

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		
	HERITAGE 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		

MEDICAL PLAN		
PC - ESSENTIALS MEDICAL \$7550/30%/\$8550		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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		
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

MEDICAL PLAN		
PC - ESSENTIALS MEDICAL \$7550/30%/\$8550		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MATERNITY & REPRODUCTIVE CARE		
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

MEDICAL PLAN		
PC - ESSENTIALS MEDICAL \$7550/30%/\$8550		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
CHEMICAL DEPENDENCY & MENTAL HEALTH		
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 Tier 2 = Subject to Deductible, then 30% Tier 3 = Subject to Deductible, then 30% Tier 4 = Subject to Deductible, then 50% (cost shares apply to the OOP Max)	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 Tier 2 = Subject to Deductible, then 30% Tier 3 = Subject to Deductible, then 30% Tier 4 = Subject to Deductible, then 50% (cost shares apply to the OOP Max)	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

MEDICAL PLAN		
PC - ESSENTIALS MEDICAL \$7550/30%/\$8550		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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
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.

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 \$8550/0%/\$8550		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$8,550 PCY	\$17,100 PCY
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	0%	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 0%	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 0%	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)	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

MEDICAL PLAN		
PC - ESSENTIALS MEDICAL \$8550/0%/\$8550		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Basic Diagnostic Imaging	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Major Diagnostic Imaging	In Network Deductible, then 0%	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 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Inpatient Professional Services	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Surgery Facility	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Facility	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Skilled Nursing Facility (60 days PCY)	In Network Deductible, then 0%	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 0%	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 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Home Health Visits (130 visits PCY)	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
MATERNITY & REPRODUCTIVE CARE		
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 PLAN		
PC - ESSENTIALS MEDICAL \$8550/0%/\$8550		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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 0%	In Network Deductible, then 0%
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)	In Network Deductible, then 0%	In Network Deductible, then 0%
Emergency Room Physician	In Network Deductible, then 0%	In Network Deductible, then 0%
Urgent Care Center	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Ambulance Transportation (Unlimited)	In Network Deductible, then 0%	In Network Deductible, then 0%
Non-Emergent Ground Ambulance (Unlimited)	In Network Deductible, then 0%	In Network Deductible, then 0%
Air Ambulance (Unlimited)	In Network Deductible, then 0%	In Network Deductible, then 0%
Non-Emergent Air Ambulance (Unlimited)	In Network Deductible, then 0%	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		
Chemical Dependency Inpatient Facility Care (Unlimited)	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Chemical Dependency Outpatient Professional Care (Unlimited)	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Mental Health Inpatient Facility Care (Unlimited)	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Mental Health Outpatient Professional Care (Unlimited)	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
PHARMACY		
Formulary Drug List	E1 Essentials Formulary No Tiers	E1 Essentials Formulary No Tiers

MEDICAL PLAN		
PC - ESSENTIALS MEDICAL \$8550/0%/\$8550		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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)	In Network Deductible, then 0%	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)	In Network Deductible, then 0%	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 0%	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 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
OTHER SERVICES		
Allergy/Therapeutic Injections	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Medical Supplies, Equipment, Prosthetics (MS: Unlimited, ME: Unlimited, Pro: Unlimited)	In Network Deductible, then 0%	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
Hearing Hardware (Not Covered)	Not Covered	Not Covered
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited

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Autism: Mental Health, Psychological & Neuropsychological Testing, Outpatient Professional & Facility Care covered as any other service.

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MEDICAL PLAN		
PC - HP \$100/20%/\$1000/\$20/\$50		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$100 PCY	\$200 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)	\$1,000 PCY	\$45,000 PCY
Non Specialist Office Visit Cost Share	\$20 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Specialist Office Visit Cost Share	\$50 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		
Professional Office Visit (Includes Telemedicine)	Non Specialist: \$20 Copay, applies to the Out of Pocket Maximum; Specialist: \$50 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

MEDICAL PLAN		
PC - HP \$100/20%/\$1000/\$20/\$50		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	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 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
Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/40% Participating	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 (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 20% 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 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		

MEDICAL PLAN		
PC - HP \$100/20%/\$1000/\$20/\$50		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 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)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred
Non-Emergent Ground Ambulance (Unlimited)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred
Air Ambulance (Unlimited)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred
Non-Emergent Air Ambulance (Unlimited)	\$100 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		

MEDICAL PLAN		
PC - HP \$100/20%/\$1000/\$20/\$50		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Acupuncture (12 visits PCY)	\$20 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)	\$20 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)	\$20 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)	\$20 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 20% 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)	\$50 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		
Routine Vision Exam (1 PCY; \$350 PCY, shared with Vision Hardware)	Waive In Network Deductible, then 10%	Waive In Network Deductible, then 10%
Vision Hardware (1 set of frames every 2 consecutive years, \$90 max; 1 pair of lenses PCY; contacts \$170 PCY max; Vision Exam/Test and Hardware \$350 PCY max)	Covered in Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)	\$20 Copay, applies to the Out of Pocket Maximum	\$20 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 every 2 calendar years)	Waive In Network Deductible, then 20%	Waive In Network Deductible, then 20%
Hearing Hardware (\$3,000 every 3 calendar 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 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.

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 - HP \$1000/20%/\$4500/\$25/\$60		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$1,000 PCY	\$2,000 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)	\$4,500 PCY	\$45,000 PCY
Non Specialist Office Visit Cost Share	\$25 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Specialist Office Visit Cost Share	\$60 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		
Professional Office Visit (Includes Telemedicine)	Non Specialist: \$25 Copay, applies to the Out of Pocket Maximum; Specialist: \$60 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

MEDICAL PLAN		
PC - HP \$1000/20%/\$4500/\$25/\$60		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	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 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
Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/40% Participating	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 (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 20% 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 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		

MEDICAL PLAN		
PC - HP \$1000/20%/\$4500/\$25/\$60		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 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)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred
Non-Emergent Ground Ambulance (Unlimited)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred
Air Ambulance (Unlimited)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred
Non-Emergent Air Ambulance (Unlimited)	\$100 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		

MEDICAL PLAN		
PC - HP \$1000/20%/\$4500/\$25/\$60		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Acupuncture (12 visits PCY)	\$25 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)	\$25 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)	\$25 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)	\$25 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 20% 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)	\$60 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		
Routine Vision Exam (1 PCY; \$350 PCY, shared with Vision Hardware)	Waive In Network Deductible, then 10%	Waive In Network Deductible, then 10%
Vision Hardware (1 set of frames every 2 consecutive years, \$90 max; 1 pair of lenses PCY; contacts \$170 PCY max; Vision Exam/Test and Hardware \$350 PCY max)	Covered in Full	Covered in Full
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 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 every 2 calendar years)	Waive In Network Deductible, then 20%	Waive In Network Deductible, then 20%
Hearing Hardware (\$3,000 every 3 calendar 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 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.

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 - HP \$2000/20%/\$4500/\$25/\$65		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$2,000 PCY	\$4,000 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)	\$4,500 PCY	\$45,000 PCY
Non Specialist Office Visit Cost Share	\$25 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		
Professional Office Visit (Includes Telemedicine)	Non Specialist: \$25 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

MEDICAL PLAN		
PC - HP \$2000/20%/\$4500/\$25/\$65		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	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 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
Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/40% Participating	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 (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 20% 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 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		

MEDICAL PLAN		
PC - HP \$2000/20%/\$4500/\$25/\$65		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 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)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred
Non-Emergent Ground Ambulance (Unlimited)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred
Air Ambulance (Unlimited)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred
Non-Emergent Air Ambulance (Unlimited)	\$100 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		

MEDICAL PLAN		
PC - HP \$2000/20%/\$4500/\$25/\$65		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Acupuncture (12 visits PCY)	\$25 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)	\$25 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)	\$25 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)	\$25 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 20% 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)	\$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		
Routine Vision Exam (1 PCY; \$350 PCY, shared with Vision Hardware)	Waive In Network Deductible, then 10%	Waive In Network Deductible, then 10%
Vision Hardware (1 set of frames every 2 consecutive years, \$90 max; 1 pair of lenses PCY; contacts \$170 PCY max; Vision Exam/Test and Hardware \$350 PCY max)	Covered in Full	Covered in Full
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 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 every 2 calendar years)	Waive In Network Deductible, then 20%	Waive In Network Deductible, then 20%
Hearing Hardware (\$3,000 every 3 calendar 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 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.

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 - HP \$250/20%/\$2000/\$20/\$50		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$250 PCY	\$500 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)	\$2,000 PCY	\$45,000 PCY
Non Specialist Office Visit Cost Share	\$20 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Specialist Office Visit Cost Share	\$50 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		
Professional Office Visit (Includes Telemedicine)	Non Specialist: \$20 Copay, applies to the Out of Pocket Maximum; Specialist: \$50 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

MEDICAL PLAN		
PC - HP \$250/20%/\$2000/\$20/\$50		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	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 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
Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/40% Participating	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 (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 20% 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 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		

MEDICAL PLAN		
PC - HP \$250/20%/\$2000/\$20/\$50		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 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)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred
Non-Emergent Ground Ambulance (Unlimited)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred
Air Ambulance (Unlimited)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred
Non-Emergent Air Ambulance (Unlimited)	\$100 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		

MEDICAL PLAN		
PC - HP \$250/20%/\$2000/\$20/\$50		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Acupuncture (12 visits PCY)	\$20 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)	\$20 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)	\$20 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)	\$20 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 20% 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)	\$50 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		
Routine Vision Exam (1 PCY; \$350 PCY, shared with Vision Hardware)	Waive In Network Deductible, then 10%	Waive In Network Deductible, then 10%
Vision Hardware (1 set of frames every 2 consecutive years, \$90 max; 1 pair of lenses PCY; contacts \$170 PCY max; Vision Exam/Test and Hardware \$350 PCY max)	Covered in Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)	\$20 Copay, applies to the Out of Pocket Maximum	\$20 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 every 2 calendar years)	Waive In Network Deductible, then 20%	Waive In Network Deductible, then 20%
Hearing Hardware (\$3,000 every 3 calendar 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 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.

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 - 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		
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

MEDICAL PLAN		
PC - HP \$3000/20%/\$6000/\$30/\$65		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	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 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
Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/40% Participating	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 (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 20% 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 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		

MEDICAL PLAN		
PC - HP \$3000/20%/\$6000/\$30/\$65		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 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)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred
Non-Emergent Ground Ambulance (Unlimited)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred
Air Ambulance (Unlimited)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred
Non-Emergent Air Ambulance (Unlimited)	\$100 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		

MEDICAL PLAN		
PC - HP \$3000/20%/\$6000/\$30/\$65		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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 & NEURO		
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 20% 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)	\$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		
Routine Vision Exam (1 PCY; \$350 PCY, shared with Vision Hardware)	Waive In Network Deductible, then 10%	Waive In Network Deductible, then 10%
Vision Hardware (1 set of frames every 2 consecutive years, \$90 max; 1 pair of lenses PCY; contacts \$170 PCY max; Vision Exam/Test and Hardware \$350 PCY max)	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 every 2 calendar years)	Waive In Network Deductible, then 20%	Waive In Network Deductible, then 20%
Hearing Hardware (\$3,000 every 3 calendar 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.

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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 - HP \$4000/20%/\$6000/\$30/\$65		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$4,000 PCY	\$8,000 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		
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

MEDICAL PLAN		
PC - HP \$4000/20%/\$6000/\$30/\$65		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	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 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
Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/40% Participating	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 (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 20% 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 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		

MEDICAL PLAN		
PC - HP \$4000/20%/\$6000/\$30/\$65		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 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)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred
Non-Emergent Ground Ambulance (Unlimited)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred
Air Ambulance (Unlimited)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred
Non-Emergent Air Ambulance (Unlimited)	\$100 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		

MEDICAL PLAN		
PC - HP \$4000/20%/\$6000/\$30/\$65		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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 & NEURO		
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 20% 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)	\$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		
Routine Vision Exam (1 PCY; \$350 PCY, shared with Vision Hardware)	Waive In Network Deductible, then 10%	Waive In Network Deductible, then 10%
Vision Hardware (1 set of frames every 2 consecutive years, \$90 max; 1 pair of lenses PCY; contacts \$170 PCY max; Vision Exam/Test and Hardware \$350 PCY max)	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 every 2 calendar years)	Waive In Network Deductible, then 20%	Waive In Network Deductible, then 20%
Hearing Hardware (\$3,000 every 3 calendar 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 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.

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 - HP \$500/20%/\$3500/\$20/\$60		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$500 PCY	\$1,000 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)	\$3,500 PCY	\$45,000 PCY
Non Specialist Office Visit Cost Share	\$20 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Specialist Office Visit Cost Share	\$60 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		
Professional Office Visit (Includes Telemedicine)	Non Specialist: \$20 Copay, applies to the Out of Pocket Maximum; Specialist: \$60 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

MEDICAL PLAN		
PC - HP \$500/20%/\$3500/\$20/\$60		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	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 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
Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/40% Participating	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 (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 20% 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 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		

MEDICAL PLAN		
PC - HP \$500/20%/\$3500/\$20/\$60		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 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)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred
Non-Emergent Ground Ambulance (Unlimited)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred
Air Ambulance (Unlimited)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred
Non-Emergent Air Ambulance (Unlimited)	\$100 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		

MEDICAL PLAN		
PC - HP \$500/20%/\$3500/\$20/\$60		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Acupuncture (12 visits PCY)	\$20 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)	\$20 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)	\$20 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)	\$20 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 20% 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)	\$60 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		
Routine Vision Exam (1 PCY; \$350 PCY, shared with Vision Hardware)	Waive In Network Deductible, then 10%	Waive In Network Deductible, then 10%
Vision Hardware (1 set of frames every 2 consecutive years, \$90 max; 1 pair of lenses PCY; contacts \$170 PCY max; Vision Exam/Test and Hardware \$350 PCY max)	Covered in Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)	\$20 Copay, applies to the Out of Pocket Maximum	\$20 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 every 2 calendar years)	Waive In Network Deductible, then 20%	Waive In Network Deductible, then 20%
Hearing Hardware (\$3,000 every 3 calendar 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 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.

