

# 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                                                                                                                 |                                                                                                                                                        |                                                                                |
|------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
|                                                                                                                              | STANDARD BRONZE II                                                                                                                                     |                                                                                |
|                                                                                                                              | LEGACY AND DENTAL SELECT IN-NETWORK                                                                                                                    | OUT-OF-NETWORK                                                                 |
| <b>Deductible</b> (In-network only - Family embedded deductible 2X Individual)                                               | \$7,500 PCY                                                                                                                                            | \$22,500 PCY                                                                   |
| <b>Coinsurance</b>                                                                                                           | 50% Preferred/50% Participating                                                                                                                        | Hospital & Professional: 60% Non-Participating                                 |
| <b>Out of Pocket Maximum (includes deductible, copays, coinsurance and pharmacy)</b> (Family embedded OOP max 2X Individual) | \$12,000 PCY                                                                                                                                           | Unlimited                                                                      |
| <b>Designated PCP Office Visit Cost Share</b>                                                                                | \$50 Copay, applies to the Out of Pocket Maximum                                                                                                       | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>Specialist and non designated PCP Office Visit Cost Share</b>                                                             | \$100 Copay, applies to the Out of Pocket Maximum                                                                                                      | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>Annual Maximum</b>                                                                                                        | Unlimited                                                                                                                                              | Unlimited                                                                      |
| <b>1 Ambulatory Patient Services</b>                                                                                         |                                                                                                                                                        |                                                                                |
| <b>Professional Office Visit (Includes Telemedicine)</b>                                                                     | Designated PCP: \$50 Copay, applies to the Out of Pocket Maximum; Specialist and non designated PCP: \$100 Copay, applies to the Out of Pocket Maximum | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>Urgent Care Office Visits</b>                                                                                             | \$75 Copay, applies to the Out of Pocket Maximum                                                                                                       | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>Outpatient Professional Services</b>                                                                                      | In Network Deductible, then 50% Preferred/50% Participating                                                                                            | 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 |

| MEDICAL PLAN                                                                                                                |                                                             |                                                                                |
|-----------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------------------------|
| STANDARD BRONZE II                                                                                                          |                                                             |                                                                                |
|                                                                                                                             | LEGACY AND DENTAL SELECT IN-NETWORK                         | OUT-OF-NETWORK                                                                 |
| <b>2 Emergency Care</b>                                                                                                     |                                                             |                                                                                |
| <b>Emergency Room - Facility</b>                                                                                            | In Network Deductible, then 50% Preferred/50% Participating | In Network Deductible, then 50% Preferred/50% Participating                    |
| <b>Ambulance Service - Ground</b> (Unlimited)                                                                               | In Network Deductible, then 50% Preferred/50% Participating | In Network Deductible, then 50% Preferred/50% Participating                    |
| <b>Ambulance Service - Air</b> (Unlimited)                                                                                  | In Network Deductible, then 50% Preferred/50% Participating | In Network Deductible, then 50% Preferred/50% Participating                    |
| <b>Ambulance Service - Air Non Emergent</b> (Unlimited)                                                                     | In Network Deductible, then 50% Preferred/50% Participating | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>3 Hospitalization</b>                                                                                                    |                                                             |                                                                                |
| <b>Inpatient Medical and Surgical Room and Board</b> (Unlimited)                                                            | In Network Deductible, then 50% Preferred/50% Participating | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>Inpatient Professional Services</b>                                                                                      | In Network Deductible, then 50% Preferred/50% Participating | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>Skilled Nursing Facility</b> (60 days PCY)                                                                               | In Network Deductible, then 50% Preferred/50% Participating | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>Hospice Inpatient Facility</b> (10 days Inpatient; within the 6 month lifetime maximum)                                  | In Network Deductible, then 50% Preferred/50% Participating | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>Organ Transplants</b> (Unlimited; \$75,000 donor)                                                                        | Covered as any other service                                | Not Covered                                                                    |
| <b>4 Maternity &amp; Newborn Care</b>                                                                                       |                                                             |                                                                                |
| <b>Maternity Delivery - Inpatient Facility</b> (Coverage for subscriber, spouse, dependent)                                 | In Network Deductible, then 50% Preferred/50% Participating | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>Maternity Prenatal, Delivery and Postnatal Care - Professional Services</b> (Coverage for subscriber, spouse, dependent) | In Network Deductible, then 50% Preferred/50% Participating | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>5 Mental Health &amp; Substance Use Disorder Services, including Behavioral Health Treatment</b>                         |                                                             |                                                                                |
| <b>Chemical Dependency Office Visit</b> (Unlimited)                                                                         | \$50 Copay, applies to the Out of Pocket Maximum            | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>Chemical Dependency Outpatient Facility</b> (Unlimited)                                                                  | In Network Deductible, then 50% Preferred                   | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>Chemical Dependency Inpatient Facility</b> (Unlimited)                                                                   | In Network Deductible, then 50% Preferred                   | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>Mental Health Office Visit</b> (Unlimited)                                                                               | \$50 Copay, applies to the Out of Pocket Maximum            | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>Mental Health Outpatient Facility</b> (Unlimited)                                                                        | In Network Deductible, then 50% Preferred                   | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>Mental Health Inpatient Facility</b> (Unlimited)                                                                         | In Network Deductible, then 50% Preferred                   | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>6 Prescription Drug</b>                                                                                                  |                                                             |                                                                                |

