PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Benefit Summary Report (for Internal use only)

Group Number: 4003399

Alaska Public Broadcasting Health Trust

Effective Date: 01/01/2020

Product Name: CareCompass360 PBCBS AK - Large Group - 1/2020	Specification and Benefit Limits	Model Code	Comments
Plan Name: 2020 IHM			
CORE PROGRAMS			
Personal Health Support	Included	ICM-C	
Prior Authorization	Option B3 - Contracted providers with penalty, provider liability; non contracted providers with penalty, member liability	PRA-H	
Advanced Imaging	Option B3 - Contracted providers with penalty, provider liability; non contracted providers with penalty, member liability	AVI-J	
Nurseline	Included	RN-C	
Newborn (NICU) Program	Included	NICU-A	
Maternity Program	Included	MATP-A	
Outpatient Rehab Utilization Management	Included	RHB-A	
Chronic Condition Management	Excluded	CCM-D	
Premera Pulse	Basic	PUL-A	
PHARMACY PROGRAMS			
Rebate	Not Applicable	REB-E	
RationalMed	Included	RTM-A	
Enhanced Controlled Substance Utilization Program	No Program	OPD-B	
Polypharmacy	Included	POL-A	
Point of Sale	Standard (POS + Biotech/Oral Chemo)	POS-C	

Comments

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Product Name: F3T HSA Qualified HeritagePlus Aggregate NGF - Large Group - 1/2020	Specification and Benefit Limits	Heritage In-Network	Out-of-Network	Model Code	Comments
Plan Name: 2020 HERITAGE PLUS HSA AGG $2,000/20%/$3,500 W/ESSENTIALS					
MEDICAL COST SHARE OPTIONS					
Individual Deductible PCY	Family aggregate deductible 2x Individual	$2,000 PCY/$4,000 PCY	Shared with In-Network	DFR-D DVI-R DVO-A	
Fourth Quarter Deductible Carryover	No			QTR-B	
Coinsurance (Member's percentage of costs after deductible based on allowable charges)		20% Preferred/40% Participating	Hospital and Professional: 60%	COI-J COO-W	
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable	Family embedded OOP max 2X Individual	$3,500 PCY/$7,000 Family PCY	$7,000 Individual PCY / $14,000 Family PCY	OFR-B OMI-Z OMO-Z	
Office Visit Cost Share		In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	OVI-A OVO-A	
Annual Plan Maximum		Unlimited	Unlimited	LT-D LT-D	
Health coverage meets the minimum value standard for benefits provided	Yes			MVS-A	
FACILITY CARE					
Inpatient Facility		In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	IPI-A IPO-A	
Outpatient Surgery Facility		In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	OSF-A OSF-A	
Outpatient Facility		In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	HOF-A HOF-A	

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Plan Name: 2020 HERITAGE PLUS HSA AGG $2,000/20%/$3,500 W/ESSENTIALS					
Skilled Nursing Facility	60 days PCY	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	SNF-A SNFC-A SNFC-A	
Hospice Inpatient Facility	10 days Inpatient; within the 6 month lifetime maximum	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	HPC-A HPCC-A HPCC-A	
Inpatient Facility - Maternity	Coverage for subscriber, spouse, dependent	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	MCD-A MGC-E MGC-E	
PREMERA DESIGNATED CENTERS OF EXCELLENCE					
Centers of Excellence Packaged Services	Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement), Spine & Gynecology	In Network Deductible, then 0%	Covered as any other service	COEP-C COE-B COE-B	
Travel and Care Coordination	See Elective Procedure Travel	See Elective Procedure Travel	See Elective Procedure Travel	TRLL-C TRL-D TRL-D	
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% Preferred	In Network Deductible, then 20% Preferred	TVL-L TVL-L TVL-L	
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	MTS-C MTS-C MTS-C	
EMERGENCY CARE					
Emergency Care (Includes ER physician and facility)		In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred	ERV-AF ERV-AF	

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Emergency Room Physician		In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred	ERP-A ERP-A	
Urgent Care Center		In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	UCC-F UCC-F	
Ambulance Transportation	Unlimited	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred	AAM-C AMB-O AMB-O	
Non-Emergent Ground Ambulance	Unlimited	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred	AAM-C AMB-O AMB-O	
Air Ambulance	Unlimited	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred	AAM-C AMB-O AMB-O	
Non-Emergent Air Ambulance	Unlimited	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then 60%	AAM-C AMB-O AMB-O	
DIAGNOSTIC SERVICES					
Preventive Professional Diagnostic Imaging and Laboratory Services - Including PAP/PSA		Covered In Full	Out of Network Deductible, then Hospital and Professional: 60%	DXL-BM DXL-BM	
Preventive Mammography		Covered In Full	Out of Network Deductible, then Hospital and Professional: 60%	MMO-AE MMO-AE	
Other Professional Diagnostic Imaging		In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	DXL-BM DXL-BM	
Professional Diagnostic Major Imaging		In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	DXL-BM DXL-BM	
Diagnostic Mammography		In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	MMO-AE MMO-AE	
Other Professional Diagnostic Laboratory/Pathology		In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	DXL-BM DXL-BM	

