



FOR BUSINESSES WITH
1-50 EMPLOYEES

—

2025 health plan guide



Innovative health plans created for today's evolving healthcare needs

Your employees are at the center of all we do,
even those located outside of Alaska.
That's why your local Premera Blue Cross
Blue Shield of Alaska team offers a range of
comprehensive plans that fit your budget and
your employees' diverse needs.



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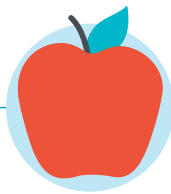


Here's why businesses choose Premera



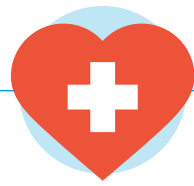
Unmatched access and deep discounts

We offer a variety of provider network options so you can choose the level of access that works best for your employees.



Well-rounded benefits package

Choose from a range of plans to find the right balance that best fits the needs and budget for your business and your employees.



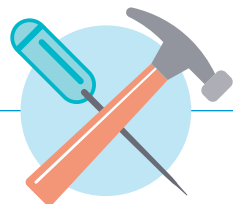
High-value care

Enhanced services that support your employees and their covered dependents when they seek care from a Premera Designated Center of Excellence provider as part of our Elective Procedure Travel program.



Digital health messages

Members who opt in receive personalized healthcare messages to their mobile phone. They get the latest updates on member benefits, healthcare savings, and more.



Administrative ease and support

Integrated benefits with Premera make for a streamlined experience. We make it simple for you to promote components of your healthcare benefits with your employees or explain to them how to best use their plan.



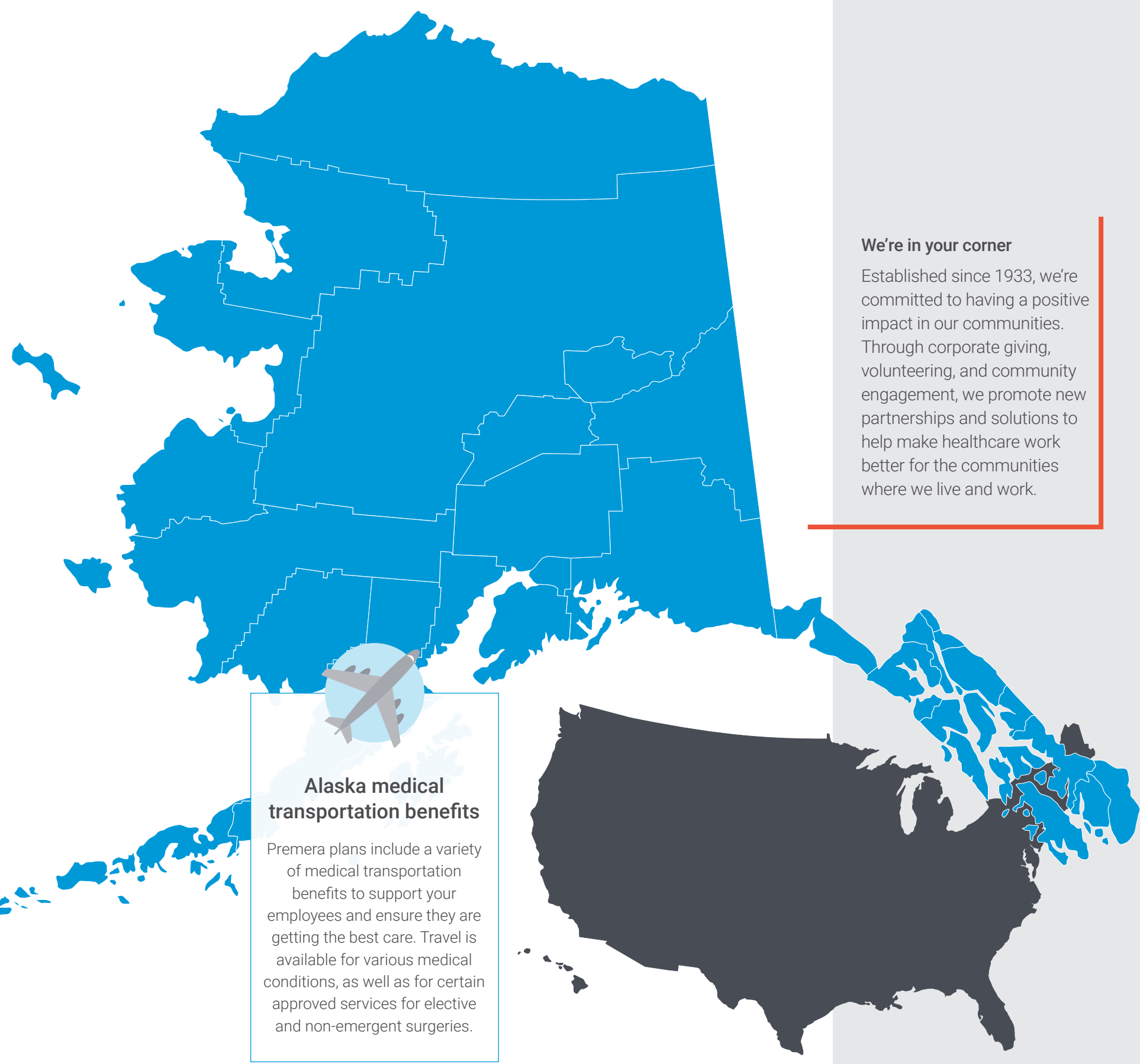
Meeting members where they are

With the broadest provider network in the state, Premera supports every member no matter where they are on their healthcare journey. From physical well-being to behavioral health and virtual care, we provide the support you need.



Alaska medical transportation benefits

Premera plans include a variety of medical transportation benefits to support your employees and ensure they are getting the best care. Travel is available for various medical conditions, as well as for certain approved services for elective and non-emergent surgeries.



We're in your corner

Established since 1933, we're committed to having a positive impact in our communities. Through corporate giving, volunteering, and community engagement, we promote new partnerships and solutions to help make healthcare work better for the communities where we live and work.

Diabetes Condition Management Plus

Chronic conditions like diabetes are costly and highly prevalent. Two in three adults living with diabetes also have hypertension and nine out of ten are overweight or obese.^{1,2} Premera has included a comprehensive diabetes condition management solution that supports the whole member as part of your health plan.

How Diabetes Condition Management Plus works

MULTI-CONDITION SUPPORT

Members must have diabetes diagnosis to be eligible to enroll in Diabetes Management Plus.

Diabetes Management Plus

+ Hypertension support

+ Digital mental health

+ Standard weight management

Multi-faceted program design

Diabetes Condition Management Plus takes a comprehensive approach. Once enrolled, members will receive support for their primary condition and standard weight management and digital mental health services.



Comprehensive support

Integrated support that goes beyond the primary condition specific program.



Improved outcomes

Members who manage chronic conditions in one place can overcome care fragmentation and improve their health outcomes² to reduce total cost of care.



Holistic approach

No matter what program the member is engaged with, digital mental health and weight support is embedded.

Chronic Condition Management Plus access



Fully insured: Diabetes Management Plus included as part of your plan



Did you know?

Members enrolled in Diabetes Management Plus can also access standard weight management and digital mental health support.



Tools for success

Members who qualify can receive a smart scale or blood pressure cuff in the Diabetes Management Plus program.

¹National Diabetes Statistics Report." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention , www.cdc.gov/diabetes/php/data-research/index.html. Accessed 11 July 2024

² <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10170908/#:~:text=Some%20promising%20research%20has%20shown%20that%20patient%E2%80%90centered%20care%2C,%28Joo%20%26%20Liu%2C%202017%3B%20McKay%20et%20al.%2C%202019%29>

Know before you go

Navigating the healthcare landscape can be daunting when it comes to surgeries and elective procedures. Premera makes it simple for members to find and access high-quality, cost-effective care, near or far.

Medical transportation benefits

Some of your employees may choose to travel outside of Alaska to access care and Premera has them covered.

Medical Access Transportation

Applies to certain travel-related expenses for medically necessary care that your employees' local doctor can't provide. The care must be given at an in-network provider within Alaska or Seattle, if that's the closest location where the care can be provided.

Elective Procedure Travel

Covers certain travel-related expenses for preapproved, non-emergency (elective) surgeries at an in-network facility located in the lower 48 states.

Premera Designated Centers of Excellence

Includes enhanced services that support your employees and their covered dependents when they seek care from a Premera Designated Centers of Excellence provider as a part of our Elective Procedure Travel program.

Premera Designated Centers of Excellence

Improving access to providers committed to delivering predictable, high-value specialty care.



Concierge level support and navigation



Specialty procedures offered

- Total joint replacement (knee and hip)
- Spine surgeries
- Gynecological procedures



Bundled agreements in Anchorage and Seattle

Significant savings and member satisfaction

Premera Designated Centers of Excellence delivers

Anchorage TJR

9.6
satisfaction
score

\$14k
average
savings

Seattle TJR

8.6
satisfaction
score

\$39k
average
savings



Did you know?

Members must engage with Personal Health Support to recognize the savings that come with Premera Designated Centers of Excellence. Personal Health Support at Premera is made up of licensed clinicians who can help members:

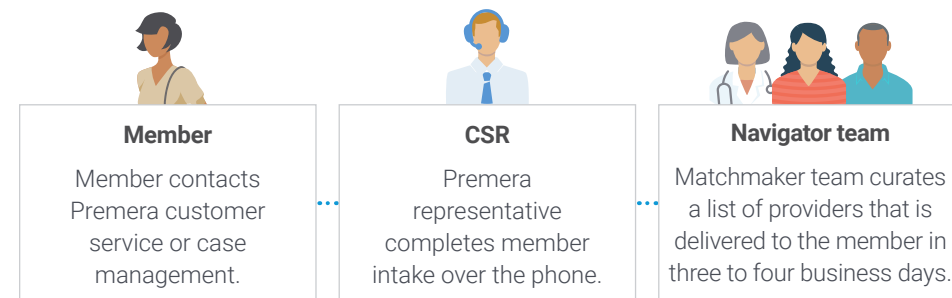
- Coordinate care to help get the best treatment
- Assist in scheduling and preparing for appointments
- Remove barriers to follow treatment plan

Finding the right provider for you

Two out of three employers rank employee mental health as a top health priority.¹ Premera has made it easier than ever for members to access behavioral health services virtually or in person.

Matchmaker™ for Behavioral Health

Matchmaker for Behavioral Health is an expansion of our commitment to improve access and lessen the hurdles members face when seeking behavioral health services. With Matchmaker for Behavioral Health, members receive a highly personalized list of behavioral health providers based on their plan, needs, and preferences.



