# Highlights of your Health Care Coverage

City of Dillingham
Group Number: 1039935

Effective Date: 01/01/2021

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** | **PREMERA PREFERRED CHOICE - HP $3000/20%/$6000/$30/$65** | |
|---|---|---|
| | **HERITAGE IN-NETWORK** | **OUT-OF-NETWORK** |
| **MEDICAL COST SHARE OPTIONS** | | |
| **Individual Deductible PCY** (Family embedded deductible 2X Individual) | $3,000 PCY | $6,000 PCY |
| **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 2X Individual) | $6,000 PCY | $45,000 PCY |
| **Office Visit Cost Share** | $30 Copay Non Specialist, applies to the Out of Pocket Maximum; $65 Copay Specialist, applies to the Out of Pocket Maximum | Out of Network Deductible, then Hospital and Professional: 60% |
| **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% |
| **Immunizations** (Unlimited, subject to standard medical guidelines) | Covered in Full | Out of Network Deductible, then Hospital and Professional: 60% |
| **Health Education (HE)** (Unlimited) | Covered in Full | Covered In Full |
| **Diabetes Health Education (DE)** (Unlimited) | Covered in Full | Covered In Full |
| **PROFESSIONAL CARE** | | |
| **Professional Office Visit (Includes TeleMedicine)** | $30 Copay Non Specialist, applies to the Out of Pocket Maximum; $65 Copay Specialist, applies to the Out of Pocket Maximum | Out of Network Deductible, then Hospital and Professional: 60% |
| **VIRTUAL CARE SERVICES** | | |
| **Telemedicine - General Medical (Virtual Care Only)** | Covered in Full | 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 |
| **DIAGNOSTIC SERVICE OPTIONS** | | |
| **Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA** | Covered in Full | Out of Network Deductible, then Hospital and Professional: 60% |

| MEDICAL PLAN | PREMERA PREFERRED CHOICE - HP $3000/20%/$6000/$30/$65 | |
|---|---|---|
| | **HERITAGE IN-NETWORK** | **OUT-OF-NETWORK** |
| **Other Professional Diagnostic Imaging** | In Network Deductible, then 20% Preferred/40% Participating | Out of Network Deductible, then Hospital and Professional: 60% |
| **Other Professional Diagnostic Laboratory/Pathology** | In Network Deductible, then 20% Preferred/40% Participating | Out of Network Deductible, then Hospital and Professional: 60% |
| **Diagnostic Mammography** | In Network Deductible, then 20% Preferred/40% Participating | Out of Network Deductible, then Hospital and Professional: 60% |
| **FACILITY CARE OPTIONS** | | |
| **Inpatient Facility** | In Network Deductible, then 20% Preferred/40% Participating | Out of Network Deductible, then Hospital and Professional: 60% |
| **Inpatient Professional Services** | In Network Deductible, then 20% Preferred/40% Participating | Out of Network Deductible, then Hospital and Professional: 60% |
| **Outpatient Surgery Facility** | In Network Deductible, then 20% Preferred/40% Participating | Out of Network Deductible, then Hospital and Professional: 60% |
| **Skilled Nursing Facility** (60 days PCY) | In Network Deductible, then 20% Preferred/40% Participating | Out of Network Deductible, then Hospital and Professional: 60% |
| **HOSPICE & HOME HEALTH CARE** | | |
| **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% |
| **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% |
| **Home Health Visits** (130 visits PCY) | In Network Deductible, then 20% Preferred/40% Participating | Out of Network Deductible, then Hospital and Professional: 60% |
| **MATERNITY & REPRODUCTIVE CARE** | | |
| **Contraceptive Management Services** (Unlimited) | Covered in Full | Out of Network Deductible, then Hospital and Professional: 60% |
| **Sterilization - Female** (Unlimited) | Covered in Full | Out of Network Deductible, then Hospital and Professional: 60% |
| **Sterilization - Male** (Unlimited) | In Network Deductible, then 20% Preferred/40% Participating | Out of Network Deductible, then Hospital and Professional: 60% |
| **PREMERA DESIGNATED CENTERS OF EXCELLENCE** | | |
| **Centers of Excellence Packaged Services** (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement), Spine & Gynecology) | Covered in Full | Covered as any other service |
| **Travel and Care Coordination** (See Elective Procedure Travel) | See Elective Procedure Travel | See Elective Procedure Travel |
| **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 |