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PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION					
Preventive Office Visit	Unlimited, subject to standard medical guidelines	Covered In Full	Out of Network Deductible, then Hospital and Professional: 60%	PRC-D PCC-L PCC-L	
Immunizations	Unlimited, subject to standard medical guidelines	Covered In Full	Out of Network Deductible, then Hospital and Professional: 60%	PRC-D IMM-AB IMM-AB	
Seasonal Immunization provided at a mass immunizer location	Unlimited, subject to standard medical guidelines	Covered In Full	Covered In Full	PRC-D IMM-AB IMM-AB	
Preventive Colon Health	Unlimited; subsequent colonoscopies within a 5 year limit apply to deductible and coinsurance	Covered In Full	Out of Network Deductible, then Hospital and Professional: 60%	COL-D COL-D COL-D	
Health Education (HE)	Unlimited	Covered In Full	Covered In Full	HED-U HCW-AH HCW-AH	
Nicotine Dependency Programs (ND)	Unlimited	Covered In Full	Covered In Full	HED-U HCW-AH HCW-AH	
Diabetes Health Education (DE)	Unlimited	Covered In Full	Covered In Full	HED-U HCW-AH HCW-AH	
PROFESSIONAL CARE					
Professional Office Visit (Includes Telemedicine)		In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	OVI-A OVO-A	
Inpatient Professional Services		In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	IPP-A IPP-A	
Contraceptive Management	Unlimited	Covered In Full	Out of Network Deductible, then Hospital and Professional: 60%	CMI-I CMI-I CMI-I	

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Plan Name: 2020 HERITAGE PLUS HSA AGG $2,000/20%/$3,500 W/ESSENTIALS					
Maternity Prenatal, Delivery and Postnatal Care	Coverage for subscriber, spouse, dependent	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	MCD-A MGC-E MGC-E	
Sterilization - Female	Unlimited	Covered In Full	Out of Network Deductible, then Hospital and Professional: 60%	CMI-I CMI-I CMI-I	
Sterilization - Male	Unlimited	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	CMI-I CMI-I CMI-I	
VIRTUAL CARE - ON DEMAND					
Virtual Care - General Medical/Dermatology (Voice/Video)		In Network Deductible, then 20% Preferred	Not Applicable	VGD-I VGD-I	
Virtual Care - Acute Care & General Medical (Secure Chat)		In Network Deductible, then 20% Preferred	Not Applicable	VER-I VER-I	
OTHER SERVICES					
Mental Health Inpatient Facility Care	Unlimited	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital and Professional: 60%	MHL-AC MH-BA MH-BA	
Mental Health Outpatient Facility Care	Unlimited	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital and Professional: 60%	MHL-AC MH-BA MH-BA	
Mental Health Outpatient Professional Care	Unlimited	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital and Professional: 60%	MHL-AC MH-BA MH-BA	
Telemedicine - Mental Health		Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Applicable	VBH-A VBH-A	
Mental Health Residential Care		In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital and Professional: 60%	MH-BA MH-BA	
Manipulations (Spinal and other)	12 visits PCY	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	CC-Q CCC-BG CCC-BG	

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Plan Name: 2020 HERITAGE PLUS HSA AGG $2,000/20%/$3,500 W/ESSENTIALS					
Acupuncture	12 visits PCY	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	CC-Q CCC-BG CCC-BG	
Naturopathy Services	Unlimited	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	CC-Q CCC-BG CCC-BG	
Psychological & Neuropsychological Testing & Evaluation (Shared with Rehab, Neuro dev & Mental Health)	Unlimited	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	PNT-N PNT-N PNT-N	
Rehab Inpatient Facility	30 days PCY	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	RNT-A RNC-A RNC-A	
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab; and Chronic Pain	45 visits PCY	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	RNT-A RNC-A RNC-A	
Telemedicine - Physical Therapy		Not Covered	Not Applicable	VPT-C VPT-C	
Medical Supplies (MS), Equipment (ME), Prosthetics (Pro)	MS: Unlimited, ME: Unlimited, Pro: Unlimited	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	SUP-AM SUPC-L SUPC-L	
Foot Orthotics, Orthopedic Shoes and Accessories	$300 PCY (Unlimited Diabetes Related)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	SUP-AM SUPC-L SUPC-L	
Chemical Dependency Inpatient Facility Care	Unlimited	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital and Professional: 60%	CD-AC CD-AC CD-AC	
Chemical Dependency Outpatient Facility Care	Unlimited	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital and Professional: 60%	CD-AC CD-AC CD-AC	
Chemical Dependency Outpatient Professional Care	Unlimited	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital and Professional: 60%	CD-AC CD-AC CD-AC	
Home Health Care	130 visits PCY	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	HOH-A HOHC-A HOHC-A	

