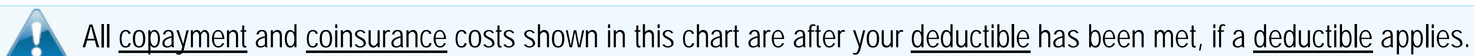
Premera Blue Cross Blue Shield of Alaska : HeritageSelect Coinsurance H3T NGF

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


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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	0% coinsurance	Deductible applies.
	Specialist visit	0% coinsurance	0% coinsurance	Deductible applies.
	Preventive care/screening/ immunization	No charge	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance for Preferred/ 20% coinsurance for Participating	40% coinsurance	Deductible applies.
	Imaging (CT/PET scans, MRIs)	0% coinsurance for Preferred/ 20% coinsurance for Participating	40% coinsurance	Prior authorization is required for some outpatient imaging tests. Penalty for non-contract provider: 50% of allowable charge to $1,500 per occurrence. Deductible applies.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://client.formularynavigator.com/Search.aspx?siteCode=1214076976.	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	
	Specialty drugs	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% coinsurance for Preferred/ 20% coinsurance for Participating	40% coinsurance	Prior authorization is required for some services. Penalty for non-contract provider: 50% of allowable charge to $1,500 per occurrence. Deductible applies.
	Physician/surgeon fees	0% coinsurance	0% coinsurance	Deductible applies.
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	Deductible applies.
	Emergency medical transportation	0% coinsurance	0% coinsurance	Deductible 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)	
	Urgent care	Hospital-based: 0% coinsurance Freestanding center: 0% coinsurance	Hospital-based: 0% coinsurance Freestanding center: 0% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance for Preferred/ 20% coinsurance for Participating	40% coinsurance	Prior authorization is required for all planned inpatient stays. Penalty for non-contract provider: 50% of allowable charge to $1,500 per occurrence. Deductible applies.
	Physician/surgeon fees	0% coinsurance	0% coinsurance	Deductible applies.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	0% coinsurance	None
	Inpatient services	0% coinsurance	40% coinsurance	Prior authorization is required for all planned inpatient stays. Penalty for non-contract provider: 50% of allowable charge to $1,500 per occurrence. Deductible applies.
If you are pregnant	Office visits	0% coinsurance	0% coinsurance	Deductible applies.
	Childbirth/delivery professional services	0% coinsurance	0% coinsurance	Deductible applies.
	Childbirth/delivery facility services	0% coinsurance for Preferred/ 20% coinsurance for Participating	40% coinsurance	Deductible 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	Home health care	0% coinsurance	40% coinsurance	Limited to 130 visits per calendar year. Deductible applies.
	Rehabilitation services	Outpatient: 0% coinsurance Inpatient: 0% coinsurance/ 20% coinsurance for Participating	Outpatient: 0% coinsurance Inpatient: 40% coinsurance	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.
	Habilitation services	Outpatient: 0% coinsurance Inpatient: 0% coinsurance/ 20% coinsurance for Participating	Outpatient: 0% coinsurance Inpatient: 40% coinsurance	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.
	Skilled nursing care	0% coinsurance/ 20% coinsurance for Participating	40% coinsurance	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. Deductible applies.
	Durable medical equipment	0% coinsurance	0% coinsurance	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. Deductible applies.
	Hospice services	Outpatient: 0% coinsurance Inpatient: 0% coinsurance/ 20% coinsurance for Participating	40% coinsurance	Limited to 240 respite hours, limited to 10 inpatient days - 6 month overall lifetime benefit limit, except when approved otherwise. Deductible applies.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	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 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, kwiijigo 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

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

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

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$5,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$5,020**

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

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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