| MEDICAL PLAN | PREMERA PREFERRED CHOICE - HP $3000/20%/$6000/$30/$65 | |
|---|---|---|
| | **HERITAGE IN-NETWORK** | **OUT-OF-NETWORK** |
| **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) | Covered in Full | Travel: Covered In Full; Medical Procedures: covered as any other service |
| **EMERGENCY CARE** | | |
| **Emergency Care (If applicable, waive copay if admitted to inpatient facility)** | $100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred | $100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred |
| **Emergency Room Physician** | In Network Deductible, then 20% Preferred | In Network Deductible, then 20% Preferred |
| **Urgent Care Center** | $40 Copay, applies to the Out of Pocket Maximum | Out of Network Deductible, then Hospital and Professional: 60% |
| **Ambulance Transportation** (Unlimited) | $100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred | $100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred |
| **Non-Emergent Ground Ambulance** (Unlimited) | $100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred | $100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred |
| **Air Ambulance** (Unlimited) | $100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred | $100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred |
| **Non-Emergent Air Ambulance** (Unlimited) | $100 Copay, applies to the Out of Pocket Maximum; then In Network Deductible, 20% Preferred/40% Participating | Out of Network Deductible, then 60% |
| **ALTERNATIVE CARE** | | |
| **Acupuncture** (12 visits PCY) | $30 Copay Non Specialist, applies to the Out of Pocket Maximum | Out of Network Deductible, then Hospital and Professional: 60% |
| **Manipulations (Spinal and other)** (12 visits PCY) | $30 Copay Non Specialist, applies to the Out of Pocket Maximum | Out of Network Deductible, then Hospital and Professional: 60% |
| **CHEMICAL DEPENDENCY & MENTAL HEALTH** | | |
| **Chemical Dependency Inpatient Facility Care** (Unlimited) | In Network Deductible, then 20% Preferred | Out of Network Deductible, then Hospital and Professional: 60% |
| **Chemical Dependency Outpatient Professional Care** (Unlimited) | $30 Copay Non Specialist, applies to the Out of Pocket Maximum | Out of Network Deductible, then Hospital and Professional: 60% |
| **Mental Health Inpatient Facility Care** (Unlimited) | In Network Deductible, then 20% Preferred | Out of Network Deductible, then Hospital and Professional: 60% |
| **Mental Health Outpatient Professional Care** (Unlimited) | $30 Copay Non Specialist, applies to the Out of Pocket Maximum | Out of Network Deductible, then Hospital and Professional: 60% |
| **REHABILITATION & NEURO** | | |

| MEDICAL PLAN | PREMERA PREFERRED CHOICE - HP $3000/20%/$6000/$30/$65 | |
|---|---|---|
| | **HERITAGE IN-NETWORK** | **OUT-OF-NETWORK** |
| **Rehab Inpatient Facility** (30 days PCY) | In Network Deductible, then 20% Preferred/40% Participating | Out of Network Deductible, then Hospital and Professional: 60% |
| **Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab.; and Chronic Pain** (45 visits PCY) | $65 Copay Specialist, applies to the Out of Pocket Maximum | Out of Network Deductible, then Hospital and Professional: 60% |
| **OTHER SERVICES** | | |
| **Allergy/Therapeutic Injections** | In Network Deductible, then 20% Preferred/40% Participating | Out of Network Deductible, then Hospital and Professional: 60% |
| **Medical Supplies, Equipment, Prosthetics** (MS: Unlimited, ME: Unlimited, Pro: Unlimited) | In Network Deductible, then 20% Preferred/40% Participating | Out of Network 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 |
| **SUPPLEMENTAL BENEFITS** | | |
| **Routine Vision Exam** (1 PCY; $350 PCY, shared with Vision Hardware) | Waive In Network Deductible, then 10% | Waive In Network Deductible, then 10% |
| **Vision Hardware** (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 |
| **Pediatric Vision Exam** (1 PCY Under age 19) | Subject to Office Visit Cost Share Non-Specialist | Subject to Office Visit Cost Share Non-Specialist |
| **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 2 calendar years) | Waive In Network Deductible, then 20% | Waive In Network Deductible, then 20% |
| **Hearing Hardware** ($3,000 every 3 calendar years) | Waive In Network Deductible, then 20% | Waive In Network Deductible, then 20% |
| **ANNUAL PLAN MAXIMUM** | | |
| **Annual Plan Maximum** | Unlimited | Unlimited |