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 - HP \$5000/30%/\$7150/\$45/\$80		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$5,000 PCY	\$10,000 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)	\$7,150 PCY	\$45,000 PCY
Non Specialist Office Visit Cost Share	\$45 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Specialist Office Visit Cost Share	\$80 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		
Professional Office Visit (Includes Telemedicine)	Non Specialist: \$45 Copay, applies to the Out of Pocket Maximum; Specialist: \$80 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

MEDICAL PLAN		
PC - HP \$5000/30%/\$7150/\$45/\$80		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	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		
PC - HP \$5000/30%/\$7150/\$45/\$80		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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 30% 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 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)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 30% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 30% Preferred
Emergency Room Physician	In Network Deductible, then 30% Preferred	In Network Deductible, then 30% Preferred
Urgent Care Center	\$40, applies to the OOP Max	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Ambulance Transportation (Unlimited)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 30% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 30% Preferred
Non-Emergent Ground Ambulance (Unlimited)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 30% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 30% Preferred
Air Ambulance (Unlimited)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 30% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 30% Preferred
Non-Emergent Air Ambulance (Unlimited)	\$100 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		

MEDICAL PLAN		
PC - HP \$5000/30%/\$7150/\$45/\$80		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Acupuncture (12 visits PCY)	\$45 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)	\$45 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 30% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Chemical Dependency Outpatient Professional Care (Unlimited)	\$45 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 30% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Mental Health Outpatient Professional Care (Unlimited)	\$45 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
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)	\$80 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 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 (1 PCY; \$350 PCY, shared with Vision Hardware)	Waive In Network Deductible, then 10%	Waive In Network Deductible, then 10%
Vision Hardware (1 set of frames every 2 consecutive years, \$90 max; 1 pair of lenses PCY; contacts \$170 PCY max; Vision Exam/Test and Hardware \$350 PCY max)	Covered in Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)	\$45 Copay, applies to the Out of Pocket Maximum	\$45 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 every 2 calendar years)	Waive In Network Deductible, then 20%	Waive In Network Deductible, then 20%
Hearing Hardware (\$3,000 every 3 calendar 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 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.

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 - HP \$6000/30%/\$7350/\$45/\$80		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$6,000 PCY	\$12,000 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)	\$7,350 PCY	\$45,000 PCY
Non Specialist Office Visit Cost Share	\$45 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Specialist Office Visit Cost Share	\$80 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		
Professional Office Visit (Includes Telemedicine)	Non Specialist: \$45 Copay, applies to the Out of Pocket Maximum; Specialist: \$80 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

MEDICAL PLAN		
PC - HP \$6000/30%/\$7350/\$45/\$80		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	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		
PC - HP \$6000/30%/\$7350/\$45/\$80		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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 30% 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 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)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 30% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 30% Preferred
Emergency Room Physician	In Network Deductible, then 30% Preferred	In Network Deductible, then 30% Preferred
Urgent Care Center	\$40, applies to the OOP Max	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Ambulance Transportation (Unlimited)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 30% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 30% Preferred
Non-Emergent Ground Ambulance (Unlimited)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 30% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 30% Preferred
Air Ambulance (Unlimited)	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 30% Preferred	\$100 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 30% Preferred
Non-Emergent Air Ambulance (Unlimited)	\$100 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		

MEDICAL PLAN		
PC - HP \$6000/30%/\$7350/\$45/\$80		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Acupuncture (12 visits PCY)	\$45 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)	\$45 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 30% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Chemical Dependency Outpatient Professional Care (Unlimited)	\$45 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 30% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Mental Health Outpatient Professional Care (Unlimited)	\$45 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
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)	\$80 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 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 (1 PCY; \$350 PCY, shared with Vision Hardware)	Waive In Network Deductible, then 10%	Waive In Network Deductible, then 10%
Vision Hardware (1 set of frames every 2 consecutive years, \$90 max; 1 pair of lenses PCY; contacts \$170 PCY max; Vision Exam/Test and Hardware \$350 PCY max)	Covered in Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)	\$45 Copay, applies to the Out of Pocket Maximum	\$45 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 every 2 calendar years)	Waive In Network Deductible, then 20%	Waive In Network Deductible, then 20%
Hearing Hardware (\$3,000 every 3 calendar 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 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.

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 - HP HSA QUALIFIED AGG \$1650/20%/\$3300		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family aggregate deductible 2x Individual)	\$1,650 PCY/\$3,300 PCY	Shared with In-Network
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 aggregate OOP max 2x Individual)	\$3,300 PCY/\$6,600 PCY	\$45,000 PCY/\$90,000 PCY
Office Visit Cost Share	In Network Deductible, then 20% 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 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
APP-BASED VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	In Network Deductible, then 20% Preferred	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered

MEDICAL PLAN		
PC - HP HSA QUALIFIED AGG \$1650/20%/\$3300		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	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 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	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Supplemental Breast Exam	In Network Deductible, then 0%	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
Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/40% Participating	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 (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 20% 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 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		
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

MEDICAL PLAN		
PC - HP HSA QUALIFIED AGG \$1650/20%/\$3300		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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)	In Network Deductible, then 0%	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)	\$1,650 PCY/\$3,300 PCY Deductible, then 0%	\$1,650 PCY/\$3,300 PCY Deductible, then 0%
Medical Services from Elective Procedure Travel	Covered as any other service	Covered as any other service
EMERGENCY CARE		
Emergency Care	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Emergency Room Physician	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Urgent Care Center	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Ambulance Transportation (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Ground Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then 60% Non-Participating
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Manipulations (Spinal and other) (12 visits PCY)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating

MEDICAL PLAN		
PC - HP HSA QUALIFIED AGG \$1650/20%/\$3300		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
PHARMACY		
Formulary Drug List	Open A1 No Tiers	Open A1 No Tiers
Enhanced Preventive Drug List (PV Core)	Covered in Full	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)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 20% 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 20% Preferred	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		
Routine Vision Exam (1 PCY; \$350 PCY, shared with Vision Hardware)	Waive In Network Deductible, then 10%	Waive In Network Deductible, then 10%
Vision Hardware (1 set of frames every 2 consecutive years, \$90 max; 1 pair of lenses PCY; contacts \$170 PCY max; Vision Exam/Test and Hardware \$350 PCY max)	Covered in Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
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 every 2 calendar years)	In Network Deductible, then 20%	In Network Deductible, then 20%
Hearing Hardware (\$3,000 every 3 calendar years)	In Network Deductible, then 20%	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 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.

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 - HP HSA QUALIFIED AGG \$1650/20%/\$3300 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family aggregate deductible 2x Individual)	\$1,650 PCY/\$3,300 PCY	Shared with In-Network
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 aggregate OOP max 2x Individual)	\$3,300 PCY/\$6,600 PCY	\$45,000 PCY/\$90,000 PCY
Office Visit Cost Share	In Network Deductible, then 20% 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 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
APP-BASED VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	In Network Deductible, then 20% Preferred	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered

MEDICAL PLAN		
PC - HP HSA QUALIFIED AGG \$1650/20%/\$3300 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	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 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	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Supplemental Breast Exam	In Network Deductible, then 0%	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
Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/40% Participating	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 (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 20% 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 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		
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

MEDICAL PLAN		
PC - HP HSA QUALIFIED AGG \$1650/20%/\$3300 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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)	In Network Deductible, then 0%	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)	\$1,650 PCY/\$3,300 PCY Deductible, then 0%	\$1,650 PCY/\$3,300 PCY Deductible, then 0%
Medical Services from Elective Procedure Travel	Covered as any other service	Covered as any other service
EMERGENCY CARE		
Emergency Care	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Emergency Room Physician	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Urgent Care Center	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Ambulance Transportation (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Ground Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then 60% Non-Participating
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Manipulations (Spinal and other) (12 visits PCY)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating

MEDICAL PLAN		
PC - HP HSA QUALIFIED AGG \$1650/20%/\$3300 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
PHARMACY		
Formulary Drug List	E1 Essentials Formulary No Tiers	E1 Essentials Formulary No Tiers
Enhanced Preventive Drug List (PV Core)	Covered in Full	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)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 20% 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 20% Preferred	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		
Routine Vision Exam (1 PCY; \$350 PCY, shared with Vision Hardware)	Waive In Network Deductible, then 10%	Waive In Network Deductible, then 10%
Vision Hardware (1 set of frames every 2 consecutive years, \$90 max; 1 pair of lenses PCY; contacts \$170 PCY max; Vision Exam/Test and Hardware \$350 PCY max)	Covered in Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
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 every 2 calendar years)	In Network Deductible, then 20%	In Network Deductible, then 20%
Hearing Hardware (\$3,000 every 3 calendar years)	In Network Deductible, then 20%	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 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.

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 - HP HSA QUALIFIED AGG \$2000/20%/\$5000		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family aggregate deductible 2x Individual)	\$2,000 PCY/\$4,000 PCY	Shared with In-Network
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)	\$5,000 PCY	\$45,000 PCY
Office Visit Cost Share	In Network Deductible, then 20% 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 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
APP-BASED VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	In Network Deductible, then 20% Preferred	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered

MEDICAL PLAN		
PC - HP HSA QUALIFIED AGG \$2000/20%/\$5000		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	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 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	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Supplemental Breast Exam	In Network Deductible, then 0%	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
Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/40% Participating	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 (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 20% 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 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		
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

MEDICAL PLAN		
PC - HP HSA QUALIFIED AGG \$2000/20%/\$5000		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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)	In Network Deductible, then 0%	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)	\$2,000 PCY/\$4,000 PCY Deductible, then 0%	\$2,000 PCY/\$4,000 PCY Deductible, then 0%
Medical Services from Elective Procedure Travel	Covered as any other service	Covered as any other service
EMERGENCY CARE		
Emergency Care	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Emergency Room Physician	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Urgent Care Center	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Ambulance Transportation (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Ground Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then 60% Non-Participating
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Manipulations (Spinal and other) (12 visits PCY)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating

MEDICAL PLAN		
PC - HP HSA QUALIFIED AGG \$2000/20%/\$5000		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
PHARMACY		
Formulary Drug List	Open A1 No Tiers	Open A1 No Tiers
Enhanced Preventive Drug List (PV Core)	Covered in Full	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)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 20% 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 20% Preferred	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		
Routine Vision Exam (1 PCY; \$350 PCY, shared with Vision Hardware)	Waive In Network Deductible, then 10%	Waive In Network Deductible, then 10%
Vision Hardware (1 set of frames every 2 consecutive years, \$90 max; 1 pair of lenses PCY; contacts \$170 PCY max; Vision Exam/Test and Hardware \$350 PCY max)	Covered in Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
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 every 2 calendar years)	In Network Deductible, then 20%	In Network Deductible, then 20%
Hearing Hardware (\$3,000 every 3 calendar years)	In Network Deductible, then 20%	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 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.

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 - HP HSA QUALIFIED AGG \$2000/20%/\$5000 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family aggregate deductible 2x Individual)	\$2,000 PCY/\$4,000 PCY	Shared with In-Network
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)	\$5,000 PCY	\$45,000 PCY
Office Visit Cost Share	In Network Deductible, then 20% 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 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
APP-BASED VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	In Network Deductible, then 20% Preferred	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered

MEDICAL PLAN		
PC - HP HSA QUALIFIED AGG \$2000/20%/\$5000 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	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 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	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Supplemental Breast Exam	In Network Deductible, then 0%	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
Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/40% Participating	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 (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 20% 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 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		
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

MEDICAL PLAN		
PC - HP HSA QUALIFIED AGG \$2000/20%/\$5000 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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)	In Network Deductible, then 0%	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)	\$2,000 PCY/\$4,000 PCY Deductible, then 0%	\$2,000 PCY/\$4,000 PCY Deductible, then 0%
Medical Services from Elective Procedure Travel	Covered as any other service	Covered as any other service
EMERGENCY CARE		
Emergency Care	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Emergency Room Physician	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Urgent Care Center	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Ambulance Transportation (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Ground Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then 60% Non-Participating
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Manipulations (Spinal and other) (12 visits PCY)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating

MEDICAL PLAN		
PC - HP HSA QUALIFIED AGG \$2000/20%/\$5000 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
PHARMACY		
Formulary Drug List	E1 Essentials Formulary No Tiers	E1 Essentials Formulary No Tiers
Enhanced Preventive Drug List (PV Core)	Covered in Full	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)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 20% 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 20% Preferred	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		
Routine Vision Exam (1 PCY; \$350 PCY, shared with Vision Hardware)	Waive In Network Deductible, then 10%	Waive In Network Deductible, then 10%
Vision Hardware (1 set of frames every 2 consecutive years, \$90 max; 1 pair of lenses PCY; contacts \$170 PCY max; Vision Exam/Test and Hardware \$350 PCY max)	Covered in Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
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 every 2 calendar years)	In Network Deductible, then 20%	In Network Deductible, then 20%
Hearing Hardware (\$3,000 every 3 calendar years)	In Network Deductible, then 20%	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 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.

