

FOR BUSINESSES WITH
1–50 EMPLOYEES

2027 health plan guide

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

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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Why businesses choose Premera

As a not-for-profit health plan serving Alaska since 1933, we're committed to providing our clients with affordable health plans, access to high-quality care networks, and an experience designed to meet members and employers where they are.

Affordability

Healthcare is expensive, and we take seriously our responsibility to make each dollar work harder, ensuring access to quality care at a fair price.



Pharmacy

We promote safe, lower-cost alternatives like generics and biosimilars—which can cost up to 40% less. These are medications that are highly similar to an existing biologic drug and work the same way, with no meaningful differences in safety or effectiveness. We also give members tools to find additional savings.



Provider access

We invested $30 million to expand the primary care workforce in Washington and Alaska. Partnerships with Kinwell primary care clinics in Washington improve access and are expected to reduce total cost of care by 4%.



System waste

We cut waste by preventing billing errors, fighting fraud, and using prior authorization to avoid unnecessary or duplicative treatments.



Right care, right time, right place

We offer options for members to seek care from high-quality, lower-cost settings that have proven results, such as Centers of Excellence providers or ambulatory surgery centers. This helps reduce costs while improving health outcomes.

Access

We work hard to connect members and their families to the care they need, when they need it, from providers who understand them.



Primary care

Some of our plan designs allow members to designate a primary care provider for themselves and their dependents.



Rural care

We're expanding the rural healthcare workforce by investing in training and residency programs that build a stronger pipeline of providers in rural areas.[1]



Behavioral health

Premera members have greater access to behavioral health providers through our expanded networks, virtual care, and personalized matching services like Matchmaker™ for Behavioral Health.

Experience



Enhanced case management

With one point of contact, secure chat, and built-in behavioral health support, members get coordinated, whole-person care that's easier to manage. Our Personal Health Support program builds on this approach with one-on-one concierge support to help members navigate care, understand their benefits, manage claims, and connect with the right providers.



Smarter digital tools

We're investing in smarter digital tools that make healthcare easier to access and understand. Our redesigned member portal, Find Care tool, and mobile app give members simple, self-service options to check benefits, find providers, and see cost estimates, all in one place. We also use Quest Analytics' BetterDoctor portal to keep our provider directory accurate and up to date.



Artificial intelligence (AI)

Premera uses AI to make healthcare faster and easier. AI helps approve claims and prior authorizations faster, reducing wait times and improving service. Through Premera Health Hub, AI also connects members to wellness and condition-management programs that fit their individual needs.[2]

[1]Murphy, Brendam. "Recipe for More Rural Physicians: More Exposure in Residency Training." American Medical Association, American Medical Association, 27 Sept. 2022, www.ama-assn.org/education/improve-gme/recipe-more-rural-physicians-more-exposure-residency-training.
[2]Premera Health Hub is available to self-funded and OptiFlex groups.

Premera pharmacy

Optimizing your pharmacy benefit to meet your needs

There's no one-size-fits-all approach for pharmacy. Premera assesses formulary design, coverage decisions, and personalized member support programs, to help you develop a targeted pharmacy plan that complements your medical benefits.

Where a 6-tier formulary design has impact

- Aligns member cost share to drug value
- Improves cost predictability over time
- Supports access to clinically effective treatments

SUMMIT FORMULARY

PLANS WITH 6 TIERS	
FIRST TIER	Value generic
SECOND TIER	Preferred generic
THIRD TIER	Preferred brand
FOURTH TIER	Non-preferred generic and brand
FIFTH TIER	Preferred specialty
SIXTH TIER	Non-preferred specialty

Member pharmacy alerts and savings

Employers and members can save on prescription drugs with personalized alerts from Rx Savings Solutions (RxSS). RxSS identifies and notifies members of opportunities to spend less on their prescription drugs with little to no impact on the member's healthcare journey.

Members can save by:

- Switching to another pharmacy
- Trying a new or different generic medication
- Changing to a therapeutic alternative

Did you know?

When a member acts on an RxSS savings alert, RxSS manages the entire switch with the provider so all the member has to do is pick up their prescription.

NEW FOR 2027

Introducing Price Assure for 2027

Price Assure is an embedded discount card program that provides automatic savings on prescriptions for members at the point of sale.

Benefits to employers

- No additional cost
- Included with every pharmacy plan
- Improved employee satisfaction with their plan

Benefits to members

- No extra steps
- Payments count toward deductible and out-of-pocket maximum
- Each prescription is assessed for drug interactions
- Eligible for 30- and 90-day prescription fills at retail pharmacy



Foster a healthy workforce with Blue365

Premera members can access Blue365—a health and wellness discount program offered through the Blue Cross Blue Shield (BCBS) system at no cost for the member or the group.

Health and wellness for less



Gym memberships | Fitness gear | Hearing aids | Prescription glasses | Healthy eating options

National access and well-known brands

Keep members healthy by connecting them to exclusive discounts.

- Gym memberships to more than 13,000 locations starting at $19/month
- Wearable devices from Fitbit, Garmin, Polar, and more
- LASIK eye surgery, hearing aids, and more

Blue365 access

Fully insured: Included as part of your plan

Reduce healthcare costs

$2.71

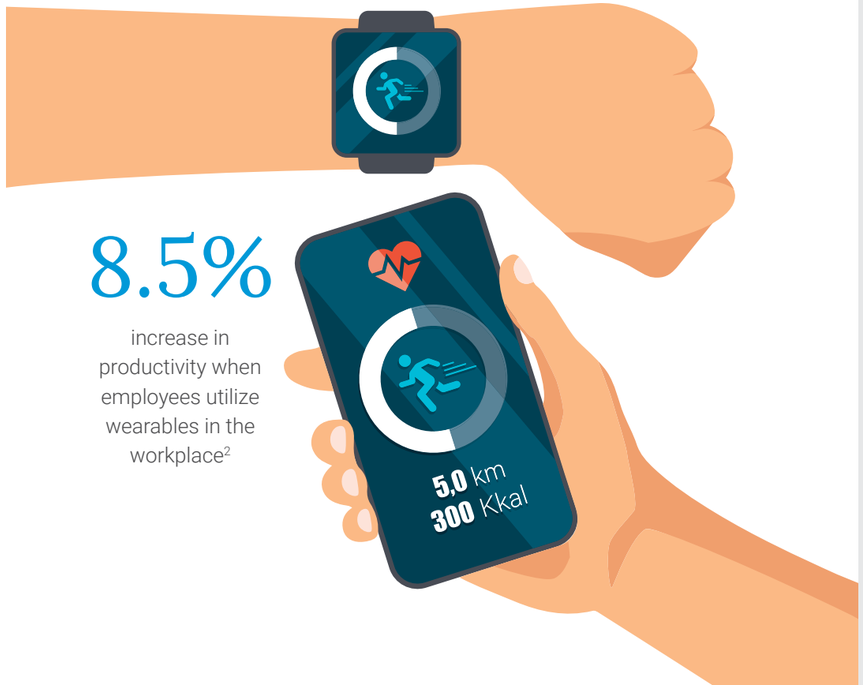
estimated return for every dollar spent on wellness programs[1]



Increase productivity

8.5%

increase in productivity when employees utilize wearables in the workplace[2]



How employers benefit

- Minimal setup
- Group discounts
- Access to healthy tips

Getting started is easy

Members can register at **blue365deals.com/premera** to browse their exclusive deals and discounts.

FINDING NEW REFERENCE

[1]Berry, Leonard L., et al. "What's the Hard Return on Employee Wellness Programs?" Harvard Business Review, Harvard Business Review, 1 Dec. 2010, hbr.org/2010/12/whats-the-hard-return-on-employeewellness-programs.

[2]References Staff. "Employees Using Wearables Are More Productive | MHL News." Home | MHL News, MHL News, 25 Aug. 2016, https://www.mhlnews.com/technology-automation/article/22051683/employees-using-wearables-are-more-productive.

