

# Highlights of your Health Care Coverage

Effective Date: 01/01/2026

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

Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

| MEDICAL PLAN                                                                                                                                            |                                                  |                                                                                |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------|
| PC - HP SHARED NO VISION \$5500/30%/\$7150/\$45/\$80                                                                                                    |                                                  |                                                                                |
|                                                                                                                                                         | IN-NETWORK                                       | OUT-OF-NETWORK                                                                 |
| MEDICAL COST SHARES                                                                                                                                     |                                                  |                                                                                |
| <b>Individual Deductible PCY</b> (Family embedded deductible 2X Individual)                                                                             | \$5,500 PCY                                      | Shared with In-Network                                                         |
| <b>Coinsurance (Member's percentage of costs after deductible based on allowable charges)</b>                                                           | 30% Preferred/40% Participating                  | Hospital & Professional: 60% Non-Participating                                 |
| <b>Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable</b> (Family embedded OOP max 2X Individual) | \$7,150 PCY                                      | Shared with In-Network                                                         |
| <b>Non Specialist Office Visit Cost Share</b>                                                                                                           | \$45 Copay, applies to the Out of Pocket Maximum | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>Specialist Office Visit Cost Share</b>                                                                                                               | \$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                                                                                                            |                                                  |                                                                                |
| <b>Preventive Office Visit</b> (Unlimited, subject to standard medical guidelines)                                                                      | Covered in Full                                  | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>Immunizations</b> (Unlimited, subject to standard medical guidelines)                                                                                | Covered in Full                                  | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>Health Education (HE)</b> (Unlimited)                                                                                                                | Covered in Full                                  | Covered In Full                                                                |
| <b>Diabetes Health Education (DE)</b> (Unlimited)                                                                                                       | Covered in Full                                  | Covered In Full                                                                |
| CHRONIC CONDITION MANAGEMENT PROGRAMS                                                                                                                   |                                                  |                                                                                |
| <b>Diabetes Management Plus</b>                                                                                                                         | Included                                         | Included                                                                       |
| <b>Diabetes Prevention Plus</b>                                                                                                                         | Excluded                                         | Excluded                                                                       |
| <b>Hypertension Plus</b>                                                                                                                                | Excluded                                         | Excluded                                                                       |
| <b>Weight Management</b>                                                                                                                                | Excluded                                         | Excluded                                                                       |
| PROFESSIONAL CARE                                                                                                                                       |                                                  |                                                                                |

| MEDICAL PLAN                                           |                                                                                                                                |                                                                                |
|--------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| PC - HP SHARED NO VISION \$5500/30%/\$7150/\$45/\$80   |                                                                                                                                |                                                                                |
|                                                        | IN-NETWORK                                                                                                                     | OUT-OF-NETWORK                                                                 |
| 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 |
| <b>APP-BASED VIRTUAL CARE SERVICES</b>                 |                                                                                                                                |                                                                                |
| Telemedicine - General Medical (Virtual Care Only)     | Covered in Full                                                                                                                | Not Covered                                                                    |
| Telemedicine - Mental Health (Virtual Care Only)       | Subject to Mental Health Outpatient Professional Care In-Network Cost Share                                                    | Not Covered                                                                    |
| Telemedicine - Chemical Dependency (Virtual Care Only) | Subject to Chemical Dependency Outpatient Office Visit Cost Share                                                              | Not Covered                                                                    |
| <b>DIAGNOSTIC SERVICES</b>                             |                                                                                                                                |                                                                                |
| Preventive Imaging and Laboratory                      | Covered in Full                                                                                                                | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| Diagnostic Laboratory                                  | 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                                                   |
| <b>FACILITY CARE</b>                                   |                                                                                                                                |                                                                                |
| 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 |
| Hospital Outpatient Surgery Facility                   | In Network Deductible, then 30% Preferred/40% Participating                                                                    | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| Ambulatory Surgery Center                              | In Network Deductible, then 20%                                                                                                | 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 |
| <b>HOSPICE &amp; HOME HEALTH CARE</b>                  |                                                                                                                                |                                                                                |
| Hospice Inpatient Facility (Unlimited)                 | In Network Deductible, then 30% Preferred/40% Participating                                                                    | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |

