

Highlights of your Health Care Coverage

Effective Date: 01/01/2027

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

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

MEDICAL PLAN		
PC - HP HSA QUALIFIED AGG \$1750/20%/\$3500		
	YUKON IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
Individual Deductible PCY (Family aggregate deductible 2x Individual)	\$1,750 PCY/\$3,500 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)	\$3,500 PCY/\$7,000 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
PREMERA HEALTH HUB		
Diabetes Management (Included)	Covered in Full	Not Applicable
Digestive Health (Included)	Covered in Full	Not Applicable
Hypertension (Included)	Covered in Full	Not Applicable
Behavioral Health (Included)	Covered in Full	Not Applicable
Musculoskeletal Health (Included)	Covered in Full	Not Applicable
Tobacco Cessation (Included)	Covered in Full	Not Applicable
Weight Management (Included (without clinical support))	Covered in Full	Not Applicable
Women's Health (Included)	Covered in Full	Not Applicable

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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 - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit Cost Share	Not Covered
DIAGNOSTIC SERVICES		
Preventive Imaging and Laboratory	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Diagnostic Laboratory	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Basic Diagnostic Imaging	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Major Diagnostic Imaging	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Breast Cancer Screening (including mammography)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
FACILITY CARE		
Inpatient Facility	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Inpatient Professional Services	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Hospital Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Ambulatory Surgery Center	In Network Deductible, then 10%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Facility	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Skilled Nursing Facility (60 days PCY)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Hospice Care (Home Health and Respite) (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating

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Home Health Visits (130 visits PCY)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
MATERNITY & REPRODUCTIVE CARE			
Birth Center	In Network Deductible, then 10%	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Contraceptive Management Services (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Sterilization - Female (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Sterilization - Male (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
MEDICAL CARE COORDINATION AND TRAVEL SERVICES			
Centers of Excellence Packaged Services (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement), Spine & Gynecology)	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)	In Network Deductible, then 0%	In Network 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	

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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
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 & NEURODEVELOPMENTAL THERAPY		
Inpatient Rehab (30 days PCY)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Rehab, Including Physical and Occupational Therapy; Cardiac and Pulmonary Rehab (45 visits PCY)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Massage Therapy (Applies to the outpatient rehab limit)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Speech Therapy (Applies to the outpatient rehab limit)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Inpatient Neurodevelopmental Therapy	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Neurodevelopmental Therapy (45 visits PCY)	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

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SUPPLEMENTAL BENEFITS			
Routine Vision Exam (1 PCY)		Waive In Network Deductible, then 10%	Waive In Network Deductible, then 10%
Vision Hardware (\$350 PCY)		Covered in Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)		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 PCY)		In Network Deductible, then 20%	In Network Deductible, then 20%
Hearing Hardware (1 device per ear every 3 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.

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

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

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

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

무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.

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

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

呼吁提供免费的语言援助服务和适当的辅助设备及服务。

呼籲提供免費的語言援助服務和適當的輔助設備及服務。

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

ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.

無料言語支援サービスと適切な補助器具及びサービスをお求めください。

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

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

Звертайтеся за безкоштовною мовною підтримкою та відповідними додатковими послугами.

ติดต่อขอบริการช่วยเหลือด้านภาษาฟรีพร้อมความช่วยเหลือและบริการอื่นๆ เพิ่มเติม

Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.

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

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

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

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

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

اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.

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

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