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 - HP HSA QUALIFIED EMB \$3300/20%/\$5000		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$3,300 PCY	Shared with In-Network
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)	\$5,000 PCY	\$45,000 PCY
Office Visit Cost Share	In Network Deductible, then 20% 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 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
APP-BASED VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	In Network Deductible, then 20% Preferred	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$3300/20%/\$5000		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	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 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	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Supplemental Breast Exam	In Network Deductible, then 0%	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
Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/40% Participating	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 (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 20% 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 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		
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

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$3300/20%/\$5000		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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)	In Network Deductible, then 0%	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)	\$3,300 PCY Deductible, then 0%	\$3,300 PCY Deductible, then 0%
Medical Services from Elective Procedure Travel	Covered as any other service	Covered as any other service
EMERGENCY CARE		
Emergency Care	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Emergency Room Physician	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Urgent Care Center	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Ambulance Transportation (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Ground Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then 60% Non-Participating
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Manipulations (Spinal and other) (12 visits PCY)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$3300/20%/\$5000		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
PHARMACY		
Formulary Drug List	Open A1 No Tiers	Open A1 No Tiers
Enhanced Preventive Drug List (PV Core)	Covered in Full	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)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 20% 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 20% Preferred	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		
Routine Vision Exam (1 PCY; \$350 PCY, shared with Vision Hardware)	Waive In Network Deductible, then 10%	Waive In Network Deductible, then 10%
Vision Hardware (1 set of frames every 2 consecutive years, \$90 max; 1 pair of lenses PCY; contacts \$170 PCY max; Vision Exam/Test and Hardware \$350 PCY max)	Covered in Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
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 every 2 calendar years)	In Network Deductible, then 20%	In Network Deductible, then 20%
Hearing Hardware (\$3,000 every 3 calendar years)	In Network Deductible, then 20%	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 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.

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 - HP HSA QUALIFIED EMB \$3300/20%/\$5000 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$3,300 PCY	Shared with In-Network
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)	\$5,000 PCY	\$45,000 PCY
Office Visit Cost Share	In Network Deductible, then 20% 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 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
APP-BASED VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	In Network Deductible, then 20% Preferred	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$3300/20%/\$5000 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	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 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	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Supplemental Breast Exam	In Network Deductible, then 0%	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
Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/40% Participating	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 (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 20% 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 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		
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

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$3300/20%/\$5000 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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)	In Network Deductible, then 0%	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)	\$3,300 PCY Deductible, then 0%	\$3,300 PCY Deductible, then 0%
Medical Services from Elective Procedure Travel	Covered as any other service	Covered as any other service
EMERGENCY CARE		
Emergency Care	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Emergency Room Physician	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Urgent Care Center	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Ambulance Transportation (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Ground Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then 60% Non-Participating
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Manipulations (Spinal and other) (12 visits PCY)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$3300/20%/\$5000 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
PHARMACY		
Formulary Drug List	E1 Essentials Formulary No Tiers	E1 Essentials Formulary No Tiers
Enhanced Preventive Drug List (PV Core)	Covered in Full	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)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 20% 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 20% Preferred	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		
Routine Vision Exam (1 PCY; \$350 PCY, shared with Vision Hardware)	Waive In Network Deductible, then 10%	Waive In Network Deductible, then 10%
Vision Hardware (1 set of frames every 2 consecutive years, \$90 max; 1 pair of lenses PCY; contacts \$170 PCY max; Vision Exam/Test and Hardware \$350 PCY max)	Covered in Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
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 every 2 calendar years)	In Network Deductible, then 20%	In Network Deductible, then 20%
Hearing Hardware (\$3,000 every 3 calendar years)	In Network Deductible, then 20%	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 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.

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 - HP HSA QUALIFIED EMB \$4000/20%/\$6000		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$4,000 PCY	Shared with In-Network
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
Office Visit Cost Share	In Network Deductible, then 20% 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 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
APP-BASED VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	In Network Deductible, then 20% Preferred	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$4000/20%/\$6000		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	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 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	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Supplemental Breast Exam	In Network Deductible, then 0%	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
Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/40% Participating	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 (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 20% 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 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		
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

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$4000/20%/\$6000		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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)	In Network Deductible, then 0%	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)	\$4,000 PCY Deductible, then 0%	\$4,000 PCY Deductible, then 0%
Medical Services from Elective Procedure Travel	Covered as any other service	Covered as any other service
EMERGENCY CARE		
Emergency Care	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Emergency Room Physician	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Urgent Care Center	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Ambulance Transportation (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Ground Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then 60% Non-Participating
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Manipulations (Spinal and other) (12 visits PCY)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$4000/20%/\$6000		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
PHARMACY		
Formulary Drug List	Open A1 No Tiers	Open A1 No Tiers
Enhanced Preventive Drug List (PV Core)	Covered in Full	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)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 20% 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 20% Preferred	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		
Routine Vision Exam (1 PCY; \$350 PCY, shared with Vision Hardware)	Waive In Network Deductible, then 10%	Waive In Network Deductible, then 10%
Vision Hardware (1 set of frames every 2 consecutive years, \$90 max; 1 pair of lenses PCY; contacts \$170 PCY max; Vision Exam/Test and Hardware \$350 PCY max)	Covered in Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
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 every 2 calendar years)	In Network Deductible, then 20%	In Network Deductible, then 20%
Hearing Hardware (\$3,000 every 3 calendar years)	In Network Deductible, then 20%	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 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.

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 - HP HSA QUALIFIED EMB \$4000/20%/\$6000 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$4,000 PCY	Shared with In-Network
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
Office Visit Cost Share	In Network Deductible, then 20% 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 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
APP-BASED VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	In Network Deductible, then 20% Preferred	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$4000/20%/\$6000 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	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 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	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Supplemental Breast Exam	In Network Deductible, then 0%	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
Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/40% Participating	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 (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 20% 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 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		
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

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$4000/20%/\$6000 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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)	In Network Deductible, then 0%	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)	\$4,000 PCY Deductible, then 0%	\$4,000 PCY Deductible, then 0%
Medical Services from Elective Procedure Travel	Covered as any other service	Covered as any other service
EMERGENCY CARE		
Emergency Care	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Emergency Room Physician	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Urgent Care Center	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Ambulance Transportation (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Ground Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then 60% Non-Participating
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Manipulations (Spinal and other) (12 visits PCY)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$4000/20%/\$6000 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
PHARMACY		
Formulary Drug List	E1 Essentials Formulary No Tiers	E1 Essentials Formulary No Tiers
Enhanced Preventive Drug List (PV Core)	Covered in Full	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)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 20% 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 20% Preferred	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		
Routine Vision Exam (1 PCY; \$350 PCY, shared with Vision Hardware)	Waive In Network Deductible, then 10%	Waive In Network Deductible, then 10%
Vision Hardware (1 set of frames every 2 consecutive years, \$90 max; 1 pair of lenses PCY; contacts \$170 PCY max; Vision Exam/Test and Hardware \$350 PCY max)	Covered in Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
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 every 2 calendar years)	In Network Deductible, then 20%	In Network Deductible, then 20%
Hearing Hardware (\$3,000 every 3 calendar years)	In Network Deductible, then 20%	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 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.

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 - HP HSA QUALIFIED EMB \$5000/20%/\$6550		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$5,000 PCY	Shared with In-Network
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)	\$6,550 PCY	\$45,000 PCY
Office Visit Cost Share	In Network Deductible, then 20% 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 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
APP-BASED VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	In Network Deductible, then 20% Preferred	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$5000/20%/\$6550		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	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 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	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Supplemental Breast Exam	In Network Deductible, then 0%	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
Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/40% Participating	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 (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 20% 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 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		
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

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$5000/20%/\$6550		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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)	In Network Deductible, then 0%	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)	\$5,000 PCY Deductible, then 0%	\$5,000 PCY Deductible, then 0%
Medical Services from Elective Procedure Travel	Covered as any other service	Covered as any other service
EMERGENCY CARE		
Emergency Care	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Emergency Room Physician	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Urgent Care Center	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Ambulance Transportation (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Ground Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then 60% Non-Participating
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Manipulations (Spinal and other) (12 visits PCY)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$5000/20%/\$6550		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
PHARMACY		
Formulary Drug List	Open A1 No Tiers	Open A1 No Tiers
Enhanced Preventive Drug List (PV Core)	Covered in Full	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)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 20% 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 20% Preferred	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		
Routine Vision Exam (1 PCY; \$350 PCY, shared with Vision Hardware)	Waive In Network Deductible, then 10%	Waive In Network Deductible, then 10%
Vision Hardware (1 set of frames every 2 consecutive years, \$90 max; 1 pair of lenses PCY; contacts \$170 PCY max; Vision Exam/Test and Hardware \$350 PCY max)	Covered in Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
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 every 2 calendar years)	In Network Deductible, then 20%	In Network Deductible, then 20%
Hearing Hardware (\$3,000 every 3 calendar years)	In Network Deductible, then 20%	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 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.

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 - HP HSA QUALIFIED EMB \$5000/20%/\$6550 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$5,000 PCY	Shared with In-Network
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)	\$6,550 PCY	\$45,000 PCY
Office Visit Cost Share	In Network Deductible, then 20% 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 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
APP-BASED VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	In Network Deductible, then 20% Preferred	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$5000/20%/\$6550 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	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 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	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Supplemental Breast Exam	In Network Deductible, then 0%	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
Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/40% Participating	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 (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 20% 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 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		
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

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$5000/20%/\$6550 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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)	In Network Deductible, then 0%	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)	\$5,000 PCY Deductible, then 0%	\$5,000 PCY Deductible, then 0%
Medical Services from Elective Procedure Travel	Covered as any other service	Covered as any other service
EMERGENCY CARE		
Emergency Care	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Emergency Room Physician	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Urgent Care Center	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Ambulance Transportation (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Ground Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then 60% Non-Participating
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Manipulations (Spinal and other) (12 visits PCY)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$5000/20%/\$6550 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
PHARMACY		
Formulary Drug List	E1 Essentials Formulary No Tiers	E1 Essentials Formulary No Tiers
Enhanced Preventive Drug List (PV Core)	Covered in Full	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)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 20% 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 20% Preferred	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		
Routine Vision Exam (1 PCY; \$350 PCY, shared with Vision Hardware)	Waive In Network Deductible, then 10%	Waive In Network Deductible, then 10%
Vision Hardware (1 set of frames every 2 consecutive years, \$90 max; 1 pair of lenses PCY; contacts \$170 PCY max; Vision Exam/Test and Hardware \$350 PCY max)	Covered in Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
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 every 2 calendar years)	In Network Deductible, then 20%	In Network Deductible, then 20%
Hearing Hardware (\$3,000 every 3 calendar years)	In Network Deductible, then 20%	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 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.

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 - HP HSA QUALIFIED EMB \$6000/20%/\$6550		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$6,000 PCY	Shared with In-Network
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)	\$6,550 PCY	\$45,000 PCY
Office Visit Cost Share	In Network Deductible, then 20% 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 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
APP-BASED VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	In Network Deductible, then 20% Preferred	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$6000/20%/\$6550		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	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 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	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Supplemental Breast Exam	In Network Deductible, then 0%	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
Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/40% Participating	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 (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 20% 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 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		
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

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$6000/20%/\$6550		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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)	In Network Deductible, then 0%	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)	\$6,000 PCY Deductible, then 0%	\$6,000 PCY Deductible, then 0%
Medical Services from Elective Procedure Travel	Covered as any other service	Covered as any other service
EMERGENCY CARE		
Emergency Care	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Emergency Room Physician	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Urgent Care Center	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Ambulance Transportation (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Ground Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then 60% Non-Participating
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Manipulations (Spinal and other) (12 visits PCY)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$6000/20%/\$6550		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
PHARMACY		
Formulary Drug List	Open A1 No Tiers	Open A1 No Tiers
Enhanced Preventive Drug List (PV Core)	Covered in Full	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)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 20% 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 20% Preferred	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		
Routine Vision Exam (1 PCY; \$350 PCY, shared with Vision Hardware)	Waive In Network Deductible, then 10%	Waive In Network Deductible, then 10%
Vision Hardware (1 set of frames every 2 consecutive years, \$90 max; 1 pair of lenses PCY; contacts \$170 PCY max; Vision Exam/Test and Hardware \$350 PCY max)	Covered in Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
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 every 2 calendar years)	In Network Deductible, then 20%	In Network Deductible, then 20%
Hearing Hardware (\$3,000 every 3 calendar years)	In Network Deductible, then 20%	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 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.