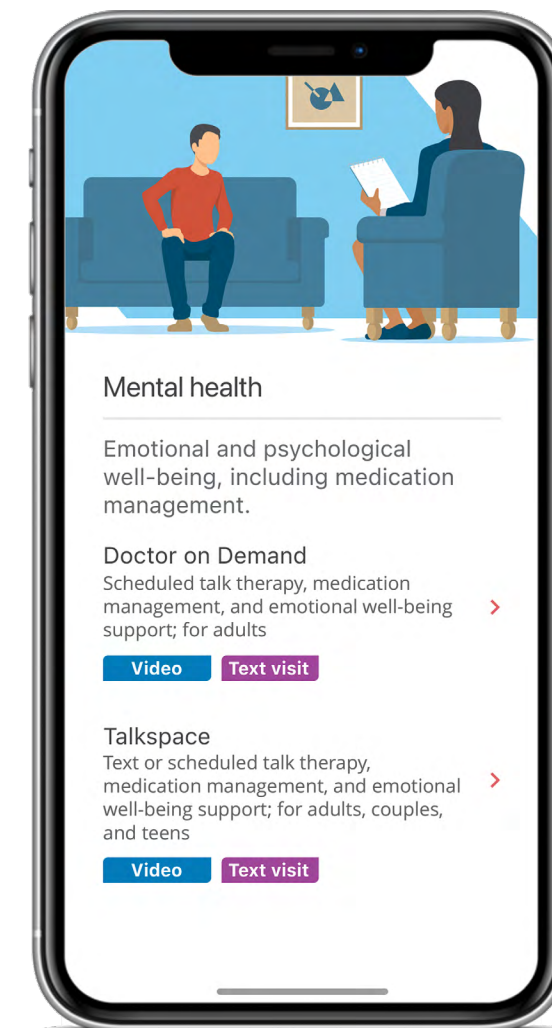
The Matchmaker for Behavioral Health intake asks members for their information and their appointment preferences: :

- Religious affiliation
- In-person or virtual appointments
- Gender, race, and ethnicity
- Language
- And more

Every Matchmaker for Behavioral Health list includes a minimum of two in-network providers.

Behavioral health in the palm of your hand

Premera has partnered with industry-leading behavioral health virtual care vendors to ensure our members get the care they need, when they need it, and in a way that works for them.



83%

of employers offer behavioral health services through virtual care.¹



Virtual behavioral health care can support members with the following:

- Generalized anxiety
- Depression
- Adjustment disorders
- And more



Members struggling with substance use disorder (SUD) have access to confidential and high-quality virtual care including medically assisted treatment (MAT).² **Contact your Premera account representative for more information.**

¹2022 Best Practices in Healthcare Employer Survey, 2022 Global Benefit Attitudes Survey

²Medically assisted treatment (MAT) may be prohibited to certain U.S. states in order to meet federal in-person prescribing requirements.

Care when you need it

For the times when you can't wait for an in-person visit, virtual care is there. Premera virtual care providers offer secure text or video visits to treat a variety of primary care needs.

Virtual care can help with these conditions:

- Common cold symptoms
- COVID-19 treatments
- Follow-up visits with a physician
- Sinus infections
- Urinary tract infections (UTIs)

Benefits

- **Improved employee experience**—Your employees no longer need to wait days or weeks for an appointment. Give them near-instant access to board-certified physicians, psychiatrists, therapists, and specialists who offer specialized treatments, from initial evaluations to ongoing treatment plans. Your employees can conveniently access all these services from the safety and comfort of their homes.
- **Cost savings**—We offer care at a lower cost than in-person care, provide timely treatment to support condition management, and keep employees within network.
- **Quality**—We deliver the highest quality care providers and innovative provider options for your employees. High-quality care improves continuity of care and retention, which is critical to the well-being of your employees.



Did you know?

Every Premera medical plan includes our 24-Hour NurseLine. Members can call day or night to receive free and confidential health advice from a registered nurse.



Healthcare that travels with you

We believe in working closely with providers and hospitals to fully satisfy our customers. That's why our provider networks are more than just a collection of contracts. They also give members access to quality care and good experiences.

Heritage network

For decades, Premera has maintained one of the largest networks of providers and medical facilities in Alaska. As a result, we offer great network stability and deep discounts for covered in-network services.

6,063

preferred providers in Alaska

23

preferred hospitals in Alaska

National and worldwide network coverage with BlueCard

Every Premera health plan includes the BlueCard® program. This program provides access to networks of contracted preferred and participating Blue Cross Blue Shield providers across the country. Just like here at home, these networks provide valuable discounts on billed charges. Plus, they have the added advantage of direct billing.

The BlueCard program includes worldwide coverage with Blue Cross Blue Shield Global Core. This program provides members access to an international network of participating providers and hospitals for a broad range of medical care services. This access means they can feel safe wherever they go.





Medical plans

Premera offers a wide range of bronze, silver, gold, and platinum plans. All of these plans offer broad access to providers and hospitals through the Heritage network. The plans also offer pediatric vision and pediatric dental at no additional cost.

DECIDE WHICH PLAN IS RIGHT FOR YOU

Plus PPO plans

All of the medical plans outlined in this guide are preferred provider organization (PPO) plans. PPO plans work with a network of contracted providers to offer you savings on your health plan costs.

Plus HSA-qualified plans

Health savings account (HSA)-qualified plans offer valuable benefits for covered services. They also work in combination with an employee-owned, tax-advantaged HSA. These plans offer the option for an independent company to administer HSA accounts for Premera customers at a federally insured bank.

ALL SMALL GROUP PLANS INCLUDE RX SAVINGS SOLUTIONS

Members receive personalized alerts regarding savings opportunities including generic drugs, combination fills, pharmacy changes, and more. The Rx Savings Solutions concierge team can manage the change on behalf of the member, by request, enabling a seamless transition to the new prescription.



	PLUS PPO	PLUS HSA
PLAN TYPE		
PPO plan	X	
HSA-qualified with the option to use the Premera vendor for account support		X
NETWORK		
Heritage	X	X
LEVELS		
Platinum	X	
Gold	X	X
Silver	X	X
Bronze	X	X
DENTAL		
Pediatric	X	X
Adult	OPTIONAL BENEFIT ENHANCEMENT	
VISION		
Pediatric	X	X
Adult	OPTIONAL BENEFIT ENHANCEMENT	



Consider bundling medical, vision, and dental

Together, the purchase of Premera medical, dental, and vision plans encourage healthy habits and better outcomes. We provide a robust network of providers and make it easy to take great care of your employees.

Did you know?

Pediatric vision and pediatric dental are included in every medical plan at no additional cost.



Plus Bronze 5500

Medical plan for 1–50 employees starting January 1, 2025

The deductible applies whenever there is a coinsurance listed, unless otherwise noted.

Ded = Deductible
Coins = Coinsurance

		PLUS BRONZE 5500		
		IN NETWORK		OUT OF NETWORK
		PREFERRED	PARTICIPATING	NON-PARTICIPATING
Individual deductible	Per calendar year = PCY Family = 2x individual deductible (in network only)	\$5,500		2x Individual deductible
Coinsurance	Amount you pay after your deductible is met	30%	40%	60%
Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	\$9,200		\$45,000
Office visits	Designated primary care provider (PCP) office visit	\$55		Deductible, then 60%
	Non-designated PCP or specialist office visit	\$120		
Network		Heritage		Out of network
10 ESSENTIAL BENEFITS COVERED SERVICES				
1 Ambulatory patient services	Outpatient services	Deductible, then 30%	Deductible, then 40%	Deductible, then 60%
	Office visits	\$55		
2 Emergency services	Emergency care Copay waived if directly admitted to inpatient facility	\$250 copay, then in-network deductible and coinsurance		
	Ambulance transportation (air and ground)	\$25 copay, then deductible and in-network coinsurance	Emergent: same as in network; Non-emergent: Air – ded, then 40%; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60%; Ground – same as in network
3 Hospitalization	Inpatient	Deductible, then 30%	Deductible, then 40%	Deductible, then 60%
	Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum			Not covered
	Organ and tissue transplants, inpatient unlimited, except \$75,000 donor coverage limit and \$7,500 travel and lodging limit per transplant			
4 Maternity and newborn care	Prenatal, delivery, and postnatal care	Deductible, then 60%		
5 Mental health and substance use disorder services, including behavioral health treatment	Office visit	\$55		
	Inpatient hospital: mental and behavioral health services	Deductible, then 30%	Deductible, then 40%	Deductible, then 60%
	Outpatient services			
Rehabilitative and habilitative services and devices	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			
6 Therapy	Physical, speech, occupational, and massage therapy: 45 visits PCY	Deductible, then \$120		Deductible, then 60%
	Rehabilitation and habilitative therapy benefits have the same number of visits, but are counted separately	Deductible, then 30%	Deductible, then 40%	
7 Laboratory services	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET (preapproval required for certain services)	Deductible, then 60%		
8 Preventive/wellness services and chronic disease management	Screenings Exams and vaccinations	Covered in full		
	Eye exam: 1 PCY	\$25		
9 Pediatric services, including vision care under age 19	Eyewear: 1 pair of glasses PCY (frames and lenses); or 12-month supply of contacts PCY, in lieu of glasses (frames and lenses)	Covered in full		
	Dental: pediatric dental class I (cleanings, exams, and X-rays)	Deductible waived, covered in full		Deductible waived, then 10%
	Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible waived, then 30%		Deductible waived, then 50%
	Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50%		
10 Prescription drugs	Retail up to 90-day supply (3x 30-day supply cost)	\$25 / Ded, \$85 / Ded, \$175		
	Mail order 90-day supply (2.5x retail supply cost)	\$62.50 / Ded, \$212.50 / Ded, \$437.50		
	Specialty Rx 30-day supply	Deductible, then 40%		
	Drug formulary M4	Deductible, then 40%		
ADDITIONAL BENEFIT EMBEDDED WITHIN THE MEDICAL PLAN				
Hearing	Hearing exam: 1 per 2 calendar years Hearing aids and hardware: \$3,000 every 3 calendar years	Deductible waived, then 20%		
Virtual care (general medicine)	A full list of services is available on premera.com/ak/member	Covered in full	Not covered	
	Premera-Designated Centers of Excellence		Covered as any other service	

Plus Bronze 7100

Medical plan for 1–50 employees starting January 1, 2025

The deductible applies whenever there is a coinsurance listed, unless otherwise noted.

