

# Highlights of your Health Care Coverage

UIC (Ukpeagvik Inupiat Corporation)

Group Number: 4002747

Effective Date: 01/01/2020

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.

<b>MEDICAL PLAN</b>		
<b>2020 HP HDHP WITH HSA \$1,500/20%/\$3,000 - ESSENTIALS, a UIC (Ukpeagvik Inupiat Corporation) plan administered by Premera Blue Cross Blue Shield of Alaska*</b>		
	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>MEDICAL COST SHARE OPTIONS</b>		
Individual Deductible PCY (Family aggregate deductible 2x Individual)	\$1,500 PCY/\$3,000 PCY	\$3,000 PCY/\$6,000 PCY
<b>Company - Funded HSA</b>	\$750 Individual/\$1,500 Family	
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20% Preferred/30% Participating	Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	\$3,000 PCY/\$6,000 PCY	\$6,000 PCY/\$12,000 PCY
Office Visit Cost Share	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
<b>PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION</b>		
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered In Full	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Immunizations (Unlimited, subject to standard medical guidelines)	Covered In Full	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Health Education (HE) (Unlimited)	Covered In Full	Covered In Full
Diabetes Health Education (DE) (Unlimited)	Covered In Full	Covered In Full

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	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>PROFESSIONAL CARE</b>		
Professional Office Visit (Includes TeleMedicine)	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Inpatient Professional Services	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Contraceptive Management Services (Unlimited)	Covered In Full	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
<b>VIRTUAL CARE - ON DEMAND</b>		
Virtual Care - General Medical/ Dermatology (Voice/Video)	In Network Deductible, then 20% Preferred	Not Applicable
<b>DIAGNOSTIC SERVICE OPTIONS</b>		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Other Professional Diagnostic Imaging	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Other Professional Diagnostic Laboratory/Pathology	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Diagnostic Mammography	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
<b>FACILITY CARE OPTIONS</b>		
Inpatient Facility	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Skilled Nursing Facility (100 days PCY)	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Hospice Inpatient Facility (Inpatient: Unlimited; Respite: 240 hours; 6 month limit)	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network

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	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>PREMERA DESIGNATED CENTERS OF EXCELLENCE</b>		
<b>Centers of Excellence Packaged Services</b> (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement), Spine & Gynecology)	In Network Deductible, then 0%	Covered as any other service
<b>Travel and Care Coordination</b> (See Elective Procedure Travel)	See Elective Procedure Travel	See Elective Procedure Travel
<b>ALASKA MEDICAL TRANSPORTATION BENEFITS</b>		
<b>Medical Access Transportation</b> (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
<b>Elective Procedure Travel</b> (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: In Network Deductible, then 0%	Travel: In Network Deductible, then 0%; Medical Procedures: In Network Deductible, then 0%
<b>EMERGENCY CARE</b>		
<b>Emergency Care</b>	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
<b>Emergency Room Physician</b>	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
<b>Urgent Care Center</b>	In Network Deductible, then 20% Preferred & Participating	Same as In-Network
<b>Ambulance Transportation</b> (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
<b>Non-Emergent Ground Ambulance</b> (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
<b>Air Ambulance</b> (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
<b>Non-Emergent Air Ambulance</b> (Unlimited)	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then 60%
<b>OTHER SERVICES</b>		
<b>Allergy/Therapeutic Injections</b>	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
<b>Mental Health Inpatient Facility Care</b> (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
<b>Mental Health Outpatient Professional Care</b> (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
<b>Telemedicine - Mental Health</b>	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Applicable
<b>Chemical Dependency Inpatient Facility Care</b> (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network

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	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Chemical Dependency Outpatient Professional Care</b> (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
<b>Rehab Inpatient Facility</b> (100 days PCY)	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
<b>Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac &amp; Pulmonary Rehab.; and Chronic Pain</b> (45 visits PCY)	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
<b>Medical Supplies, Equipment, Prosthetics</b> (Unlimited)	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
<b>Foot Orthotics, Orthopedic Shoes and Accessories</b> (Unlimited)	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
<b>Home Health Visits</b> (130 visits PCY)	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
<b>Hospice Care (Home Health and Respite)</b> (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
<b>Transplants</b> (Unlimited; \$75,000 donor and \$7,500 travel and lodging limits) (Transplant services provided at Blue Distinction Transplant Centers covered at 100%; all other In-Network providers covered as any other service)	Covered as any other service	Not Covered
<b>Drug List</b>	E4 Essentials Formulary Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = preferred specialty Tier 4 = non-preferred all drugs	E4 Essentials Formulary Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = preferred specialty Tier 4 = non-preferred all drugs
<b>Prescription Drugs - Retail</b> (Specific preventive drugs and legend Retail: 90 day supply/Mail: 90 day supply/Specialty: 30 day supply)	In Network Deductible, then \$10/In Network Deductible, then \$30/In Network Deductible, then 30%; All cost shares apply to the Out of Pocket Maximum	In Network Deductible, then \$10/In Network Deductible, then \$30/In Network Deductible, then 30%; All cost shares apply to the Out of Pocket Maximum
<b>Prescription Drugs - Mail</b> (Specific preventive drugs and legend Retail: 90 day supply/Mail: 90 day supply/Specialty: 30 day supply)	In Network Deductible, then \$25/In Network Deductible, then \$75/In Network Deductible, then 30%; All cost shares apply to the Out of Pocket Maximum	Not Covered
<b>Specialty Pharmacy</b> (Mandatory - Exclusive)	In Network Deductible, then \$50; applies to the Out of Pocket Maximum	Not covered

**ALTERNATIVE CARE**

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			<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>Manipulations (Spinal and other) (20 visits PCY)</b>			In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network	
<b>Acupuncture (12 visits PCY)</b>			In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network	
<b>SUPPLEMENTAL BENEFITS</b>					
<b>Routine Hearing Exam (1 PCY)</b>			Exam & Test: In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then 40%	
<b>Hearing Hardware (\$800 limit every 3 consecutive years)</b>			In Network Deductible, then 20%	In Network Deductible, then 20%	
<b>ANNUAL PLAN MAXIMUM</b>					
<b>Annual Plan Maximum</b>			Unlimited	Unlimited	

\*This benefit highlight is for members of the UIC (Ukpeagvik Inupiat Corporation) medical plan. This plan is self-funded by UIC (Ukpeagvik Inupiat Corporation), which means that UIC (Ukpeagvik Inupiat Corporation) is financially responsible for the payment of plan benefits. UIC (Ukpeagvik Inupiat Corporation) has the final discretionary authority to determine eligibility for benefits and construe the terms used in this plan.

UIC (Ukpeagvik Inupiat Corporation) has contracted with Premera Blue Cross Blue Shield of Alaska, an Independent Licensee of the Blue Cross Blue Shield Association, to perform administrative duties, including the processing of claims, under the plan. Premera Blue Cross Blue Shield of Alaska does not insure the benefits of this plan.

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.*