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Plan Name: 2020 HERITAGE PLUS HSA AGG $2,000/20%/$3,500 W/ESSENTIALS					
Hospice Care (Home Health and Respite)	Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	HPC-A HPCC-A HPCC-A	
Transplants	Unlimited; $75,000 donor and $7,500 travel and lodging limits	Covered as any other service	Not Covered	TRA-Q TRA-Q TPO-A	
TMJ (Temporomandibular Joint Disorders)	Not Covered	Not Covered	Not Covered	TMJ-A TMJ-A TMJ-A	
Orthognathic/Maxillofacial Care	Not Covered	Not Covered	Not Covered	OGS-A OGS-A OGS-A	
Allergy/Therapeutic Injections		In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	INJ-A INJ-A	
End Stage Renal Disease (ESRD) During Medicare's Waiting Period		In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	ESRD-G ESRD-G	
End Stage Renal Disease (ESRD) After Medicare's Waiting Period	Without Premium Reimbursement	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital and Professional: 60%	ESRD-G ESRD-G ESRD-G	
Infertility/Assisted Reproductive Services	Not Covered	Not Covered	Not Covered	INF-B INF-B INF-B	
Pharmacy Pricing	Level Billing			PPR-A	
Drug List	E1 Essentials Formulary No Tiers	E1 Essentials Formulary	E1 Essentials Formulary	FOR-AD FOR-AD FOR-AD	
Preventive Pharmacy Buy-Up	Not Purchased	Covered In Full	Covered In Full	PBU-C PBU-C PBU-C	
Smart 90	Not Applicable			SMT-A	

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Plan Name: 2020 HERITAGE PLUS HSA AGG $2,000/20%/$3,500 W/ESSENTIALS					
Prescription Drugs - Retail	Specific preventive drugs and legend Retail: 90 day supply/Mail: 90 day supply/Specialty: 30 day supply	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred	RMM-Q RMM-Q RMM-Q	
Prescription Drugs - Mail Order	Specific preventive drugs and legend Retail: 90 day supply/Mail: 90 day supply/Specialty: 30 day supply	In Network Deductible, then 20% Preferred	Not Covered	RMM-Q RMM-Q RMM-Q	
Specialty Pharmacy	Mandatory - Exclusive	In Network Deductible, then 20% Preferred	Not covered	RSP-F RMM-Q RMM-Q	
Generics Required When Available	Member pays the appropriate cost share (No DAW 1 and 2 provision)			DAW-D	
Anti-cancer Medications		In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred	RMM-Q RMM-Q	
ADMINISTRATIVE OPTIONS					
BlueCard/National Coverage Program	Standard Alaska PPO			BCP-AM	
Obstetrical Care for Dependent Daughters	Yes			MCD-A	
SUPPLEMENTAL BENEFITS					
Routine Vision Exam	1 PCY	Covered In Full	Covered In Full	VSL-H VSC-Z VSC-Z	
Vision Hardware	$200 PCY	Covered In Full	Covered In Full	VSL-H VHC-B VHC-B	
Pediatric Vision Exam	1 PCY Under age 19	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred	PEDV-AN PEDV-AN PEDV-AN	

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Plan Name: 2020 HERITAGE PLUS HSA AGG $2,000/20%/$3,500 W/ESSENTIALS					
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	PEDV-AN PEDV-AN PEDV-AN	
Routine Hearing Exam	Not Covered	Not Covered	Not Covered	HEA-H HEC-A HEC-A	
Hearing Hardware	Not Covered	Not Covered	Not Covered	HEA-H HHC-A HHC-A	
Calypso	Included			CLS-A	
Fiduciary Services	Included			FID-A	

Comments

No DAW
Rx copays accrue to medical plan OOP Maximum

Anti-cancer rx will be deductible, then coinsurance

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Product Name: Dental Optima - Large Group - 1/2020	Specification and Benefit Limits	In-Network	Out-Of-Network	Model Code	Comments
Plan Name: 2020 DENTAL OPTIMA					
COVERED SERVICES					
Individual/Family Deductible	$50 PCY / $150 PCY			DD-C	
Diagnostic/Preventive		Covered In Full	Covered In Full	DST-A DST-A	
Basic		Deductible, then 20%	Deductible, then 20%	DST-A DST-A	
Major		Deductible, then 50%	Deductible, then 50%	DST-A DST-A	
Annual Maximum	$1,500 PCY applies to basic and major services			DL-M	
Dental Waiting Periods (Major Services)	0 months			WTP-A	
Reimbursement Level	Dental Choice Network	AK fee schedule	80th percentile (in-state) and 90th percentile (out-of-state)	DNWK-A DRM-K DRM-K	
ADDITIONAL SERVICES					
Dental Benefit Enhancement		Endodontics & Periodontal Treatment (In Basic)	Endodontics & Periodontal Treatment (In Basic)	DBR-C DBR-C	
TMJ	Not Covered	Not Covered	Not Covered	TMJ-A TMJ-A TMJ-A	
Orthodontia Monthly Adjustments/Treatment	Not Covered	Not Covered	Not Covered	ORT-A ORT-A ORT-A	

Comments