Ded = Deductible
Coins = Coinsurance

		PLUS BRONZE 7100		
		IN NETWORK		OUT OF NETWORK
		PREFERRED	PARTICIPATING	NON-PARTICIPATING
Individual deductible	Per calendar year = PCY Family = 2x individual deductible (in network only)	\$7,100		2x individual deductible
Coinsurance	Amount you pay after your deductible is met	30%	40%	60%
Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	\$9,200		\$45,000
Office visits	Designated primary care provider (PCP) office visit	\$55		Deductible, then 60%
	Non-designated PCP or specialist office visit	\$120		
Network		Heritage		Out of network
10 ESSENTIAL BENEFITS COVERED SERVICES				
1 Ambulatory patient services	Outpatient services	Deductible, then 30%	Deductible, then 40%	Deductible, then 60%
	Office visits	\$55		
2 Emergency services	Emergency care Copay waived if directly admitted to inpatient facility	\$250 copay, then in-network deductible and coinsurance		
	Ambulance transportation (air and ground)	\$25 copay, then deductible and in-network coinsurance	Emergent: same as in network; Non-emergent: Air – ded, then 40%; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60%; Ground – same as in network
3 Hospitalization	Inpatient	Deductible, then 30%	Deductible, then 40%	Deductible, then 60%
	Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum			Not covered
	Organ and tissue transplants, inpatient unlimited, except \$75,000 donor coverage limit and \$7,500 travel and lodging limit per transplant			
4 Maternity and newborn care	Prenatal, delivery, and postnatal care	Deductible, then 60%		
5 Mental health and substance use disorder services, including behavioral health treatment	Office visit	\$55		
	Inpatient hospital: mental and behavioral health services	Deductible, then 30%	Deductible, then 40%	Deductible, then 60%
	Outpatient services			
Rehabilitative and habilitative services and devices	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			
6 Therapy	Physical, speech, occupational, and massage therapy: 45 visits PCY	Deductible, then \$120		Deductible, then 60%
	Rehabilitation and habilitative therapy benefits have the same number of visits, but are counted separately	Deductible, then 30%	Deductible, then 40%	
7 Laboratory services	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET (preapproval required for certain services)	Deductible, then 60%		
8 Preventive/wellness services and chronic disease management	Screenings Exams and vaccinations	Covered in full		
	Eye exam: 1 PCY	\$25		
9 Pediatric services, including vision care under age 19	Eyewear: 1 pair of glasses PCY (frames and lenses); or 12-month supply of contacts PCY, in lieu of glasses (frames and lenses)	Covered in full		
	Dental: pediatric dental class I (cleanings, exams, and X-rays)	Deductible waived, covered in full		Deductible waived, then 10%
	Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible waived, then 30%		Deductible waived, then 50%
	Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50%		
10 Prescription drugs	Retail up to 90-day supply (3x 30-day supply cost)	\$25 / Ded, \$85 / Ded, \$175		
	Mail order 90-day supply (2.5x retail supply cost)	\$62.50 / Ded, \$212.50 / Ded, \$437.50		
	Specialty Rx 30-day supply	Deductible, then 40%		
	Drug formulary M4	Deductible, then 40%		
ADDITIONAL BENEFIT EMBEDDED WITHIN THE MEDICAL PLAN				
Hearing	Hearing exam: 1 per 2 calendar years Hearing aids and hardware: \$3,000 every 3 calendar years	Deductible waived, then 20%		
Virtual care (general medicine)	A full list of services is available on premera.com/ak/member	Covered in full	Not covered	
	Premera-Designated Centers of Excellence		Covered as any other service	



Plus Bronze 9000

Medical plan for 1–50 employees starting January 1, 2025

The deductible applies whenever there is a coinsurance listed, unless otherwise noted.

Ded = Deductible
Coins = Coinsurance

		PLUS BRONZE 9000		
		IN NETWORK		OUT OF NETWORK
		PREFERRED	PARTICIPATING	NON-PARTICIPATING
Individual deductible	Per calendar year = PCY Family = 2x individual deductible (in network only)	\$9,000		2x individual deductible
Coinsurance	Amount you pay after your deductible is met	30%	40%	60%
Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	\$9,200		\$45,000
Office visits	Cost share	Deductible, then 0%		Deductible, then 60%
Network		Heritage		Out of network
10 ESSENTIAL BENEFITS COVERED SERVICES				
1 Ambulatory patient services	Outpatient services	Deductible, then 30%	Deductible, then 40%	Deductible, then 60%
Office visits	Spinal manipulation (12 visits PCY); Acupuncture (12 visits PCY)	Deductible, then 30%		
2 Emergency services	Emergency care Copay waived if directly admitted to inpatient facility	Deductible, then 30%		
	Ambulance transportation (air and ground)	Deductible and in-network coinsurance	Emergent: same as in network; Non-emergent: Air - ded, then 40%; Ground - same as in network	Emergent: same as in network; Non-emergent: Air - ded, then 60%; Ground - same as in network
3 Hospitalization	Inpatient Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum Organ and tissue transplants, inpatient unlimited, except \$75,000 donor coverage limit and \$7,500 travel and lodging limit per transplant			Deductible, then 60%
4 Maternity and newborn care	Prenatal, delivery, and postnatal care	Deductible, then 30%	Deductible, then 40%	Not covered
5 Mental health and substance use disorder services, including behavioral health treatment	Office visit Inpatient hospital: mental and behavioral health services Outpatient services			Deductible, then 60%
6 Rehabilitation and habilitative services and devices	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			Deductible, then 60%
7 Therapy	Physical, speech, occupational, and massage therapy: 45 visits PCY	Deductible, then 30%		Deductible, then 60%
8 Rehabilitation and habilitative therapy benefits have the same number of visits, but are counted separately	Rehabilitation and habilitative services and devices Skilled nursing facility: 60 days PCY	Deductible, then 30%	Deductible, then 40%	
9 Laboratory services	Includes X-ray, pathology, imaging/diagnostics, MRI, CT, PET (preapproval required for certain services)			Deductible, then 60%
10 Preventive/wellness services and chronic disease management	Screenings, exams, and vaccinations	Covered in full		
9 Pediatric services, including vision care under age 19	Eye exam: 1 PCY	\$25		
	Eyewear: 1 pair of glasses PCY (frames and lenses); or 12-month supply of contacts PCY, in lieu of glasses (frames and lenses)	Covered in full		
	Dental: pediatric dental class I (cleanings, exams, and X-rays)	Deductible waived, covered in full	Deductible waived, then 10%	
	Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible waived, then 30%	Deductible waived, then 50%	
10 Prescription drugs	Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50%	Deductible, then 50%	
	Retail up to 90-day supply (3x 30-day supply cost)	\$30 / Ded, 30% / Ded, 30%		Retail and specialty: same as in network; Mail order: not covered
	Mail order 90-day supply (2.5x retail supply cost)	\$75 / Ded, 30% / Ded, 30%		
	Specialty Rx 30-day supply	Deductible, then 30%		
Drug formulary M4				
ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN				
Hearing	Hearing exam: 1 per 2 calendar years Hearing aids and hardware: \$3,000 every 3 calendar years	Deductible waived, then 20%		
Virtual care (general medicine)	A full list of services is available on premera.com/ak/member	Covered in full	Not covered	
Premera-Designated Centers of Excellence		Covered as any other service		

Plus Silver 2000

Medical plan for 1–50 employees starting January 1, 2025

The deductible applies whenever there is a coinsurance listed, unless otherwise noted.

Ded = Deductible
Coins = Coinsurance

		PLUS SILVER 2000		
		IN NETWORK		OUT OF NETWORK
		PREFERRED	PARTICIPATING	NON-PARTICIPATING
Individual deductible	Per calendar year = PCY Family = 2x individual deductible (in network only)	\$2,000		2x individual deductible
Coinsurance	Amount you pay after your deductible is met	30%	40%	60%
Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	\$8,550		\$45,000
Office visits	Designated primary care provider (PCP) office visit	\$35		Deductible, then 60%
	Non-designated PCP or specialist office visit	\$85		
Network		Heritage		Out of network
10 ESSENTIAL BENEFITS COVERED SERVICES				
1 Ambulatory patient services	Outpatient services	Deductible, then 30%	Deductible, then 40%	Deductible, then 60%
Office visits	Spinal manipulation (12 visits PCY); Acupuncture (12 visits PCY)	\$35		
2 Emergency services	Emergency care Copay waived if directly admitted to inpatient facility	\$250 copay, then in-network deductible and coinsurance		
	Ambulance transportation (air and ground)	\$25 copay, then deductible and in-network coinsurance	Emergent: same as in network; Non-emergent: Air - ded, then 40%; Ground - same as in network	Emergent: same as in network; Non-emergent: Air - ded, then 60%; Ground - same as in network
3 Hospitalization	Inpatient Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum Organ and tissue transplants, inpatient unlimited, except \$75,000 donor coverage limit and \$7,500 travel and lodging limit per transplant	Deductible, then 30%	Deductible, then 40%	Deductible, then 60%
4 Maternity and newborn care	Prenatal, delivery, and postnatal care			Not covered
5 Mental health and substance use disorder services, including behavioral health treatment	Office visit Inpatient hospital: mental and behavioral health services Outpatient services	\$85		Deductible, then 60%
6 Rehabilitation and habilitative services and devices	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY	Deductible, then 30%	Deductible, then 40%	
7 Therapy	Physical, speech, occupational, and massage therapy: 45 visits PCY	Deductible, then \$85		
8 Rehabilitation and habilitative therapy benefits have the same number of visits, but are counted separately	Rehabilitation and habilitative services and devices Skilled nursing facility: 60 days PCY	Deductible, then 30%	Deductible, then 40%	
9 Laboratory services	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET (preapproval required for certain services)			Deductible, then 60%
10 Preventive/wellness services and chronic disease management	Screenings Exams and vaccinations	Covered in full		
9 Pediatric services, including vision care under age 19	Eye exam: 1 PCY	\$25		
	Eyewear: 1 pair of glasses PCY (frames and lenses); or 12-month supply of contacts PCY, in lieu of glasses (frames and lenses)	Covered in full		
	Dental: pediatric dental class I (cleanings, exams, and X-rays)	Deductible waived, covered in full	Deductible waived, then 10%	
	Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible waived, then 30%	Deductible waived, then 50%	
10 Prescription drugs	Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50%		
	Retail up to 90-day supply (3x 30-day supply cost)	\$25 / \$70 / \$150		Retail and specialty: same as in network; Mail order: not covered
	Mail order 90-day supply (2.5x retail supply cost)	\$62.50 / \$175 / \$375		
	Specialty Rx 30-day supply	Deductible, then 40%		
Drug formulary M4				
ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN				
Hearing	Hearing exam: 1 per 2 calendar years Hearing aids and hardware: \$3,000 every 3 calendar years	Deductible waived, then 20%		
Virtual care (general medicine)	A full list of services is available on premera.com/ak/member	Covered in full	Not covered	
Premera-Designated Centers of Excellence		Covered as any other service		



Plus Silver 2500

Medical plan for 1–50 employees starting January 1, 2025

The deductible applies whenever there is a coinsurance listed, unless otherwise noted.

Ded = Deductible
Coins = Coinsurance

		PLUS SILVER 2500		
		IN NETWORK		OUT OF NETWORK
		PREFERRED	PARTICIPATING	NON-PARTICIPATING
Individual deductible	Per calendar year = PCY Family = 2x individual deductible (in network only)	\$2,500		2x individual deductible
Coinsurance	Amount you pay after your deductible is met	30%	40%	60%
Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	\$8,550		\$45,000
Office visits	Designated primary care provider (PCP) office visit	\$35		Deductible, then 60%
	Non-designated PCP or specialist office visit	\$85		
Network		Heritage		Out of network
10 ESSENTIAL BENEFITS COVERED SERVICES				
1 Ambulatory patient services	Outpatient services	Deductible, then 30%	Deductible, then 40%	Deductible, then 60%
Office visits	Spinal manipulation (12 visits PCY); Acupuncture (12 visits PCY)	\$35		
2 Emergency services	Emergency care Copay waived if directly admitted to inpatient facility	\$250 copay, then in-network deductible and coinsurance		
	Ambulance transportation (air and ground)	\$25 copay, then deductible and in-network coinsurance	Emergent: same as in network; Non-emergent: Air – ded, then 40%; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60%; Ground – same as in network
3 Hospitalization	Inpatient	Deductible, then 30%	Deductible, then 40%	Deductible, then 60%
	Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum			Not covered
	Organ and tissue transplants, inpatient unlimited, except \$75,000 donor coverage limit and \$7,500 travel and lodging limit per transplant			
4 Maternity and newborn care	Prenatal, delivery, and postnatal care			
5 Mental health and substance use disorder services, including behavioral health treatment	Office visit	\$85		Deductible, then 60%
	Inpatient hospital: mental and behavioral health services	Deductible, then 30%	Deductible, then 40%	
	Outpatient services			
Rehabilitative and habilitative services and devices	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			
6 Therapy	Physical, speech, occupational, and massage therapy: 45 visits PCY	Deductible, then \$85		
Rehabilitation and habilitative therapy benefits have the same number of visits, but are counted separately	Rehabilitation and habilitative services and devices Skilled nursing facility: 60 days PCY	Deductible, then 30%	Deductible, then 40%	
7 Laboratory services	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET (preapproval required for certain services)			
8 Preventive/wellness services and chronic disease management	Screenings Exams and vaccinations	Covered in full		
9 Pediatric services, including vision care under age 19	Eye exam: 1 PCY	\$25		
	Eyewear: 1 pair of glasses PCY (frames and lenses); or 12-month supply of contacts PCY, in lieu of glasses (frames and lenses)	Covered in full		
	Dental: pediatric dental class I (cleanings, exams, and X-rays)	Deductible waived, covered in full	Deductible waived, then 10%	
	Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible waived, then 30%	Deductible waived, then 50%	
	Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50%		
10 Prescription drugs	Retail up to 90-day supply (3x 30-day supply cost)	\$25 / \$ 65 / \$150		Retail and specialty: same as in network; Mail order: not covered
	Mail order 90-day supply (2.5x retail supply cost)	\$75 / \$195 / \$450		
	Specialty Rx 30-day supply	Deductible, then 40%		
	Drug formulary M4			
ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN				
Hearing	Hearing exam: 1 per 2 calendar years Hearing aids and hardware: \$3,000 every 3 calendar years	Deductible waived, then 20%		
Virtual care (general medicine)	A full list of services is available on premera.com/ak/member	Covered in full	Not covered	
Premera-Designated Centers of Excellence		Covered as any other service		

