PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Highlights of your Health Care Coverage

Alaska Radiology Associates
Group Number: 1040097

Effective Date: 01/01/2024

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	**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.
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 of the plan. This benefit highlight is not a contract and may change. Please see your benefit booklet or call Customer Service for full coverage information including a description of waiting periods, limitations, and exclusions.

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MEDICAL PLAN	**PLUS HSA QUALIFIED SILVER $3200/25%/$7000**	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Deductible (Family embedded deductible 2X Individual)	$3,200 PCY	$6,400 PCY
Coinsurance	25% Preferred/40% Participating	Hospital & Professional: 60% Non-Participating
Out of Pocket Maximum (includes deductible, copays, coinsurance and pharmacy) (Family embedded OOP max 2X Individual)	$7,000 PCY	$45,000 PCY
Office Visit Cost Share	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Annual Maximum	Unlimited	Unlimited
1 Ambulatory Patient Services		
Professional Office Visit (Includes Telemedicine)	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Urgent Care Office Visits	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Professional Services	25% Preferred/40% Participating	Hospital & Professional: 60% Non-Participating; ARP/ABA Certified: Same as In-Network
Contraceptive Management Services (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
2 Emergency Care		
Emergency Room - facility	In Network Deductible, then 25% Preferred/40% Participating	In Network Deductible, then 25% Preferred/40% Participating
Ambulance Service - ground (Unlimited)	In Network Deductible, then 25% Preferred/40% Participating	In Network Deductible, then 25% Preferred/40% Participating
Ambulance Service - air (Unlimited)	In Network Deductible, then 25% Preferred/40% Participating	In Network Deductible, then 25% Preferred/40% Participating
Ambulance Service - air non emergent (Unlimited)	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
3 Hospitalization		
Inpatient Medical and Surgical Room and Board (Unlimited)	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating

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MEDICAL PLAN	PLUS HSA QUALIFIED SILVER $3200/25%/$7000	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Skilled Nursing Facility (60 days PCY)	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Inpatient Professional Services	25% Preferred/40% Participating	Hospital & Professional: 60% Non-Participating; ARP/ABA Certified: Same as In-Network
Organ Transplants (Unlimited; $75,000 donor)	Covered as any other service	Not Covered
4 Maternity & Newborn Care		
Prenatal, Delivery, Postnatal (Coverage for subscriber, spouse, dependent)	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
5 Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment		
Chemical Dependency Office Visit (Unlimited)	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Chemical Dependency Outpatient Facility (Unlimited)	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Chemical Dependency Inpatient Facility (Unlimited)	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Mental Health Office Visit (Unlimited)	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Mental Health Outpatient Facility (Unlimited)	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Mental Health Inpatient Facility (Unlimited)	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
6 Prescription Drug		
Drug List	M1 No Tiers	M1 No Tiers
Enhanced Preventive Drug List (PV Core)	Covered in Full	Covered in Full
Prescription Drugs - Retail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	In Network Deductible, then 25% Preferred/40% Participating	In Network Deductible, then 25% Preferred/40% Participating
Prescription Drugs - Mail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	In Network Deductible, then 25% Preferred/40% Participating	Not Covered
7 Rehabilitative & Habilitative Services & Devices		
Inpatient Rehabilitation (30 days PCY)	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating

MEDICAL PLAN	PLUS HSA QUALIFIED SILVER $3200/25%/$7000	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Inpatient Habilitation (30 days PCY)	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Rehab Outpatient Professional - physical, speech, occupational therapy (45 visits PCY)	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Habilitation Outpatient Professional - physical, speech, occupational therapy (45 visits PCY)	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Massage Therapy (Applies to rehab or neurodevelopmental therapy)	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Durable Medical Equipment (Unlimited)	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
8 Laboratory/Imaging Services		
Pathology	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Imaging - basic	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Imaging - major (MRI, CT, PET)	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Diagnostic Mammography	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 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: 60% Non-Participating
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Preventive Laboratory Screens	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Preventive Imaging	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Preventive Routine Mammography	Covered in Full	Out of Network Deductible, then Hospital & Professional: 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, then 10%
Pediatric Dental - Basic	Deductible, then 30%	Deductible, then 50%