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 - HP HSA QUALIFIED EMB \$6000/20%/\$6550 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$6,000 PCY	Shared with In-Network
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)	\$6,550 PCY	\$45,000 PCY
Office Visit Cost Share	In Network Deductible, then 20% 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 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
APP-BASED VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	In Network Deductible, then 20% Preferred	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$6000/20%/\$6550 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	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 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	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Supplemental Breast Exam	In Network Deductible, then 0%	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
Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/40% Participating	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 (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 20% 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 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		
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

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$6000/20%/\$6550 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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)	In Network Deductible, then 0%	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)	\$6,000 PCY Deductible, then 0%	\$6,000 PCY Deductible, then 0%
Medical Services from Elective Procedure Travel	Covered as any other service	Covered as any other service
EMERGENCY CARE		
Emergency Care	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Emergency Room Physician	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Urgent Care Center	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Ambulance Transportation (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Ground Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
Non-Emergent Air Ambulance (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then 60% Non-Participating
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Manipulations (Spinal and other) (12 visits PCY)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$6000/20%/\$6550 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
PHARMACY		
Formulary Drug List	E1 Essentials Formulary No Tiers	E1 Essentials Formulary No Tiers
Enhanced Preventive Drug List (PV Core)	Covered in Full	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)	In Network Deductible, then 20% Preferred	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)	In Network Deductible, then 20% Preferred	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 20% 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 20% Preferred	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		
Routine Vision Exam (1 PCY; \$350 PCY, shared with Vision Hardware)	Waive In Network Deductible, then 10%	Waive In Network Deductible, then 10%
Vision Hardware (1 set of frames every 2 consecutive years, \$90 max; 1 pair of lenses PCY; contacts \$170 PCY max; Vision Exam/Test and Hardware \$350 PCY max)	Covered in Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred
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 every 2 calendar years)	In Network Deductible, then 20%	In Network Deductible, then 20%
Hearing Hardware (\$3,000 every 3 calendar years)	In Network Deductible, then 20%	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 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.

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 - HP HSA QUALIFIED EMB \$6500/0%/\$6500		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$6,500 PCY	Shared with In-Network
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	0%	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)	\$6,500 PCY	\$45,000 PCY
Office Visit Cost Share	In Network Deductible, then 0%	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 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
APP-BASED VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	In Network Deductible, then 0%	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$6500/0%/\$6500		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	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 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Basic Diagnostic Imaging	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Major Diagnostic Imaging	In Network Deductible, then 0%	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	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Supplemental Breast Exam	In Network Deductible, then 0%	Covered as any other service
FACILITY CARE		
Inpatient Facility	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Inpatient Professional Services	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Surgery Facility	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Facility	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Skilled Nursing Facility (60 days PCY)	In Network Deductible, then 0%	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 0%	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 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Home Health Visits (130 visits PCY)	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
MATERNITY & REPRODUCTIVE CARE		
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

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$6500/0%/\$6500		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Sterilization - Male (Unlimited)	In Network Deductible, then 0%	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)	In Network Deductible, then 0%	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 0%	In Network Deductible, then 0%
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)	\$6,500 PCY Deductible, then 0%	\$6,500 PCY Deductible, then 0%
Medical Services from Elective Procedure Travel	Covered as any other service	Covered as any other service
EMERGENCY CARE		
Emergency Care	In Network Deductible, then 0%	In Network Deductible, then 0%
Emergency Room Physician	In Network Deductible, then 0%	In Network Deductible, then 0%
Urgent Care Center	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Ambulance Transportation (Unlimited)	In Network Deductible, then 0%	In Network Deductible, then 0%
Non-Emergent Ground Ambulance (Unlimited)	In Network Deductible, then 0%	In Network Deductible, then 0%
Air Ambulance (Unlimited)	In Network Deductible, then 0%	In Network Deductible, then 0%
Non-Emergent Air Ambulance (Unlimited)	In Network Deductible, then 0%	Out of Network Deductible, then 60% Non-Participating
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Manipulations (Spinal and other) (12 visits PCY)	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Chemical Dependency Outpatient Professional Care (Unlimited)	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Mental Health Inpatient Facility Care (Unlimited)	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Mental Health Outpatient Professional Care (Unlimited)	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$6500/0%/\$6500		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
PHARMACY		
Formulary Drug List	Open A1 No Tiers	Open A1 No Tiers
Enhanced Preventive Drug List (PV Core)	Covered in Full	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)	In Network Deductible, then 0%	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)	In Network Deductible, then 0%	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 0%	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 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
OTHER SERVICES		
Allergy/Therapeutic Injections	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Medical Supplies, Equipment, Prosthetics (MS: Unlimited, ME: Unlimited, Pro: Unlimited)	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
SUPPLEMENTAL BENEFITS		
Routine Vision Exam (1 PCY; \$350 PCY, shared with Vision Hardware)	Waive In Network Deductible, then 10%	Waive In Network Deductible, then 10%
Vision Hardware (1 set of frames every 2 consecutive years, \$90 max; 1 pair of lenses PCY; contacts \$170 PCY max; Vision Exam/Test and Hardware \$350 PCY max)	Covered in Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)	In Network Deductible, then 0%	In Network Deductible, then 0%
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 every 2 calendar years)	In Network Deductible, then 20%	In Network Deductible, then 20%
Hearing Hardware (\$3,000 every 3 calendar years)	In Network Deductible, then 20%	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 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

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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 - HP HSA QUALIFIED EMB \$6500/0%/\$6500 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$6,500 PCY	Shared with In-Network
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	0%	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)	\$6,500 PCY	\$45,000 PCY
Office Visit Cost Share	In Network Deductible, then 0%	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 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
APP-BASED VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	In Network Deductible, then 0%	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Not Covered	Not Covered

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$6500/0%/\$6500 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	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 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Basic Diagnostic Imaging	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Major Diagnostic Imaging	In Network Deductible, then 0%	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	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Supplemental Breast Exam	In Network Deductible, then 0%	Covered as any other service
FACILITY CARE		
Inpatient Facility	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Inpatient Professional Services	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Surgery Facility	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Facility	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Skilled Nursing Facility (60 days PCY)	In Network Deductible, then 0%	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 0%	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 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Home Health Visits (130 visits PCY)	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
MATERNITY & REPRODUCTIVE CARE		
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

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$6500/0%/\$6500 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Sterilization - Male (Unlimited)	In Network Deductible, then 0%	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)	In Network Deductible, then 0%	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 0%	In Network Deductible, then 0%
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)	\$6,500 PCY Deductible, then 0%	\$6,500 PCY Deductible, then 0%
Medical Services from Elective Procedure Travel	Covered as any other service	Covered as any other service
EMERGENCY CARE		
Emergency Care	In Network Deductible, then 0%	In Network Deductible, then 0%
Emergency Room Physician	In Network Deductible, then 0%	In Network Deductible, then 0%
Urgent Care Center	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Ambulance Transportation (Unlimited)	In Network Deductible, then 0%	In Network Deductible, then 0%
Non-Emergent Ground Ambulance (Unlimited)	In Network Deductible, then 0%	In Network Deductible, then 0%
Air Ambulance (Unlimited)	In Network Deductible, then 0%	In Network Deductible, then 0%
Non-Emergent Air Ambulance (Unlimited)	In Network Deductible, then 0%	Out of Network Deductible, then 60% Non-Participating
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Manipulations (Spinal and other) (12 visits PCY)	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Chemical Dependency Outpatient Professional Care (Unlimited)	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Mental Health Inpatient Facility Care (Unlimited)	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Mental Health Outpatient Professional Care (Unlimited)	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating

MEDICAL PLAN		
PC - HP HSA QUALIFIED EMB \$6500/0%/\$6500 - ESSENTIALS RX		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
PHARMACY		
Formulary Drug List	E1 Essentials Formulary No Tiers	E1 Essentials Formulary No Tiers
Enhanced Preventive Drug List (PV Core)	Covered in Full	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)	In Network Deductible, then 0%	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)	In Network Deductible, then 0%	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 0%	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 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
OTHER SERVICES		
Allergy/Therapeutic Injections	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Medical Supplies, Equipment, Prosthetics (MS: Unlimited, ME: Unlimited, Pro: Unlimited)	In Network Deductible, then 0%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
SUPPLEMENTAL BENEFITS		
Routine Vision Exam (1 PCY; \$350 PCY, shared with Vision Hardware)	Waive In Network Deductible, then 10%	Waive In Network Deductible, then 10%
Vision Hardware (1 set of frames every 2 consecutive years, \$90 max; 1 pair of lenses PCY; contacts \$170 PCY max; Vision Exam/Test and Hardware \$350 PCY max)	Covered in Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)	In Network Deductible, then 0%	In Network Deductible, then 0%
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 every 2 calendar years)	In Network Deductible, then 20%	In Network Deductible, then 20%
Hearing Hardware (\$3,000 every 3 calendar years)	In Network Deductible, then 20%	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 Premiera Blue Cross Blue Shield of Alaska. Members are responsible for amounts in excess of the allowable charge.

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coverage information including a description of waiting periods, limitations, and exclusions.

Highlights of your Health Care Coverage

Effective Date: 01/01/2025

Below is a brief overview of your pharmacy benefit. For more information, please refer to your benefit booklet or sign into www.premera.com to find drug costs and coverages specific to your plan.

PHARMACY PLAN	
PC - RX \$150-\$15/\$60/\$100/50% - ESSENTIALS	
PRESCRIPTION DRUGS	
Formulary Drug List	E4 Essentials Formulary Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = preferred specialty Tier 4 = non-preferred all drugs
Annual Benefit Maximum	Unlimited
Individual Deductible PCY	\$150 ded waived for preferred generics
Family Deductible PCY	Family Deductible 2x Individual
Out of Network (Non-participating retail pharmacies)	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Enhanced Preventive Drug List	No Buy Up
Retail Cost Shares	Tier 1 = \$15 Tier 2 = \$60 Tier 3 = \$100 Tier 4 = 50%
Mail Cost Shares	Tier 1 = \$37.50 Tier 2 = \$150 Tier 3 = \$100 Tier 4 = 50%
Day Supply	Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days
Mandatory Home Delivery for Maintenance Drugs	Excluded
Specialty Pharmacy	Mandatory - Exclusive

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.

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Highlights of your Health Care Coverage

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PHARMACY PLAN	
PC - RX \$10/\$20/\$40	
PRESCRIPTION DRUGS	
Formulary Drug List	Preferred B3 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands
Annual Benefit Maximum	Unlimited
Individual Deductible PCY	\$0
Family Deductible PCY	No Family Deductible
Out of Network (Non-participating retail pharmacies)	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Enhanced Preventive Drug List	No Buy Up
Retail Cost Shares	Tier 1 = \$10 Tier 2 = \$20 Tier 3 = \$40
Mail Cost Shares	Tier 1 = \$25 Tier 2 = \$50 Tier 3 = \$100
Day Supply	Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days
Mandatory Home Delivery for Maintenance Drugs	Excluded
Specialty Pharmacy	Mandatory - Exclusive

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.

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Highlights of your Health Care Coverage

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PHARMACY PLAN	
PC - RX \$10/\$25/\$45/30% - ESSENTIALS	
PRESCRIPTION DRUGS	
Formulary Drug List	E4 Essentials Formulary Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = preferred specialty Tier 4 = non-preferred all drugs
Annual Benefit Maximum	Unlimited
Individual Deductible PCY	\$0
Family Deductible PCY	No Family Deductible
Out of Network (Non-participating retail pharmacies)	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Enhanced Preventive Drug List	No Buy Up
Retail Cost Shares	Tier 1 = \$10 Tier 2 = \$25 Tier 3 = \$45 Tier 4 = 30%
Mail Cost Shares	Tier 1 = \$25 Tier 2 = \$62.50 Tier 3 = \$45 Tier 4 = 30%
Day Supply	Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days
Mandatory Home Delivery for Maintenance Drugs	Excluded
Specialty Pharmacy	Mandatory - Exclusive

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.

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PHARMACY PLAN	
PC - RX \$10/\$30/\$30/30%	
PRESCRIPTION DRUGS	
Formulary Drug List	Preferred B4 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands Tier 4 = specialty
Annual Benefit Maximum	Unlimited
Individual Deductible PCY	\$0
Family Deductible PCY	No Family Deductible
Out of Network (Non-participating retail pharmacies)	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Enhanced Preventive Drug List	No Buy Up
Retail Cost Shares	Tier 1 = \$10 Tier 2 = \$30 Tier 3 = \$30 Tier 4 = 30%
Mail Cost Shares	Tier 1 = \$25 Tier 2 = \$75 Tier 3 = \$75 Tier 4 = 30%
Day Supply	Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days
Mandatory Home Delivery for Maintenance Drugs	Excluded
Specialty Pharmacy	Mandatory - Exclusive

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.

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Highlights of your Health Care Coverage

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PHARMACY PLAN	
PC - RX \$10/\$30/\$50	
PRESCRIPTION DRUGS	
Formulary Drug List	Preferred B3 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands
Annual Benefit Maximum	Unlimited
Individual Deductible PCY	\$0
Family Deductible PCY	No Family Deductible
Out of Network (Non-participating retail pharmacies)	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Enhanced Preventive Drug List	No Buy Up
Retail Cost Shares	Tier 1 = \$10 Tier 2 = \$30 Tier 3 = \$50
Mail Cost Shares	Tier 1 = \$25 Tier 2 = \$75 Tier 3 = \$125
Day Supply	Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days
Mandatory Home Delivery for Maintenance Drugs	Excluded
Specialty Pharmacy	Mandatory - Exclusive

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.
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Highlights of your Health Care Coverage

Effective Date: 01/01/2025

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PHARMACY PLAN	
PC - RX \$15/\$30/\$50/30%	
PRESCRIPTION DRUGS	
Formulary Drug List	Preferred B4 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands Tier 4 = specialty
Annual Benefit Maximum	Unlimited
Individual Deductible PCY	\$0
Family Deductible PCY	No Family Deductible
Out of Network (Non-participating retail pharmacies)	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Enhanced Preventive Drug List	No Buy Up
Retail Cost Shares	Tier 1 = \$15 Tier 2 = \$30 Tier 3 = \$50 Tier 4 = 30%
Mail Cost Shares	Tier 1 = \$37.50 Tier 2 = \$75 Tier 3 = \$125 Tier 4 = 30%
Day Supply	Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days
Mandatory Home Delivery for Maintenance Drugs	Excluded
Specialty Pharmacy	Mandatory - Exclusive

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.