Plus Silver 3000/3750

Medical plan for 1–50 employees starting January 1, 2025

The deductible applies whenever there is a coinsurance listed, unless otherwise noted.

Ded = Deductible
Coins = Coinsurance

		PLUS SILVER 3000/3750		
		IN NETWORK		OUT OF NETWORK
		PREFERRED	PARTICIPATING	NON-PARTICIPATING
Individual deductible	Per calendar year = PCY Family = 2x individual deductible (in network only)	\$3,000/\$3,750		2x individual deductible
Coinsurance	Amount you pay after your deductible is met	30%	40%	60%
Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	\$8,550		\$45,000
Office visits	Designated primary care provider (PCP) office visit	\$35		Deductible, then 60%
	Non-designated PCP or specialist office visit	\$85		
Network		Heritage		Out of network
10 ESSENTIAL BENEFITS COVERED SERVICES				
1 Ambulatory patient services	Outpatient services	Deductible, then 20%	Deductible, then 40%	Deductible, then 60%
Office visits	Spinal manipulation (12 visits PCY); Acupuncture (12 visits PCY)	\$35		
2 Emergency services	Emergency care Copay waived if directly admitted to inpatient facility	\$250 copay, then in-network deductible and coinsurance		
	Ambulance transportation (air and ground)	\$25 copay, then deductible and in-network coinsurance	Emergent: same as in network; Non-emergent: Air – ded, then 40%; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60%; Ground – same as in network
3 Hospitalization	Inpatient	Deductible, then 30%	Deductible, then 40%	Deductible, then 60%
	Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum			Not covered
	Organ and tissue transplants, inpatient unlimited, except \$75,000 donor coverage limit and \$7,500 travel and lodging limit per transplant			
4 Maternity and newborn care	Prenatal, delivery, and postnatal care			
5 Mental health and substance use disorder services, including behavioral health treatment	Office visit	\$85		Deductible, then 60%
	Inpatient hospital: mental and behavioral health services	Deductible, then 30%	Deductible, then 40%	
	Outpatient services			
Rehabilitative and habilitative services and devices	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			
6 Therapy	Physical, speech, occupational, and massage therapy: 45 visits PCY	Deductible, then \$85		
Rehabilitation and habilitative therapy benefits have the same number of visits, but are counted separately	Rehabilitation and habilitative services and devices Skilled nursing facility: 60 days PCY	Deductible, then 30%	Deductible, then 40%	
7 Laboratory services	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET (preapproval required for certain services)			
8 Preventive/wellness services and chronic disease management	Screenings Exams and vaccinations	Covered in full		
9 Pediatric services, including vision care under age 19	Eye exam: 1 PCY	\$25		
	Eyewear: 1 pair of glasses PCY (frames and lenses); or 12-month supply of contacts PCY, in lieu of glasses (frames and lenses)	Covered in full		
	Dental: pediatric dental class I (cleanings, exams, and X-rays)	Deductible waived, covered in full	Deductible waived, then 10%	
	Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible waived, then 30%	Deductible waived, then 50%	
	Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50%		
10 Prescription drugs	Retail up to 90-day supply (3x 30-day supply cost)	\$25 / \$65 / \$150		Retail and specialty: same as in network; Mail order: not covered
	Mail order 90-day supply (2.5x retail supply cost)	\$62.50 / \$162.50 / \$375		
	Specialty Rx 30-day supply	Deductible, then 40%		
	Drug formulary M4			
ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN				
Hearing	Hearing exam: 1 per 2 calendar years Hearing aids and hardware: \$3,000 every 3 calendar years	Deductible waived, then 20%		
Virtual care (general medicine)	A full list of services is available on premera.com/ak/member	Covered in full	Not covered	
Premera-Designated Centers of Excellence		Covered as any other service		



Plus Gold 500

Medical plan for 1–50 employees starting January 1, 2025

The deductible applies whenever there is a coinsurance listed, unless otherwise noted.

Ded = Deductible
Coins = Coinsurance

		PLUS GOLD 500		
		IN NETWORK		OUT OF NETWORK
		PREFERRED	PARTICIPATING	NON-PARTICIPATING
Individual deductible	Per calendar year = PCY Family = 2x individual deductible (in network only)	\$500		2x individual deductible
Coinsurance	Amount you pay after your deductible is met	20%	40%	60%
Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	\$7,000		\$45,000
Office visits	Designated primary care provider (PCP) office visit	\$25		Deductible, then 60%
	Non-designated PCP or specialist office visit	\$50		
Network		Heritage		Out of network
10 ESSENTIAL BENEFITS COVERED SERVICES				
1 Ambulatory patient services	Outpatient services	Deductible, then 20%	Deductible, then 40%	Deductible, then 60%
Office visits	Spinal manipulation (12 visits PCY); Acupuncture (12 visits PCY)	\$25		
2 Emergency services	Emergency care Copay waived if directly admitted to inpatient facility	\$250 copay, then in-network deductible and coinsurance		
	Ambulance transportation (air and ground)	\$25 copay, then deductible and in-network coinsurance	Emergent: same as in network; Non-emergent: Air – ded, then 40%; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60%; Ground – same as in network
3 Hospitalization	Inpatient			Deductible, then 60%
	Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum			
	Organ and tissue transplants, inpatient unlimited, except \$75,000 donor coverage limit and \$7,500 travel and lodging limit per transplant	Deductible, then 20%	Deductible, then 40%	
4 Maternity and newborn care	Prenatal, delivery, and postnatal care			
5 Mental health and substance use disorder services, including behavioral health treatment	Office visit	\$50		
	Inpatient hospital: mental and behavioral health services			
	Outpatient services	Deductible, then 20%	Deductible, then 40%	
6 Rehabilitative and habilitative services and devices	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			
	Physical, speech, occupational, and massage therapy: 45 visits PCY	Deductible, then \$50		Deductible, then 60%
7 Rehabilitation and habilitative therapy benefits have the same number of visits, but are counted separately	Rehabilitation and habilitative services and devices Skilled nursing facility: 60 days PCY	Deductible, then 20%		Deductible, then 40%
	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET (preapproval required for certain services)			
8 Preventive/wellness services and chronic disease management	Screenings Exams and vaccinations	Covered in full		
9 Pediatric services, including vision care under age 19	Eye exam: 1 PCY	\$25		
	Eyewear: 1 pair of glasses PCY (frames and lenses); or 12-month supply of contacts PCY, in lieu of glasses (frames and lenses)	Covered in full		
	Dental: pediatric dental class I (cleanings, exams, and X-rays)	Deductible waived, covered in full		Deductible waived, then 10%
	Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible waived, then 30%		Deductible waived, then 50%
	Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50%		
10 Prescription drugs Tier 1: Preferred generic Tier 2: Preferred brand Tier 3: Non-preferred generic and brand Tier 4: Specialty	Retail up to 90-day supply (3x 30-day supply cost)	\$20 / \$50 / \$100		Retail and specialty: same as in network; Mail order: not covered
	Mail order 90-day supply (2.5x retail supply cost)	\$50 / \$125 / \$250		
	Specialty Rx 30-day supply	Deductible, then 20%		
	Drug formulary M4			
ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN				
Hearing	Hearing exam: 1 per 2 calendar years Hearing aids and hardware: \$3,000 every 3 calendar years	Deductible waived, then 20%		
Virtual care (general medicine)	A full list of services is available on premera.com/ak/member	Covered in full	Not covered	
Premera-Designated Centers of Excellence			Covered as any other service	

Plus Gold 1000

Medical plan for 1–50 employees starting January 1, 2025

The deductible applies whenever there is a coinsurance listed, unless otherwise noted.

Ded = Deductible
Coins = Coinsurance

		PLUS GOLD 1000		
		IN NETWORK		OUT OF NETWORK
		PREFERRED	PARTICIPATING	NON-PARTICIPATING
Individual deductible	Per calendar year = PCY Family = 2x individual deductible (in network only)	\$1,000		2x individual deductible
Coinsurance	Amount you pay after your deductible is met	20%	40%	60%
Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	\$7,000		\$45,000
Office visits	Designated primary care provider (PCP) office visit	\$25		Deductible, then 60%
	Non-designated PCP or specialist office visit	\$50		
Network		Heritage		Out of network
10 ESSENTIAL BENEFITS COVERED SERVICES				
1 Ambulatory patient services	Outpatient services	Deductible, then 20%	Deductible, then 40%	Deductible, then 60%
Office visits	Spinal manipulation (12 visits PCY); Acupuncture (12 visits PCY)	\$25		
2 Emergency services	Emergency care Copay waived if directly admitted to inpatient facility	\$250 copay, then in-network deductible and coinsurance		
	Ambulance transportation (air and ground)	\$25 copay, then deductible and in-network coinsurance	Emergent: same as in network; Non-emergent: Air – ded, then 40%; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60%; Ground – same as in network
3 Hospitalization	Inpatient			Deductible, then 60%
	Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum			
	Organ and tissue transplants, inpatient unlimited, except \$75,000 donor coverage limit and \$7,500 travel and lodging limit per transplant	Deductible, then 20%	Deductible, then 40%	
4 Maternity and newborn care	Prenatal, delivery, and postnatal care			
5 Mental health and substance use disorder services, including behavioral health treatment	Office visit	\$50		
	Inpatient hospital: mental and behavioral health services			
	Outpatient services	Deductible, then 20%	Deductible, then 40%	
6 Rehabilitative and habilitative services and devices	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			
	Physical, speech, occupational, and massage therapy: 45 visits PCY	Deductible, then \$50		Deductible, then 60%
7 Rehabilitation and habilitative therapy benefits have the same number of visits, but are counted separately	Rehabilitation and habilitative services and devices Skilled nursing facility: 60 days PCY	Deductible, then 20%		Deductible, then 40%
	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET (preapproval required for certain services)			
8 Preventive/wellness services and chronic disease management	Screenings Exams and vaccinations	Covered in full		
9 Pediatric services, including vision care under age 19	Eye exam: 1 PCY	\$25		
	Eyewear: 1 pair of glasses PCY (frames and lenses); or 12-month supply of contacts PCY, in lieu of glasses (frames and lenses)	Covered in full		
	Dental: pediatric dental class I (cleanings, exams, and X-rays)	Deductible waived, covered in full		Deductible waived, then 10%
	Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible waived, then 30%		Deductible waived, then 50%
	Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50%		
10 Prescription drugs Tier 1: Preferred generic Tier 2: Preferred brand Tier 3: Non-preferred generic and brand Tier 4: Specialty	Retail up to 90-day supply (3x 30-day supply cost)	\$10 / \$40 / \$100		Retail and specialty: same as in network; Mail order: not covered
	Mail order 90-day supply (2.5x retail supply cost)	\$25 / \$100 / \$250		
	Specialty Rx 30-day supply	Deductible, then 20%		
	Drug formulary M4			
ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN				
Hearing	Hearing exam: 1 per 2 calendar years Hearing aids and hardware: \$3,000 every 3 calendar years	Deductible waived, then 20%		
Virtual care (general medicine)	A full list of services is available on premera.com/ak/member	Covered in full	Not covered	
Premera-Designated Centers of Excellence			Covered as any other service	



Plus Gold 1500

Medical plan for 1–50 employees starting January 1, 2025

The deductible applies whenever there is a coinsurance listed, unless otherwise noted.