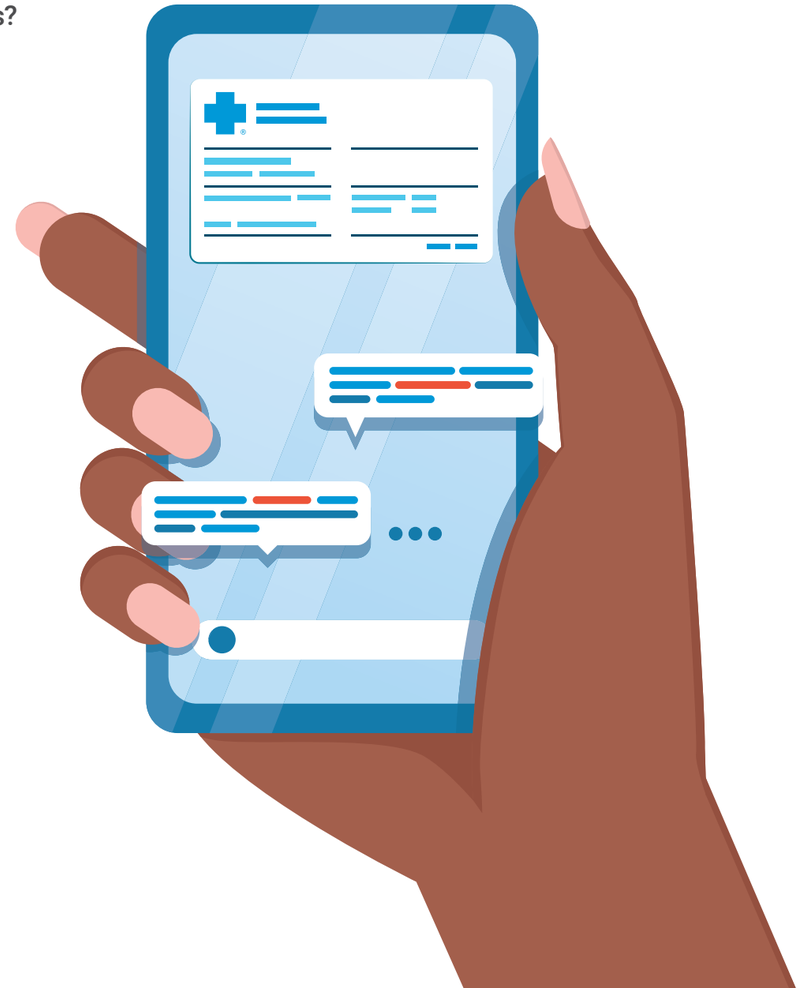
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Personalized messages at your fingertips

Premera launched Digital Health Messages as a way to reach our members and help them better understand their benefits, make personalized healthy choices, and more.

What are Digital Health Messages?

Digital Health Messages are text messages sent to members' mobile phones. These personalized text messages point members to customized feeds with primary care guidance, seasonal health tips, and information about their health plan.



Interaction with Digital Health Messages

9% click-through rate to custom member feed

22% average take-action rate

Digital Health Messages access

✓ **Fully insured:** Included as part of your plan

Did you know?

The most successful Digital Health Message campaign was for Rx Savings Solutions (RxSS). RxSS offers members opportunities to save more on their prescriptions. **Learn more about RxSS**.

Enhanced Case Management



Mitigate rising healthcare costs with innovative predictive technology and robust digital tools with Enhanced Case Management.

An integrated case management approach

Our core case management program at Premera focuses on the whole person, addressing members' physical and behavioral health challenges, social determinants of health, and barriers within the healthcare delivery system. The program identifies members with high-risk or complex health conditions who could benefit from intervention and guidance from a dedicated personal health support clinician.

The benefits of Enhanced Case Management

- Reduces future clinical visits and their associated costs
- Enhances the member experience
- Increases access to support

Harnessing actionable data insights can maximize early intervention opportunities.

87%

precision in predicting future high-cost claimants[1]

Studies indicate that using **digital member programs** with **case management intervention** leads to **improved member health outcomes**.[2]

[1]Health, Prealize. "Data Expertise & Accuracy – Prealize." Prealize, Prealize Health, 2026, https://www.prealizehealth.com/data-expertise-accuracy/.
[2]A pragmatic methodology for the evaluation of digital care management in the context of multimorbidity, Journal of Medical Economics, Volume 24, 2021 — Issue 1

A valuable member experience

Our Enhanced Case Management program includes a digital case management mobile app that provides your employees and their families with the following resources:

- **Secure chat** — flexibility for members to engage with their personal health support clinician when they want, using their preferred communication method.
- **Navigation support** — ability to identify healthcare needs for more members in your population and easily direct them to the right care programs, providers, and high-value services.
- **Member resource center** — access to clinically reviewed health and wellness articles and extensive condition and self-management programs. Members can easily filter, scan, and find information they need.

Download the flyer to learn more about Enhanced Case Management

Enhanced Case Management access

✓ **Fully insured:** Included as part of your plan

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. 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. Members and their covered dependents must receive care from in-network provider within Alaska or Seattle that's at the closest location where the care can be provided.
Elective Procedure Travel	Covers certain travel-related expenses for preapproved, elective (non-emergency) 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		Seattle TJR	
9.6 satisfaction score	**$14K** average savings	**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.



Member

Member contacts Premera customer service or case management.



CSR

Premera representative completes member intake over the phone.



Navigator team

Matchmaker team curates a list of providers that is delivered to the member in three to four business days.

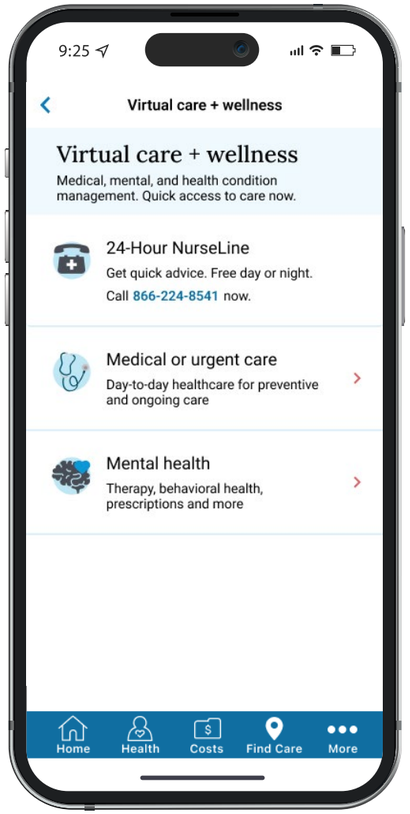
The Matchmaker for Behavioral Health intake asks members for their information and their appointment preferences:

- 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.**

[1]2022 Best Practices in Healthcare Employer Survey, 2022 Global Benefit Attitudes Survey

[2]Medically 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

Our carefully selected virtual care offerings significantly expand in-network access to high-quality primary and urgent care as well as treatment for mental health and substance use disorder.

Virtual care by the numbers

24%

Expected virtual care usage growth from 2024 to 2030[1]

80%

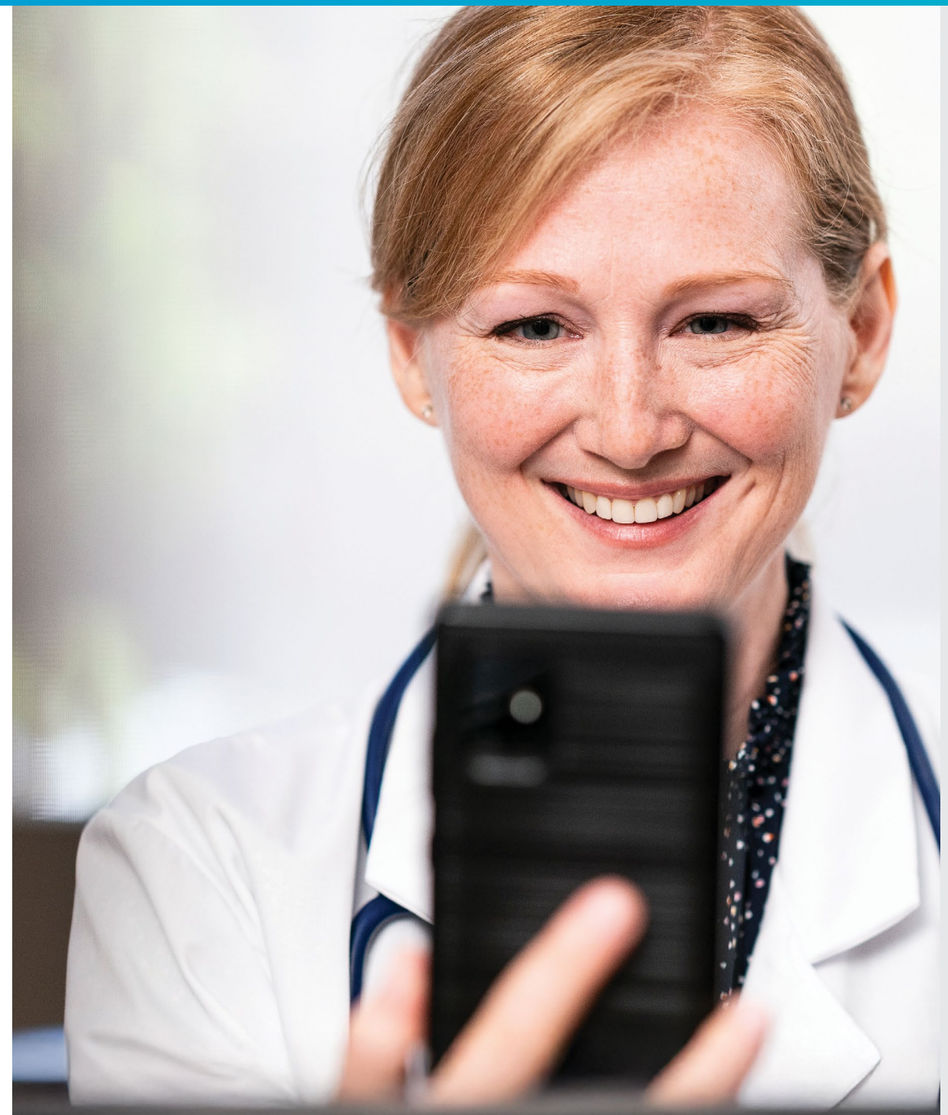
Employees who believe that integrating virtual care with in-person care services is valuable[2]

