

Highlights of your Health Care Coverage

Effective Date: 01/01/2025

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 - ESSENTIALS MEDICAL \$7550/30%/\$8550		
	IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$7,550 PCY	\$15,100 PCY
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	30% 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)	\$8,550 PCY	Unlimited
Office Visit Cost Share	In Network Deductible, then 30% Preferred	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		
Professional Office Visit (Includes Telemedicine)	In Network Deductible, then 30% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
APP-BASED VIRTUAL CARE SERVICES		

MEDICAL PLAN		
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	IN-NETWORK	OUT-OF-NETWORK
Telemedicine - General Medical (Virtual Care Only)	Covered in Full	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Covered in Full	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	Covered in Full	Not Covered
Telemedicine - Outpatient Rehab (Virtual Care Only) (Not Covered)	Not Covered	Not Covered
DIAGNOSTIC SERVICES		
Preventive Imaging and Lab	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Diagnostic Lab	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Basic Diagnostic Imaging	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Major Diagnostic Imaging	In Network Deductible, then 30% 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 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Inpatient Professional Services	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Surgery Facility	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Facility	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Skilled Nursing Facility (60 days PCY)	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Hospice Care (Home Health and Respite) (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Home Health Visits (130 visits PCY)	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
MATERNITY & REPRODUCTIVE CARE		

MEDICAL PLAN		
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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)	Covered in Full	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 30% Preferred	In Network Deductible, then 30% 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)	\$450 Copay applies to the Out of Pocket Maximum; then In Network Deductible, 30%	\$450 Copay applies to the Out of Pocket Maximum; then In Network Deductible, 30%
Emergency Room Physician	In Network Deductible, then 30% Preferred	In Network Deductible, then 30% Preferred
Urgent Care Center	In Network Deductible, then 30% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Ambulance Transportation (Unlimited)	\$450 Copay applies to the Out of Pocket Maximum; then In Network Deductible, 30%	\$450 Copay applies to the Out of Pocket Maximum; then In Network Deductible, 30%
Non-Emergent Ground Ambulance (Unlimited)	\$450 Copay applies to the Out of Pocket Maximum; then In Network Deductible, 30%	\$450 Copay applies to the Out of Pocket Maximum; then In Network Deductible, 30%
Air Ambulance (Unlimited)	\$450 Copay applies to the Out of Pocket Maximum; then In Network Deductible, 30%	\$450 Copay applies to the Out of Pocket Maximum; then In Network Deductible, 30%
Non-Emergent Air Ambulance (Unlimited)	\$450 Copay applies to the Out of Pocket Maximum; then In Network Deductible, 30% Preferred/40% Participating	Out of Network Deductible, then 60% Non-Participating
ALTERNATIVE CARE		
Acupuncture (Not Covered)	Not Covered	Not Covered
Manipulations (Spinal and other) (Not Covered)	Not Covered	Not Covered
CHEMICAL DEPENDENCY & MENTAL HEALTH		

MEDICAL PLAN		
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	IN-NETWORK	OUT-OF-NETWORK
Chemical Dependency Inpatient Facility Care (Unlimited)	In Network Deductible, then 30% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Chemical Dependency Outpatient Professional Care (Unlimited)	In Network Deductible, then 30% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Mental Health Inpatient Facility Care (Unlimited)	In Network Deductible, then 30% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Mental Health Outpatient Professional Care (Unlimited)	In Network Deductible, then 30% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
PHARMACY		
Formulary Drug List	E4 Essentials Formulary Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = preferred specialty Tier 4 = non-preferred all drugs	E4 Essentials Formulary Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = preferred specialty Tier 4 = non-preferred all drugs
Enhanced Preventive Drug List (No Buy Up)	Subject to Standard Rx Cost share	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Prescription Drugs - Retail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	Tier 1 = \$30, applies to OOP Max Tier 2 = Subject to Deductible, then 30% Tier 3 = Subject to Deductible, then 30% Tier 4 = Subject to Deductible, then 50%	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Prescription Drugs - Mail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	Tier 1 = \$90, applies to OOP Max Tier 2 = Subject to Deductible, then 30% Tier 3 = Subject to Deductible, then 30% Tier 4 = Subject to Deductible, then 50%	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab.; and Chronic Pain (45 visits PCY)	In Network Deductible, then 30% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
OTHER SERVICES		
Allergy/Therapeutic Injections	In Network Deductible, then 30% 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 30% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
SUPPLEMENTAL BENEFITS		
Routine Vision Exam (Not Covered)	Not Covered	Not Covered
Vision Hardware (Not Covered)	Not Covered	Not Covered
Pediatric Vision Exam (Not Covered)	Not Covered	Not Covered
Pediatric Vision Hardware (Not Covered)	Not Covered	Not Covered
Routine Hearing Exam (Not Covered)	Not Covered	Not Covered

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	IN-NETWORK	OUT-OF-NETWORK
Hearing Hardware (Not Covered)	Not Covered	Not Covered
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 Premiera 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.

Звертайтеся за безкоштовною мовною підтримкою та відповідними додатковими послугами.

ติดต่อขอบริการช่วยเหลือด้านภาษาฟรีพร้อมความช่วยเหลือและบริการอื่นๆ 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.

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