpatient services	0% <u>coinsurance</u>	40% <u>coinsurance</u>	Prior authorization is required for all planned inpatient stays. Penalty for non-contract provider: 50% of allowable charge to \$1,500 per occurrence. <u>Deductible</u> applies.
If you are pregnant	Office visits	0% <u>coinsurance</u> for Preferred/20% <u>coinsurance</u> for Participating	40% <u>coinsurance</u>	<u>Deductible</u> applies.
	Childbirth/delivery professional services	0% <u>coinsurance</u> for Preferred/20% <u>coinsurance</u> for Participating	40% <u>coinsurance</u>	<u>Deductible</u> applies.
	Childbirth/delivery facility services	0% <u>coinsurance</u> for Preferred/20% <u>coinsurance</u> for Participating	40% <u>coinsurance</u>	<u>Deductible</u> applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u> for Preferred/20% <u>coinsurance</u> for Participating	40% <u>coinsurance</u>	Limited to 130 visits per calendar year. <u>Deductible</u> applies.
	<u>Rehabilitation services</u>	Outpatient: 0% <u>coinsurance</u> for Preferred/20% <u>coinsurance</u> for Participating Inpatient: 0% <u>coinsurance</u> for Preferred/20% <u>coinsurance</u> for Participating	40% <u>coinsurance</u>	Limited to 45 outpatient professional visits per calendar year, limited to 30 inpatient days per calendar year. Prior authorization is required for all planned inpatient stays. Penalty for non-contract provider: 50% of allowable charge to \$1,500 per occurrence.
	<u>Habilitation services</u>	Outpatient: 0% <u>coinsurance</u> for Preferred/20% <u>coinsurance</u> for Participating Inpatient: 0% <u>coinsurance</u> for Preferred/20% <u>coinsurance</u> for Participating	40% <u>coinsurance</u>	Limited to 45 outpatient professional visits per calendar year, limited to 30 inpatient days per calendar year. Prior authorization is required for all planned inpatient stays. Penalty for non-contract provider: 50% of allowable charge to \$1,500 per occurrence.
	<u>Skilled nursing care</u>	0% <u>coinsurance</u> for Preferred/20% <u>coinsurance</u> for Participating	40% <u>coinsurance</u>	Limited to 60 days per calendar year. Prior authorization is required for all planned inpatient stays. Penalty for non-contract provider: 50% of allowable charge to \$1,500 per occurrence. <u>Deductible</u> applies.
	<u>Durable medical equipment</u>	0% <u>coinsurance</u> for Preferred/20% <u>coinsurance</u> for Participating	40% <u>coinsurance</u>	Prior authorization is required for purchase of some durable medical equipment over \$500. Penalty for non-contract provider: 50% of allowable charge to \$1,500 per occurrence. <u>Deductible</u> applies.
	<u>Hospice services</u>	0% <u>coinsurance</u> for Preferred/20% <u>coinsurance</u> for Participating	40% <u>coinsurance</u>	Limited to 240 respite hours, limited to 10 inpatient days - 6 month overall lifetime benefit limit, except when approved otherwise. <u>Deductible</u> applies.
	If your child needs dental or eye care	Children's eye exam	Not covered	Not covered
Children's glasses		Not covered	Not covered	None
Children's dental check-up		Not covered	Not covered	None

## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Assisted fertilization treatment
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic care or other spinal manipulations
- Foot care
- Hearing aids
- Non-emergency care when traveling outside the U.S.

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 907-269-7900 or 1-800-467-8725 for the state insurance department, or the insurer at 1-800-508-4722. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your plan at 1-800-508-4722.

**Does this plan provide Minimum Essential Coverage?** Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet Minimum Value Standards?** Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-508-4722.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-508-4722.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-508-4722.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-508-4722.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*-----

About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$5,000
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$5,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,060</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$5,000
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$5,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$5,020</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$5,000
- Specialist coinsurance 0%
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

This EXAMPLE event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$1,900
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>