PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Highlights of your Health Care Coverage

The Foraker Group

Group Number: 1037514

Effective Date: 12/01/2020

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.
Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

MEDICAL PLAN	GOLD PLUS HSA $1500/20%/$3000	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Deductible (Family aggregate deductible 2x Individual)	$1,500 PCY/$3,000 PCY	$3,000 PCY/$6,000 PCY
Coinsurance	20%	Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Out of Pocket Maximum (includes deductible, copays, coinsurance and pharmacy) (Family aggregate OOP max 2x Individual)	$3,000 PCY/$6,000 PCY	$45,000 PCY/$90,000 PCY
Office Visit Cost Share	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Annual Maximum	Unlimited	Unlimited
1 Ambulatory Patient Services		
Professional Office Visit (Includes Telemedicine)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Virtual Care (Designated Provider)	In Network Deductible, then 20%	Not Covered
Urgent Care Office Visits	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Outpatient Professional Services	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Contraceptive Management Services (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
2 Emergency Care		
Emergency Room - facility	In Network Deductible, then 20%	In Network Deductible, then 20%
Ambulance Service - ground (Unlimited)	In Network Deductible, then 20%	In Network Deductible, then 20%
Ambulance Service - air (Unlimited)	In Network Deductible, then 20%	In Network Deductible, then 20%

MEDICAL PLAN	GOLD PLUS HSA $1500/20%/$3000	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Ambulance Service - air non emergent (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then 40% Non-Preferred; 60% Non-Participating
3 Hospitalization		
Inpatient Medical and Surgical Room and Board (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Skilled Nursing Facility (60 days PCY)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Inpatient Professional Services	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Organ Transplants (Unlimited; $75,000 donor and $7,500 travel and lodging limits)	Covered as any other service	Not Covered
4 Maternity & Newborn Care		
Prenatal, Delivery, Postnatal (Coverage for subscriber, spouse, dependent)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
5 Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment		
Chemical Dependency Office Visit (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Chemical Dependency Outpatient Facility (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Chemical Dependency Inpatient Facility (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Mental Health Office Visit (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Mental Health Outpatient Facility (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating

MEDICAL PLAN	GOLD PLUS HSA $1500/20%/$3000	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Mental Health Inpatient Facility (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
6 Prescription Drug		
Drug List	M1 No Tiers	M1 No Tiers
Specific Generic Preventive Drugs (Retail: 90 day supply, one copay every 30 day supply; Mail: 90 day supply; Specialty: 30 day supply)	Covered in Full	Covered in Full
Retail (preferred generic/preferred brand/non-preferred) (Retail: 90 day supply, one copay every 30 day supply; Mail: 90 day supply; Specialty: 30 day supply)	In Network Deductible, then 20%	In Network Deductible, then 20%
Mail Order (preferred generic/preferred brand/non-preferred) (Retail: 90 day supply, one copay every 30 day supply; Mail: 90 day supply; Specialty: 30 day supply)	In Network Deductible, then 20%	Not Covered
Specialty Rx (Retail: 90 day supply, one copay every 30 day supply; Mail: 90 day supply; Specialty: 30 day supply)	In Network Deductible, then 20%	In Network Deductible, then 20%
7 Rehabilitative & Habilitative Services & Devices		
Inpatient Rehabilitation (30 days PCY)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Inpatient Habilitation (30 days PCY)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Rehab Outpatient Professional - physical, speech, occupational therapy (45 visits PCY)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Habilitation Outpatient Professional - physical, speech, occupational therapy (45 visits PCY)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Massage Therapy (Applies to rehab or neurodevelopmental therapy)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Durable Medical Equipment (MS: Unlimited, ME: Unlimited, Pro: Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
8 Laboratory/Imaging Services		
Pathology	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating

MEDICAL PLAN	GOLD PLUS HSA $1500/20%/$3000	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Imaging - basic	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Imaging - major (MRI, CT, PET)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Diagnostic Mammography	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
9 Preventive/Wellness Services & Chronic Disease Management		
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Preventive Laboratory Screens	Covered in Full	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Preventive Imaging	Covered in Full	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Preventive Routine Mammography	Covered in Full	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
10 Pediatric Services, including Oral & Vision Care		
Pediatric Vision Exam (1 PCY under age 19)	$25 Copay, applies to the Out of Pocket Maximum	$25 Copay, applies to the Out of Pocket Maximum
Pediatric Eyewear (Under age 19: One pair of glasses PCY (frames & lenses). 12 month supply of contacts PCY, in lieu of glasses (frames & lenses).)	Covered in Full	Covered In Full
Pediatric Dental (preventive)	Covered in Full	Waive Deductible, 10%
Pediatric Dental (basic)	Deductible, then 30%	Deductible, then 50%
Pediatric Dental (major)	Deductible, then 50%	Deductible, then 50%
Routine Hearing		
Routine Hearing Exam (1 every 2 calendar years)	In Network Deductible, then 20%	In Network Deductible, then 20%
Routine Hearing Aids and Hardware ($3,000 every 3 calendar years)	In Network Deductible, then 20%	In Network Deductible, then 20%
Alternative Care		