Ded = Deductible
Coins = Coinsurance

		PLUS GOLD 1500		
		IN NETWORK		OUT OF NETWORK
		PREFERRED	PARTICIPATING	NON-PARTICIPATING
Individual deductible	Per calendar year = PCY Family = 2x individual deductible (in network only)	\$1,500		2x individual deductible
Coinsurance	Amount you pay after your deductible is met	20%	40%	60%
Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	\$7,000		\$45,000
Office visits	Designated primary care provider (PCP) office visit	\$25		Deductible, then 60%
	Non-designated PCP or specialist office visit	\$50		
Network		Heritage		Out of network
10 ESSENTIAL BENEFITS COVERED SERVICES				
1 Ambulatory patient services	Outpatient services	Deductible, then 20%	Deductible, then 40%	Deductible, then 60%
Office visits	Spinal manipulation (12 visits PCY); Acupuncture (12 visits PCY)	\$25		
2 Emergency services	Emergency care Copay waived if directly admitted to inpatient facility	\$250 copay, then in-network deductible and coinsurance		
	Ambulance transportation (air and ground)	\$25 copay, then deductible and in-network coinsurance	Emergent: same as in network; Non-emergent: Air – ded, then 40%; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60%; Ground – same as in network
3 Hospitalization	Inpatient	Deductible, then 20%	Deductible, then 40%	Deductible, then 60%
	Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum			Not covered
	Organ and tissue transplants, inpatient unlimited, except \$75,000 donor coverage limit and \$7,500 travel and lodging limit per transplant			
4 Maternity and newborn care	Prenatal, delivery, and postnatal care			
5 Mental health and substance use disorder services, including behavioral health treatment	Office visit	\$50		
	Inpatient hospital: mental and behavioral health services	Deductible, then 20%	Deductible, then 40%	Deductible, then 60%
	Outpatient services			
Rehabilitative and habilitative services and devices	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			
6 Therapy	Physical, speech, occupational, and massage therapy: 45 visits PCY	Deductible, then \$50		Deductible, then 60%
Rehabilitation and habilitative therapy benefits have the same number of visits, but are counted separately	Rehabilitation and habilitative services and devices Skilled nursing facility: 60 days PCY	Deductible, then 20%	Deductible, then 40%	
7 Laboratory services	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET (preapproval required for certain services)			
8 Preventive/wellness services and chronic disease management	Screenings Exams and vaccinations	Covered in full		
9 Pediatric services, including vision care under age 19	Eye exam: 1 PCY	\$25		
	Eyewear: 1 pair of glasses PCY (frames and lenses); or 12-month supply of contacts PCY, in lieu of glasses (frames and lenses)	Covered in full		
	Dental: pediatric dental class I (cleanings, exams, and X-rays)	Deductible waived, covered in full	Deductible waived, then 10%	
	Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible waived, then 30%	Deductible waived, then 50%	
	Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50%		
10 Prescription drugs	Retail up to 90-day supply (3x 30-day supply cost)	\$10 / \$40 / \$100		Retail and specialty: same as in network; Mail order: not covered
	Mail order 90-day supply (2.5x retail supply cost)	\$25 / \$100 / \$250		
	Specialty Rx 30-day supply	Deductible, then 20%		
	Drug formulary M4			
ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN				
Hearing	Hearing exam: 1 per 2 calendar years Hearing aids and hardware: \$3,000 every 3 calendar years	Deductible waived, then 20%		
Virtual care (general medicine)	A full list of services is available on premera.com/ak/member	Covered in full	Not covered	
Premera-Designated Centers of Excellence		Covered as any other service		

Plus Gold 2000

Medical plan for 1–50 employees starting January 1, 2025

The deductible applies whenever there is a coinsurance listed, unless otherwise noted.

Ded = Deductible
Coins = Coinsurance

		PLUS GOLD 2000		
		IN NETWORK		OUT OF NETWORK
		PREFERRED	PARTICIPATING	NON-PARTICIPATING
Individual deductible	Per Calendar Year = PCY Family = 2x individual deductible (in network only)	\$2,000		2x individual deductible
Coinsurance	Amount you pay after your deductible is met	20%	40%	60%
Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket-max	\$7,000		\$45,000
Office visits	Designated primary care provider (PCP) office visit	\$25		Deductible, then 60%
	Non-designated PCP or specialist office visit	\$50		
Network		Heritage		Out of network
10 ESSENTIAL BENEFITS COVERED SERVICES				
1 Ambulatory patient services	Outpatient services	Deductible, then 20%	Deductible, then 40%	Deductible, then 60%
Office visits	Spinal manipulation (12 visits PCY); Acupuncture (12 visits PCY)	\$25		
2 Emergency services	Emergency care Copay waived if directly admitted to inpatient facility	\$250 copay, then in-network deductible and coinsurance		
	Ambulance transportation (air and ground)	\$25 copay, then deductible and in-network coinsurance	Emergent: same as in network; Non-emergent: Air - ded, then 40%; Ground - same as in network	Emergent: same as in network; Non-emergent: Air - ded, then 60%; Ground - same as in network
3 Hospitalization	Inpatient	Deductible, then 20%	Deductible, then 40%	Deductible, then 60%
	Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum			Not covered
	Organ and tissue transplants, inpatient unlimited, except \$75,000 donor coverage limit and \$7,500 travel and lodging per transplant			
4 Maternity and newborn care	Prenatal, delivery, and postnatal care			
5 Mental health and substance use disorder services, including behavioral health treatment	Office visit	\$50		
	Inpatient hospital: mental and behavioral health services	Deductible, then 20%	Deductible, then 40%	Deductible, then 60%
	Outpatient services			
Rehabilitative and habilitative services and devices	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			
6 Therapy	Physical, speech, occupational, and massage therapy: 45 visits PCY	Deductible, then \$60		Deductible, then 60%
Rehabilitation and habilitative therapy benefits have the same number of visits, but are counted separately	Rehabilitation and habilitative services and devices Skilled nursing facility: 60 days PCY	Deductible, then 20%	Deductible, then 40%	
7 Laboratory services	Includes X-ray, pathology, imaging/diagnostics, MRI, CT, PET (preapproval required for certain services)			
8 Preventive/wellness services and chronic disease management	Screenings Exams and vaccinations	Covered in full		
9 Pediatric services, including vision care under age 19	Eye exam: 1 PCY	\$25		
	Eyewear: 1 pair of glasses PCY (frames and lenses); or 12-month supply of contracts PCY, in lieu of glasses (frames and lenses)	Covered in full		
	Dental: pediatric dental class I (cleanings, exams, and X-rays)	Deductible waived, covered in full	Deductible waived, then 10%	
	Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible waived, then 30%	Deductible waived, then 50%	
	Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50%		
10 Prescription drugs	Retail up to 90-day supply (3x 30-day supply cost)	\$10 / \$40 / \$100		Retail and specialty: same as in network; Mail order: not covered
	Mail order 90-day supply (2.5x retail supply cost)	\$25 / \$100 / \$250		
	Specialty Rx 30-day supply	Deductible, then 20%		
	Drug formulary M4			
ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN				
Hearing	Hearing Exam: 1 per 2 calendar years Hearing aids and hardware: \$3,000 every 3 calendar years	Deductible waived, then 20%		
Virtual care (general medicine)	A full list of services is available on premera.com/ak/member	Covered in full	Not covered	
Premera-Designated Centers of Excellence		Covered as any other service		



Plus Platinum 250

Medical plan for 1–50 employees starting January 1, 2025

The deductible applies whenever there is a coinsurance listed, unless otherwise noted.

Ded = Deductible
Coins = Coinsurance

		PLUS PLATINUM 250		
		IN NETWORK		OUT OF NETWORK
		PREFERRED	PARTICIPATING	NON-PARTICIPATING
Individual deductible	Per calendar year = PCY Family = 2x individual deductible (in network only)	\$250		2x individual deductible
Coinsurance	Amount you pay after your deductible is met	20%	40%	60%
Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	\$2,250		\$45,000
Office visits	Designated primary care provider (PCP) office visit	\$25		Deductible, then 60%
	Non-designated PCP or specialist office visit	\$50		
Network		Heritage		Out of network
10 ESSENTIAL BENEFITS COVERED SERVICES				
1 Ambulatory patient services	Outpatient services	Deductible, then 20%	Deductible, then 40%	Deductible, then 60%
	Office visits	\$25		
2 Emergency services	Emergency care Copay waived if directly admitted to inpatient facility	\$250 copay, then in-network deductible and coinsurance		
	Ambulance transportation (air and ground)	\$25 copay, then deductible and in-network coinsurance	Emergent: same as in network; Non-emergent: Air – ded, then 40%; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60%; Ground – same as in network
3 Hospitalization	Inpatient	Deductible, then 20%	Deductible, then 40%	Deductible, then 60%
	Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum			Not covered
	Organ and tissue transplants, inpatient unlimited, except \$75,000 donor coverage limit and \$7,500 travel and lodging limit per transplant			
4 Maternity and newborn care	Prenatal, delivery, and postnatal care			
5 Mental health and substance use disorder services, including behavioral health treatment	Office visit	\$50		Deductible, then 60%
	Inpatient hospital: mental and behavioral health services	Deductible, then 20%	Deductible, then 40%	
	Outpatient services			
6 Rehabilitation and habilitative services and devices	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY	Deductible, then 20%	Deductible, then 40%	Deductible, then 60%
	Therapy			
7 Rehabilitation and habilitative therapy benefits have the same number of visits, but are counted separately	Physical, speech, occupational, and massage therapy: 45 visits PCY	Deductible, then 20%	Deductible, then 40%	Deductible, then 60%
	Rehabilitation and habilitative services and devices Skilled nursing facility: 60 days PCY			
8 Laboratory services	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET (preapproval required for certain services)			
9 Preventive/wellness services and chronic disease management	Screenings Exams and vaccinations	Covered in full		
	Eye exam: 1 PCY	\$25		
10 Pediatric services, including vision care under age 19	Eyewear: 1 pair of glasses PCY (frames and lenses); or 12-month supply of contacts PCY, in lieu of glasses (frames and lenses)	Covered in full		
	Dental: pediatric dental class I (cleanings, exams, and X-rays)	Deductible waived, covered in full		Deductible waived, then 10%
	Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible waived, then 30%		Deductible waived, then 50%
	Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50%		
11 Prescription drugs	Retail up to 90-day supply (3x 30-day supply cost)	\$10 / \$40 / \$100		Retail and specialty: same as in network; Mail order: not covered
	Mail order 90-day supply (2.5x retail supply cost)	\$25 / \$100 / \$250		
	Specialty Rx 30-day supply	Deductible, then 20%		
	Drug formulary M4			
ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN				
Hearing	Hearing exam: 1 per 2 calendar years Hearing aids and hardware: \$3,000 every 3 calendar years	Deductible waived, then 20%		
Virtual care (general medicine)	A full list of services is available on premera.com/ak/member	Covered in full	Not covered	
	Premera-Designated Centers of Excellence		Covered as any other service	

Plus Platinum 500

Medical plan for 1–50 employees starting January 1, 2025

The deductible applies whenever there is a coinsurance listed, unless otherwise noted.