22%

Savings when an employee has a telehealth visit compared to an in-person visit[3]

$1,500+

Savings per visit when diverting patients from emergency departments to virtual care[4]



Employer benefits

- **Expanded access**—Your employees can access care via text, video, phone, or chat, and they can do so from the safety, convenience, and comfort of their homes.
- **Increased productivity**—Virtual visits are available at a time most convenient for them.
- **Improved experience**—Employees have on-demand access to a variety of care options, which allows them to receive care faster and diagnoses sooner.

Did you know?

Every Premera medical plan includes our 24-Hour NurseLine at no extra cost. Members can call day or night to receive confidential health advice from a registered nurse.

Virtual care can help with:

- Common colds
- COVID-19
- Follow-up visits with a doctor
- Sinus infections
- Urinary tract infections (UTIs)

[1]"Telehealth Market Size, Share, Growth Analysis Report, 2030." grandviewresearch.com. Accessed 20 Sept. 2024.

[2]"Telehealth and Virtual Care Policy Position Statement." Businessgroupthealth.org, 2024, businessgroupthealth.org/resources/business-group-on-healths-position-statement-on-telehealth. Accessed 3 Oct. 2024.

[3]"Employee Telemed Visits 25 Percent Less Costly for Health System." pennmedicine.org/news/news-releases/2023/june/employee-telemed-visits-25-percent-less-costly-for-health-system.

[4]Garrison Nord BBA, et al. "On-Demand Synchronous Audio Video Telemedicine Visits Are Cost Effective." The American Journal of Emergency Medicine, W.B. Saunders, 7 Aug. 2018, sciencedirect.com/science/article/abs/pii/S0735675718306533.

Healthcare that travels with you

Premera believes 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.

6,881
preferred providers in Alaska

28
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 with 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.

Rx Savings Solutions is an independent company that does not provide Blue Cross Blue Shield products or services.

	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.

Ded = Deductible
Coins = Coinsurance

Plus Bronze 5500

Medical plan for 1–50 employees starting January 1, 2027

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

			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	40% coinsurance	50% coinsurance	60% coinsurance
	Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	$12,000		$45,000
	Office visits	Designated primary care provider (PCP) office visit	$55		Deductible, then 60% coinsurance
		Non-designated PCP or specialist office visit	$120		
	Network		Heritage		Out of network
	10 ESSENTIAL BENEFITS | COVERED SERVICES				
1	**Ambulatory patient services**	Outpatient services	Ded, then 40% coins	Ded, then 50% coins	Deductible, then 60% coinsurance
1	**Office visits**	Spinal manipulation (12 visits PCY); Acupuncture (12 visits PCY)	$55		
2	**Emergency services**	Emergency care Copay waived if directly admitted to inpatient facility	$450 copay, then in-network deductible and coinsurance		
2		Ambulance transportation (air and ground)	$25 copay, then deductible and in-network coinsurance	Emergent: same as in network; Non-emergent: Air – ded, then 40% coins; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60% coins; Ground – same as in network
3	**Hospitalization**	Inpatient	Deductible, then 40% coinsurance	Deductible, then 50% coinsurance	Deductible, then 60% coinsurance
3		Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum			
3		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			Deductible, then 60% coinsurance
5	**Mental health and substance use disorder services, including behavioral health treatment**	Office visit	$55		
5		Inpatient hospital: mental and behavioral health services	Deductible, then 40% coinsurance	Deductible, then 50% coinsurance	
5		Outpatient services			
6	**Rehabilitative and habilitative services and devices**	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			
6	**Therapy**	Physical, speech, and occupational therapy: 45 visits PCY Massage therapy: 20 visits PCY	Deductible, then $120		
6	**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 40% coinsurance	Deductible, then 50% coinsurance	
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		
9		**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		
9		**Dental:** pediatric dental class I (cleanings, exams, and x-rays)	Deductible waived, covered in full		Deductible waived, then 10% coinsurance
9		Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible waived, then 30% coinsurance		Deductible waived, then 50% coinsurance
9		Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50% coinsurance		
10	**Prescription drugs** Tier 1: Value generic Tier 2: Preferred generic Tier 3: Preferred brand Tier 4: Non-preferred generic and brand Tier 5: Preferred specialty Tier 6: Non-preferred specialty	**Retail** up to 90-day supply (3x 30-day supply cost)	$15 / $50 / Ded, $100 / Ded, $175		Retail and specialty: same as in network Mail order: not covered
10		**Mail order** 90-day supply (2.5x retail supply cost)	$37.50 / $125 / Ded, $250/ Ded, $437.50		
10		**Specialty Rx** 30-day supply	Preferred: Deductible, then 40% coinsurance Non-Preferred: Deductible, then 50% coinsurance		
10		**Drug formulary** S6			
	ADDITIONAL BENEFIT EMBEDDED WITHIN THE MEDICAL PLAN				
	Hearing	Hearing exam: 1 per calendar year Hearing aids and hardware: 1 aide per ear every 3 cal years	Deductible waived, then 20% coinsurance		
	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	

Ded = Deductible
Coins = Coinsurance

Plus Bronze 7500

Medical plan for 1–50 employees starting January 1, 2027

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

			PLUS BRONZE 7500		
			IN NETWORK		OUT OF NETWORK
			PREFERRED	PARTICIPATING	NON-PARTICIPATING
	Individual deductible	Per calendar year = PCY Family = 2x individual deductible (in network only)	$7,500		2x individual deductible
	Coinsurance	Amount you pay after your deductible is met	40% coinsurance	50% coinsurance	60% coinsurance
	Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	$12,000		$45,000
	Office visits	Designated primary care provider (PCP) office visit	$55		Deductible, then 60% coinsurance
		Non-designated PCP or specialist office visit	$120		
	Network		Heritage		Out of network
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9		**Dental:** pediatric dental class I (cleanings, exams, and x-rays)	Deductible waived, covered in full		Deductible waived, then 10% coinsurance
9		Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible waived, then 30% coinsurance		Deductible waived, then 50% coinsurance
9		Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50% coinsurance		
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10		**Mail order** 90-day supply (2.5x retail supply cost)	$37.50 / $125 / Ded, $250/ Ded, $437.50		
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10		**Drug formulary** S6			
	ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN				
	Hearing	Hearing exam: 1 per calendar year Hearing aids and hardware: 1 aide per ear every 3 cal years	Deductible waived, then 20% coinsurance		
	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 9500