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coverage information including a description of waiting periods, limitations, and exclusions.

Highlights of your Health Care Coverage

Effective Date: 01/01/2025

Below is a brief overview of your pharmacy benefit. For more information, please refer to your benefit booklet or sign into www.premera.com to find drug costs and coverages specific to your plan.

PHARMACY PLAN	
PC - RX \$15/\$30/\$50/30% - ESSENTIALS	
PRESCRIPTION DRUGS	
Formulary Drug List	E4 Essentials Formulary Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = preferred specialty Tier 4 = non-preferred all drugs
Annual Benefit Maximum	Unlimited
Individual Deductible PCY	\$0
Family Deductible PCY	No Family Deductible
Out of Network (Non-participating retail pharmacies)	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Enhanced Preventive Drug List	No Buy Up
Retail Cost Shares	Tier 1 = \$15 Tier 2 = \$30 Tier 3 = \$50 Tier 4 = 30%
Mail Cost Shares	Tier 1 = \$37.50 Tier 2 = \$75 Tier 3 = \$50 Tier 4 = 30%
Day Supply	Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days
Mandatory Home Delivery for Maintenance Drugs	Excluded
Specialty Pharmacy	Mandatory - Exclusive

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.

Highlights of your Health Care Coverage

Effective Date: 01/01/2025

Below is a brief overview of your pharmacy benefit. For more information, please refer to your benefit booklet or sign into www.premera.com to find drug costs and coverages specific to your plan.

PHARMACY PLAN	
PC - RX \$150-\$15/\$30/\$50/30%	
PRESCRIPTION DRUGS	
Formulary Drug List	Preferred B4 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands Tier 4 = specialty
Annual Benefit Maximum	Unlimited
Individual Deductible PCY	\$150 ded waived for generics
Family Deductible PCY	Family Deductible 2x Individual
Out of Network (Non-participating retail pharmacies)	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Enhanced Preventive Drug List	No Buy Up
Retail Cost Shares	Tier 1 = \$15 Tier 2 = \$30 Tier 3 = \$50 Tier 4 = 30%
Mail Cost Shares	Tier 1 = \$37.50 Tier 2 = \$75 Tier 3 = \$125 Tier 4 = 30%
Day Supply	Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days
Mandatory Home Delivery for Maintenance Drugs	Excluded
Specialty Pharmacy	Mandatory - Exclusive

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.

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coverage information including a description of waiting periods, limitations, and exclusions.

Highlights of your Health Care Coverage

Effective Date: 01/01/2025

Below is a brief overview of your pharmacy benefit. For more information, please refer to your benefit booklet or sign into www.premera.com to find drug costs and coverages specific to your plan.

PHARMACY PLAN	
PC - RX \$20/\$40/\$60	
PRESCRIPTION DRUGS	
Formulary Drug List	Preferred B3 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands
Annual Benefit Maximum	Unlimited
Individual Deductible PCY	\$0
Family Deductible PCY	No Family Deductible
Out of Network (Non-participating retail pharmacies)	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Enhanced Preventive Drug List	No Buy Up
Retail Cost Shares	Tier 1 = \$20 Tier 2 = \$40 Tier 3 = \$60
Mail Cost Shares	Tier 1 = \$50 Tier 2 = \$100 Tier 3 = \$150
Day Supply	Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days
Mandatory Home Delivery for Maintenance Drugs	Excluded
Specialty Pharmacy	Mandatory - Exclusive

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.

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Highlights of your Health Care Coverage

Effective Date: 01/01/2025

Below is a brief overview of your pharmacy benefit. For more information, please refer to your benefit booklet or sign into www.premera.com to find drug costs and coverages specific to your plan.

PHARMACY PLAN	
PC - RX \$20/\$50/50%/30%	
PRESCRIPTION DRUGS	
Formulary Drug List	Preferred B4 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands Tier 4 = specialty
Annual Benefit Maximum	Unlimited
Individual Deductible PCY	\$0
Family Deductible PCY	No Family Deductible
Out of Network (Non-participating retail pharmacies)	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Enhanced Preventive Drug List	No Buy Up
Retail Cost Shares	Tier 1 = \$20 Tier 2 = \$50 Tier 3 = 50% Tier 4 = 30%
Mail Cost Shares	Tier 1 = \$50 Tier 2 = \$125 Tier 3 = 50% Tier 4 = 30%
Day Supply	Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days
Mandatory Home Delivery for Maintenance Drugs	Excluded
Specialty Pharmacy	Mandatory - Exclusive

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.

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coverage information including a description of waiting periods, limitations, and exclusions.

Highlights of your Dental Coverage

Effective Date: 01/01/2025

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

DENTAL PLAN		PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$1500 SHARED FAMILY + MAX WAIVER	
	IN-NETWORK	OUT-OF-NETWORK	
Dental Cost Share			
Individual Deductible	\$50	Shared with In Network	
Family Deductible	\$150	Shared with In Network	
Preventive Cost Share	Covered in Full	Covered in Full	
Basic Cost Share	Deductible, then 20%	Deductible, then 20%	
Major Cost Share	Deductible, then 50%	Deductible, then 50%	
Dental Reimbursement (Dental Choice Network)	AK fee schedule	80th percentile (in-state) and 90th percentile (out-of-state)	
Dental Annual Maximum	\$1500 SHARED PCY applies to basic and major services (Family shared PCY maximum limit – up to 3x Individual)	Shared with In Network	
Benefit Enhancement Rider			
Benefit Enhancement Rider	Endodontics & Periodontal Treatment (In Major)	Endodontics & Periodontal Treatment (In Major)	
Office Visit			
Routine Comprehensive / Periodic Oral Exams (2 PCY)	Covered in Full	Covered in Full	
Problem Focused/Emergency Exam (2 PCY)	Covered in Full	Covered in Full	
Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine))	Covered in Full	Covered in Full	
Preventive Services			
Prophylaxis - Cleaning (2 PCY)	Covered in Full	Covered in Full	
Fluoride Treatments (2 PCY; under the age of 20)	Covered in Full	Covered in Full	
Sealants (Under age 20 limited to permanent molars only, Replacements limited to once every 24 consecutive months)	Covered in Full	Covered in Full	

Highlights of your Dental Coverage

Effective Date: 01/01/2025

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

DENTAL PLAN		PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$1500 SHARED FAMILY + MAX WAIVER	
	IN-NETWORK	OUT-OF-NETWORK	
Space Maintainers (Members under age 20)	Covered in Full	Covered in Full	
Diagnostic Imaging			
Bitewings X-rays (Unlimited)	Covered in Full	Covered in Full	
Panoramic X-ray or comparable Conebeam view (1 complete series, 1 panoramic or 1 comparable cone beam view in any 36 consecutive months)	Covered in Full	Covered in Full	
Restorative			
Fillings (1 per surface every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%	
Installation of Inlays, Onlays and Crowns (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%	
Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%	
Repair Crown/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%	
Endodontics			
Endodontic Therapy - Root Canal (Once per tooth every 24 consecutive months)	Deductible, then 50%	Deductible, then 50%	
Periodontics			
Periodontal Maintenance (4 PCY)	Deductible, then 20%	Deductible, then 20%	
Full Mouth Debridement (Once every 36 consecutive months)	Deductible, then 50%	Deductible, then 50%	
Periodontal Scaling and Root Planing (Once per quadrant every 24 consecutive months)	Deductible, then 50%	Deductible, then 50%	
Periodontal Surgery (Once per quadrant every 36 consecutive months)	Deductible, then 50%	Deductible, then 50%	
Periodontal Soft Tissue Grafts (Once per quadrant every 36 consecutive months)	Deductible, then 50%	Deductible, then 50%	
Prosthodontics (Dentures/Bridges)			
Installation or Replacement of Dentures, Partials and Fixed Bridges (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%	

Highlights of your Dental Coverage

Effective Date: 01/01/2025

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

DENTAL PLAN			PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$1500 SHARED FAMILY + MAX WAIVER		
			IN-NETWORK		OUT-OF-NETWORK
Repair or Re-cement Bridgework and Dentures (When performed 6 or more months after placement)			Deductible, then 20%		Deductible, then 20%
Implant Services					
Implant Crowns/Bridge/Denture (1 every 5 calendar years)			Deductible, then 50%		Deductible, then 50%
Oral Surgery					
Simple Extractions (Unlimited)			Deductible, then 20%		Deductible, then 20%
Surgical Extractions (Unlimited)			Deductible, then 20%		Deductible, then 20%
Oral Surgery (Unlimited)			Deductible, then 20%		Deductible, then 20%
General Services					
Anesthesia - Intravenous or General (Unlimited)			Deductible, then 20%		Deductible, then 20%
Anesthesia - Nitrous Oxide (Unlimited)			Deductible, then 20%		Deductible, then 20%
Palliative (Emergency) Treatment of Dental Pain (Unlimited)			Deductible, then 20%		Deductible, then 20%
Orthodontia					
Orthodontia Cost Share			Not Covered		Not Covered
Lifetime Maximum Benefit			Not Covered		Not Covered
TMJ Rider					
TMJ Rider (Not Covered)			Not Covered		Not Covered

Diagnostic and Preventive Care Services aren't subject to the calendar year deductible. 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.

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Highlights of your Dental Coverage

Effective Date: 01/01/2025

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

DENTAL PLAN		
PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$1000		
	IN-NETWORK	OUT-OF-NETWORK
Dental Cost Share		
Individual Deductible	\$50	Shared with In Network
Family Deductible	\$150	Shared with In Network
Preventive Cost Share	Covered in Full	Covered in Full
Basic Cost Share	Deductible, then 20%	Deductible, then 20%
Major Cost Share	Deductible, then 50%	Deductible, then 50%
Dental Reimbursement (Dental Choice Network)	AK fee schedule	80th percentile (in-state) and 90th percentile (out-of-state)
Dental Annual Maximum	\$1,000 PCY	Shared with In Network
Benefit Enhancement Rider		
Benefit Enhancement Rider	Endodontics & Periodontal Treatment (In Major)	Endodontics & Periodontal Treatment (In Major)
Office Visit		
Routine Comprehensive / Periodic Oral Exams (2 PCY)	Covered in Full	Covered in Full
Problem Focused/Emergency Exam (2 PCY)	Covered in Full	Covered in Full
Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine))	Covered in Full	Covered in Full
Preventive Services		
Prophylaxis - Cleaning (2 PCY)	Covered in Full	Covered in Full
Fluoride Treatments (2 PCY; under the age of 20)	Covered in Full	Covered in Full
Sealants (Under age 20 limited to permanent molars only, Replacements limited to once every 24 consecutive months)	Covered in Full	Covered in Full
Space Maintainers (Members under age 20)	Covered in Full	Covered in Full
Diagnostic Imaging		

Highlights of your Dental Coverage

Effective Date: 01/01/2025

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

DENTAL PLAN		
PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$1000		
	IN-NETWORK	OUT-OF-NETWORK
Bitewings X-rays (Unlimited)	Covered in Full	Covered in Full
Panoramic X-ray or comparable Conebeam view (1 complete series, 1 panoramic or 1 comparable cone beam view in any 36 consecutive months)	Covered in Full	Covered in Full
Restorative		
Fillings (1 per surface every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%
Installation of Inlays, Onlays and Crowns (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Repair Crown/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Endodontics		
Endodontic Therapy - Root Canal (Once per tooth every 24 consecutive months)	Deductible, then 50%	Deductible, then 50%
Periodontics		
Periodontal Maintenance (4 PCY)	Deductible, then 20%	Deductible, then 20%
Full Mouth Debridement (Once every 36 consecutive months)	Deductible, then 50%	Deductible, then 50%
Periodontal Scaling and Root Planing (Once per quadrant every 24 consecutive months)	Deductible, then 50%	Deductible, then 50%
Periodontal Surgery (Once per quadrant every 36 consecutive months)	Deductible, then 50%	Deductible, then 50%
Periodontal Soft Tissue Grafts (Once per quadrant every 36 consecutive months)	Deductible, then 50%	Deductible, then 50%
Prosthodontics (Dentures/Bridges)		
Installation or Replacement of Dentures, Partials and Fixed Bridges (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Repair or Re-cement Bridgework and Dentures (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Implant Services		

Highlights of your Dental Coverage

Effective Date: 01/01/2025

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

DENTAL PLAN		
PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$1000		
	IN-NETWORK	OUT-OF-NETWORK
Implant Crowns/Bridge/Denture (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Oral Surgery		
Simple Extractions (Unlimited)	Deductible, then 20%	Deductible, then 20%
Surgical Extractions (Unlimited)	Deductible, then 20%	Deductible, then 20%
Oral Surgery (Unlimited)	Deductible, then 20%	Deductible, then 20%
General Services		
Anesthesia - Intravenous or General (Unlimited)	Deductible, then 20%	Deductible, then 20%
Anesthesia - Nitrous Oxide (Unlimited)	Deductible, then 20%	Deductible, then 20%
Palliative (Emergency) Treatment of Dental Pain (Unlimited)	Deductible, then 20%	Deductible, then 20%
Orthodontia		
Orthodontia Cost Share	Not Covered	Not Covered
Lifetime Maximum Benefit	Not Covered	Not Covered
TMJ Rider		
TMJ Rider (Not Covered)	Not Covered	Not Covered

Diagnostic and Preventive Care Services aren't subject to the calendar year deductible. 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.