Ded = Deductible
Coins = Coinsurance

		PLUS PLATINUM 500		
		IN NETWORK		OUT OF NETWORK
		PREFERRED	PARTICIPATING	NON-PARTICIPATING
Individual deductible	Per calendar year = PCY Family = 2x individual deductible (in network only)	\$500		2x individual deductible
Coinsurance	Amount you pay after your deductible is met	20%	40%	60%
Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	\$2,000		\$45,000
Office visits	Designated primary care provider (PCP) office visit	\$25		Deductible, then 60%
	Non-designated PCP or specialist office visit	\$50		
Network		Heritage		Out of network
10 ESSENTIAL BENEFITS COVERED SERVICES				
1 Ambulatory patient services	Outpatient services	Deductible, then 20%	Deductible, then 40%	Deductible, then 60%
	Office visits	\$25		
2 Emergency services	Emergency care Copay waived if directly admitted to inpatient facility	\$250 copay, then in-network deductible and coinsurance		
	Ambulance transportation (air and ground)	\$25 copay, then deductible and in-network coinsurance	Emergent: same as in network; Non-emergent: Air – ded, then 40%; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60%; Ground – same as in network
3 Hospitalization	Inpatient	Deductible, then 20%	Deductible, then 40%	Deductible, then 60%
	Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum			Not covered
	Organ and tissue transplants, inpatient unlimited, except \$75,000 donor coverage limit and \$7,500 travel and lodging limit per transplant			
4 Maternity and newborn care	Prenatal, delivery, and postnatal care			
5 Mental health and substance use disorder services, including behavioral health treatment	Office visit	\$50		Deductible, then 60%
	Inpatient hospital: mental and behavioral health services	Deductible, then 20%	Deductible, then 40%	
	Outpatient services			
6 Rehabilitation and habilitative services and devices	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY	Deductible, then 20%	Deductible, then 40%	Deductible, then 60%
	Therapy			
7 Rehabilitation and habilitative therapy benefits have the same number of visits, but are counted separately	Physical, speech, occupational, and massage therapy: 45 visits PCY	Deductible, then 20%	Deductible, then 40%	Deductible, then 60%
	Rehabilitation and habilitative services and devices Skilled nursing facility: 60 days PCY			
8 Laboratory services	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET (preapproval required for certain services)			
9 Preventive/wellness services and chronic disease management	Screenings Exams and vaccinations	Covered in full		
	Eye exam: 1 PCY	\$25		
10 Pediatric services, including vision care under age 19	Eyewear: 1 pair of glasses PCY (frames and lenses); or 12-month supply of contacts PCY, in lieu of glasses (frames and lenses)	Covered in full		
	Dental: pediatric dental class I (cleanings, exams, and X-rays)	Deductible waived, covered in full		Deductible waived, then 10%
	Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible waived, then 30%		Deductible waived, then 50%
	Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50%		
11 Prescription drugs	Retail up to 90-day supply (3x 30-day supply cost)	\$10 / \$40 / \$100		Retail and specialty: same as in network; Mail order: not covered
	Mail order 90-day supply (2.5x retail supply cost)	\$25 / \$100 / \$250		
	Specialty Rx 30-day supply	Deductible, then 20%		
	Drug formulary M4			
ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN				
Hearing	Hearing exam: 1 per 2 calendar years Hearing aids and hardware: \$3,000 every 3 calendar years	Deductible waived, then 20%		
Virtual care (general medicine)	A full list of services is available on premera.com/ak/member	Covered in full	Not covered	
	Premera-Designated Centers of Excellence		Covered as any other service	



Plus HSA Qualified Bronze 6000

(Embedded deductible)

Medical plan for 1–50 employees starting January 1, 2025

The deductible applies whenever there is a coinsurance listed, unless otherwise noted.

Ded = Deductible
Coins = Coinsurance

		PLUS HSA QUALIFIED BRONZE 6000 (EMBEDDED)		
		IN NETWORK		OUT OF NETWORK
		PREFERRED	PARTICIPATING	NON-PARTICIPATING
Individual deductible	Per calendar year = PCY Family = 2x individual deductible (in network only)	\$6,000		2x individual deductible
Coinsurance	Amount you pay after your deductible is met	50%		60%
Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	\$8,050		\$45,000
Office visits	Cost share	Deductible, then 50%		Deductible, then 60%
Network		Heritage		Out of network

10 ESSENTIAL BENEFITS COVERED SERVICES

1 Ambulatory patient services	Outpatient services	Deductible, then 50%		Deductible, then 60%
Office visits	Spinal manipulation (12 visits PCY); Acupuncture (12 visits PCY)	Deductible, then 50%		Deductible, then 60%
2 Emergency services	Emergency care	Deductible, then 50%		
	Ambulance transportation (air and ground)	Deductible, then 50%	Emergent: same as in network; Non-emergent: Air – ded, then 50%; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60%; Ground – same as in network
3 Hospitalization	Inpatient Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum Organ and tissue transplants, inpatient unlimited, except \$75,000 donor coverage limit and \$7,500 travel and lodging limit per transplant			Deductible, then 60%
4 Maternity and newborn care	Prenatal, delivery, and postnatal care			Not covered
5 Mental health and substance use disorder services, including behavioral health treatment	Office visit Inpatient hospital: mental and behavioral health services Outpatient services	Deductible, then 50%		
6 Rehabilitative and habilitative services and devices	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			Deductible, then 60%
Therapy	Physical, speech, occupational, and massage therapy: 45 visits PCY			Deductible, then 60%
Rehabilitation and habilitative therapy benefits have the same number of visits, but are counted separately	Rehabilitation and habilitative services and devices Skilled nursing facility: 60 days PCY			
7 Laboratory services	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET (preapproval required for certain services)			
8 Preventive/wellness services and chronic disease management	Screenings Exams and vaccinations	Covered in full		
9 Pediatric services, including vision care under age 19	Eye exam: 1 PCY	\$25		
	Eyewear: 1 pair of glasses PCY (frames and lenses); or 12-month supply of contacts PCY, in lieu of glasses (frames and lenses)	Covered in full		
	Dental: pediatric dental class I (cleanings, exams, and X-rays)	Deductible waived, covered in full		Deductible waived, then 10%
	Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible, then 30%		Deductible, then 50%
	Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50%		
10 Prescription drugs	Retail up to 90-day supply (3x 30-day supply cost)			Retail and specialty: same as in network; Mail order: not covered
	Mail order 90-day supply (2.5x retail supply cost)	Deductible, then 50%		
	Specialty Rx 30-day supply			
	Drug formulary M1			

ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN

Hearing	Hearing exam: 1 per 2 calendar years Hearing aids and hardware: \$3,000 every 3 calendar years	Deductible, then 20%	
Virtual care (general medicine)	A full list of services is available on premera.com/ak/member	Deductible, then 50%	Not covered
Premera-Designated Centers of Excellence		Deductible, then 0%	Covered as any other service

Plus HSA Qualified Silver 3300

(Embedded deductible)

Medical plan for 1–50 employees starting January 1, 2025

The deductible applies whenever there is a coinsurance listed, unless otherwise noted.

Ded = Deductible
Coins = Coinsurance

		PLUS HSA QUALIFIED SILVER 3300 (EMBEDDED)		
		IN NETWORK		OUT OF NETWORK
		PREFERRED	PARTICIPATING	NON-PARTICIPATING
Individual deductible	Per calendar year = PCY Family = 2x individual deductible (in network only)	\$3,300		2x individual deductible
Coinsurance	Amount you pay after your deductible is met	30%	40%	60%
Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	\$8,050		\$45,000
Office visits	Cost share	Deductible, then 30%	Deductible, then 40%	Deductible, then 60%
Network		Heritage		Out of network

10 ESSENTIAL BENEFITS COVERED SERVICES

1 Ambulatory patient services	Outpatient services	Deductible, then 30%	Deductible, then 40%	Deductible, then 60%
Office visits	Spinal manipulation (12 visits PCY); Acupuncture (12 visits PCY)	Deductible, then 30%	Deductible, then 40%	Deductible, then 60%
2 Emergency services	Emergency care	Deductible, then 30%		
	Ambulance transportation (air and ground)		Emergent: same as in network; Non-emergent: Air – ded, then 40%; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60%; Ground – same as in network
3 Hospitalization	Inpatient Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum Organ and tissue transplants, inpatient unlimited, except \$75,000 donor coverage limit and \$7,500 travel and lodging limit per transplant			Deductible, then 60%
4 Maternity and newborn care	Prenatal, delivery, and postnatal care			Not covered
5 Mental health and substance use disorder services, including behavioral health treatment	Office visit Inpatient hospital: mental and behavioral health services Outpatient services	Deductible, then 30%	Deductible, then 40%	
6 Rehabilitative and habilitative services and devices	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			Deductible, then 60%
Therapy	Physical, speech, occupational, and massage therapy: 45 visits PCY			Deductible, then 60%
Rehabilitation and habilitative therapy benefits have the same number of visits, but are counted separately	Rehabilitation and habilitative services and devices Skilled nursing facility: 60 days PCY			
7 Laboratory services	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET (preapproval required for certain services)			
8 Preventive/wellness services and chronic disease management	Screenings Exams and vaccinations	Covered in full		
9 Pediatric services, including vision care under age 19	Eye exam: 1 PCY	\$25		
	Eyewear: 1 pair of glasses PCY (frames and lenses); or 12-month supply of contacts PCY, in lieu of glasses (frames and lenses)	Covered in full		
	Dental: pediatric dental class I (cleanings, exams, and X-rays)	Deductible waived, covered in full		Deductible waived, then 10%
	Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible, then 30%		Deductible, then 50%
	Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50%		
10 Prescription drugs	Retail up to 90-day supply (3x 30-day supply cost)			Retail and specialty: same as in network; Mail order: not covered
	Mail order 90-day supply (2.5x retail supply cost)	Deductible, then 30%		
	Specialty Rx 30-day supply			
	Drug formulary M1			

ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN

Hearing	Hearing exam: 1 per 2 calendar years Hearing aids and hardware: \$3,000 every 3 calendar years	Deductible, then 20%		
Virtual care (general medicine)	A full list of services is available on premera.com/ak/member	Deductible, then 30%	Not covered	
Premera-Designated Centers of Excellence		Deductible, then 0%	Covered as any other service	



Plus HSA Qualified Silver 3500

(Embedded deductible)

Medical plan for 1–50 employees starting January 1, 2025

The deductible applies whenever there is a coinsurance listed, unless otherwise noted.

