PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Highlights of your Health Care Coverage

City & Borough of Sitka

Group Number: 1011203

Effective Date: 04/01/2016

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	**2016 AK HERITAGEPLUS $1000/20%/$2000/$30**	
	IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 3X Individual)	$1,000 PCY	Shared with In-Network
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20% Preferred/40% Participating	Hospital and Professional: 60%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 3X Individual)	$2,000 PCY	Not Applicable
Office Visit Cost Share	$30 Copay Preferred, applies to OOP max/40% Participating	Deductible, then Hospital and Professional: 60%
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited)	Covered In Full[1]	Deductible, then Hospital and Professional: 60%
Immunizations (Unlimited)	Covered In Full[‡]	Deductible, then Hospital and Professional: 60%[‡]
Health Education (HE) (Unlimited)	Covered In Full[1]	Covered In Full
Community Wellness, Prevention and Safety Programs (CW) ($250 PCY)	Covered In Full[1]	Covered In Full
Diabetes Health Education (DE) (Unlimited)	Covered In Full[1]	Covered In Full
PROFESSIONAL CARE		
Professional Office Visit Including Urgent Care	$30 Copay Preferred, applies to OOP max/40% Participating	Deductible, then Hospital and Professional: 60%
Inpatient Professional Services	Deductible, then 20% Preferred/40% Participating	Deductible, then Hospital and Professional: 60%
Contraceptive Management Services (Unlimited)	Covered In Full	Deductible, then Hospital and Professional: 60%
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	Deductible, then Hospital and Professional: 60%
Other Professional Diagnostic Imaging	Deductible, then 20% Preferred/40% Participating	Deductible, then Hospital and Professional: 60%
Other Professional Diagnostic Laboratory/Pathology	Deductible, then 20% Preferred/40% Participating	Deductible, then Hospital and Professional: 60%
Diagnostic Mammography	Deductible, then 20% Preferred/40% Participating	Deductible, then Hospital and Professional: 60%

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	IN-NETWORK	OUT-OF-NETWORK
FACILITY CARE OPTIONS		
Inpatient Facility	Deductible, then 20% Preferred/40% Participating	Deductible, then Hospital and Professional: 60%
Outpatient Surgery Facility	Deductible, then 20% Preferred/40% Participating	Deductible, then Hospital and Professional: 60%
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	Deductible, then 20% Preferred/40% Participating	Deductible, then Hospital and Professional: 60%
EMERGENCY CARE AND TRANSPORTATION OPTIONS		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$75 Copay applies to OOP max, then deductible, 20% preferred coinsurance	Same as In-Network Cost Share
Emergency Room Physician	Deductible, then 20% Preferred	Deductible, then 20% Preferred
Ambulance Transportation (Unlimited)	$75 Copay applies to OOP max, then deductible, 20% preferred coinsurance	Same as In-Network Cost Share
Non-Emergent Ground Ambulance (Unlimited)	$75 Copay applies to OOP max, then deductible, 20% preferred coinsurance	Same as In-Network Cost Share
Air Ambulance (Unlimited)	$75 Copay applies to OOP max, then deductible, 20% preferred coinsurance	Same as In-Network Cost Share
Non-Emergent Air Ambulance (Unlimited)	$75 Copay applies to OOP max, then deductible, 20% preferred coinsurance	Deductible; then 60% Coinsurance
Air Or Surface Transportation (2 Round Trips PCY Paid at highest benefit level; Coinsurance Preferred)	2 Round Trips PCY Paid at highest benefit level; Coinsurance Preferred	2 Round Trips PCY Paid at highest benefit level; Coinsurance Preferred
Medical Travel Support (Prior Authorization Required: Member & 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: Covered In Full; Medical Procedures: covered as any other service	Travel: Covered In Full; Medical Procedures: covered as any other service
OTHER SERVICES		
Allergy/Therapeutic Injections	Deductible, then 20% Preferred/40% Participating	Deductible, then Hospital and Professional: 60%
Mental Health Inpatient Facility Care (Unlimited)	Deductible, then 20% Preferred†	Deductible, then Hospital and Professional: 60%†
Mental Health Outpatient Professional Care (Unlimited)	$30 Copay Preferred, applies to OOP max†	Deductible, then Hospital and Professional: 60%†
Chemical Dependency Inpatient Facility Care (Unlimited)	Deductible, then 20% Preferred	Deductible, then Hospital and Professional: 60%
Chemical Dependency Outpatient Professional Care (Unlimited)	$30 Copay Preferred, applies to OOP max	Deductible, then Hospital and Professional: 60%
Rehab Inpatient Facility (30 days PCY)	Deductible, then 20% Preferred/40% Participating	Deductible, then Hospital and Professional: 60%