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Highlights of your Dental Coverage

Effective Date: 01/01/2025

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

DENTAL PLAN		
PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$1500		
	IN-NETWORK	OUT-OF-NETWORK
Dental Cost Share		
Individual Deductible	\$50	Shared with In Network
Family Deductible	\$150	Shared with In Network
Preventive Cost Share	Covered in Full	Covered in Full
Basic Cost Share	Deductible, then 20%	Deductible, then 20%
Major Cost Share	Deductible, then 50%	Deductible, then 50%
Dental Reimbursement (Dental Choice Network)	AK fee schedule	80th percentile (in-state) and 90th percentile (out-of-state)
Dental Annual Maximum	\$1,500 PCY	Shared with In Network
Benefit Enhancement Rider		
Benefit Enhancement Rider	Endodontics & Periodontal Treatment (In Major)	Endodontics & Periodontal Treatment (In Major)
Office Visit		
Routine Comprehensive / Periodic Oral Exams (2 PCY)	Covered in Full	Covered in Full
Problem Focused/Emergency Exam (2 PCY)	Covered in Full	Covered in Full
Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine))	Covered in Full	Covered in Full
Preventive Services		
Prophylaxis - Cleaning (2 PCY)	Covered in Full	Covered in Full
Fluoride Treatments (2 PCY; under the age of 20)	Covered in Full	Covered in Full
Sealants (Under age 20 limited to permanent molars only, Replacements limited to once every 24 consecutive months)	Covered in Full	Covered in Full
Space Maintainers (Members under age 20)	Covered in Full	Covered in Full
Diagnostic Imaging		

Highlights of your Dental Coverage

Effective Date: 01/01/2025

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

DENTAL PLAN		
PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$1500		
	IN-NETWORK	OUT-OF-NETWORK
Bitewings X-rays (Unlimited)	Covered in Full	Covered in Full
Panoramic X-ray or comparable Conebeam view (1 complete series, 1 panoramic or 1 comparable cone beam view in any 36 consecutive months)	Covered in Full	Covered in Full
Restorative		
Fillings (1 per surface every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%
Installation of Inlays, Onlays and Crowns (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Repair Crown/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Endodontics		
Endodontic Therapy - Root Canal (Once per tooth every 24 consecutive months)	Deductible, then 50%	Deductible, then 50%
Periodontics		
Periodontal Maintenance (4 PCY)	Deductible, then 20%	Deductible, then 20%
Full Mouth Debridement (Once every 36 consecutive months)	Deductible, then 50%	Deductible, then 50%
Periodontal Scaling and Root Planing (Once per quadrant every 24 consecutive months)	Deductible, then 50%	Deductible, then 50%
Periodontal Surgery (Once per quadrant every 36 consecutive months)	Deductible, then 50%	Deductible, then 50%
Periodontal Soft Tissue Grafts (Once per quadrant every 36 consecutive months)	Deductible, then 50%	Deductible, then 50%
Prosthodontics (Dentures/Bridges)		
Installation or Replacement of Dentures, Partials and Fixed Bridges (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Repair or Re-cement Bridgework and Dentures (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Implant Services		

Highlights of your Dental Coverage

Effective Date: 01/01/2025

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

DENTAL PLAN		
PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$1500		
	IN-NETWORK	OUT-OF-NETWORK
Implant Crowns/Bridge/Denture (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Oral Surgery		
Simple Extractions (Unlimited)	Deductible, then 20%	Deductible, then 20%
Surgical Extractions (Unlimited)	Deductible, then 20%	Deductible, then 20%
Oral Surgery (Unlimited)	Deductible, then 20%	Deductible, then 20%
General Services		
Anesthesia - Intravenous or General (Unlimited)	Deductible, then 20%	Deductible, then 20%
Anesthesia - Nitrous Oxide (Unlimited)	Deductible, then 20%	Deductible, then 20%
Palliative (Emergency) Treatment of Dental Pain (Unlimited)	Deductible, then 20%	Deductible, then 20%
Orthodontia		
Orthodontia Cost Share	Not Covered	Not Covered
Lifetime Maximum Benefit	Not Covered	Not Covered
TMJ Rider		
TMJ Rider (Not Covered)	Not Covered	Not Covered

Diagnostic and Preventive Care Services aren't subject to the calendar year deductible. 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.

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Highlights of your Dental Coverage

Effective Date: 01/01/2025

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

DENTAL PLAN		
PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$1500 MAX WAIVER		
	IN-NETWORK	OUT-OF-NETWORK
Dental Cost Share		
Individual Deductible	\$50	Shared with In Network
Family Deductible	\$150	Shared with In Network
Preventive Cost Share	Covered in Full	Covered in Full
Basic Cost Share	Deductible, then 20%	Deductible, then 20%
Major Cost Share	Deductible, then 50%	Deductible, then 50%
Dental Reimbursement (Dental Choice Network)	AK fee schedule	80th percentile (in-state) and 90th percentile (out-of-state)
Dental Annual Maximum	\$1,500 PCY applies to basic and major services	Shared with In Network
Benefit Enhancement Rider		
Benefit Enhancement Rider	Endodontics & Periodontal Treatment (In Basic)	Endodontics & Periodontal Treatment (In Basic)
Office Visit		
Routine Comprehensive / Periodic Oral Exams (2 PCY)	Covered in Full	Covered in Full
Problem Focused/Emergency Exam (2 PCY)	Covered in Full	Covered in Full
Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine))	Covered in Full	Covered in Full
Preventive Services		
Prophylaxis - Cleaning (2 PCY)	Covered in Full	Covered in Full
Fluoride Treatments (2 PCY; under the age of 20)	Covered in Full	Covered in Full
Sealants (Under age 20 limited to permanent molars only, Replacements limited to once every 24 consecutive months)	Covered in Full	Covered in Full
Space Maintainers (Members under age 20)	Covered in Full	Covered in Full

Highlights of your Dental Coverage

Effective Date: 01/01/2025

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

DENTAL PLAN		
PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$1500 MAX WAIVER		
	IN-NETWORK	OUT-OF-NETWORK
Diagnostic Imaging		
Bitewings X-rays (Unlimited)	Covered in Full	Covered in Full
Panoramic X-ray or comparable Conebeam view (1 complete series, 1 panoramic or 1 comparable cone beam view in any 36 consecutive months)	Covered in Full	Covered in Full
Restorative		
Fillings (1 per surface every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%
Installation of Inlays, Onlays and Crowns (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Repair Crown/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Endodontics		
Endodontic Therapy - Root Canal (Once per tooth every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%
Periodontics		
Periodontal Maintenance (4 PCY)	Deductible, then 20%	Deductible, then 20%
Full Mouth Debridement (Once every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%
Periodontal Scaling and Root Planing (Once per quadrant every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%
Periodontal Surgery (Once per quadrant every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%
Periodontal Soft Tissue Grafts (Once per quadrant every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%
Prosthodontics (Dentures/Bridges)		
Installation or Replacement of Dentures, Partials and Fixed Bridges (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Repair or Re-cement Bridgework and Dentures (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%

Highlights of your Dental Coverage

Effective Date: 01/01/2025

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DENTAL PLAN		
PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$1500 MAX WAIVER		
	IN-NETWORK	OUT-OF-NETWORK
Implant Services		
Implant Crowns/Bridge/Denture (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Oral Surgery		
Simple Extractions (Unlimited)	Deductible, then 20%	Deductible, then 20%
Surgical Extractions (Unlimited)	Deductible, then 20%	Deductible, then 20%
Oral Surgery (Unlimited)	Deductible, then 20%	Deductible, then 20%
General Services		
Anesthesia - Intravenous or General (Unlimited)	Deductible, then 20%	Deductible, then 20%
Anesthesia - Nitrous Oxide (Unlimited)	Deductible, then 20%	Deductible, then 20%
Palliative (Emergency) Treatment of Dental Pain (Unlimited)	Deductible, then 20%	Deductible, then 20%
Orthodontia		
Orthodontia Cost Share	Not Covered	Not Covered
Lifetime Maximum Benefit	Not Covered	Not Covered
TMJ Rider		
TMJ Rider (Not Covered)	Not Covered	Not Covered

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Highlights of your Dental Coverage

Effective Date: 01/01/2025

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DENTAL PLAN		PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$1500 ENHANCED+MAX WAIVER+ORTHO	
	IN-NETWORK	OUT-OF-NETWORK	
Dental Cost Share			
Individual Deductible	\$50	Shared with In Network	
Family Deductible	\$150	Shared with In Network	
Preventive Cost Share	Covered in Full	Covered in Full	
Basic Cost Share	Deductible, then 20%	Deductible, then 20%	
Major Cost Share	Deductible, then 50%	Deductible, then 50%	
Dental Reimbursement (Dental Choice Network)	AK fee schedule	80th percentile (in-state) and 90th percentile (out-of-state)	
Dental Annual Maximum	\$1,500 PCY applies to basic and major services	Shared with In Network	
Benefit Enhancement Rider			
Benefit Enhancement Rider	Endodontics & Periodontal Treatment (In Basic)	Endodontics & Periodontal Treatment (In Basic)	
Office Visit			
Routine Comprehensive / Periodic Oral Exams (2 PCY)	Covered in Full	Covered in Full	
Problem Focused/Emergency Exam (2 PCY)	Covered in Full	Covered in Full	
Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine))	Covered in Full	Covered in Full	
Preventive Services			
Prophylaxis - Cleaning (2 PCY)	Covered in Full	Covered in Full	
Fluoride Treatments (2 PCY; under the age of 20)	Covered in Full	Covered in Full	
Sealants (Under age 20 limited to permanent molars only, Replacements limited to once every 24 consecutive months)	Covered in Full	Covered in Full	
Space Maintainers (Members under age 20)	Covered in Full	Covered in Full	

Highlights of your Dental Coverage

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DENTAL PLAN		PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$1500 ENHANCED+MAX WAIVER+ORTHO	
	IN-NETWORK	OUT-OF-NETWORK	
Diagnostic Imaging			
Bitewings X-rays (Unlimited)	Covered in Full	Covered in Full	
Panoramic X-ray or comparable Conebeam view (1 complete series, 1 panoramic or 1 comparable cone beam view in any 36 consecutive months)	Covered in Full	Covered in Full	
Restorative			
Fillings (1 per surface every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%	
Installation of Inlays, Onlays and Crowns (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%	
Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%	
Repair Crown/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%	
Endodontics			
Endodontic Therapy - Root Canal (Once per tooth every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%	
Periodontics			
Periodontal Maintenance (4 PCY)	Deductible, then 20%	Deductible, then 20%	
Full Mouth Debridement (Once every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%	
Periodontal Scaling and Root Planing (Once per quadrant every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%	
Periodontal Surgery (Once per quadrant every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%	
Periodontal Soft Tissue Grafts (Once per quadrant every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%	
Prosthodontics (Dentures/Bridges)			
Installation or Replacement of Dentures, Partials and Fixed Bridges (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%	

Highlights of your Dental Coverage

Effective Date: 01/01/2025

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DENTAL PLAN			PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$1500 ENHANCED+MAX WAIVER+ORTHO		
		IN-NETWORK		OUT-OF-NETWORK	
Repair or Re-cement Bridgework and Dentures (When performed 6 or more months after placement)		Deductible, then 20%		Deductible, then 20%	
Implant Services					
Implant Crowns/Bridge/Denture (1 every 5 calendar years)		Deductible, then 50%		Deductible, then 50%	
Oral Surgery					
Simple Extractions (Unlimited)		Deductible, then 20%		Deductible, then 20%	
Surgical Extractions (Unlimited)		Deductible, then 20%		Deductible, then 20%	
Oral Surgery (Unlimited)		Deductible, then 20%		Deductible, then 20%	
General Services					
Anesthesia - Intravenous or General (Unlimited)		Deductible, then 20%		Deductible, then 20%	
Anesthesia - Nitrous Oxide (Unlimited)		Deductible, then 20%		Deductible, then 20%	
Palliative (Emergency) Treatment of Dental Pain (Unlimited)		Deductible, then 20%		Deductible, then 20%	
Orthodontia					
Orthodontia Cost Share		100% up to Lifetime Max		100% up to Lifetime Max	
Lifetime Maximum Benefit		\$1,500 Lifetime		\$1,500 Lifetime	
TMJ Rider					
TMJ Rider (Not Covered)		Not Covered		Not Covered	

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Highlights of your Dental Coverage