Ded = Deductible
Coins = Coinsurance

		PLUS HSA QUALIFIED SILVER 3500 (EMBEDDED)		
		IN NETWORK		OUT OF NETWORK
		PREFERRED	PARTICIPATING	NON-PARTICIPATING
Individual deductible	Per calendar year = PCY Family = 2x individual deductible (in network only)	\$3,500		2x individual deductible
Coinsurance	Amount you pay after your deductible is met	30%	40%	60%
Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	\$8,050		\$45,000
Office visits	Cost share	Deductible, then 30%	Deductible, then 40%	Deductible, then 60%
Network		Heritage		Out of network
10 ESSENTIAL BENEFITS	COVERED SERVICES			
1 Ambulatory patient services	Outpatient services	Deductible, then 30%	Deductible, then 40%	Deductible, then 60%
Office visits	Spinal manipulation (12 visits PCY); Acupuncture (12 visits PCY)			
2 Emergency services	Emergency care (copay waived if directly admitted to inpatient facility)	Deductible, then 30%		
	Ambulance transportation (air and ground)		Emergent: same as in network; Non-emergent: Air – ded, then 40%; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60%; Ground – same as in network
3 Hospitalization	Inpatient Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum Organ and tissue transplants, inpatient unlimited, except \$75,000 donor coverage limit and \$7,500 travel and lodging limit per transplant			Deductible, then 60%
4 Maternity and newborn care	Prenatal, delivery, and postnatal care			Not covered
5 Mental health and substance use disorder services, including behavioral health treatment	Office visit Inpatient hospital: mental and behavioral health services Outpatient services	Deductible, then 30%	Deductible, then 40%	
6 Rehabilitative and habilitative services and devices	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			Deductible, then 60%
7 Therapy	Physical, speech, occupational, and massage therapy: 45 visits PCY			Deductible, then 60%
8 Rehabilitation and habilitative therapy benefits have the same number of visits, but are counted separately	Rehabilitation and habilitative services and devices Skilled nursing facility: 60 days PCY			Deductible, then 60%
9 Laboratory services	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET (preapproval required for certain services)			
8 Preventive/wellness services and chronic disease management	Screenings Exams and vaccinations	Covered in full		
9 Pediatric services, including vision care under age 19	Eye exam: 1 PCY	\$25		
	Eyewear: 1 pair of glasses PCY (frames and lenses); or 12-month supply of contacts PCY, in lieu of glasses (frames and lenses)	Covered in full		
	Dental: pediatric dental class I (cleanings, exams, and X-rays)	Deductible waived, covered in full		Deductible waived, then 10%
	Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible, then 30%		Deductible, then 50%
	Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50%		
10 Prescription drugs	Retail up to 90-day supply (3x 30-day supply cost)			
	Mail order 90-day supply (2.5x retail supply cost)	Deductible, then 30%		Retail and specialty: same as in network; Mail order: not covered
	Specialty Rx 30-day supply			
	Drug formulary M1			
ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN				
Hearing	Hearing exam: 1 per 2 calendar years Hearing aids and hardware: \$3,000 every 3 calendar years	Deductible, then 20%		
Virtual care (general medicine)	A full list of services is available on premera.com/ak/member	Deductible, then 30%	Not covered	
Premera-Designated Centers of Excellence		Deductible, then 0%	Covered as any other service	

Plus HSA Qualified Silver 4000

(Embedded deductible)

Medical plan for 1–50 employees starting January 1, 2025

The deductible applies whenever there is a coinsurance listed, unless otherwise noted.

Ded = Deductible
Coins = Coinsurance

		PLUS HSA QUALIFIED SILVER 4000 (EMBEDDED)		
		IN NETWORK		OUT OF NETWORK
		PREFERRED	PARTICIPATING	NON-PARTICIPATING
Individual deductible	Per calendar year = PCY Family = 2x individual deductible (in network only)	\$4,000		2x individual deductible
Coinsurance	Amount you pay after your deductible is met	30%	40%	60%
Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	\$7,500		\$45,000
Office visits	Cost share	Deductible, then 30%	Deductible, then 40%	Deductible, then 60%
Network		Heritage		Out of network
10 ESSENTIAL BENEFITS	COVERED SERVICES			
1 Ambulatory patient services	Outpatient services	Deductible, then 30%	Deductible, then 40%	Deductible, then 60%
Office visits	Spinal manipulation (12 visits PCY); Acupuncture (12 visits PCY)			
2 Emergency services	Emergency care (copay waived if directly admitted to inpatient facility)	Deductible, then 30%		
	Ambulance transportation (air and ground)		Emergent: same as in network; Non-emergent: Air – ded, then 40%; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60%; Ground – same as in network
3 Hospitalization	Inpatient Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum Organ and tissue transplants, inpatient unlimited, except \$75,000 donor coverage limit and \$7,500 travel and lodging limit per transplant			Deductible, then 60%
4 Maternity and newborn care	Prenatal, delivery, and postnatal care			Not covered
5 Mental health and substance use disorder services, including behavioral health treatment	Office visit Inpatient hospital: mental and behavioral health services Outpatient services	Deductible, then 30%	Deductible, then 40%	
6 Rehabilitative and habilitative services and devices	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			Deductible, then 60%
7 Therapy	Physical, speech, occupational, and massage therapy: 45 visits PCY			Deductible, then 60%
8 Rehabilitation and habilitative therapy benefits have the same number of visits, but are counted separately	Rehabilitation and habilitative services and devices Skilled nursing facility: 60 days PCY			Deductible, then 60%
9 Laboratory services	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET (preapproval required for certain services)			
8 Preventive/wellness services and chronic disease management	Screenings Exams and vaccinations	Covered in full		
9 Pediatric services, including vision care under age 19	Eye exam: 1 PCY	\$25		
	Eyewear: 1 pair of glasses PCY (frames and lenses); or 12-month supply of contacts PCY, in lieu of glasses (frames and lenses)	Covered in full		
	Dental: pediatric dental class I (cleanings, exams, and X-rays)	Deductible waived, covered in full		Deductible waived, then 10%
	Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible, then 30%		Deductible, then 50%
	Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50%		
10 Prescription drugs	Retail up to 90-day supply (3x 30-day supply cost)			
	Mail order 90-day supply (2.5x retail supply cost)	Deductible, then 30%		Retail and specialty: same as in network; Mail order: not covered
	Specialty Rx 30-day supply			
	Drug formulary M1			
ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN				
Hearing	Hearing exam: 1 per 2 calendar years Hearing aids and hardware: \$3,000 every 3 calendar years	Deductible, then 20%		
Virtual care (general medicine)	A full list of services is available on premera.com/ak/member	Deductible, then 30%	Not covered	
Premera-Designated Centers of Excellence		Deductible, then 0%	Covered as any other service	



Plus HSA Qualified Gold 1650

(Aggregate deductible)

Medical plan for 1–50 employees starting January 1, 2025

The deductible applies whenever there is a coinsurance listed, unless otherwise noted.

Ded = Deductible
Coins = Coinsurance

		PLUS HSA QUALIFIED GOLD 1650 (AGGREGATE)		
		IN NETWORK		OUT OF NETWORK
		PREFERRED	PARTICIPATING	NON-PARTICIPATING
Individual deductible	Per calendar year = PCY Family = 2x individual deductible (aggregate)	Individual: \$1,650		2x individual deductible
Coinsurance	Amount you pay after your deductible is met	20%	40%	60%
Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum (aggregate)	Individual: \$4,000		\$45,000
Office visits	Cost share	Deductible, then 20%	Deductible, then 40%	Deductible, then 60%
Network		Heritage		Out of network
10 ESSENTIAL BENEFITS COVERED SERVICES				
1 Ambulatory patient services	Outpatient services	Deductible, then 20%	Deductible, then 40%	Deductible, then 60%
Office visits	Spinal manipulation (12 visits PCY); Acupuncture (12 visits PCY)			
2 Emergency services	Emergency care	Deductible, then 20%		
	Ambulance transportation (air and ground)		Emergent: same as in network; Non-emergent: Air – ded, then 40%; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60%; Ground – same as in network
3 Hospitalization	Inpatient			Deductible, then 60%
	Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum			
	Organ and tissue transplants, inpatient unlimited, except \$75,000 donor coverage limit and \$7,500 travel and lodging limit per transplant			Not covered
4 Maternity and newborn care	Prenatal, delivery, and postnatal care			
5 Mental health and substance use disorder services, including behavioral health treatment	Office visit	Deductible, then 20%		
	Inpatient hospital: mental and behavioral health services			
	Outpatient services		Deductible, then 40%	
6 Rehabilitative and habilitative services and devices	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			
Therapy	Physical, speech, occupational, and massage therapy: 45 visits PCY			Deductible, then 60%
7 Rehabilitation and habilitative therapy benefits have the same number of visits, but are counted separately	Rehabilitation and habilitative services and devices Skilled nursing facility: 60 days PCY			
8 Laboratory services	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET (preapproval required for certain services)			
9 Preventive/wellness services and chronic disease management	Screenings Exams and vaccinations	Covered in full		
	Eye exam: 1 PCY	\$25		
	Eyewear: 1 pair of glasses PCY (frames and lenses); or 12-month supply of contacts PCY, in lieu of glasses (frames and lenses)	Covered in full		
	Dental: pediatric dental class I (cleanings, exams, and X-rays)	Deductible waived, covered in full		Deductible waived, then 10%
	Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible, then 30%		Deductible, then 50%
	Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50%		
10 Prescription drugs	Retail up to 90-day supply (3x 30-day supply cost)			
	Mail order 90-day supply (2.5x retail supply cost)			
	Specialty Rx 30-day supply	Deductible, then 20%		Retail and specialty: same as in network; Mail order: not covered
	Drug formulary M1			
ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN				
Hearing	Hearing exam: 1 per 2 calendar years Hearing aids and hardware: \$3,000 every 3 calendar years	Deductible, then 20%		
Virtual care (general medicine)	A full list of services is available on premera.com/ak/member	Deductible, then 20%	Not covered	
Premera-Designated Centers of Excellence		Deductible, then 0%	Covered as any other service	





Dental plans

Good oral health is important to your employees' overall health. Here's why: Regular preventive oral health visits assist with early detection and management of diseases.³ When you offer your employees both dental and medical benefits from Premera, you help encourage healthy habits.

Why Premera dental?

- One health plan for both medical and dental
- Wide variety of dental plans to fit your needs and budget
- Healthier, happier employees
- Broad network of dentists available to your employees with an emphasis on preventive care
- Dental expertise from serving dental customers for over 30 years

CHOOSE BETWEEN THREE ADULT (ANYONE AGE 19 OR OLDER) DENTAL PLANS

	ADULT CORE DENTAL	ADULT DENTAL OPTIMA	ADULT DENTAL OPTIMA VOLUNTARY
Cost to employer	\$	\$\$	\$0
Member's out-of-pocket cost	Member coinsurance is higher when seeing an out-of-network dentist	Member coinsurance is the same for in-network and out-of-network dentists	Member coinsurance is the same for in-network and out-of-network dentists
Expanded benefits for major dental services (such as dentures and oral surgery)	Not covered	Covered	Covered (implants not included)
Orthodontia¹	No option	Optional	No option
Employee-funded plan²	No	No	Yes

Note: For a summary of plan benefits, see plan details to follow or speak to your producer for more details.