| MEDICAL PLAN                                                                                                  |                                                                                                                                                              |                                                                                                                                                             |
|---------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                               | STANDARD BRONZE II                                                                                                                                           |                                                                                                                                                             |
|                                                                                                               | LEGACY AND DENTAL SELECT IN-NETWORK                                                                                                                          | OUT-OF-NETWORK                                                                                                                                              |
| <b>Formulary Drug List</b>                                                                                    | M4<br>Tier 1 = Preferred Generic<br>Tier 2 = Preferred Brand<br>Tier 3 = Non-preferred Generic and Brand<br>Tier 4 = Specialty                               | M4<br>Tier 1 = Preferred Generic<br>Tier 2 = Preferred Brand<br>Tier 3 = Non-preferred Generic and Brand<br>Tier 4 = Specialty                              |
| <b>Prescription Drugs - Retail</b> (Retail: 90 Days; Mail: 90 Days; Specialty: 30 Days)                       | Tier 1 = \$25<br>Tier 2 = Deductible, then \$50<br>Tier 3 = Deductible, then \$100<br>Tier 4 = Deductible, then \$500<br>(cost shares apply to the OOP Max)  | Tier 1 = \$25<br>Tier 2 = Deductible, then \$50<br>Tier 3 = Deductible, then \$100<br>Tier 4 = Deductible, then \$500<br>(cost shares apply to the OOP Max) |
| <b>Prescription Drugs - Mail</b> (Retail: 90 Days; Mail: 90 Days; Specialty: 30 Days)                         | Tier 1 = \$75<br>Tier 2 = Deductible, then \$150<br>Tier 3 = Deductible, then \$300<br>Tier 4 = Deductible, then \$500<br>(cost shares apply to the OOP Max) | Not Covered                                                                                                                                                 |
| <b>7 Rehabilitative &amp; Habilitative Services &amp; Devices</b>                                             |                                                                                                                                                              |                                                                                                                                                             |
| <b>Inpatient Rehabilitation</b> (30 days PCY)                                                                 | In Network Deductible, then 50% Preferred/50% Participating                                                                                                  | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating                                                                              |
| <b>Outpatient Rehabilitation - Physical, Occupational Therapy</b> (45 visits PCY; shared with speech therapy) | \$50 Copay, applies to the Out of Pocket Maximum                                                                                                             | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating                                                                              |
| <b>Outpatient Habilitation - Physical, Occupational Therapy</b> (45 visits PCY; shared with speech therapy)   | \$50 Copay, applies to the Out of Pocket Maximum                                                                                                             | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating                                                                              |
| <b>Outpatient Massage Therapy</b> (20 visits PCY)                                                             | \$50 Copay, applies to the Out of Pocket Maximum                                                                                                             | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating                                                                              |
| <b>Outpatient Speech Therapy</b> (45 visits PCY; shared with outpatient rehab)                                | \$50 Copay, applies to the Out of Pocket Maximum                                                                                                             | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating                                                                              |
| <b>Inpatient Habilitation</b> (30 days PCY)                                                                   | In Network Deductible, then 50% Preferred/50% Participating                                                                                                  | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating                                                                              |
| <b>Durable Medical Equipment</b> (MS: Unlimited, ME: Unlimited, Pro: Unlimited)                               | In Network Deductible, then 50% Preferred/50% Participating                                                                                                  | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating                                                                              |
| <b>8 Laboratory/Imaging Services</b>                                                                          |                                                                                                                                                              |                                                                                                                                                             |
| <b>Diagnostic Laboratory &amp; Pathology</b>                                                                  | In Network Deductible, then 50% Preferred/50% Participating                                                                                                  | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating                                                                              |
| <b>Diagnostic Imaging - Basic</b>                                                                             | In Network Deductible, then 50% Preferred/50% Participating                                                                                                  | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating                                                                              |
| <b>Diagnostic Imaging - Major (MRI, CT, PET)</b>                                                              | In Network Deductible, then 50% Preferred/50% Participating                                                                                                  | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating                                                                              |
| <b>9 Preventive/Wellness Services</b>                                                                         |                                                                                                                                                              |                                                                                                                                                             |
| <b>Preventive Office Visit</b> (Unlimited, subject to standard medical guidelines)                            | Covered in Full                                                                                                                                              | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating                                                                              |

