Premera Blue Cross Blue Shield of Alaska: Preferred Gold 1500

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 1-800-809-9361 (TTY: 711) or visit us at https://www.premera.com/ak/SBC. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-800-809-9361 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $1,500 Individual / $3,000 Family Out-of-network: $4,500 Individual	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 copayments, certain prescription drugs and 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: $6,300 Individual / $12,600 Family Out-of-network: Not Applicable	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 Legacy and Dental Select medical network. For a list of in-network providers, see https://www.premera.com or call 1-800-809-9361.	You pay the least if you use a provider in our preferred network. You pay more if you use a provider in our non-preferred 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 overall deductible has been met, if a 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 visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	First two visits: $1 copay / visit, deductible does not apply. Additional visits: $30 copay / visit, deductible does not apply.	Non-Participating: 60% coinsurance	——————none——————
	Specialist visit	$60 copay / visit, deductible does not apply.	Non-Participating: 60% coinsurance	——————none——————
	Preventive care / screening / immunization	No charge	Non-Participating: 60% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Preferred: 30% coinsurance. Participating: 40% coinsurance	Non-Participating: 60% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	Preferred: 30% coinsurance. Participating: 40% coinsurance	Non-Participating: 60% coinsurance	Prior authorization required for some outpatient imaging tests. The penalty is: 50% of the allowable charge up to a maximum of $1,500 per occurrence.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.premera.com/documents/062279_2	Preferred generic drugs	$15 copay / prescription (retail) $45 copay / prescription (mail) Deductible does not apply.	$15 copay / prescription (retail) Not covered (mail) Deductible does not apply.	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). No charge for specific preventive drugs. Prior authorization required for some drugs.
	Preferred brand drugs	$45 copay / prescription (retail) $135 copay / prescription (mail) Deductible does not apply.	$45 copay / prescription (retail) Not covered (mail) Deductible does not apply.	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). No charge for specific preventive drugs. Prior authorization required for some drugs.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
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025.pdf.	Non-preferred brand drugs	50% coinsurance	50% coinsurance (retail) Not covered (mail)	Covers up to a 30 day supply (retail), covers up to a 90 day supply (mail). No charge for specific preventive drugs. Prior authorization required for some drugs.
	Specialty drugs	40% coinsurance	40% coinsurance	Covers up to a 30 day supply. Only covered at specific contracted specialty pharmacies. Prior authorization required for some drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Preferred: 30% coinsurance. Participating: 40% coinsurance	Non-Participating: 60% coinsurance	Prior authorization required for some services. The penalty is: 50% of the allowable charge up to a maximum of $1,500 per occurrence.
	Physician/surgeon fees	Preferred: 30% coinsurance. Participating: 40% coinsurance	Non-Participating: 60% coinsurance	——————none——————
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	——————none——————
	Emergency medical transportation	30% coinsurance	30% coinsurance	——————none——————
	Urgent care	Hospital-based: 30% coinsurance Freestanding center: $60 copay / visit, deductible does not apply.	Hospital-based: 30% coinsurance Freestanding center: Non-Participating: 60% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	Preferred: 30% coinsurance. Participating: 40% coinsurance	Non-Participating: 60% coinsurance	Prior authorization required for all planned inpatient stays. The penalty is: 50% of the allowable charge up to a maximum of $1,500 per occurrence.
	Physician/surgeon fees	Preferred: 30% coinsurance. Participating: 40% coinsurance	Non-Participating: 60% coinsurance	——————none——————

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 mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $60 copay / visit, deductible does not apply. Facility: Preferred: 30% coinsurance. Participating: 40% coinsurance	Non-Participating: 60% coinsurance	——————none——————
	Inpatient services	Preferred: 30% coinsurance. Participating: 40% coinsurance	Non-Participating: 60% coinsurance	Prior authorization required for all planned inpatient stays. The penalty is: 50% of the allowable charge up to a maximum of $1,500 per occurrence.
If you are pregnant	Office visits	30% coinsurance	Non-Participating: 60% coinsurance	Cost-sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).
	Childbirth/delivery professional services	Preferred: 30% coinsurance. Participating: 40% coinsurance	Non-Participating: 60% coinsurance	Cost-sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).
	Childbirth/delivery facility services	Preferred: 30% coinsurance. Participating: 40% coinsurance	Non-Participating: 60% coinsurance	Cost-sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound). Prior authorization is not required. However, you should notify the carrier of your admission for delivery as soon as reasonably possible.
If you need help recovering or have	Home health care	Preferred: 30% coinsurance. Participating: 40% coinsurance	Non-Participating: 60% coinsurance	Limited to 130 visits per calendar year

