PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Highlights of your Health Care Coverage

Effective Date: 01/01/2027

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.
Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

MEDICAL PLAN	**PLUS GOLD $500/25%/$9000/FIRST 2 OFFICE VISITS $10, THEN $25/$50**	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Deductible (In-network only - Family embedded deductible 2X Individual)	$500 PCY	$1,000 PCY
Coinsurance	25% Preferred/35% Participating	Hospital & Professional: 60% Non-Participating
Out of Pocket Maximum (includes deductible, copays, coinsurance and pharmacy) (Family embedded OOP max 2X Individual)	$9,000 PCY	$45,000 PCY
Designated PCP Office Visit Cost Share	First 2 visits $10 Copay, additional visits $25 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Specialist and non designated PCP Office Visit Cost Share	$50 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Annual Maximum	Unlimited	Unlimited
1 Ambulatory Patient Services		
Professional Office Visit (Includes Telemedicine)	Designated PCP: First 2 visits $10 Copay, additional visits $25 Copay, applies to the Out of Pocket Maximum; Specialist and non designated PCP: $50 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Urgent Care Office Visits	$50 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Professional Services	In Network Deductible, then 25% Preferred/35% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Contraceptive Management Services (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
2 Emergency Care		
Emergency Room - Facility	$300 Copay, applies to the Out of Pocket Maximum; then In Network Deductible, 25% Preferred	$300 Copay, applies to the Out of Pocket Maximum; then In Network Deductible, 25% Preferred

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MEDICAL PLAN	PLUS GOLD $500/25%/$9000/FIRST 2 OFFICE VISITS $10, THEN $25/$50	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Ambulance Service - Ground (Unlimited)	$25 Copay, applies to the Out of Pocket Maximum; then In Network Deductible, 25% Preferred	$25 Copay, applies to the Out of Pocket Maximum; then In Network Deductible, 25% Preferred
Ambulance Service - Air (Unlimited)	$25 Copay, applies to the Out of Pocket Maximum; then In Network Deductible, 25% Preferred	$25 Copay, applies to the Out of Pocket Maximum; then In Network Deductible, 25% Preferred
Ambulance Service - Air Non Emergent (Unlimited)	$25 Copay, applies to the Out of Pocket Maximum; then In Network Deductible, 25% Preferred/35% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
3 Hospitalization		
Inpatient Medical and Surgical Room and Board (Unlimited)	In Network Deductible, then 25% Preferred/35% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Inpatient Professional Services	In Network Deductible, then 25% Preferred/35% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Skilled Nursing Facility (60 days PCY)	In Network Deductible, then 25% Preferred/35% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 25% Preferred/35% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Organ Transplants (Unlimited; $75,000 donor)	Covered as any other service	Not Covered
4 Maternity & Newborn Care		
Maternity Delivery - Inpatient Facility (Coverage for subscriber, spouse, dependent)	In Network Deductible, then 25% Preferred/35% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Maternity Prenatal, Delivery and Postnatal Care - Professional Services (Coverage for subscriber, spouse, dependent)	In Network Deductible, then 25% Preferred/35% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
5 Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment		
Chemical Dependency Office Visit (Unlimited)	$50 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Chemical Dependency Outpatient Facility (Unlimited)	In Network Deductible, then 25% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Chemical Dependency Inpatient Facility (Unlimited)	In Network Deductible, then 25% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Mental Health Office Visit (Unlimited)	$50 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Mental Health Outpatient Facility (Unlimited)	In Network Deductible, then 25% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Mental Health Inpatient Facility (Unlimited)	In Network Deductible, then 25% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
6 Prescription Drug		

MEDICAL PLAN	PLUS GOLD $500/25%/$9000/FIRST 2 OFFICE VISITS $10, THEN $25/$50	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Formulary Drug List	Summit S6 Tier 1 = Value Generic Tier 2 = Preferred Generic Tier 3 = Preferred Brand Tier 4 = Non Preferred Generic/Brand Tier 5 = Preferred Specialty Tier 6 = Non Preferred Specialty	Summit S6 Tier 1 = Value Generic Tier 2 = Preferred Generic Tier 3 = Preferred Brand Tier 4 = Non Preferred Generic/Brand Tier 5 = Preferred Specialty Tier 6 = Non Preferred Specialty
Prescription Drugs - Retail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	Tier 1 = $10 Tier 2 = $40 Tier 3 = $75 Tier 4 = $150 Tier 5 = Subject to Deductible, then 40% Tier 6 = Subject to Deductible, then 50% (cost shares apply to the OOP Max)	Tier 1 = $10 Tier 2 = $40 Tier 3 = $75 Tier 4 = $150 Tier 5 = Subject to Deductible, then 40% Tier 6 = Subject to Deductible, then 50% (cost shares apply to the OOP Max)
Prescription Drugs - Mail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	Tier 1 = $25 Tier 2 = $100 Tier 3 = $187.50 Tier 4 = $375 Tier 5 = Subject to Deductible, then 40% Tier 6 = Subject to Deductible, then 50% (cost shares apply to the OOP Max)	Specialty Drugs: Same as in-network cost share; All other Drugs: Not Covered
7 Rehabilitative & Habilitative Services & Devices		
Inpatient Rehabilitation (30 days PCY)	In Network Deductible, then 25% Preferred/35% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Rehabilitation - Physical, Occupational Therapy (45 visits PCY; shared with speech therapy)	In Network Deductible, then $50 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Habilitation - Physical, Occupational Therapy (45 visits PCY; shared with speech therapy)	In Network Deductible, then $50 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Massage Therapy (20 visits PCY)	In Network Deductible, then $50 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Speech Therapy (45 visits PCY; shared with outpatient rehab)	In Network Deductible, then $50 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Inpatient Habilitation (30 days PCY)	In Network Deductible, then 25% Preferred/35% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Durable Medical Equipment (Unlimited)	In Network Deductible, then 25% Preferred/35% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
8 Laboratory/Imaging Services		
Diagnostic Laboratory & Pathology	In Network Deductible, then 25% Preferred/35% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Diagnostic Imaging - Basic	In Network Deductible, then 25% Preferred/35% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating