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MEDICAL PLAN	**2016 AK HERITAGEPLUS $1000/20%/$2000/$30**	
	IN-NETWORK	**OUT-OF-NETWORK**
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab.; and Chronic Pain (45 visits PCY)	$30 Copay Preferred, applies to OOP max/40% Participating*	Deductible, then Hospital and Professional: 60%*
Medical Supplies, Equipment, Prosthetics (MS, ME, PRO: Unlimited)	Deductible, then 20% Preferred/40% Participating	Deductible, then Hospital and Professional: 60%
Foot Orthotics, Orthopedic Shoes and Accessories ($600 PCY (Unlimited Diabetes Related))	Deductible, then 20% Preferred/40% Participating	Deductible, then Hospital and Professional: 60%
Home Health Visits (130 visits PCY)	Deductible, then 20% Preferred/40% Participating	Deductible, then Hospital and Professional: 60%
Hospice Care (Home Health and Respite) (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	Deductible, then 20% Preferred/40% Participating	Deductible, then Hospital and Professional: 60%
Transplants (Unlimited; $75,000 donor and $7,500 travel and lodging limits)	Covered as any other service	Not Covered
ALTERNATIVE CARE		
Manipulations (Spinal and other) (24 visits PCY)	$30 Copay Preferred, applies to OOP max/40% Participating	Deductible, then Hospital and Professional: 60%
Acupuncture (12 visits PCY)	$30 Copay Preferred, applies to OOP max/40% Participating	Deductible, then Hospital and Professional: 60%
Nutritional Therapy (Unlimited)	Covered In Full	Deductible, then Hospital and Professional: 60%
SUPPLEMENTAL BENEFITS		
Routine Vision Exam (1 PCY)	$30 Copay	Deductible/Coinsurance
Vision Hardware ($300 every 2 consecutive calendar years)	Covered In Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)	$30 Copay Preferred, applies to OOP max	$30 Copay Preferred, applies to OOP max
Pediatric Vision Hardware (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
Routine Hearing Exam (1 every 3 years to combined max of $800 limit every 3 consecutive years)	Waive Deductible, then 20%	Waive Deductible, then 20%
Hearing Hardware (Combined $800 limit every 3 consecutive years)	Waive Deductible, then 20%	Waive Deductible, then 20%
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited

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MEDICAL PLAN	2016 AK HERITAGEPLUS $1000/20%/$2000/$30	
	IN-NETWORK	OUT-OF-NETWORK

[1]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.

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Pharmacy Benefits

Tier 1 = Generic
Tier 2 = Preferred Brand Name
Tier 3 = Non Preferred Brand Name

Below is a brief overview of what you can expect to pay for a prescription drug, depending on which "tier" category it falls under in the Preferred Drug List for your plan when using an In-Network Pharmacy. For more information on your pharmacy benefits, including Out-of-Network benefits, see your benefit booklet. To find out what tier applies to a specific medication, see out Preferred Drug List in your pharmacy packet or at www.premera.com.

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PHARMACY PLAN	**2016 RX PLAN - $15/$25/$50**
	Cost Share Category Tier1/Tier2/Tier3
PRESCRIPTION DRUGS	
Retail Cost Shares	$15/$25/$50
Mail Cost Shares	$37/$62/$125
Day Supply	Retail: 90 Days; Mail: 90 Days; Specialty: 30 Days
Individual Deductible PCY	$0
(Non-participating retail pharmacies)	Same as in-network
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Annual Benefit Maximum	Unlimited
Drug List	Preferred B3
Specialty Pharmacy	Mandatory

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Highlights of your Dental Coverage

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DENTAL PLAN	**2016 DENTAL STANDARD $50-0%/20%/50%/$2000**
COVERED SERVICES	
Individual/Family Deductible PCY	$50 PCY / $150 PCY
Diagnostic/Preventive -cleanings (limited to 2 PCY) -emergency exams (limited to 1 PCY) -fluoride treatments (limited to 2 applications PCY for members under age 20) -routine oral exams (limited to 2 PCY) -sealants (for members under age 19) -space maintainers (for members under age 20) -x-rays (including bitewing x-rays; complete series or panoramic X-ray once per 36 consecutive months)	Covered In Full
Basic -emergency palliative treatment -endodontic (root canal) treatment (limited to 2 per arch when performed in conjunction with overdentures) -fillings (limited to once per tooth surface every 24 consecutive months) -full mouth debridement (limited to once every 3 calendar years) -general anesthesia (limited to covered dental procedures at a dental-care provider's office when dentally necessary) -oral surgery (including simple and surgical extractions) -periodontal maintenance (limited to 4 visits per calendar year) -periodontal scaling (limited to once per quadrant every 2 calendar years) -periodontal surgery	Deductible, then 20%
Major -dentures, partial & fixed bridges (replacements limited to once every 5 calendar years) -inlays, onlays & crowns (replacements limited to once per tooth every 5 years) -recementing & repair of crowns, inlays, bridgework & dentures	Deductible, then 50%
Annual Maximum	$2,000 PCY

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