| MEDICAL PLAN                                                                                                                                               |                                                                                                                                                        |                                                                                |
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|                                                                                                                                                            | STANDARD BRONZE II                                                                                                                                     |                                                                                |
|                                                                                                                                                            | LEGACY AND DENTAL SELECT IN-NETWORK                                                                                                                    | OUT-OF-NETWORK                                                                 |
| <b>Immunizations</b> (Unlimited, subject to standard medical guidelines)                                                                                   | Covered in Full                                                                                                                                        | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>Preventive Laboratory Screens</b>                                                                                                                       | Covered in Full                                                                                                                                        | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>Preventive Imaging</b>                                                                                                                                  | Covered in Full                                                                                                                                        | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>Breast Cancer Screening (Including Mammography)</b>                                                                                                     | Covered in Full                                                                                                                                        | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>10 Pediatric Services, including Oral &amp; Vision Care</b>                                                                                             |                                                                                                                                                        |                                                                                |
| <b>Pediatric Vision Exam</b> (1 PCY under age 19)                                                                                                          | \$30 Copay, applies to the Out of Pocket Maximum                                                                                                       | \$30 Copay, applies to the Out of Pocket Maximum                               |
| <b>Pediatric Eyewear</b> (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                                                                |
| <b>Pediatric Dental - Preventive</b>                                                                                                                       | Covered in Full                                                                                                                                        | Deductible, then 30%                                                           |
| <b>Pediatric Dental - Basic</b>                                                                                                                            | Deductible, then 20%                                                                                                                                   | Deductible, then 40%                                                           |
| <b>Pediatric Dental - Major</b>                                                                                                                            | Deductible, then 50%                                                                                                                                   | Deductible, then 50%                                                           |
| <b>App-Based Virtual Care Services</b>                                                                                                                     |                                                                                                                                                        |                                                                                |
| <b>Telemedicine – General Medical (Virtual Care Only)</b>                                                                                                  | Designated PCP: \$50 Copay, applies to the Out of Pocket Maximum; Specialist and non designated PCP: \$100 Copay, applies to the Out of Pocket Maximum | Not Covered                                                                    |
| <b>Telemedicine - Mental Health (Virtual Care Only)</b>                                                                                                    | Subject to Mental Health Office Visit Cost Share                                                                                                       | Not Covered                                                                    |
| <b>Telemedicine - Chemical Dependency (Virtual Care Only)</b>                                                                                              | Subject to Chemical Dependency Outpatient Office Visit Cost Share                                                                                      | Not Covered                                                                    |
| <b>Routine Hearing</b>                                                                                                                                     |                                                                                                                                                        |                                                                                |
| <b>Routine Hearing Exam</b> (1 PCY)                                                                                                                        | \$100 Copay, applies to the Out of Pocket Maximum                                                                                                      | \$100 Copay, applies to the Out of Pocket Maximum                              |
| <b>Routine Hearing Aids and Hardware</b> (1 device per ear every 3 years)                                                                                  | Waive In Network Deductible, then 20%                                                                                                                  | Waive In Network Deductible, then 20%                                          |
| <b>Alternative Care</b>                                                                                                                                    |                                                                                                                                                        |                                                                                |
| <b>Chiropractic</b> (20 visits PCY)                                                                                                                        | \$50 Copay, applies to the Out of Pocket Maximum                                                                                                       | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>Acupuncture</b> (12 visits PCY)                                                                                                                         | \$50 Copay, applies to the Out of Pocket Maximum                                                                                                       | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>Naturopath</b>                                                                                                                                          | Designated PCP: \$50 Copay, applies to the Out of Pocket Maximum; Specialist and non designated PCP: \$100 Copay, applies to the Out of Pocket Maximum | Out of Network Deductible, then Hospital & Professional: 60% Non-Participating |
| <b>Alaska Medical Transportation Benefits</b>                                                                                                              |                                                                                                                                                        |                                                                                |

| MEDICAL PLAN                                                                                                                                                                                                                                               |                                                                           |                                                                           | STANDARD BRONZE II |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------|--|
|                                                                                                                                                                                                                                                            | LEGACY AND DENTAL SELECT IN-NETWORK                                       | OUT-OF-NETWORK                                                            |                    |  |
| <b>Medical Access Transportation</b> (Standard Option one round trip transport per occurrence patient only PCY.)                                                                                                                                           | In Network Deductible, then 50% Preferred                                 | In Network Deductible, then 50% Preferred                                 |                    |  |
| <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) | Travel: Covered In Full; Medical Procedures: covered as any other service | Travel: Covered In Full; Medical Procedures: covered as any other service |                    |  |
| <b>Medical Services from Elective Procedure Travel</b>                                                                                                                                                                                                     | Covered as any other service                                              | Covered as any other service                                              |                    |  |
| <b>Premera Designated Centers of Excellence Package Services</b> (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement), Spine & Gynecology)                                                                                         | Covered in Full                                                           | Covered as any other service                                              |                    |  |

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.

Звертайте 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>.