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)	
other special health needs	Rehabilitation services	Outpatient: $60 copay / visit Inpatient: Preferred: 30% coinsurance. Participating: 40% coinsurance	Non-Participating: 60% coinsurance	Limited to 45 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Prior authorization required for all planned inpatient stays. The penalty is: 50% of the allowable charge up to a maximum of $1,500 per occurrence.
	Habilitation services	Outpatient: $60 copay / visit Inpatient: Preferred: 30% coinsurance. Participating: 40% coinsurance	Non-Participating: 60% coinsurance	Limited to 45 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Prior authorization required for all planned inpatient stays. The penalty is: 50% of the allowable charge up to a maximum of $1,500 per occurrence.
	Skilled nursing care	Preferred: 30% coinsurance. Participating: 40% coinsurance	Non-Participating: 60% coinsurance	Limited to 60 days per calendar year. Prior authorization required for all planned inpatient stays. The penalty is: 50% of the allowable charge up to a maximum of $1,500 per occurrence.
	Durable medical equipment	Preferred: 30% coinsurance. Participating: 40% coinsurance	Non-Participating: 60% coinsurance	Prior authorization required to buy some medical equipment over $750. The penalty is: 50% of the allowable charge up to a maximum of $1,500 per occurrence.
	Hospice service	Preferred: 30% coinsurance. Participating: 40% coinsurance	Non-Participating: 60% coinsurance	Limited to 240 respite hours, limited to 10 inpatient days – 6 months overall lifetime benefit limit.
If your child needs dental or eye care	Children's eye exam	$30 copay / visit Deductible does not apply.	$30 copay / visit Deductible does not apply.	Limited to one exam per calendar year (under age 19).
	Children's glasses	No charge	No charge	Frames and lenses limited to 1 pair per calendar year.
	Children's dental check-up	No charge	30% coinsurance	——————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 fertility treatment
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- 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.)

- Abortion
- Acupuncture
- Chiropractic care or other spinal manipulations
- Foot care
- 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: 1-907-269-7900 or 1-800-467-8725 for the state insurance department, or the insurer at 1-800-809-9361 or TTY 711. 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 grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: your plan at 1-800-809-9361, or the state insurance department at 1-907-269-7900 or 1-800-467-8725.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Not Applicable.

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 1-800-809-9361 or TTY 711.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-809-9361 or TTY 711.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-809-9361 or TTY 711.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-809-9361 or TTY 711.

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	$1,500
Specialist copay	$60
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$1,500
Copayments	$10
Coinsurance	$3,300
What isn't covered	
Limits or exclusions	$60
The Total Peg would pay is	**$4,870**

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

The plan's overall deductible	$1,500
Specialist copay	$60
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The Total Joe would pay is	**$1,820**

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

The plan's overall deductible	$1,500
Specialist copay	$60
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The Total Mia would pay is	**$2,100**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Notice of availability and nondiscrimination 800-809-9361 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Hu thov kev pab txhais lus pub dawb thiab lwm yam khoom pab dawb thiab kev pab cuam ua tsim nyog.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Vala‘au mo auaunaga tau fesoasoani mo gagana e leai ni totogi ma fesoasoani fa‘aopo‘opo talafeagai ma auaunaga.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
Tumawag para kadagiti libre a serbisio iti tulong iti pagsasao ken dagiti nakanada nga aid ken serbisio iti komunikasion.
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
ติดต่อขอบริการช่วยเหลือด้านภาษาฟรีพร้อมความช่วยเหลือและบริการอื่น ๆ เพิ่มเติม
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d’assistance linguistique et des aides et services auxiliaires appropriés.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

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, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our 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, TTY: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our 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.