¹For groups with 26 or more enrolled employees

²Employer contributes 0%–49% of premium. Minimum enrollment is 2 or 30% of eligible employees (whichever is greater).

³Academy of General Dentistry: Know Your Teeth. January 2012. "Warning Signs in the Mouth Can Save Lives." knowyourteeth.com/infobites/abc/article/



DENTAL RESOURCES

Premera dental members can find a dentist, estimate costs, and review benefit basics in the [Dental health center](#).



Adult Core Dental

With Adult Core Dental, you can offer your adult employees and their adult dependents the core benefits they need to keep their smiles healthy.

Preventive services like routine oral exams, cleanings, and X-rays are covered in full to help them properly care for their overall health—with no waiting period.

In addition, they will have the freedom to choose any dental care provider, but will enjoy lower overall out-of-pocket costs when that provider is in network.

Did you know pediatric dental benefits are already included in Premera medical plans?

Your employees will automatically receive pediatric dental coverage. That's because it's already a part of their Premera medical plan. This allows you to provide your employees coverage for essential dental treatments for any family member under the age of 19.

A wide range of services are included—from routine dental cleanings and X-rays to root canals and extractions.

In addition, this coverage offers the following perks:

- The ability to visit any dentist*
- No waiting period for any service

Adult Core Dental covered services

Benefits apply after dental calendar year deductible is met, unless otherwise noted. Dental deductible and coinsurance represent member's cost share. PCY = Per calendar year

	IN NETWORK	OUT OF NETWORK
Individual dental deductible PCY	\$50	
Maximum allowance per person PCY	\$1,000	
DIAGNOSTIC AND PREVENTIVE		
Routine oral exams 2 PCY	Covered in full	10%
Cleanings 2 PCY		
Bitewing x-rays 2 sets (up to 4)		
Complete series x-rays once every 60 months		
BASIC		
Problem-focused exams (including emergency) 1 PCY	30%	50%
Panoramic x-rays 1 every 60 months		
Fillings once every 24 months		
Endodontic (root canal) therapy once per tooth per lifetime		
Periodontal maintenance 4 PCY		
Periodontal scaling and root planning once per quadrant every 24 months		
Simple and surgical extractions		
Intravenous or general anesthesia covered for dental procedures at a dental-care provider's office when dentally necessary		
Nitrous oxide		
MAJOR		
Porcelain, ceramic, and metal crowns once every 7 years	50%	50%
Build-ups for covered crowns only, once every 7 years		
Repair and recementing of crowns 1 every 24 months, 6 months after placement		

Note: Coinsurance amounts based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross Blue Shield of Alaska.

*Different in-network and out-of-network deductibles and coinsurance apply based on service. Speak to your producer for more details.



Adult Dental Optima

With Adult Dental Optima,™ you can offer your employees comprehensive coverage and flexibility to choose any dental care provider. They won't be billed for costs beyond the allowable amount when they use a provider who is in network.

Additionally, all plans provide benefits for periodontal maintenance, which includes up to four visits per year to help manage gum disease, as well as a broader range of major services including implants.

Choosing an Enhanced dental plan that covers endodontic and periodontic services under Basic can help reduce your employees out-of-pocket expenses.

* 1000, 1500, and 2000 Enhanced plans include an option to waive preventive and diagnostic services from the plan annual maximum.

Adult Dental Optima covered services

Benefits apply after calendar year deductible is met, unless otherwise noted.
Deductible and coinsurance represent member's cost share.
PCY = Per calendar year
CY = calendar year

ADULT DENTAL OPTIMA		1000	1500	1000 ENHANCED*	1500 ENHANCED*	2000 ENHANCED*	3000 ENHANCED								
	Annual deductible (the amount you pay before your plan starts to pay) PCY ¹			<table border="0"> <tr> <td>Individual</td> <td colspan="3">\$50</td> </tr> <tr> <td>Family</td> <td colspan="3">\$150</td> </tr> </table>				Individual	\$50			Family	\$150		
Individual	\$50														
Family	\$150														
For groups 2-9	Maximum allowance (the most your plan will pay toward services) per person, PCY	\$1,000	\$1,500	\$1,000	\$1,500	\$2,000	N/A								
For groups 10+	Maximum allowance (the most your plan will pay toward services) per person, PCY	\$1,000	\$1,500	\$1,000	\$1,500	\$2,000	\$3,000								

DIAGNOSTIC AND PREVENTIVE ¹	COST SHARES IN AND OUT OF NETWORK
Routine oral exams 2 PCY	
Problem-focused exams including emergency 1 PCY	
Cleanings limited to 2 PCY	0%
Bitewing x-rays 1 set (up to 4) PCY	
Complete series or panaoramic x-ray one per 36 consecutive months, but not both	
BASIC	
Emergency palliative treatment	
Fillings once per tooth surface every 24 consecutive months	
Periodontal maintenance 4 treatments PCY	20%
Simple and surgical extractions	
Intravenous or general anesthesia for covered dental procedures at a dental-care provider's office when dentally necessary	
Nitrous oxide	
MAJOR	
Endodontic (root canal) therapy once per tooth every 24 consecutive months	
Periodontal scaling and root planning once per quadrant every 24 consecutive months	
Periodontal surgery once per quadrant every 36 consecutive months	
Full-mouth debridement once every 36 consecutive months	50%
Oral surgery	
Inlays, onlays, and crowns once every 5 CY	
Dentures, partials, and fixed bridges once every 5 CY	
Repair and recementing of crowns, inlays, bridgework, and dentures when performed 6 or more months after placement	
Occlusal (night) guard once every 36 consecutive months	

Note: Coinsurance amounts based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross Blue Shield of Alaska.

*1000, 1500, 2000 Enhanced plans include an option to waive preventive and diagnostic services from the plan annual maximum.

¹Annual deductible waived for diagnostic and preventive services.



Adult Dental Optima Voluntary

With Adult Dental Optima Voluntary,™ you can offer valued dental coverage to your employees and help them save money by funding up to 50% of their premiums.

Additionally, all plans provide benefits for periodontal maintenance, including up to four visits per year to help manage gum disease, as well as basic and major services such as fillings, extractions, crowns, bridgework, and dentures.

Adult Dental Optima Voluntary covered services

Benefits apply after calendar year deductible is met, unless otherwise noted.
Deductible and coinsurance represent member's cost share.
PCY = per calendar year
CY = calendar year(s)

		DEDUCTIBLE/MAXIMUM ALLOWANCE	
For groups 2-50	Annual deductible PCY	Individual	\$50
		Family	\$150
	Maximum allowance per person, PCY		\$1,000
		COST SHARES IN AND OUT OF NETWORK	
DIAGNOSTIC AND PREVENTIVE¹			
Routine oral exams 2 PCY			
Cleanings 2 PCY		0%	
Bitewing x-rays 1 set (up to 4) PCY			
Routine series or panoramic x-rays one per 36 consecutive months, but not both			
BASIC			
Problem-focused exams including emergency 1 PCY			
Emergency palliative treatment			
Fillings once per tooth surface every 24 consecutive months			
Periodontal maintenance 4 visits PCY		20%	
Simple and surgical extractions			
Intravenous or general anesthesia for covered dental procedures at a dental-care provider's office when dentally necessary			
Nitrous oxide			
MAJOR²			
Endodontic (root canal) therapy once per tooth every 24 consecutive months			
Periodontal scaling and root planning once per quadrant every 24 consecutive months			
Periodontal surgery once per quadrant every 36 consecutive months			
Full-mouth debridement once every 36 consecutive months			
Oral surgery			
Inlays, onlays, and crowns once every 5 CY		50%	
Dentures, partials, and fixed bridges once every 5 CY			
Recementing and repair of crowns, inlays, bridgework, and dentures when performed 6 or more months after placement			
Occlusal (night) guard once every 36 consecutive months			

Note: Coinsurance amounts based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross Blue Shield of Alaska.

¹Annual deductible waived for diagnostic and preventive services.

²A 12-month waiting period applies to members who have not had continuous comparable dental coverage under the group's prior dental plan.



More dental options and requirements

You can choose to offer additional dental coverage to customize your benefits package.

Optional benefits

	ADULT DENTAL OPTIMA
ORTHODONTIA¹	
Diagnostic services and active and retention treatment including appliances	50% ² up to lifetime maximum
Monthly orthodontic adjustments including retention treatment	
Lifetime maximum per person	\$1,500
Age limit	No age limit

Note: Orthodontia is not available on Adult Dental Voluntary plan.

¹ Available only with 26 or more enrolled employees.

² Benefits provided at 50% allowable charges.

Participation and contribution requirements for adult dental plans

Depending on the funding type and group size, there are different options for how much you can choose to contribute to premiums. You must also meet the participation requirements in order to offer the plan.

FUNDING TYPE / GROUP SIZE	EMPLOYER CONTRIBUTION	PARTICIPATION REQUIREMENTS
Non-voluntary plans; 2–4 employees	50%–100% of premium	100% participation
Non-voluntary plans; 5–50 employees	50%–100% of premium	Minimum of 5 employees or 50% of eligible employees, whichever is greater
Voluntary plan; 2–50 employees	0%–49% of premium	Minimum of 2 employees or 30% of eligible employees, whichever is greater





Vision plans



Choose the level of vision coverage that works best for your business and your employees.

Did you know routine eye exams can lead to earlier diagnosis of chronic diseases?

Offering mandated vision benefits, along with your employees' medical and dental coverage, helps the overall health of your business and employees.

Offering all your employees' benefits with Premera means you benefit from the ease of dealing with just one health plan. Your employees and their covered dependents enjoy the simplicity of one card, one customer service phone number, and one website.

Choose from two adult (anyone age 19 or older) vision plan options

	CORE VISION	MANDATED OFFERING VISION
Exam	Covered in full up to \$125 per calendar year	1 visit per calendar year, \$25 copay
Eyewear	\$150 every 2 consecutive calendar years	1 pair of lenses, per calendar year; 1 pair of frames every 2 consecutive calendar years (\$90 retail max); contacts \$170 retail maximum; \$350 annual maximum, shared with vision exam

The gentleman I spoke with was knowledgeable and helpful. Could not have been handled better. What a relief to remove such a financial hardship. One of the best customer experiences I've had over the phone. It's awesome that they're actually paying attention, it's good to know this is a way to reach them. Got the call this morning—issue resolved! We couldn't have asked for a better person to help us through all we've been through with my wife's strokes. Shout-out to @premera Customer Service rep Carrie in Spokane WA for helping me w/my insurance. #insurance #premera #bestcustomerservice I felt so helpless, but now I feel like I have help. I have faith that Adrian will have the issue resolved today. He promised me a card and the numbers I need

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Find out more

Visit premera.com/ak/employer

Talk with your Premera representative or producer.



This brochure is not a contract. It is only a summary of the major benefits provided by these plans. For full coverage provisions, including a description of waiting periods, limitations, and exclusions, please contact your producer.