| <b>MEDICAL PLAN</b>                                                                                                                                                                                                                                        |                                                                                              |                                                                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| <b>PC - HP SHARED NO VISION \$5500/30%/\$7150/\$45/\$80</b>                                                                                                                                                                                                |                                                                                              |                                                                                              |
|                                                                                                                                                                                                                                                            | <b>IN-NETWORK</b>                                                                            | <b>OUT-OF-NETWORK</b>                                                                        |
| <b>Hospice Care (Home Health and Respite)</b> (Unlimited)                                                                                                                                                                                                  | In Network Deductible, then 30% Preferred/40% Participating                                  | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating               |
| <b>Home Health Visits</b> (130 visits PCY)                                                                                                                                                                                                                 | In Network Deductible, then 30% Preferred/40% Participating                                  | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating               |
| <b>MATERNITY &amp; REPRODUCTIVE CARE</b>                                                                                                                                                                                                                   |                                                                                              |                                                                                              |
| <b>Birth Center</b>                                                                                                                                                                                                                                        | In Network Deductible, then 20%                                                              | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating               |
| <b>Contraceptive Management Services</b> (Unlimited)                                                                                                                                                                                                       | Covered in Full                                                                              | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating               |
| <b>Sterilization - Female</b> (Unlimited)                                                                                                                                                                                                                  | Covered in Full                                                                              | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating               |
| <b>Sterilization - Male</b> (Unlimited)                                                                                                                                                                                                                    | In Network Deductible, then 30% Preferred/40% Participating                                  | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating               |
| <b>MEDICAL CARE COORDINATION AND TRAVEL SERVICES</b>                                                                                                                                                                                                       |                                                                                              |                                                                                              |
| <b>Centers of Excellence Packaged Services</b> (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement), Spine & Gynecology)                                                                                                           | Covered in Full                                                                              | Covered as any other service                                                                 |
| <b>Centers of Excellence Travel and Care Coordination</b> (See Elective Procedure Travel)                                                                                                                                                                  | See Elective Procedure Travel                                                                | See Elective Procedure Travel                                                                |
| <b>Medical Access Transportation</b> (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                                                    |
| <b>Transplants</b> (Unlimited; \$75,000 donor)                                                                                                                                                                                                             | Covered as any other service                                                                 | Not Covered                                                                                  |
| <b>Transplant Travel &amp; Lodging</b> (\$7,500 travel and lodging)                                                                                                                                                                                        | Subject to Deductible, then 0%                                                               | Subject to Deductible, then 0%                                                               |
| <b>Elective Procedure Travel</b> (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                                                                              |
| <b>Medical Services from Elective Procedure Travel</b>                                                                                                                                                                                                     | Covered as any other service                                                                 | Covered as any other service                                                                 |
| <b>EMERGENCY CARE</b>                                                                                                                                                                                                                                      |                                                                                              |                                                                                              |
| <b>Emergency Care (If applicable, waive copay if admitted to inpatient facility)</b>                                                                                                                                                                       | \$200 Copay, applies to the Out of Pocket Maximum; then In Network Deductible, 30% Preferred | \$200 Copay, applies to the Out of Pocket Maximum; then In Network Deductible, 30% Preferred |
| <b>Emergency Room Physician</b>                                                                                                                                                                                                                            | In Network Deductible, then 30% Preferred                                                    | In Network Deductible, then 30% Preferred                                                    |
| <b>Urgent Care Center</b>                                                                                                                                                                                                                                  | \$50 Copay, applies to the Out of Pocket Maximum                                             | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating               |
| <b>Ambulance Transportation</b> (Unlimited)                                                                                                                                                                                                                | \$200 Copay, applies to the Out of Pocket Maximum; then In Network Deductible, 30% Preferred | \$200 Copay, applies to the Out of Pocket Maximum; then In Network Deductible, 30% Preferred |
| <b>Non-Emergent Ground Ambulance</b> (Unlimited)                                                                                                                                                                                                           | \$200 Copay, applies to the Out of Pocket Maximum; then In Network Deductible, 30% Preferred | \$200 Copay, applies to the Out of Pocket Maximum; then In Network Deductible, 30% Preferred |