Medical plan for 1–50 employees starting January 1, 2027

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

Ded = Deductible
Coins = Coinsurance

			PLUS BRONZE 9500		
			IN NETWORK		OUT OF NETWORK
			PREFERRED	PARTICIPATING	NON-PARTICIPATING
	Individual deductible	Per calendar year = PCY Family = 2x individual deductible (in network only)	$9,500		2x individual deductible
	Coinsurance	Amount you pay after your deductible is met	40% coinsurance	50% coinsurance	60% coinsurance
	Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	$12,000		$45,000
	Office visits	Cost share	Ded, then 40% coins	Ded, then 50% coins	Ded, then 60% coins
	Network		Heritage		Out of network
10 ESSENTIAL BENEFITS | COVERED SERVICES					
1	**Ambulatory patient services**	Outpatient services	Deductible, then 40% coinsurance	Deductible, then 50% coinsurance	Deductible, then 60% coinsurance
1	**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 40% coinsurance		
2	**Emergency services**	Ambulance transportation (air and ground)	Deductible and in-network coinsurance	Emergent: same as in network; Non-emergent: Air - ded, then 40% coins; Ground - same as in network	Emergent: same as in network; Non-emergent: Air - ded, then 60% coins; Ground - same as in network
3	**Hospitalization**	Inpatient	Deductible, then 40% coinsurance	Deductible, then 50% coinsurance	Deductible, then 60% coinsurance
3	**Hospitalization**	Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum			
3	**Hospitalization**	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			Deductible, then 60% coinsurance
5	**Mental health and substance use disorder services, including behavioral health treatment**	Office visit			
5	**Mental health and substance use disorder services, including behavioral health treatment**	Inpatient hospital: mental and behavioral health services			
5	**Mental health and substance use disorder services, including behavioral health treatment**	Outpatient services			
	Rehabilitation and habilitative services and devices	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			
6	**Therapy**	Physical, speech, and occupational therapy: 45 visits PCY Massage therapy: 20 visits PCY	Deductible, then 40% coinsurance		
6	**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 40% coinsurance	Deductible, then 50% coinsurance	
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		
9	**Pediatric services, including vision care under age 19**	**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		
9	**Pediatric services, including vision care under age 19**	**Dental:** pediatric dental class I (cleanings, exams, and x-rays)	Deductible waived, covered in full		Deductible waived, then 10% coinsurance
9	**Pediatric services, including vision care under age 19**	Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible waived, then 30% coinsurance		Deductible waived, then 50% coinsurance
9	**Pediatric services, including vision care under age 19**	Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50% coinsurance		Deductible, then 50% coinsurance
10	**Prescription drugs** Tier 1: Value generic Tier 2: Preferred generic Tier 3: Preferred brand Tier 4: Non-preferred generic and brand Tier 5: Preferred specialty Tier 6: Non-preferred specialty	**Retail** up to 90-day supply (3x 30-day supply cost)	$15 / $50 / Ded, 30% / Ded, 30%		Retail and specialty: same as in network; Mail order: not covered
10	**Prescription drugs** Tier 1: Value generic Tier 2: Preferred generic Tier 3: Preferred brand Tier 4: Non-preferred generic and brand Tier 5: Preferred specialty Tier 6: Non-preferred specialty	**Mail order** 90-day supply (2.5x retail supply cost)	$37.50 / $125 / Ded, 30% / Ded, 30%		
10	**Prescription drugs** Tier 1: Value generic Tier 2: Preferred generic Tier 3: Preferred brand Tier 4: Non-preferred generic and brand Tier 5: Preferred specialty Tier 6: Non-preferred specialty	**Specialty Rx** 30-day supply	Preferred: Deductible, then 40% coinsurance Non-Preferred: Deductible, then 50% coins		
10	**Prescription drugs** Tier 1: Value generic Tier 2: Preferred generic Tier 3: Preferred brand Tier 4: Non-preferred generic and brand Tier 5: Preferred specialty Tier 6: Non-preferred specialty	**Drug formulary** S6			
ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN					
	Hearing	Hearing exam: 1 per calendar year Hearing aids and hardware: 1 aide per ear every 3 cal years	Deductible waived, then 20% coinsurance		
	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, 2027

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% coinsurance	40% coinsurance	60% coinsurance
	Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	$10,000		$45,000
	Office visits	Designated primary care provider (PCP) office visit	$35		Deductible, then 60% coinsurance
	Office visits	Non-designated PCP or specialist office visit	$85		
	Network		Heritage		Out of network
10 ESSENTIAL BENEFITS | COVERED SERVICES					
1	**Ambulatory patient services**	Outpatient services	Ded, then 30% coins	Ded, then 40% coins	Deductible, then 60% coinsurance
1	**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	$350 copay, then in-network deductible and coinsurance		
2	**Emergency services**	Ambulance transportation (air and ground)	$25 copay, then deductible and in-network coinsurance	Emergent: same as in network; Non-emergent: Air – ded, then 40% coins; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60% coins; Ground – same as in network
3	**Hospitalization**	Inpatient	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
3	**Hospitalization**	Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum			
3	**Hospitalization**	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			Deductible, then 60% coinsurance
5	**Mental health and substance use disorder services, including behavioral health treatment**	Office visit	$85		
5	**Mental health and substance use disorder services, including behavioral health treatment**	Inpatient hospital: mental and behavioral health services	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	
5	**Mental health and substance use disorder services, including behavioral health treatment**	Outpatient services			
	Rehabilitative and habilitative services and devices	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			
6	**Therapy**	Physical, speech, and occupational therapy: 45 visits PCY Massage therapy: 20 visits PCY	Deductible, then $85		
6	**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% coinsurance	Deductible, then 40% coinsurance	
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		
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		
9	**Pediatric services, including vision care under age 19**	**Dental:** pediatric dental class I (cleanings, exams, and x-rays)	Deductible waived, covered in full		Ded waived, then 10% coins
9	**Pediatric services, including vision care under age 19**	Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible waived, then 30% coinsurance		Deductible waived, then 50% coinsurance
9	**Pediatric services, including vision care under age 19**	Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50%		
10	**Prescription drugs** Tier 1: Value generic Tier 2: Preferred generic Tier 3: Preferred brand Tier 4: Non-preferred generic and brand Tier 5: Preferred specialty Tier 6: Non-preferred specialty	**Retail** up to 90-day supply (3x 30-day supply cost)	$15 / $50 / $100 / $175		Retail and specialty: same as in network; Mail order: not covered
10	**Prescription drugs** Tier 1: Value generic Tier 2: Preferred generic Tier 3: Preferred brand Tier 4: Non-preferred generic and brand Tier 5: Preferred specialty Tier 6: Non-preferred specialty	**Mail order** 90-day supply (2.5x retail supply cost)	$37.50 / $125 / $250 / $437.50		
10	**Prescription drugs** Tier 1: Value generic Tier 2: Preferred generic Tier 3: Preferred brand Tier 4: Non-preferred generic and brand Tier 5: Preferred specialty Tier 6: Non-preferred specialty	**Specialty Rx** 30-day supply	Preferred: Deductible, then 40% coinsurance Non-Preferred: Deductible, then 50% coins		
10	**Prescription drugs** Tier 1: Value generic Tier 2: Preferred generic Tier 3: Preferred brand Tier 4: Non-preferred generic and brand Tier 5: Preferred specialty Tier 6: Non-preferred specialty	**Drug formulary** S6			
ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN					
	Hearing	Hearing exam: 1 per calendar year Hearing aids and hardware: 1 aide per ear every 3 cal years	Deductible waived, then 20% coinsurance		
	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	

Ded = Deductible
Coins = Coinsurance

Plus Silver 2500

Medical plan for 1–50 employees starting January 1, 2027

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

			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% coinsurance	40% coinsurance	60% coinsurance
	Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	$10,000		$45,000
	Office visits	Designated primary care provider (PCP) office visit	$35		Deductible, then 60% coinsurance
		Non-designated PCP or specialist office visit	$85		
	Network		Heritage		Out of network
	10 ESSENTIAL BENEFITS | COVERED SERVICES				
1	**Ambulatory patient services**	Outpatient services	Ded, then 30% coins	Ded, then 40% coins	Deductible, then 60% coinsurance
1	**Office visits**	Spinal manipulation (20 visits PCY); Acupuncture (12 visits PCY)	$35		
2	**Emergency services**	Emergency care Copay waived if directly admitted to inpatient facility	$350 copay, then in-network deductible and coinsurance		
2		Ambulance transportation (air and ground)	$25 copay, then deductible and in-network coinsurance	Emergent: same as in network; Non-emergent: Air – ded, then 40% coins; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60% coins; Ground – same as in network
3	**Hospitalization**	Inpatient	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
3		Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum			
3		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			Deductible, then 60% coinsurance
5	**Mental health and substance use disorder services, including behavioral health treatment**	Office visit	$85		
5		Inpatient hospital: mental and behavioral health services	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	
5		Outpatient services			
6	**Rehabilitative and habilitative services and devices**	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			
6	**Therapy**	Physical, speech, and occupational therapy: 45 visits PCY Massage therapy: 20 visits PCY	Deductible, then $85		
6	**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% coinsurance	Deductible, then 40% coinsurance	
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		
9		**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		
9		**Dental:** pediatric dental class I (cleanings, exams, and x-rays)	Deductible waived, covered in full		Ded waived, then 10% coins
9		Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible waived, then 30% coinsurance		Deductible waived, then 50% coinsurance
9		Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50% coinsurance		
10	**Prescription drugs** Tier 1: Value generic Tier 2: Preferred generic Tier 3: Preferred brand Tier 4: Non-preferred generic and brand Tier 5: Preferred specialty Tier 6: Non-preferred specialty	**Retail** up to 90-day supply (3x 30-day supply cost)	$15 / $50 / $100 / $175		Retail and specialty: same as in network; Mail order: not covered
10		**Mail order** 90-day supply (2.5x retail supply cost)	$15 / $50 / $100 / $175		
10		**Specialty Rx** 30-day supply	Preferred: Deductible, then 40% coinsurance Non-Preferred: Deductible, then 50% coins		
10		**Drug formulary** S6			
	ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN				
	Hearing	Hearing exam: 1 per calendar year Hearing aids and hardware: 1 aide per ear every 3 cal years	Deductible waived, then 20% coinsurance		
	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	

