PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Highlights of your Health Care Coverage

Effective Date: 01/01/2026

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	**PC - HP $3000/20%/$6000/$30/$65**	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	$3,000 PCY	$6,000 PCY
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20% Preferred/40% Participating	Hospital & Professional: 60% Non-Participating
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$6,000 PCY	$45,000 PCY
Non Specialist Office Visit Cost Share	$30 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Specialist Office Visit Cost Share	$65 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
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
Health Education (HE) (Unlimited)	Covered in Full	Covered In Full
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Covered In Full
CHRONIC CONDITION MANAGEMENT PROGRAMS		
Diabetes Management Plus	Included	Included
Diabetes Prevention Plus	Excluded	Excluded
Hypertension Plus	Excluded	Excluded
Weight Management	Excluded	Excluded
PROFESSIONAL CARE		

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Professional Office Visit (Includes Telemedicine)	Non Specialist: $30 Copay, applies to the Out of Pocket Maximum; Specialist: $65 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
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
DIAGNOSTIC SERVICES		
Preventive Imaging and Laboratory	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Diagnostic Laboratory	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Basic Diagnostic Imaging	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Major Diagnostic Imaging	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Preventive Mammography	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Diagnostic Mammography	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Supplemental Breast Exam	Covered in Full	Covered as any other service
FACILITY CARE		
Inpatient Facility	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Inpatient Professional Services	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Hospital Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Ambulatory Surgery Center	In Network Deductible, then 10%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Facility	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Skilled Nursing Facility (60 days PCY)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating

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Hospice Care (Home Health and Respite) (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Home Health Visits (130 visits PCY)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
MATERNITY & REPRODUCTIVE CARE		
Birth Center	In Network Deductible, then 10%	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
Sterilization - Female (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Sterilization - Male (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
MEDICAL CARE COORDINATION AND TRAVEL SERVICES		
Centers of Excellence Packaged Services (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement), Spine & Gynecology)	Covered in Full	Covered as any other service
Centers of Excellence Travel and Care Coordination (See Elective Procedure Travel)	See Elective Procedure Travel	See Elective Procedure Travel
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 20% Preferred	In Network Deductible, then 20% Preferred
Transplants (Unlimited; $75,000 donor)	Covered as any other service	Not Covered
Transplant Travel & Lodging ($7,500 travel and lodging)	Subject to Deductible, then 0%	Subject to Deductible, then 0%
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
EMERGENCY CARE		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$200 Copay, applies to the Out of Pocket Maximum; then In Network Deductible, 20% Preferred	$200 Copay, applies to the Out of Pocket Maximum; then In Network Deductible, 20% Preferred
Emergency Room Physician	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Urgent Care Center	$40, applies to the OOP Max	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Ambulance Transportation (Unlimited)	$200 Copay, applies to the Out of Pocket Maximum; then In Network Deductible, 20% Preferred	$200 Copay, applies to the Out of Pocket Maximum; then In Network Deductible, 20% Preferred
Non-Emergent Ground Ambulance (Unlimited)	$200 Copay, applies to the Out of Pocket Maximum; then In Network Deductible, 20% Preferred	$200 Copay, applies to the Out of Pocket Maximum; then In Network Deductible, 20% Preferred

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Air Ambulance (Unlimited)	$200 Copay, applies to the Out of Pocket Maximum; then In Network Deductible, 20% Preferred	$200 Copay, applies to the Out of Pocket Maximum; then In Network Deductible, 20% Preferred
Non-Emergent Air Ambulance (Unlimited)	$200 Copay applies to the Out of Pocket Maximum; then In Network Deductible, 20% Preferred/40% Participating	Out of Network Deductible, then 60% Non-Participating
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	$30 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Manipulations (Spinal and other) (12 visits PCY)	$30 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Chemical Dependency Outpatient Professional Care (Unlimited)	$30 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Mental Health Inpatient Facility Care (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Mental Health Outpatient Professional Care (Unlimited)	$30 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
REHABILITATION & NEURODEVELOPMENTAL THERAPY		
Inpatient Rehab (30 days PCY)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Rehab, Including Physical and Occupational Therapy; Cardiac and Pulmonary Rehab (45 visits PCY)	$65 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Massage Therapy (Applies to the outpatient rehab limit)	$65 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Speech Therapy (Applies to the outpatient rehab limit)	$65 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Inpatient Neurodevelopmental Therapy	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Neurodevelopmental Therapy (45 visits PCY)	$65 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
OTHER SERVICES		
Allergy/Therapeutic Injections	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Medical Supplies, Equipment, Prosthetics (MS: Unlimited, ME: Unlimited, Pro: Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
SUPPLEMENTAL BENEFITS		

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Routine Vision Exam (1 PCY)	Waive In Network Deductible, then 10%	Waive In Network Deductible, then 10%
Vision Hardware ($350 PCY)	Covered in Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)	$30 Copay, applies to the Out of Pocket Maximum	$30 Copay, applies to the Out of Pocket Maximum
Pediatric Vision Hardware (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
Routine Hearing Exam (1 PCY)	Waive In Network Deductible, then 20%	Waive In Network Deductible, then 20%
Hearing Hardware (1 device per ear every 3 years)	Waive In Network Deductible, then 20%	Waive In Network Deductible, then 20%
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited

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.

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