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Pediatric Dental - Major	Deductible, then 50%	Deductible, then 50%
App-Based Virtual Care Services		
Telemedicine – General Medical (Virtual Care Only)	In Network Deductible, then 25% Preferred/40% Participating	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	Not Covered
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		
Chiropractic (12 visits PCY)	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Acupuncture (12 visits PCY)	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Naturopath (Unlimited)	In Network Deductible, then 25% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Alaska Medical Transportation Benefits		
Medical Access Transportation (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 25% Preferred/40% Participating	In Network Deductible, then 25% Preferred/40% Participating
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)	$3,200 PCY Deductible, then 0%	$3,200 PCY Deductible, then 0%
Medical Services from Elective Procedure Travel	Covered as any other service	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

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Highlights of your Dental Coverage

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DENTAL PLAN	ADULT DENTAL OPTIMA $50/0%-20%-50%/$2000 ENHANCED	
	IN-NETWORK	**OUT-OF-NETWORK**
Dental Cost Share		
Individual/Family Deductible	$50	Shared with In Network
Preventive Cost Share	Covered in Full	Covered in Full
Basic Cost Share	Deductible, then 20%	Deductible, then 20%
Major Cost Share	Deductible, then 50%	Deductible, then 50%
Dental Reimbursement (Dental Choice Network)	AK fee schedule	80th percentile (in-state) and 90th percentile (out-of-state)
Dental Annual Maximum	$2,000 PCY	Shared with In Network
Benefit Enhancement Rider		
Benefit Enhancement Rider	Endodontics & Periodontal Treatment (In Basic)	Endodontics & Periodontal Treatment (In Basic)
Office Visit		
Routine Oral Exams (2 PCY)	Covered in Full	Covered in Full
Emergency Exams (1 PCY)	Covered in Full	Covered in Full
Preventive Services		
Cleanings (2 PCY)	Covered in Full	Covered in Full
Diagnostic Imaging		
Bitewings X-rays (1 set (up to 4) PCY)	Covered in Full	Covered in Full
Routine X-rays (1 complete series, 1 panoramic or 1 comparable cone beam view in any 36 consecutive months)	Covered in Full	Covered in Full
Restorative		
Fillings (1 per surface every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%
Installation of Crowns (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Re-cementing/Repair of Crowns (When performed 6 or more months after placement)	Deductible, then 50%	Deductible, then 50%
Build-Ups (Once every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Endodontics		
Endodontics (Once per tooth every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%

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DENTAL PLAN	ADULT DENTAL OPTIMA $50/0%-20%-50%/$2000 ENHANCED	
	IN-NETWORK	OUT-OF-NETWORK
Direct Pulp Cap (Unlimited)	Deductible, then 20%	Deductible, then 20%
Periodontics		
Periodontal Maintenance (4 PCY)	Deductible, then 20%	Deductible, then 20%
Full Mouth Debridement (Once every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%
Periodontal Scaling and Root Planing (Once per quadrant every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%
Prosthodontics (Dentures/Bridges)		
Installation or Replacement of Dentures, Partials and Fixed Bridges (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Repair or Re-cement Bridgework and Dentures (When performed 6 or more months after placement)	Deductible, then 50%	Deductible, then 50%
Implant Services		
Implants (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Oral Surgery		
Simple Extractions (Unlimited)	Deductible, then 20%	Deductible, then 20%
Surgical Extractions (Unlimited)	Deductible, then 20%	Deductible, then 20%
Oral Surgery (Unlimited)	Deductible, then 50%	Deductible, then 50%
General Services		
General Anesthesia (Unlimited)	Deductible, then 20%	Deductible, then 20%
Anesthesia - Nitrous Oxide (Unlimited)	Deductible, then 20%	Deductible, then 20%
Limited Occlusal Adjustment (1 every 12 consecutive months as dentally necessary)	Deductible, then 20%	Deductible, then 20%
Emergency Palliative Treatment (Unlimited)	Deductible, then 20%	Deductible, then 20%

Diagnostic and Preventive Care Services aren't subject to the calendar year deductible.
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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, sex, gender identity, or sexual orientation. 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, sex, gender identity, or sexual orientation, 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, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 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.

037379 (07-01-2021)