Ded = Deductible
Coins = Coinsurance

Plus Silver 3000

Medical plan for 1–50 employees starting January 1, 2027

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

			PLUS SILVER 3000		
			IN NETWORK		OUT OF NETWORK
			PREFERRED	PARTICIPATING	NON-PARTICIPATING
	Individual deductible	Per calendar year = PCY Family = 2x individual deductible (in network only)	$3,000		2x individual deductible
	Coinsurance	Amount you pay after your deductible is met	30% coinsurance	40% coinsurance	60% coinsurance
	Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	$10,000		$45,000
	Office visits	Designated primary care provider (PCP) office visit	$35		Deductible, then 60% coinsurance
		Non-designated PCP or specialist office visit	$85		
	Network		Heritage		Out of network
	10 ESSENTIAL BENEFITS | COVERED SERVICES				
1	**Ambulatory patient services**	Outpatient services	Ded, then 30% coins	Ded, then 40% coins	Deductible, then 60% coinsurance
1	**Office visits**	Spinal manipulation (20 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		
2		Ambulance transportation (air and ground)	$25 copay, then deductible and in-network coinsurance	Emergent: same as in network; Non-emergent: Air – ded, then 40% coins; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60% coins; Ground – same as in network
3	**Hospitalization**	Inpatient	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
3		Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum			
3		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			Deductible, then 60% coinsurance
5	**Mental health and substance use disorder services, including behavioral health treatment**	Office visit	$85		
5		Inpatient hospital: mental and behavioral health services	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	
5		Outpatient services			
6	**Rehabilitative and habilitative services and devices**	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			
6	**Therapy**	Physical, speech, and occupational therapy: 45 visits PCY Massage therapy: 20 visits PCY	Deductible, then $85		
6	**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% coinsurance	Deductible, then 40% coinsurance	
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		
9		**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		
9		**Dental:** pediatric dental class I (cleanings, exams, and x-rays)	Deductible waived, covered in full		Deductible waived, then 10% coinsurance
9		Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible waived, then 30% coinsurance		Deductible waived, then 50% coinsurance
9		Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50% coinsurance		
10	**Prescription drugs** Tier 1: Value generic Tier 2: Preferred generic Tier 3: Preferred brand Tier 4: Non-preferred generic and brand Tier 5: Preferred specialty Tier 6: Non-preferred specialty	**Retail** up to 90-day supply (3x 30-day supply cost)	$15 / $50 / $100 / $175		Retail and specialty: same as in network; Mail order: not covered
10		**Mail order** 90-day supply (2.5x retail supply cost)	$37.50 / $125 / $250 / $437.50		
10		**Specialty Rx** 30-day supply	Preferred: Deductible, then 40% coinsurance Non-Preferred: Deductible, then 50% coinsurance		
10		**Drug formulary** S6			
	ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN				
	Hearing	Hearing exam: 1 per calendar year Hearing aids and hardware: 1 aide per ear every 3 cal years	Deductible waived, then 20% coinsurance		
	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	

Ded = Deductible
Coins = Coinsurance

Plus Silver 4000

Medical plan for 1–50 employees starting January 1, 2027

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

			PLUS SILVER 4000		
			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% coinsurance	40% coinsurance	60% coinsurance
	Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	$10,000		$45,000
	Office visits	Designated primary care provider (PCP) office visit	$35		Deductible, then 60% coinsurance
		Non-designated PCP or specialist office visit	$85		
	Network		Heritage		Out of network
	10 ESSENTIAL BENEFITS | COVERED SERVICES				
1	**Ambulatory patient services**	Outpatient services	Ded, then 30% coins	Ded, then 40% coins	Deductible, then 60% coinsurance
1	**Office visits**	Spinal manipulation (20 visits PCY); Acupuncture (12 visits PCY)	$35		
2	**Emergency services**	Emergency care Copay waived if directly admitted to inpatient facility	$350 copay, then in-network deductible and coinsurance		
2		Ambulance transportation (air and ground)	$25 copay, then deductible and in-network coinsurance	Emergent: same as in network; Non-emergent: Air – ded, then 45% coins; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60% coins; Ground – same as in network
3	**Hospitalization**	Inpatient	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
3		Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum			
3		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			Deductible, then 60% coinsurance
5	**Mental health and substance use disorder services, including behavioral health treatment**	Office visit	$85		
5		Inpatient hospital: mental and behavioral health services	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	
5		Outpatient services			
6	**Rehabilitative and habilitative services and devices**	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			
6	**Therapy**	Physical, speech, and occupational therapy: 45 visits PCY Massage therapy: 20 visits PCY			
6	**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		
9		**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		
9		**Dental:** pediatric dental class I (cleanings, exams, and x-rays)	Deductible waived, covered in full		Deductible waived, then 10% coinsurance
9		Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible waived, then 30% coinsurance		Deductible waived, then 50% coinsurance
9		Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50% coinsurance		
10	**Prescription drugs** Tier 1: Value generic Tier 2: Preferred generic Tier 3: Preferred brand Tier 4: Non-preferred generic and brand Tier 5: Preferred specialty Tier 6: Non-preferred specialty	**Retail** up to 90-day supply (3x 30-day supply cost)	$15 / $50 / $100 / $175		Retail and specialty: same as in network; Mail order: not covered
10		**Mail order** 90-day supply (2.5x retail supply cost)	$37.50 / $125 / $250 / $437.50		
10		**Specialty Rx** 30-day supply	Preferred: Deductible, then 40% coinsurance Non-Preferred: Deductible, then 50% coinsurance		
10		**Drug formulary** S6			
	ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN				
	Hearing	Hearing exam: 1 per calendar year Hearing aids and hardware: 1 aide per ear every 3 cal years	Deductible waived, then 20% coinsurance		
	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

Ded = Deductible
Coins = Coinsurance

Plus Gold 500

Medical plan for 1–50 employees starting January 1, 2026

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

			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	25% coinsurance	35% coinsurance	60% coinsurance
	Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	$9,000		$45,000
	Office visits	Designated primary care provider (PCP) office visit	First 2 office visits $10, then $25		Deductible, then 60% coinsurance
		Non-designated PCP or specialist office visit	$50		
	Network		Heritage		Out of network
	10 ESSENTIAL BENEFITS | COVERED SERVICES				
1	**Ambulatory patient services**	Outpatient services	Ded, then 25% coins	Ded, then 35% coins	Deductible, then 60% coinsurance
1	**Office visits**	Spinal manipulation (20 visits PCY); Acupuncture (12 visits PCY)	$25		
2	**Emergency services**	Emergency care Copay waived if directly admitted to inpatient facility	$300 copay, then in-network deductible and coinsurance		
2		Ambulance transportation (air and ground)	$25 copay, then deductible and in-network coinsurance	Emergent: same as in network; Non-emergent: Air – ded, then 35% coins; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60% coins; Ground – same as in network
3	**Hospitalization**	Inpatient	Deductible, then 25% coinsurance	Deductible, then 35% coinsurance	Deductible, then 60% coinsurance
3		Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum			
3		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			Deductible, then 60% coinsurance
5	**Mental health and substance use disorder services, including behavioral health treatment**	Office visit	$50		
5		Inpatient hospital: mental and behavioral health services	Deductible, then 25% coinsurance	Deductible, then 35% coinsurance	
5		Outpatient services			
6	**Rehabilitative and habilitative services and devices**	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			
6	**Therapy**	Physical, speech, and occupational therapy: 45 visits PCY Massage therapy: 20 visits PCY	Deductible, then $50		
6	**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 25% coinsurance	Deductible, then 35% coinsurance	
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		
9		**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		
9		**Dental:** pediatric dental class I (cleanings, exams, and x-rays)	Deductible waived, covered in full		Deductible waived, then 10% coinsurance
9		Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible waived, then 30%		Deductible waived, then 50% coinsurance
9		Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50% coinsurance		
10	**Prescription drugs** Tier 1: Value generic Tier 2: Preferred generic Tier 3: Preferred brand Tier 4: Non-preferred generic and brand Tier 5: Preferred specialty Tier 6: Non-preferred specialty	**Retail** up to 90-day supply (3x 30-day supply cost)	$10 / $40 / $75 / $150		Retail and specialty: same as in network; Mail order: not covered
10		**Mail order** 90-day supply (2.5x retail supply cost)	$25 / $100 / $187.50 / $375		
10		**Specialty Rx** 30-day supply	Preferred: Deductible, then 40% coinsurance Non-Preferred: Deductible, then 50% coinsurance		
10		**Drug formulary** S6			
	ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN				
	Hearing	Hearing exam: 1 per calendar year Hearing aids and hardware: 1 aide per ear every 3 cal years	Deductible waived, then 20% coinsurance		
	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