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DENTAL PLAN		
PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$1500 VOLUNTARY		
	IN-NETWORK	OUT-OF-NETWORK
Dental Cost Share		
Individual Deductible	\$50	Shared with In Network
Family Deductible	\$150	Shared with In Network
Preventive Cost Share	Covered in Full	Covered in Full
Basic Cost Share	Deductible, then 20%	Deductible, then 20%
Major Cost Share	Deductible, then 50%	Deductible, then 50%
Dental Reimbursement (Dental Choice Network)	AK fee schedule	80th percentile (in-state) and 90th percentile (out-of-state)
Dental Annual Maximum	\$1,500 PCY	Shared with In Network
Benefit Enhancement Rider		
Benefit Enhancement Rider	Endodontics & Periodontal Treatment (In Major)	Endodontics & Periodontal Treatment (In Major)
Office Visit		
Routine Comprehensive / Periodic Oral Exams (2 PCY)	Covered in Full	Covered in Full
Problem Focused/Emergency Exam (2 PCY)	Deductible, then 20%	Deductible, then 20%
Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine))	Covered in Full	Covered in Full
Preventive Services		
Prophylaxis - Cleaning (2 PCY)	Covered in Full	Covered in Full
Fluoride Treatments (2 PCY; under the age of 20)	Covered in Full	Covered in Full
Sealants (Under age 20 limited to permanent molars only, Replacements limited to once every 24 consecutive months)	Covered in Full	Covered in Full
Space Maintainers (Members under age 20)	Deductible, then 20%	Deductible, then 20%
Diagnostic Imaging		

Highlights of your Dental Coverage

Effective Date: 01/01/2025

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DENTAL PLAN		
PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$1500 VOLUNTARY		
	IN-NETWORK	OUT-OF-NETWORK
Bitewings X-rays (Unlimited)	Covered in Full	Covered in Full
Panoramic X-ray or comparable Conebeam view (1 complete series, 1 panoramic or 1 comparable cone beam view in any 36 consecutive months)	Covered in Full	Covered in Full
Restorative		
Fillings (1 per surface every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%
Installation of Inlays, Onlays and Crowns (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Repair Crown/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Endodontics		
Endodontic Therapy - Root Canal (Once per tooth every 24 consecutive months)	Deductible, then 50%	Deductible, then 50%
Periodontics		
Periodontal Maintenance (4 PCY)	Deductible, then 20%	Deductible, then 20%
Full Mouth Debridement (Once every 36 consecutive months)	Deductible, then 50%	Deductible, then 50%
Periodontal Scaling and Root Planing (Once per quadrant every 24 consecutive months)	Deductible, then 50%	Deductible, then 50%
Periodontal Surgery (Once per quadrant every 36 consecutive months)	Deductible, then 50%	Deductible, then 50%
Periodontal Soft Tissue Grafts (Once per quadrant every 36 consecutive months)	Deductible, then 50%	Deductible, then 50%
Prosthodontics (Dentures/Bridges)		
Installation or Replacement of Dentures, Partials and Fixed Bridges (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Repair or Re-cement Bridgework and Dentures (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Implant Services		

Highlights of your Dental Coverage

Effective Date: 01/01/2025

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DENTAL PLAN		
PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$1500 VOLUNTARY		
	IN-NETWORK	OUT-OF-NETWORK
Implant Crowns/Bridge/Denture (Not Covered)	Not Covered	Not Covered
Oral Surgery		
Simple Extractions (Unlimited)	Deductible, then 20%	Deductible, then 20%
Surgical Extractions (Unlimited)	Deductible, then 20%	Deductible, then 20%
Oral Surgery (Unlimited)	Deductible, then 50%	Deductible, then 50%
General Services		
Anesthesia - Intravenous or General (Unlimited)	Deductible, then 50%	Deductible, then 50%
Anesthesia - Nitrous Oxide (Unlimited)	Deductible, then 20%	Deductible, then 20%
Palliative (Emergency) Treatment of Dental Pain (Unlimited)	Deductible, then 20%	Deductible, then 20%
Orthodontia		
Orthodontia Cost Share	Not Covered	Not Covered
Lifetime Maximum Benefit	Not Covered	Not Covered
TMJ Rider		
TMJ Rider (Not Covered)	Not Covered	Not Covered

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

Highlights of your Dental Coverage

Effective Date: 01/01/2025

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

DENTAL PLAN		PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$1500 VOLUNTARY+MAX WAIVER	
	IN-NETWORK	OUT-OF-NETWORK	
Dental Cost Share			
Individual Deductible	\$50	Shared with In Network	
Family Deductible	\$150	Shared with In Network	
Preventive Cost Share	Covered in Full	Covered in Full	
Basic Cost Share	Deductible, then 20%	Deductible, then 20%	
Major Cost Share	Deductible, then 50%	Deductible, then 50%	
Dental Reimbursement (Dental Choice Network)	AK fee schedule	80th percentile (in-state) and 90th percentile (out-of-state)	
Dental Annual Maximum	\$1,500 PCY applies to basic and major services	Shared with In Network	
Benefit Enhancement Rider			
Benefit Enhancement Rider	Endodontics & Periodontal Treatment (In Major)	Endodontics & Periodontal Treatment (In Major)	
Office Visit			
Routine Comprehensive / Periodic Oral Exams (2 PCY)	Covered in Full	Covered in Full	
Problem Focused/Emergency Exam (2 PCY)	Deductible, then 20%	Deductible, then 20%	
Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine))	Covered in Full	Covered in Full	
Preventive Services			
Prophylaxis - Cleaning (2 PCY)	Covered in Full	Covered in Full	
Fluoride Treatments (2 PCY; under the age of 20)	Covered in Full	Covered in Full	
Sealants (Under age 20 limited to permanent molars only, Replacements limited to once every 24 consecutive months)	Covered in Full	Covered in Full	
Space Maintainers (Members under age 20)	Deductible, then 20%	Deductible, then 20%	

Highlights of your Dental Coverage

Effective Date: 01/01/2025

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DENTAL PLAN		PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$1500 VOLUNTARY+MAX WAIVER	
		IN-NETWORK	OUT-OF-NETWORK
Diagnostic Imaging			
Bitewings X-rays (Unlimited)		Covered in Full	Covered in Full
Panoramic X-ray or comparable Conebeam view (1 complete series, 1 panoramic or 1 comparable cone beam view in any 36 consecutive months)		Covered in Full	Covered in Full
Restorative			
Fillings (1 per surface every 24 consecutive months)		Deductible, then 20%	Deductible, then 20%
Installation of Inlays, Onlays and Crowns (1 every 5 calendar years)		Deductible, then 50%	Deductible, then 50%
Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement)		Deductible, then 20%	Deductible, then 20%
Repair Crown/Inlay/Onlay (When performed 6 or more months after placement)		Deductible, then 20%	Deductible, then 20%
Endodontics			
Endodontic Therapy - Root Canal (Once per tooth every 24 consecutive months)		Deductible, then 50%	Deductible, then 50%
Periodontics			
Periodontal Maintenance (4 PCY)		Deductible, then 20%	Deductible, then 20%
Full Mouth Debridement (Once every 36 consecutive months)		Deductible, then 50%	Deductible, then 50%
Periodontal Scaling and Root Planing (Once per quadrant every 24 consecutive months)		Deductible, then 50%	Deductible, then 50%
Periodontal Surgery (Once per quadrant every 36 consecutive months)		Deductible, then 50%	Deductible, then 50%
Periodontal Soft Tissue Grafts (Once per quadrant every 36 consecutive months)		Deductible, then 50%	Deductible, then 50%
Prosthodontics (Dentures/Bridges)			
Installation or Replacement of Dentures, Partials and Fixed Bridges (1 every 5 calendar years)		Deductible, then 50%	Deductible, then 50%

Highlights of your Dental Coverage

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DENTAL PLAN			PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$1500 VOLUNTARY+MAX WAIVER		
		IN-NETWORK		OUT-OF-NETWORK	
Repair or Re-cement Bridgework and Dentures (When performed 6 or more months after placement)		Deductible, then 20%		Deductible, then 20%	
Implant Services					
Implant Crowns/Bridge/Denture (Not Covered)		Not Covered		Not Covered	
Oral Surgery					
Simple Extractions (Unlimited)		Deductible, then 20%		Deductible, then 20%	
Surgical Extractions (Unlimited)		Deductible, then 20%		Deductible, then 20%	
Oral Surgery (Unlimited)		Deductible, then 50%		Deductible, then 50%	
General Services					
Anesthesia - Intravenous or General (Unlimited)		Deductible, then 50%		Deductible, then 50%	
Anesthesia - Nitrous Oxide (Unlimited)		Deductible, then 20%		Deductible, then 20%	
Palliative (Emergency) Treatment of Dental Pain (Unlimited)		Deductible, then 20%		Deductible, then 20%	
Orthodontia					
Orthodontia Cost Share		Not Covered		Not Covered	
Lifetime Maximum Benefit		Not Covered		Not Covered	
TMJ Rider					
TMJ Rider (Not Covered)		Not Covered		Not Covered	

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DENTAL PLAN		PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$2000 ENHANCED+MAX WAIVER	
	IN-NETWORK	OUT-OF-NETWORK	
Dental Cost Share			
Individual Deductible	\$50	Shared with In Network	
Family Deductible	\$150	Shared with In Network	
Preventive Cost Share	Covered in Full	Covered in Full	
Basic Cost Share	Deductible, then 20%	Deductible, then 20%	
Major Cost Share	Deductible, then 50%	Deductible, then 50%	
Dental Reimbursement (Dental Choice Network)	AK fee schedule	80th percentile (in-state) and 90th percentile (out-of-state)	
Dental Annual Maximum	\$2,000 PCY applies to basic and major services	Shared with In Network	
Benefit Enhancement Rider			
Benefit Enhancement Rider	Endodontics & Periodontal Treatment (In Basic)	Endodontics & Periodontal Treatment (In Basic)	
Office Visit			
Routine Comprehensive / Periodic Oral Exams (2 PCY)	Covered in Full	Covered in Full	
Problem Focused/Emergency Exam (2 PCY)	Covered in Full	Covered in Full	
Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine))	Covered in Full	Covered in Full	
Preventive Services			
Prophylaxis - Cleaning (2 PCY)	Covered in Full	Covered in Full	
Fluoride Treatments (2 PCY; under the age of 20)	Covered in Full	Covered in Full	
Sealants (Under age 20 limited to permanent molars only, Replacements limited to once every 24 consecutive months)	Covered in Full	Covered in Full	
Space Maintainers (Members under age 20)	Covered in Full	Covered in Full	

Highlights of your Dental Coverage

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DENTAL PLAN		PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$2000 ENHANCED+MAX WAIVER	
	IN-NETWORK	OUT-OF-NETWORK	
Diagnostic Imaging			
Bitewings X-rays (Unlimited)	Covered in Full	Covered in Full	
Panoramic X-ray or comparable Conebeam view (1 complete series, 1 panoramic or 1 comparable cone beam view in any 36 consecutive months)	Covered in Full	Covered in Full	
Restorative			
Fillings (1 per surface every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%	
Installation of Inlays, Onlays and Crowns (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%	
Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%	
Repair Crown/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%	
Endodontics			
Endodontic Therapy - Root Canal (Once per tooth every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%	
Periodontics			
Periodontal Maintenance (4 PCY)	Deductible, then 20%	Deductible, then 20%	
Full Mouth Debridement (Once every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%	
Periodontal Scaling and Root Planing (Once per quadrant every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%	
Periodontal Surgery (Once per quadrant every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%	
Periodontal Soft Tissue Grafts (Once per quadrant every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%	
Prosthodontics (Dentures/Bridges)			
Installation or Replacement of Dentures, Partials and Fixed Bridges (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%	

Highlights of your Dental Coverage

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DENTAL PLAN		PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$2000 ENHANCED+MAX WAIVER	
	IN-NETWORK	OUT-OF-NETWORK	
Repair or Re-cement Bridgework and Dentures (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%	
Implant Services			
Implant Crowns/Bridge/Denture (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%	
Oral Surgery			
Simple Extractions (Unlimited)	Deductible, then 20%	Deductible, then 20%	
Surgical Extractions (Unlimited)	Deductible, then 20%	Deductible, then 20%	
Oral Surgery (Unlimited)	Deductible, then 20%	Deductible, then 20%	
General Services			
Anesthesia - Intravenous or General (Unlimited)	Deductible, then 20%	Deductible, then 20%	
Anesthesia - Nitrous Oxide (Unlimited)	Deductible, then 20%	Deductible, then 20%	
Palliative (Emergency) Treatment of Dental Pain (Unlimited)	Deductible, then 20%	Deductible, then 20%	
Orthodontia			
Orthodontia Cost Share	Not Covered	Not Covered	
Lifetime Maximum Benefit	Not Covered	Not Covered	
TMJ Rider			
TMJ Rider (Not Covered)	Not Covered	Not Covered	

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DENTAL PLAN		PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$2000 ENHANCED+MAX WAIVER+ORTHO	
	IN-NETWORK	OUT-OF-NETWORK	
Dental Cost Share			
Individual Deductible	\$50	Shared with In Network	
Family Deductible	\$150	Shared with In Network	
Preventive Cost Share	Covered in Full	Covered in Full	
Basic Cost Share	Deductible, then 20%	Deductible, then 20%	
Major Cost Share	Deductible, then 50%	Deductible, then 50%	
Dental Reimbursement (Dental Choice Network)	AK fee schedule	80th percentile (in-state) and 90th percentile (out-of-state)	
Dental Annual Maximum	\$2,000 PCY applies to basic and major services	Shared with In Network	
Benefit Enhancement Rider			
Benefit Enhancement Rider	Endodontics & Periodontal Treatment (In Basic)	Endodontics & Periodontal Treatment (In Basic)	
Office Visit			
Routine Comprehensive / Periodic Oral Exams (2 PCY)	Covered in Full	Covered in Full	
Problem Focused/Emergency Exam (2 PCY)	Covered in Full	Covered in Full	
Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine))	Covered in Full	Covered in Full	
Preventive Services			
Prophylaxis - Cleaning (2 PCY)	Covered in Full	Covered in Full	
Fluoride Treatments (2 PCY; under the age of 20)	Covered in Full	Covered in Full	
Sealants (Under age 20 limited to permanent molars only, Replacements limited to once every 24 consecutive months)	Covered in Full	Covered in Full	
Space Maintainers (Members under age 20)	Covered in Full	Covered in Full	