MEDICAL PLAN	PLUS GOLD $500/25%/$9000/FIRST 2 OFFICE VISITS $10, THEN $25/$50	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Diagnostic Imaging - Major (MRI, CT, PET)	In Network Deductible, then 25% Preferred/35% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
9 Preventive/Wellness Services		
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Preventive Laboratory Screens	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Preventive Imaging	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Breast Cancer Screening (Including Mammography)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
10 Pediatric Services, including Oral & Vision Care		
Pediatric Vision Exam (1 PCY under age 19)	$25 Copay, applies to the Out of Pocket Maximum	$25 Copay, applies to the Out of Pocket Maximum
Pediatric Eyewear (Under age 19: One pair of glasses PCY (frames & lenses). 12 month supply of contacts PCY, in lieu of glasses (frames & lenses).)	Covered in Full	Covered In Full
Pediatric Dental - Preventive	Covered in Full	Waive Out-of-Network Medical Deductible, then 10%
Pediatric Dental - Basic	Waive In-Network Medical Deductible, then 30%	Waive Out-of-Network Medical Deductible, then 50%
Pediatric Dental - Major	In-Network Medical Deductible, then 50%	Out-of-Network Medical Deductible, then 50%
App-Based Virtual Care Services		
Telemedicine – General Medical (Virtual Care Only)	Covered in Full	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit Cost Share	Not Covered
Routine Hearing		
Routine Hearing Exam (1 PCY)	$50 Copay, applies to the Out of Pocket Maximum	$50 Copay, applies to the Out of Pocket Maximum
Routine Hearing Aids and Hardware (1 device per ear every 3 years)	Waive In Network Deductible, then 20%	Waive In Network Deductible, then 20%
Alternative Care		
Chiropractic (20 visits PCY)	$25 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Acupuncture (12 visits PCY)	$25 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Naturopath	Designated PCP: First 2 visits $10 Copay, additional visits $25 Copay, applies to the Out of Pocket Maximum; Specialist and non designated PCP: $50 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Alaska Medical Transportation Benefits		
Medical Access Transportation (3 round trips PCY for patient (includes 3 round trips PCY for parent or guardian if pt. under 19 yrs of age))	In Network Deductible, then 25% Preferred	In Network Deductible, then 25% Preferred
Elective Procedure Travel (Prior Approval Required: Member & Medically Necessary Companion - Air: 1 round-trip per episode; Surface Transportation & Parking: $35/day; Ferry Transportation $50 per person each way; Lodging $50/day per person)	Covered in Full	Covered in Full
Medical Services from Elective Procedure Travel	Covered as any other service	Covered as any other service
Premera Designated Centers of Excellence Package Services (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement), Spine & Gynecology)	Covered in Full	Covered as any other service

Benefits provided at 100% of allowable charges; not subject to deductible or coinsurance.
Seasonal immunizations provided at a pharmacy will be covered in full up to maximum allowable amount.
Autism: Mental Health, Psychological & Neuropsychological Testing, Outpatient Professional & Facility Care covered as any other service.

Copays are not subject to the deductible unless otherwise noted.
Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.
PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross Blue Shield of Alaska. Members are responsible for amounts in excess of the allowable charge.

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms of the plan.This benefit highlight is not a contract and may change. Please see your benefit booklet or call Customer Service for full coverage information including a description of waiting periods, limitations, and exclusions.

Notice of availability and nondiscrimination 800-508-4722 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.
Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.
Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.
무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.
Hu thov kev pab txhais lus pub dawb thiab lwm yam khoom pab dawb thiab kev pab cuam ua tsim nyog.
Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.
呼吁提供免费的语言援助服务和适当的辅助设备及服务。
呼籲提供免費的語言援助服務和適當的輔助設備及服務。
Vala‘au mo auaunaga tau fesoasoani mo gagana e leai ni totogi ma fesoasoani fa‘aopo‘opo talafeagai ma auaunaga.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
無料言語支援サービスと適切な補助器具及びサービスをお求めください。
Tumawag para kadagiti libre a serbisio iti tulong iti pagsasao ken dagiti nakanada nga aid ken serbisio iti komunikasion.
Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
ติดต่อขอบริการช่วยเหลือด้านภาษาฟรีพร้อมความช่วยเหลือและบริการอื่น ๆ เพิ่มเติม
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.
Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.
Appelez pour obtenir des services gratuits d’assistance linguistique et des aides et services auxiliaires appropriés.
Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.
Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.
اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.
برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

Discrimination is against the law. Premera Blue Cross Blue Shield of Alaska (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TTY: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.