Ded = Deductible
Coins = Coinsurance

Plus Gold 1000

Medical plan for 1–50 employees starting January 1, 2027

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

			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	25% coinsurance	35% coinsurance	60% coinsurance
	Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	$9,000		$45,000
	Office visits	Designated primary care provider (PCP) office visit	First 2 office visits $10, then $25		Deductible, then 60% coinsurance
		Non-designated PCP or specialist office visit	$50		
	Network		Heritage		Out of network
	10 ESSENTIAL BENEFITS | COVERED SERVICES				
1	**Ambulatory patient services**	Outpatient services	Ded, then 25% coins	Ded, then 35% coins	Deductible, then 60% coinsurance
1	**Office visits**	Spinal manipulation (20 visits PCY); Acupuncture (12 visits PCY)	$25		
2	**Emergency services**	Emergency care Copay waived if directly admitted to inpatient facility	$300 copay, then in-network deductible and coinsurance		
2		Ambulance transportation (air and ground)	$25 copay, then deductible and in-network coinsurance	Emergent: same as in network; Non-emergent: Air – ded, then 35% coins; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60% coins; Ground – same as in network
3	**Hospitalization**	Inpatient	Deductible, then 25% coinsurance	Deductible, then 35% coinsurance	Deductible, then 60% coinsurance
3		Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum			
3		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			Deductible, then 60% coinsurance
5	**Mental health and substance use disorder services, including behavioral health treatment**	Office visit	$50		
5		Inpatient hospital: mental and behavioral health services	Deductible, then 25% coinsurance	Deductible, then 35% coinsurance	
5		Outpatient services			
6	**Rehabilitative and habilitative services and devices**	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			
6	**Therapy**	Physical, speech, and occupational therapy: 45 visits PCY Massage therapy: 20 visits PCY	Deductible, then $50		
6	**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 25% coinsurance	Deductible, then 35% coinsurance	
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		
9		**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		
9		**Dental:** pediatric dental class I (cleanings, exams, and x-rays)	Deductible waived, covered in full		Deductible waived, then 10% coinsurance
9		Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible waived, then 30% coinsurance		Deductible waived, then 50% coinsurance
9		Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50% coinsurance		
10	**Prescription drugs** Tier 1: Value generic Tier 2: Preferred generic Tier 3: Preferred brand Tier 4: Non-preferred generic and brand Tier 5: Preferred specialty Tier 6: Non-preferred specialty	**Retail** up to 90-day supply (3x 30-day supply cost)	$10 / $40 / $75 / $150		Retail and specialty: same as in network; Mail order: not covered
10		**Mail order** 90-day supply (2.5x retail supply cost)	$25 / $100 / $187.50 / $375		
10		**Specialty Rx** 30-day supply	Preferred: Deductible, then 40% coinsurance Non-Preferred: Deductible, then 50% coinsurance		
10		**Drug formulary** S6			
	ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN				
	Hearing	Hearing exam: 1 per calendar year Hearing aids and hardware: 1 aide per ear every 3 cal years	Deductible waived, then 20% coinsurance		
	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	

Ded = Deductible
Coins = Coinsurance

Plus Gold 1500

Medical plan for 1–50 employees starting January 1, 2027

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

			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	25% coinsurance	35% coinsurance	60% coinsurance
	Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	$9,000		$45,000
	Office visits	Designated primary care provider (PCP) office visit	First 2 office visits $10, then $25		Deductible, then 60% coinsurance
		Non-designated PCP or specialist office visit	$50		
	Network		Heritage		Out of network
	10 ESSENTIAL BENEFITS | COVERED SERVICES				
1	**Ambulatory patient services**	Outpatient services	Ded, then 25% coins	Ded, then 35% coins	Deductible, then 60% coinsurance
1	**Office visits**	Spinal manipulation (20 visits PCY); Acupuncture (12 visits PCY)	$25		
2	**Emergency services**	Emergency care Copay waived if directly admitted to inpatient facility	$300 copay, then in-network deductible and coinsurance		
2		Ambulance transportation (air and ground)	$25 copay, then deductible and in-network coinsurance	Emergent: same as in network; Non-emergent: Air – ded, then 35% coins; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60% coins; Ground – same as in network
3	**Hospitalization**	Inpatient	Deductible, then 25% coinsurance	Deductible, then 35% coinsurance	Deductible, then 60% coinsurance
3		Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum			
3		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			Deductible, then 60% coinsurance
5	**Mental health and substance use disorder services, including behavioral health treatment**	Office visit	$50		
5		Inpatient hospital: mental and behavioral health services	Deductible, then 25% coinsurance	Deductible, then 35% coinsurance	
5		Outpatient services			
6	**Rehabilitative and habilitative services and devices**	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			
6	**Therapy**	Physical, speech, and occupational therapy: 45 visits PCY Massage therapy: 20 visits PCY	Deductible, then $50		
6	**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 25% coinsurance	Deductible, then 35% coinsurance	
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		
9		**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		
9		**Dental:** pediatric dental class I (cleanings, exams, and x-rays)	Deductible waived, covered in full		Deductible waived, then 10% coinsurance
9		Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible waived, then 30% coinsurance		Deductible waived, then 50% coinsurance
9		Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50% coinsurance		
10	**Prescription drugs** Tier 1: Value generic Tier 2: Preferred generic Tier 3: Preferred brand Tier 4: Non-preferred generic and brand Tier 5: Preferred specialty Tier 6: Non-preferred specialty	**Retail** up to 90-day supply (3x 30-day supply cost)	$10 / $40 / $75 / $150		Retail and specialty: same as in network; Mail order: not covered
10		**Mail order** 90-day supply (2.5x retail supply cost)	$25 / $100 / $187.50 / $375		
10		**Specialty Rx** 30-day supply	Preferred: Deductible, then 40% coinsurance Non-Preferred: Deductible, then 50% coinsurance		
10		**Drug formulary** S6			
	ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN				
	Hearing	Hearing exam: 1 per calendar year Hearing aids and hardware: 1 aide per ear every 3 cal years	Deductible waived, then 20% coinsurance		
	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	