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.*

# Highlights of your Health Care Coverage

City of Dillingham

Group Number: 1039935

Effective Date: 01/01/2021

Below is a brief overview of your Pharmacy Benefits. For more information on your benefits, please refer to your benefit booklets. To find out what tiers apply to a specific medication, refer to our Preferred Drug List in your Pharmacy Packet or at www.premera.com

| **PHARMACY PLAN** | **PREMERA PREFERRED CHOICE - RX $10/$25/$45/30% - ESSENTIALS** |
|---|---|
| **PRESCRIPTION DRUGS** | |
| **Drug List** | E4 Essentials Formulary<br>Tier 1 = preferred generic<br>Tier 2 = preferred brand<br>Tier 3 = preferred specialty<br>Tier 4 = non-preferred all drugs |
| **Retail Cost Shares** | $10/$25/$45/30% |
| **Mail Cost Shares** | $25/$62.50/$45/30% |
| **Day Supply** | Retail: 90 Days; Mail: 90 Days; Specialty: 30 Days |
| **Individual Deductible PCY** | $0 |
| **Family Deductible PCY** | No Family Deductible |
| **Out of Network (Non-participating retail pharmacies)** | Same as in-network cost share |
| **Out of Pocket Maximum** | Applies to the medical out of pocket maximum |
| **Annual Benefit Maximum** | Unlimited |
| **Specialty Pharmacy** | Mandatory - Exclusive |

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 PLAN** | **PREMERA PREFERRED CHOICE - RX $15/$30/$50/30% - ESSENTIALS** |
|---|---|
| **PRESCRIPTION DRUGS** | |
| **Drug List** | E4 Essentials Formulary<br>Tier 1 = preferred generic<br>Tier 2 = preferred brand<br>Tier 3 = preferred specialty<br>Tier 4 = non-preferred all drugs |
| **Retail Cost Shares** | $15/$30/$50/30% |
| **Mail Cost Shares** | $37.50/$75/$50/30% |
| **Day Supply** | Retail: 90 Days; Mail: 90 Days; Specialty: 30 Days |
| **Individual Deductible PCY** | $0 |
| **Family Deductible PCY** | No Family Deductible |
| **Out of Network (Non-participating retail pharmacies)** | Same as in-network cost share |
| **Out of Pocket Maximum** | Applies to the medical out of pocket maximum |
| **Annual Benefit Maximum** | Unlimited |
| **Specialty Pharmacy** | Mandatory - Exclusive |

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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# Highlights of your Dental Coverage

## City of Dillingham

Group Number: 1039935

Effective Date: 01/01/2021

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

| DENTAL PLAN | 2020 DOPT $50-0%/20%/50%/$1500 BER | |
|---|---|---|
| | IN-NETWORK | OUT-OF-NETWORK |
| **Dental Cost Share** | | |
| **Individual Deductible** | $50 | Shared with In Network |
| **Family Deductible** | $150 | 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 Annual Maximum** | $1,500 PCY | Shared with In Network |
| **Benefit Enhancement Rider** | | |
| **Benefit Enhancement Rider** | Endodontics & Periodontal Treatment (In Basic) | Endodontics & Periodontal Treatment (In Basic) |

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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