| MEDICAL PLAN                                                                                                      |                                                                                                               |                                                                                              |
|-------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| PC - HP SHARED NO VISION \$5500/30%/\$7150/\$45/\$80                                                              |                                                                                                               |                                                                                              |
|                                                                                                                   | IN-NETWORK                                                                                                    | OUT-OF-NETWORK                                                                               |
| <b>Air Ambulance</b> (Unlimited)                                                                                  | \$200 Copay, applies to the Out of Pocket Maximum; then In Network Deductible, 30% Preferred                  | \$200 Copay, applies to the Out of Pocket Maximum; then In Network Deductible, 30% Preferred |
| <b>Non-Emergent Air Ambulance</b> (Unlimited)                                                                     | \$200 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                                                                                                  |                                                                                                               |                                                                                              |
| <b>Acupuncture</b> (12 visits PCY)                                                                                | \$45 Copay, applies to the Out of Pocket Maximum                                                              | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating               |
| <b>Manipulations (Spinal and other)</b> (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                                                                               |                                                                                                               |                                                                                              |
| <b>Chemical Dependency Inpatient Facility Care</b> (Unlimited)                                                    | In Network Deductible, then 30% Preferred                                                                     | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating               |
| <b>Chemical Dependency Outpatient Professional Care</b> (Unlimited)                                               | \$45 Copay, applies to the Out of Pocket Maximum                                                              | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating               |
| <b>Mental Health Inpatient Facility Care</b> (Unlimited)                                                          | In Network Deductible, then 30% Preferred                                                                     | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating               |
| <b>Mental Health Outpatient Professional Care</b> (Unlimited)                                                     | \$45 Copay, applies to the Out of Pocket Maximum                                                              | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating               |
| REHABILITATION & NEURODEVELOPMENTAL THERAPY                                                                       |                                                                                                               |                                                                                              |
| <b>Inpatient Rehab</b> (30 days PCY)                                                                              | In Network Deductible, then 30% Preferred/40% Participating                                                   | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating               |
| <b>Outpatient Rehab, Including Physical and Occupational Therapy; Cardiac and Pulmonary Rehab</b> (45 visits PCY) | \$80 Copay, applies to the Out of Pocket Maximum                                                              | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating               |
| <b>Outpatient Massage Therapy</b> (Applies to the outpatient rehab limit)                                         | \$80 Copay, applies to the Out of Pocket Maximum                                                              | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating               |
| <b>Outpatient Speech Therapy</b> (Applies to the outpatient rehab limit)                                          | \$80 Copay, applies to the Out of Pocket Maximum                                                              | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating               |
| <b>Inpatient Neurodevelopmental Therapy</b>                                                                       | In Network Deductible, then 30% Preferred/40% Participating                                                   | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating               |
| <b>Outpatient Neurodevelopmental Therapy</b> (45 visits PCY)                                                      | \$80 Copay, applies to the Out of Pocket Maximum                                                              | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating               |
| OTHER SERVICES                                                                                                    |                                                                                                               |                                                                                              |
| <b>Allergy/Therapeutic Injections</b>                                                                             | In Network Deductible, then 30% Preferred/40% Participating                                                   | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating               |
| <b>Medical Supplies, Equipment, Prosthetics</b> (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                                                                                             |                                                                                                               |                                                                                              |

| MEDICAL PLAN                                      |                                       |           | PC - HP SHARED NO VISION \$5500/30%/\$7150/\$45/\$80 |           |  |
|---------------------------------------------------|---------------------------------------|-----------|------------------------------------------------------|-----------|--|
|                                                   | IN-NETWORK                            |           | OUT-OF-NETWORK                                       |           |  |
| Routine Hearing Exam (1 PCY)                      | Waive In Network Deductible, then 20% |           | Waive In Network Deductible, then 20%                |           |  |
| Hearing Hardware (1 device per ear every 3 years) | Waive In Network Deductible, then 20% |           | Waive In Network Deductible, then 20%                |           |  |
| ANNUAL PLAN MAXIMUM                               |                                       |           |                                                      |           |  |
| Annual Plan Maximum                               |                                       | Unlimited |                                                      | Unlimited |  |

Benefits provided at 100% of allowable charges; not subject to deductible or coinsurance.

Seasonal immunizations provided at a pharmacy will be covered in full up to maximum allowable amount.

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

Copays are not subject to the deductible unless otherwise noted.

Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premiera Blue Cross Blue Shield of Alaska. Members are responsible for amounts in excess of the allowable charge.

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

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

Call for free language assistance services and appropriate auxiliary aids and services.

Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.

Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.

무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.

Hu thov kev pab txhais lus pub dawb thiab lwm yam khoom pab dawb thiab kev pab cuam ua tsim nyog.

Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.

呼吁提供免费的语言援助服务和适当的辅助设备及服务。

呼籲提供免費的語言援助服務和適當的輔助設備及服務。

Vala'au mo auaunaga tau fesoasoani mo gagana e leai ni totogi ma fesoasoani fa'aopo'opo talafeagai ma auaunaga.

ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.

無料言語支援サービスと適切な補助器具及びサービスをお求めください。

Tumawag para kadagiti libre a serbisio iti tulong iti pagsasao ken dagiti nakanada nga aid ken serbisio iti komunikasion.

Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.

Звертайтеся за безкоштовною мовною підтримкою та відповідними додатковими послугами.

ติดต่อขอบริการช่วยเหลือด้านภาษาฟรีพร้อมความช่วยเหลือและบริการอื่นๆ เพิ่มเติม

Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.

Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.

Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.

Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.

Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.

Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.

اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.

برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

**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](mailto: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>.