Ded = Deductible
Coins = Coinsurance

Plus Platinum 250

Medical plan for 1–50 employees starting January 1, 2027

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

			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% coinsurance	30% coinsurance	60% coinsurance
	Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	$3,000		$45,000
	Office visits	Designated primary care provider (PCP) office visit	First 2 office visits $5, then $15		Deductible, then 60% coinsurance
		Non-designated PCP or specialist office visit	$50		
	Network		Heritage		Out of network
	10 ESSENTIAL BENEFITS | COVERED SERVICES				
1	**Ambulatory patient services**	Outpatient services	Ded, then 20% coins	Ded, then 30% coins	Deductible, then 60% coinsurance
1	**Office visits**	Spinal manipulation (20 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		
2		Ambulance transportation (air and ground)	$25 copay, then deductible and in-network coinsurance	Emergent: same as in network; Non-emergent: Air – ded, then 30% coins; Ground – dame as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60% coins; Ground – same as in network
3	**Hospitalization**	Inpatient	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	Deductible, then 60% coinsurance
3		Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum			
3		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			Deductible, then 60% coinsurance
5	**Mental health and substance use disorder services, including behavioral health treatment**	Office visit	$50		
5		Inpatient hospital: mental and behavioral health services	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	
5		Outpatient services			
6	**Rehabilitative and habilitative services and devices**	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			
6	**Therapy**	Physical, speech, and occupational therapy: 45 visits PCY Massage therapy: 20 visits PCY	Deductible, then $50		
6	**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% coinsurance	Deductible, then 30% coinsurance	
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		
9		**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		
9		**Dental:** pediatric dental class I (cleanings, exams, and x-rays)	Deductible waived, covered in full		Deductible waived, then 10% coinsurance
9		Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible waived, then 30% coinsurance		Deductible waived, then 50% coinsurance
9		Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50% coinsurance		
10	**Prescription drugs** Tier 1: Value generic Tier 2: Preferred generic Tier 3: Preferred brand Tier 4: Non-preferred generic and brand Tier 5: Preferred specialty Tier 6: Non-preferred specialty	**Retail** up to 90-day supply (3x 30-day supply cost)	$10 / $35 / $75 / $150		Retail and specialty: same as in network; Mail order: not covered
10		**Mail order** 90-day supply (2.5x retail supply cost)	$25 / $87.50 / $187.50 / $375		
10		**Specialty Rx** 30-day supply	Preferred: Deductible, then 40% coinsurance Non-Preferred: Deductible, then 50% coinsurance		
10		**Drug formulary** M4			
	ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN				
	Hearing	Hearing exam: 1 per calendar year Hearing aids and hardware: 1 aide per ear every 3 cal years	Deductible waived, then 20% coinsurance		
	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	

Ded = Deductible
Coins = Coinsurance

Plus HSA-Qualified Bronze 5000

(Embedded deductible)

Medical plan for 1–50 employees starting January 1, 2027

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

			PLUS HSA-QUALIFIED BRONZE 5000 (EMBEDDED)		
			IN NETWORK		OUT OF NETWORK
			PREFERRED	PARTICIPATING	NON-PARTICIPATING
	Individual deductible	Per calendar year = PCY Family = 2x individual deductible (in network only)	$5,000		2x individual deductible
	Coinsurance	Amount you pay after your deductible is met	50% coinsurance		60% coinsurance
	Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	$8,650		$45,000
	Office visits	Cost share	Deductible, then 50% coinsurance		Ded, then 60% coins
	Network		Heritage		Out of network
	10 ESSENTIAL BENEFITS | COVERED SERVICES				
1	**Ambulatory patient services**	Outpatient services	Deductible, then 50% coinsurance		Deductible, then 60% coinsurance
1	**Office visits**	Spinal manipulation (20 visits PCY); Acupuncture (12 visits PCY)			
2	**Emergency services**	Emergency care	Deductible, then 50% coinsurance		
2		Ambulance transportation (air and ground)	Deductible, then 50% coinsurance	Emergent: same as in network; Non-emergent: Air – ded, then 50% coins; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60% coins; Ground – same as in network
3	**Hospitalization**	Inpatient	Deductible, then 50% coinsurance		Deductible, then 60% coinsurance
3		Hospice: 10 days inpatient Respite care: 240 hours lifetime maximum			
3		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			Deductible, then 60% coinsurance
5	**Mental health and substance use disorder services, including behavioral health treatment**	Office visit			
5		Inpatient hospital: mental and behavioral health services			
5		Outpatient services			
6	**Rehabilitative and habilitative services and devices**	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			
6	**Therapy**	Physical, speech, and occupational therapy: 45 visits PCY Massage therapy: 20 visits PCY			
6	**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		
9		**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		
9		**Dental:** pediatric dental class I (cleanings, exams, and x-rays)	Deductible waived, covered in full		Deductible waived, then 10% coinsurance
9		Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible, then 30% coinsurance		Deductible, then 50% coinsurance
9		Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50% coinsurance		
10	**Prescription drugs** Tier 1: Value generic Tier 2: Preferred generic Tier 3: Preferred brand Tier 4: Non-preferred generic and brand Tier 5: Preferred specialty Tier 6: Non-preferred specialty	**Retail** up to 90-day supply (3x 30-day supply cost)	Deductible, then 50% coinsurance		Retail and specialty: same as in network; Mail order: not covered
10		**Mail order** 90-day supply (2.5x retail supply cost)			
10		**Specialty Rx** 30-day supply			
10		**Drug formulary** S1			
	ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN				
	Hearing	Hearing exam: 1 per calendar year Hearing aids and hardware: 1 aide per ear every 3 cal years	Deductible, then 20% coinsurance		
	Virtual care (general medicine)	A full list of services is available on **premera.com/ak/member**	Deductible, then 50% coinsurance	Not covered	
	Premera-Designated Centers of Excellence		Deductible, then 0%	Covered as any other service	

Ded = Deductible
Coins = Coinsurance

Plus HSA-Qualified Silver 3400

(Embedded deductible)

Medical plan for 1–50 employees starting January 1, 2027

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

			PLUS HSA-QUALIFIED SILVER 3400 (EMBEDDED)		
			IN NETWORK		OUT OF NETWORK
			PREFERRED	PARTICIPATING	NON-PARTICIPATING
	Individual deductible	Per calendar year = PCY Family = 2x individual deductible (in network only)	$3,400		2x individual deductible
	Coinsurance	Amount you pay after your deductible is met	30% coinsurance	40% coinsurance	60% coinsurance
	Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	$8,500		$45,000
	Office visits	Cost share	Ded, then 30% coins	Ded, then 40% coins	Ded, then 60% coins
	Network		Heritage		Out of network
10 ESSENTIAL BENEFITS | COVERED SERVICES					
1	**Ambulatory patient services** **Office visits**	Outpatient services Spinal manipulation (20 visits PCY); Acupuncture (12 visits PCY)	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
2	**Emergency services**	Emergency care	Deductible, then 30% coinsurance		
		Ambulance transportation (air and ground)	Deductible, then 30% coinsurance	Emergent: same as in network; Non-emergent: Air – ded, then 40% coins; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60% coins; Ground – same as in network
3	**Hospitalization**	Inpatient	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
		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			Deductible, then 60% coinsurance
5	**Mental health and substance use disorder services, including behavioral health treatment**	Office visit			
		Inpatient hospital: mental and behavioral health services			
		Outpatient services			
6	**Rehabilitative and habilitative services and devices** **Therapy** **Rehabilitation and habilitative therapy benefits have the same number of visits but are counted separately**	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY Physical, speech, and occupational therapy: 45 visits PCY Massage therapy: 20 visits PCY 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% coinsurance
		Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible, then 30% coinsurance		Deductible, then 50% coinsurance
		Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50% coinsurance		
10	**Prescription drugs** Tier 1: Value generic Tier 2: Preferred generic Tier 3: Preferred brand Tier 4: Non-preferred generic and brand Tier 5: Preferred specialty Tier 6: Non-preferred specialty	**Retail** up to 90-day supply (3x 30-day supply cost)	Deductible, then 30% coinsurance		Retail and specialty: same as in network; Mail order: not covered
		Mail order 90-day supply (2.5x retail supply cost)			
		Specialty Rx 30-day supply			
		Drug formulary S1			
ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN					
	Hearing	Hearing exam: 1 per calendar year Hearing aids and hardware: 1 aide per ear every 3 cal years	Deductible, then 20% coinsurance		
	Virtual care (general medicine)	A full list of services is available on **premera.com/ak/member**	Deductible, then 30% coinsurance	Not covered	
	Premera-Designated Centers of Excellence		Deductible, then 0%	Covered as any other service	

Ded = Deductible
Coins = Coinsurance

Plus HSA-Qualified Silver 3750

(Embedded deductible)