MEDICAL PLAN	GOLD PLUS HSA $1500/20%/$3000	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Chiropractic (12 visits PCY)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Acupuncture (12 visits PCY)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Naturopath (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Alaska Medical Transportation Benefits		
Medical Access Transportation (High Option 3 round trips PCY for patient (includes 3 round trips PCY for parent or guardian if pt. under 19 yrs of age))	In Network Deductible, then 20%	In Network Deductible, then 20%
Elective Procedure Travel (Prior Approval Required: Member & Medically Necessary Companion - Air: 1 round-trip per episode; Surface Transportation & Parking: $35/day; Ferry Transportation $50 per person each way; Lodging $50/day per person)	Travel: In Network Deductible, then 0%; Medical Procedures: covered as any other service	Travel: In Network Deductible, then 0%; Medical Procedures: covered as any other service
Premera Designated Centers of Excellence Package Services (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement), Spine & Gynecology)	In Network Deductible, then 0%	Covered as any other service

Benefits provided at 100% of allowable charges; not subject to deductible or coinsurance.
Seasonal immunizations provided at a pharmacy will be covered in full up to maximum allowable amount.
Massage therapy must be billed by a licensed physician.
Autism: Mental Health, Psychological & Neuropsychological Testing, Outpatient Professional & Facility Care covered as any other service.

Copays are not subject to the deductible unless otherwise noted.
Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.
PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross Blue Shield of Alaska. Members are responsible for amounts in excess of the allowable charge.

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms under which the program may be continued in force. This benefit highlight is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.

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MEDICAL PLAN	MANDATED ADULT VISION: VISION EXAM AND HARDWARE $350 PER CALENDAR YEAR	
	IN-NETWORK	**OUT-OF-NETWORK**
Adult Vision		
Vision exam (1 PCY; $350 PCY, shared with Vision Hardware)	$25 Copay	$25 Copay
Eyewear (1 set of frames every 2 consecutive years, $90 max; 1 pair of lenses PCY; contacts $170 PCY max; Vision Exam/Test and Hardware $350 PCY max)	Covered in Full	Covered In Full

Benefits provided at 100% of allowable charges; not subject to deductible or coinsurance.
Seasonal immunizations provided at a pharmacy will be covered in full up to maximum allowable amount.
Massage therapy must be billed by a licensed physician.
Autism: Mental Health, Psychological & Neuropsychological Testing, Outpatient Professional & Facility Care covered as any other service.

Copays are not subject to the deductible unless otherwise noted.
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Highlights of your Dental Coverage

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DENTAL PLAN	**ADULT DENTAL OPTIMA $50/0%-20%-50%/$1500**
COVERED SERVICES	
Individual/Family Deductible PCY	$50 PCY / $150 PCY
Diagnostic/Preventive	Covered in Full
Cleanings (limited to 2 PCY) Emergency exams (limited to 1 PCY) Routine oral exams (limited to 2 PCY) Bitewing x-rays, once PCY (limited to 4) Routine x-rays (complete series or panoramic x-ray once per 36 consecutive months, but not both)	
Basic	Deductible, then 20%
Emergency palliative treatment Fillings (limited to once per tooth surface every 24 consecutive months) General Anesthesia (limited to covered dental procedures at dental-care provider's office when dentally necessary) Simple and surgical extractions Periodontal maintenance (limited to 4 visits per calendar year)	
Major	Deductible, then 50%
Implants, dentures, partial & fixed bridges (replacements limited to once every 5 calendar years) Endodontic (root canal) treatment (once per tooth every 2 calendar year) Oral Surgery Full mouth debridement (limited to once every 3 calendar years) Inlays, onlays & crowns (replacements limited to once per tooth every 5 calendar years) Periodontal scaling (once per quadrant every 2 calendar years) Periodontal surgery Recementing & repair of crowns, inlays, bridgework & dentures	
Annual Maximum	$1,500 PCY

Diagnostic and Preventive Care Services aren't subject to the calendar year deductible.
PCY = Per Calendar Year.

Balance billing may apply if a provider is not contracted with Premera Blue Cross Blue Shield of Alaska. Members are responsible for amounts in excess of the allowable charge.

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Discrimination is Against the Law

Premera Blue Cross Blue Shield of Alaska (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-508-4722 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-508-4722 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-508-4722 (TTY: 711) 번으로 전화해 주십시오.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 800-508-4722 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-508-4722 (телетайп: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-508-4722 (TTY：711）。

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 800-508-4722 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ ນມ ພ ອມໃຫ ທ ່ານ. ໂທຣ 800-508-4722 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-508-4722 （TTY:711）まで、お電話にてご連絡ください。

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 800-508-4722 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-508-4722 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-508-4722 (телетайп: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-508-4722 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-508-4722 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-508-4722 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-508-4722 (رقم هاتف الصم والبكم: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-508-4722 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-508-4722 (ATS: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-508-4722 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-508-4722 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-508-4722 (TTY: 711) تماس بگیرید.