Highlights of your Dental Coverage

Effective Date: 01/01/2025

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DENTAL PLAN		PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$2000 ENHANCED+MAX WAIVER+ORTHO	
	IN-NETWORK	OUT-OF-NETWORK	
Diagnostic Imaging			
Bitewings X-rays (Unlimited)	Covered in Full	Covered in Full	
Panoramic X-ray or comparable Conebeam view (1 complete series, 1 panoramic or 1 comparable cone beam view in any 36 consecutive months)	Covered in Full	Covered in Full	
Restorative			
Fillings (1 per surface every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%	
Installation of Inlays, Onlays and Crowns (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%	
Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%	
Repair Crown/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%	
Endodontics			
Endodontic Therapy - Root Canal (Once per tooth every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%	
Periodontics			
Periodontal Maintenance (4 PCY)	Deductible, then 20%	Deductible, then 20%	
Full Mouth Debridement (Once every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%	
Periodontal Scaling and Root Planing (Once per quadrant every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%	
Periodontal Surgery (Once per quadrant every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%	
Periodontal Soft Tissue Grafts (Once per quadrant every 36 consecutive months)	Deductible, then 20%	Deductible, then 20%	
Prosthodontics (Dentures/Bridges)			
Installation or Replacement of Dentures, Partials and Fixed Bridges (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%	

Highlights of your Dental Coverage

Effective Date: 01/01/2025

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DENTAL PLAN		PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$2000 ENHANCED+MAX WAIVER+ORTHO	
		IN-NETWORK	OUT-OF-NETWORK
Repair or Re-cement Bridgework and Dentures (When performed 6 or more months after placement)		Deductible, then 20%	Deductible, then 20%
Implant Services			
Implant Crowns/Bridge/Denture (1 every 5 calendar years)		Deductible, then 50%	Deductible, then 50%
Oral Surgery			
Simple Extractions (Unlimited)		Deductible, then 20%	Deductible, then 20%
Surgical Extractions (Unlimited)		Deductible, then 20%	Deductible, then 20%
Oral Surgery (Unlimited)		Deductible, then 20%	Deductible, then 20%
General Services			
Anesthesia - Intravenous or General (Unlimited)		Deductible, then 20%	Deductible, then 20%
Anesthesia - Nitrous Oxide (Unlimited)		Deductible, then 20%	Deductible, then 20%
Palliative (Emergency) Treatment of Dental Pain (Unlimited)		Deductible, then 20%	Deductible, then 20%
Orthodontia			
Orthodontia Cost Share		100% up to Lifetime Max	100% up to Lifetime Max
Lifetime Maximum Benefit		\$1,500 Lifetime	\$1,500 Lifetime
TMJ Rider			
TMJ Rider (Not Covered)		Not Covered	Not Covered

Diagnostic and Preventive Care Services aren't subject to the calendar year deductible. 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.

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Highlights of your Dental Coverage

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DENTAL PLAN		
PC - DENTAL OPTIMA \$50/\$150 - 20%/20%/50%/\$1000		
	IN-NETWORK	OUT-OF-NETWORK
Dental Cost Share		
Individual Deductible	\$50	Shared with In Network
Family Deductible	\$150	Shared with In Network
Preventive Cost Share	Waive Deductible, then 20%	Waive Deductible, then 20%
Basic Cost Share	Deductible, then 20%	Deductible, then 20%
Major Cost Share	Deductible, then 50%	Deductible, then 50%
Dental Reimbursement (Dental Choice Network)	AK fee schedule	80th percentile (in-state) and 90th percentile (out-of-state)
Dental Annual Maximum	\$1,000 PCY	Shared with In Network
Benefit Enhancement Rider		
Benefit Enhancement Rider	Endodontics & Periodontal Treatment (In Major)	Endodontics & Periodontal Treatment (In Major)
Office Visit		
Routine Comprehensive / Periodic Oral Exams (2 PCY)	Waive Deductible, then 20%	Waive Deductible, then 20%
Problem Focused/Emergency Exam (2 PCY)	Waive Deductible, then 20%	Waive Deductible, then 20%
Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine))	Waive Deductible, then 20%	Waive Deductible, then 20%
Preventive Services		
Prophylaxis - Cleaning (2 PCY)	Waive Deductible, then 20%	Waive Deductible, then 20%
Fluoride Treatments (2 PCY; under the age of 20)	Waive Deductible, then 20%	Waive Deductible, then 20%
Sealants (Under age 20 limited to permanent molars only, Replacements limited to once every 24 consecutive months)	Waive Deductible, then 20%	Waive Deductible, then 20%
Space Maintainers (Members under age 20)	Waive Deductible, then 20%	Waive Deductible, then 20%
Diagnostic Imaging		

Highlights of your Dental Coverage

Effective Date: 01/01/2025

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DENTAL PLAN		
PC - DENTAL OPTIMA \$50/\$150 - 20%/20%/50%/\$1000		
	IN-NETWORK	OUT-OF-NETWORK
Bitewings X-rays (Unlimited)	Waive Deductible, then 20%	Waive Deductible, then 20%
Panoramic X-ray or comparable Conebeam view (1 complete series, 1 panoramic or 1 comparable cone beam view in any 36 consecutive months)	Waive Deductible, then 20%	Waive Deductible, then 20%
Restorative		
Fillings (1 per surface every 24 consecutive months)	Deductible, then 20%	Deductible, then 20%
Installation of Inlays, Onlays and Crowns (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Repair Crown/Inlay/Onlay (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Endodontics		
Endodontic Therapy - Root Canal (Once per tooth every 24 consecutive months)	Deductible, then 50%	Deductible, then 50%
Periodontics		
Periodontal Maintenance (4 PCY)	Deductible, then 20%	Deductible, then 20%
Full Mouth Debridement (Once every 36 consecutive months)	Deductible, then 50%	Deductible, then 50%
Periodontal Scaling and Root Planing (Once per quadrant every 24 consecutive months)	Deductible, then 50%	Deductible, then 50%
Periodontal Surgery (Once per quadrant every 36 consecutive months)	Deductible, then 50%	Deductible, then 50%
Periodontal Soft Tissue Grafts (Once per quadrant every 36 consecutive months)	Deductible, then 50%	Deductible, then 50%
Prosthodontics (Dentures/Bridges)		
Installation or Replacement of Dentures, Partials and Fixed Bridges (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Repair or Re-cement Bridgework and Dentures (When performed 6 or more months after placement)	Deductible, then 20%	Deductible, then 20%
Implant Services		

Highlights of your Dental Coverage

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DENTAL PLAN		
PC - DENTAL OPTIMA \$50/\$150 - 20%/20%/50%/\$1000		
	IN-NETWORK	OUT-OF-NETWORK
Implant Crowns/Bridge/Denture (1 every 5 calendar years)	Deductible, then 50%	Deductible, then 50%
Oral Surgery		
Simple Extractions (Unlimited)	Deductible, then 20%	Deductible, then 20%
Surgical Extractions (Unlimited)	Deductible, then 20%	Deductible, then 20%
Oral Surgery (Unlimited)	Deductible, then 20%	Deductible, then 20%
General Services		
Anesthesia - Intravenous or General (Unlimited)	Deductible, then 20%	Deductible, then 20%
Anesthesia - Nitrous Oxide (Unlimited)	Deductible, then 20%	Deductible, then 20%
Palliative (Emergency) Treatment of Dental Pain (Unlimited)	Deductible, then 20%	Deductible, then 20%
Orthodontia		
Orthodontia Cost Share	Not Covered	Not Covered
Lifetime Maximum Benefit	Not Covered	Not Covered
TMJ Rider		
TMJ Rider (Not Covered)	Not Covered	Not Covered

Diagnostic and Preventive Care Services aren't subject to the calendar year deductible. 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.

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Highlights of your Dental Coverage

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Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

DENTAL PLAN		PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$1500 SHARED FAMILY+ENHANCED+MAX WAIVER	
	IN-NETWORK	OUT-OF-NETWORK	
Dental Cost Share			
Individual Deductible	\$50	Shared with In Network	
Family Deductible	\$150	Shared with In Network	
Preventive Cost Share	Covered in Full	Covered in Full	
Basic Cost Share	Deductible, then 20%	Deductible, then 20%	
Major Cost Share	Deductible, then 50%	Deductible, then 50%	
Dental Reimbursement (Dental Choice Network)	AK fee schedule	80th percentile (in-state) and 90th percentile (out-of-state)	
Dental Annual Maximum	\$1500 SHARED PCY applies to basic and major services (Family shared PCY maximum limit – up to 3x Individual)	Shared with In Network	
Benefit Enhancement Rider			
Benefit Enhancement Rider	Endodontics & Periodontal Treatment (In Basic)	Endodontics & Periodontal Treatment (In Basic)	
Office Visit			
Routine Comprehensive / Periodic Oral Exams (2 PCY)	Covered in Full	Covered in Full	
Problem Focused/Emergency Exam (2 PCY)	Covered in Full	Covered in Full	
Office Visits, Prof Consults, Perio Evals (2 PCY (Shared with Routine))	Covered in Full	Covered in Full	
Preventive Services			
Prophylaxis - Cleaning (2 PCY)	Covered in Full	Covered in Full	
Fluoride Treatments (2 PCY; under the age of 20)	Covered in Full	Covered in Full	
Sealants (Under age 20 limited to permanent molars only, Replacements limited to once every 24 consecutive months)	Covered in Full	Covered in Full	

Highlights of your Dental Coverage

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DENTAL PLAN		PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$1500 SHARED FAMILY+ENHANCED+MAX WAIVER	
		IN-NETWORK	OUT-OF-NETWORK
Space Maintainers (Members under age 20)		Covered in Full	Covered in Full
Diagnostic Imaging			
Bitewings X-rays (Unlimited)		Covered in Full	Covered in Full
Panoramic X-ray or comparable Conebeam view (1 complete series, 1 panoramic or 1 comparable cone beam view in any 36 consecutive months)		Covered in Full	Covered in Full
Restorative			
Fillings (1 per surface every 24 consecutive months)		Deductible, then 20%	Deductible, then 20%
Installation of Inlays, Onlays and Crowns (1 every 5 calendar years)		Deductible, then 50%	Deductible, then 50%
Re-cement or Rebond Crowns/Inlay/Onlay (When performed 6 or more months after placement)		Deductible, then 20%	Deductible, then 20%
Repair Crown/Inlay/Onlay (When performed 6 or more months after placement)		Deductible, then 20%	Deductible, then 20%
Endodontics			
Endodontic Therapy - Root Canal (Once per tooth every 24 consecutive months)		Deductible, then 20%	Deductible, then 20%
Periodontics			
Periodontal Maintenance (4 PCY)		Deductible, then 20%	Deductible, then 20%
Full Mouth Debridement (Once every 36 consecutive months)		Deductible, then 20%	Deductible, then 20%
Periodontal Scaling and Root Planing (Once per quadrant every 24 consecutive months)		Deductible, then 20%	Deductible, then 20%
Periodontal Surgery (Once per quadrant every 36 consecutive months)		Deductible, then 20%	Deductible, then 20%
Periodontal Soft Tissue Grafts (Once per quadrant every 36 consecutive months)		Deductible, then 20%	Deductible, then 20%
Prosthodontics (Dentures/Bridges)			
Installation or Replacement of Dentures, Partials and Fixed Bridges (1 every 5 calendar years)		Deductible, then 50%	Deductible, then 50%

Highlights of your Dental Coverage

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DENTAL PLAN		PC - DENTAL OPTIMA \$50/\$150 - 0%/20%/50%/\$1500 SHARED FAMILY+ENHANCED+MAX WAIVER	
		IN-NETWORK	OUT-OF-NETWORK
Repair or Re-cement Bridgework and Dentures (When performed 6 or more months after placement)		Deductible, then 20%	Deductible, then 20%
Implant Services			
Implant Crowns/Bridge/Denture (1 every 5 calendar years)		Deductible, then 50%	Deductible, then 50%
Oral Surgery			
Simple Extractions (Unlimited)		Deductible, then 20%	Deductible, then 20%
Surgical Extractions (Unlimited)		Deductible, then 20%	Deductible, then 20%
Oral Surgery (Unlimited)		Deductible, then 20%	Deductible, then 20%
General Services			
Anesthesia - Intravenous or General (Unlimited)		Deductible, then 20%	Deductible, then 20%
Anesthesia - Nitrous Oxide (Unlimited)		Deductible, then 20%	Deductible, then 20%
Palliative (Emergency) Treatment of Dental Pain (Unlimited)		Deductible, then 20%	Deductible, then 20%
Orthodontia			
Orthodontia Cost Share		100% up to Lifetime Max	100% up to Lifetime Max
Lifetime Maximum Benefit		\$1,500 Lifetime	\$1,500 Lifetime
TMJ Rider			
TMJ Rider (Not Covered)		Not Covered	Not Covered

Diagnostic and Preventive Care Services aren't subject to the calendar year deductible. 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.

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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.

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>.