Medical plan for 1–50 employees starting January 1, 2027

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

			PLUS HSA-QUALIFIED SILVER 3750 (EMBEDDED)		
			IN NETWORK		OUT OF NETWORK
			PREFERRED	PARTICIPATING	NON-PARTICIPATING
	Individual deductible	Per calendar year = PCY Family = 2x individual deductible (in network only)	$3,750		2x individual deductible
	Coinsurance	Amount you pay after your deductible is met	30% coinsurance	40% coinsurance	60% coinsurance
	Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum	$8,500		$45,000
	Office visits	Cost share	Ded, then 30% coins	Ded, then 40% coins	Ded, then 60% coins
	Network		Heritage		Out of network
10 ESSENTIAL BENEFITS | COVERED SERVICES					
1	**Ambulatory patient services** **Office visits**	Outpatient services Spinal manipulation (20 visits PCY); Acupuncture (12 visits PCY)	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
2	**Emergency services**	Emergency care (copay waived if directly admitted to inpatient facility)	Deductible, then 30% coinsurance		
		Ambulance transportation (air and ground)	Deductible, then 30% coinsurance	Emergent: same as in network; Non-emergent: Air – ded, then 40% coins; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60% coins; Ground – same as in network
3	**Hospitalization**	Inpatient	Deductible, then 30% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
		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			Deductible, then 60% coinsurance
5	**Mental health and substance use disorder services, including behavioral health treatment**	Office visit			
		Inpatient hospital: mental and behavioral health services			
		Outpatient services			
6	**Rehabilitative and habilitative services and devices** **Therapy** **Rehabilitation and habilitative therapy benefits have the same number of visits but are counted separately**	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY Physical, speech, and occupational therapy: 45 visits PCY Massage therapy: 20 visits PCY 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% coinsurance
		Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible, then 30% coinsurance		Deductible, then 50% coinsurance
		Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50% coinsurance		
10	**Prescription drugs** Tier 2: Preferred generic Tier 3: Preferred brand Tier 4: Non-preferred generic and brand Tier 5: Preferred specialty Tier 6: Non-preferred specialty	**Retail** up to 90-day supply (3x 30-day supply cost)	Deductible, then 30% coinsurance		Retail and specialty: same as in network; Mail order: not covered
		Mail order 90-day supply (2.5x retail supply cost)			
		Specialty Rx 30-day supply			
		Drug formulary S1			
ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN					
	Hearing	Hearing exam: 1 per calendar year Hearing aids and hardware: 1 aide per ear every 3 cal years	Deductible, then 20% coinsurance		
	Virtual care (general medicine)	A full list of services is available on **premera.com/ak/member**	Deductible, then 30% coinsurance	Not covered	
	Premera-Designated Centers of Excellence		Deductible, then 0%	Covered as any other service	

Plus HSA-Qualified Gold 1900

(Aggregate deductible)

Medical plan for 1–50 employees starting January 1, 2027

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

Ded = Deductible
Coins = Coinsurance

			PLUS HSA-QUALIFIED GOLD 1900 (AGGREGATE)		
			IN NETWORK		OUT OF NETWORK
			PREFERRED	PARTICIPATING	NON-PARTICIPATING
	Individual deductible	Per calendar year = PCY Family = 2x individual deductible (aggregate)	Individual: $1,900		2x individual deductible
	Coinsurance	Amount you pay after your deductible is met	20% coinsurance	40% coinsurance	60% coinsurance
	Out-of-pocket maximum	Includes deductible, coinsurance, pharmacy, and copays Family = 2x individual out-of-pocket maximum (aggregate)	Individual: $4,325		$45,000
	Office visits	Cost share	Ded, then 20% coins	Ded, then 40% coins	Ded, then 60% coins
	Network		Heritage		Out of network
	10 ESSENTIAL BENEFITS | COVERED SERVICES				
1	**Ambulatory patient services**	Outpatient services	Deductible, then 20% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
	Office visits	Spinal manipulation (20 visits PCY); Acupuncture (12 visits PCY)			
2	**Emergency services**	Emergency care	Deductible, then 20% coinsurance		
		Ambulance transportation (air and ground)		Emergent: same as in network; Non-emergent: Air – ded, then 40% coins; Ground – same as in network	Emergent: same as in network; Non-emergent: Air – ded, then 60% coins; Ground – same as in network
3	**Hospitalization**	Inpatient			Deductible, then 60% coinsurance
		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% coinsurance	Deductible, then 40% coinsurance	Deductible, then 60% coinsurance
		Inpatient hospital: mental and behavioral health services			
		Outpatient services			
6	**Rehabilitative and habilitative services and devices**	Inpatient rehabilitation: 30 days PCY Inpatient habilitation: 30 days PCY			
	Therapy	Physical, speech, and occupational therapy: 45 visits PCY Massage therapy: 20 visits PCY			
	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% coinsurance
		Pediatric dental class II (fillings, non-surgical periodontal services, and extractions)	Deductible, then 30% coinsurance		Deductible, then 50% coinsurance
		Pediatric dental class III (crowns, root canals, and medically necessary orthodontia)	Deductible, then 50% coinsurance		
10	**Prescription drugs** Tier 2: Preferred generic Tier 3: Preferred brand Tier 4: Non-preferred generic and brand Tier 5: Preferred specialty Tier 6: Non-preferred specialty	**Retail** up to 90-day supply (3x 30-day supply cost)	Deductible, then 20% coinsurance		Retail and specialty: same as in network; Mail order: not covered
		Mail order 90-day supply (2.5x retail supply cost)			
		Specialty Rx 30-day supply			
		Drug formulary S1			
	ADDITIONAL BENEFITS EMBEDDED WITHIN THE MEDICAL PLAN				
	Hearing	Hearing exam: 1 per calendar year Hearing aids and hardware: 1 aide per ear every 3 cal years	Deductible, then 20% coinsurance		
	Virtual care (general medicine)	A full list of services is available on **premera.com/ak/member**	Deductible, then 20% coinsurance	Not covered	
	Premera-Designated Centers of Excellence		Deductible, then 0%	Covered as any other service	



Dental plans

Premera is expanding the Dental Choice network by joining the national Dental GRID[1], one of the country's leading national dental networks exclusively for members of participating Blue Cross Blue Shield plans.

Increased access

More than 125,000 dentists and 490,000 access points[2] across all 50 states and D.C—ensuring your employees can find in-network care wherever they live, work, or travel.

Lower costs

Members save an average of 30% on in-network dental services[3] through our exclusive Blue plan partnerships—reducing out-of-pocket costs and balance billing.

Better experience

One ID card. One customer service team. One seamless experience. Members can easily find an in-network dentist using the Find a Doctor tool on the Premera mobile app or website.

[1]The GRID Dental Corporation is a separate company that provides access to dental networks and services on behalf of paricipating Blue Cross Blue Shield plans.
[2]Zelis Network360 Competitive Dashboard report Janaury 2025.
[3]Based on Premera book of business. Estinated in-network discount. Actual discount may vary.

CHOOSE BETWEEN THREE ADULT (AGED 19 OR OLDER) DENTAL PLANS

	ADULT CORE DENTAL	ADULT DENTAL OPTIMA	ADULT DENTAL OPTIMA VOLUNTARY
Employer's cost	$	$$	$$$
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)
Orthodontia[1]	No option	Optional	No option
Employee-funded plan[2]	No	No	Yes

Note: For a summary of plan benefits, see plan details to follow or speak to your producer for more details.
[1] For groups with 26 or more enrolled employees
[2] Employer contributes 0%–49% of premium. Minimum enrollment is 2 or 30% of eligible employees (whichever is greater).
[3] Academy 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 included with small group medical plans.

Your employees will automatically receive pediatric dental coverage. That's because it's already a part of their Premera medical plan. Family members aged 18 or younger have access to a wide range of dental services including:

- Routine dental cleanings
- X-rays
- Root canals and extractions

Embedded pediatric benefits use Heritage and Dental Choice networks, and there's 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]	**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	0%
Problem-focused exams including emergency 1 PCY	
Cleanings limited to 2 PCY	
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	20%
Fillings once per tooth surface every 24 consecutive months	
Periodontal maintenance 4 treatments PCY	
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	50%
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	
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.
[1]Annual 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

DIAGNOSTIC AND PREVENTIVE[1]	COST SHARES IN AND OUT OF NETWORK
Routine oral exams 2 PCY	0% coinsurance
Cleanings 2 PCY	
Bitewing x-rays 1 set (up to 4) PCY	
Routine series or panoramic x-rays 1 per 36 consecutive months, but not both	
BASIC	
Problem-focused exams including emergency 1 PCY	20% coinsurance
Emergency palliative treatment	
Fillings once per tooth surface every 24 consecutive months	
Periodontal maintenance 4 visits PCY	
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[2]	
Endodontic (root canal) therapy once per tooth every 24 consecutive months	50% coinsurance
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	
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.
[1]Annual deductible waived for diagnostic and preventive services.
[2]A 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
ORTHODONTIA[1]	
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

Optional orthodontia benefit only available for the following dental plans: Adult Dental Optima 2000 Max Enhanced (38344AKD000104), Adult Dental Optima 2000 Max Enhanced + Annual Max Waiver (38344AKD000110), Adult Dental Optima 3000 Max Enhanced (38344AKD000109)

[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 your 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





Find out more

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Talk with your Premera representative or producer.

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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.

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