Highlights of your Health Care Coverage

UIC (Ukpeagvik Inupiat Corporation)
Group Number: 4002747

Effective Date: 01/01/2019

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	**2019 HP HDHP WITH HRA $2,000/20%/$3,000, a UIC (Ukpeagvik Inupiat Corporation) plan administered by Premera Blue Cross Blue Shield of Alaska***	
	IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family aggregate deductible 2x Individual)	$2,000 PCY/$4,000 PCY	$4,000 PCY/$8,000 PCY
Company – Funded HRA	$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
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
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
PROFESSIONAL CARE		
Professional Office Visit	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

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Contraceptive Management Services (Unlimited)	Covered In Full	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
DIAGNOSTIC SERVICE OPTIONS		
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
FACILITY CARE OPTIONS		
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 (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
EMERGENCY CARE		
Emergency Care	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Emergency Room Physician	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Urgent Care Center	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Ambulance Transportation (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Ground Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then 60%
ALASKA MEDICAL TRANSPORTATION BENEFITS		

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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
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: Deductible, then 0%	Travel: In Network Deductible, then 0%; Medical Procedures: Deductible, then 0%
OTHER SERVICES		
Allergy/Therapeutic Injections	In Network Deductible, then 20% Preferred/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Mental Health Inpatient Facility Care (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Mental Health Outpatient Professional Care (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Chemical Dependency Inpatient Facility Care (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Chemical Dependency Outpatient Professional Care (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Rehab Inpatient 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
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/30% Participating	Out of Network Deductible, then Hospital/CD & Professional: 40%; ARP/Certified ABA: Same as In-Network
Medical Supplies, Equipment, Prosthetics (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
Foot Orthotics, Orthopedic Shoes and Accessories (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
Home Health Visits (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
Hospice Care (Home Health and 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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Transplants (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
Drug List	Open A1 No Tiers	Open A1 No Tiers
Prescription Drugs - Retail (Generic/Preferred Brand/Non-Preferred Brand/Specialty)	Deductible, then $10/$30/$50/30% (up to $150 max per specialty prescription, then plan pays 100%) (per 30 days supply)	Deductible, then 20%
Prescription Drugs - Mail (Generic/Preferred Brand/Non-Preferred Brand)	Deductible, then $20/$60/$100 (per 90 days supply)	Not Covered
Specialty Pharmacy (Mandatory - Dual)	Deductible, then 30% (up to $150 max per specialty prescription, then plan pays 100%) (per 30 days supply)	Not covered
ALTERNATIVE CARE		
Manipulations (Spinal and other) (20 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
Acupuncture (12 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
SUPPLEMENTAL BENEFITS		
Routine Hearing Exam (Exam: 1 PCY)	Exam & Test: INN: Deductible, then 20% Preferred/30% Participating	OON: Deductible, then 40%
Hearing Hardware (HW: $800 limit every 3 consecutive years)	In Network Deductible, then 20%	In Network Deductible, then 20%
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	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.