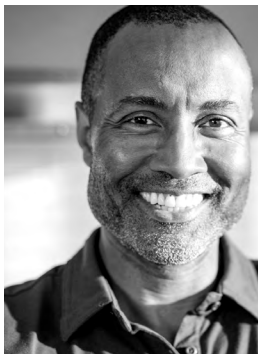
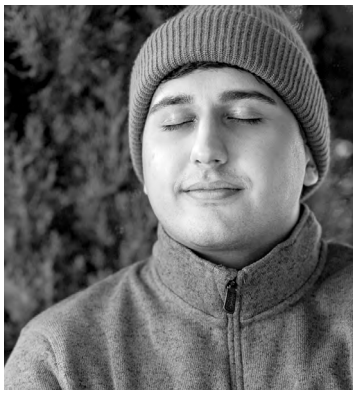
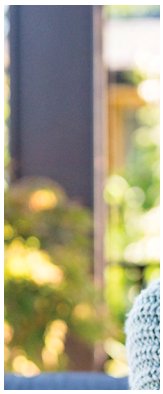
FOR BUSINESSES WITH
51+ EMPLOYEES

# 2025 health plan guide







PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

# Innovative health plans created for today's evolving healthcare needs

At Premera Blue Cross Blue Shield of Alaska, the customer is at the center of all we do, including our customers located outside of Alaska. That's why your local Premera team offers a range of comprehensive plans that fit your budget and your employees' diverse needs.

FOR OPTIFLEX AND SELF-FUNDED GROUPS ONLY

# Table of contents

# Here's why businesses choose Premera

### Unmatched access and deep discounts

We offer a variety of provider network options so you can choose the level of access that works best for your employees.

### Well-rounded benefits package

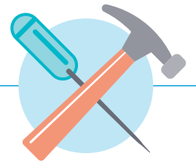
Choose from a range of plans to find the right balance that best fits the needs and budget for your business and your employees.

### Programs for employees

Our built-in support programs encourage your employees to engage in their healthcare.

### Digital health messages

Members who opt-in received personalized healthcare updates on their mobile phone. Text messages may include member benefits, tips on how to save on care, and more.

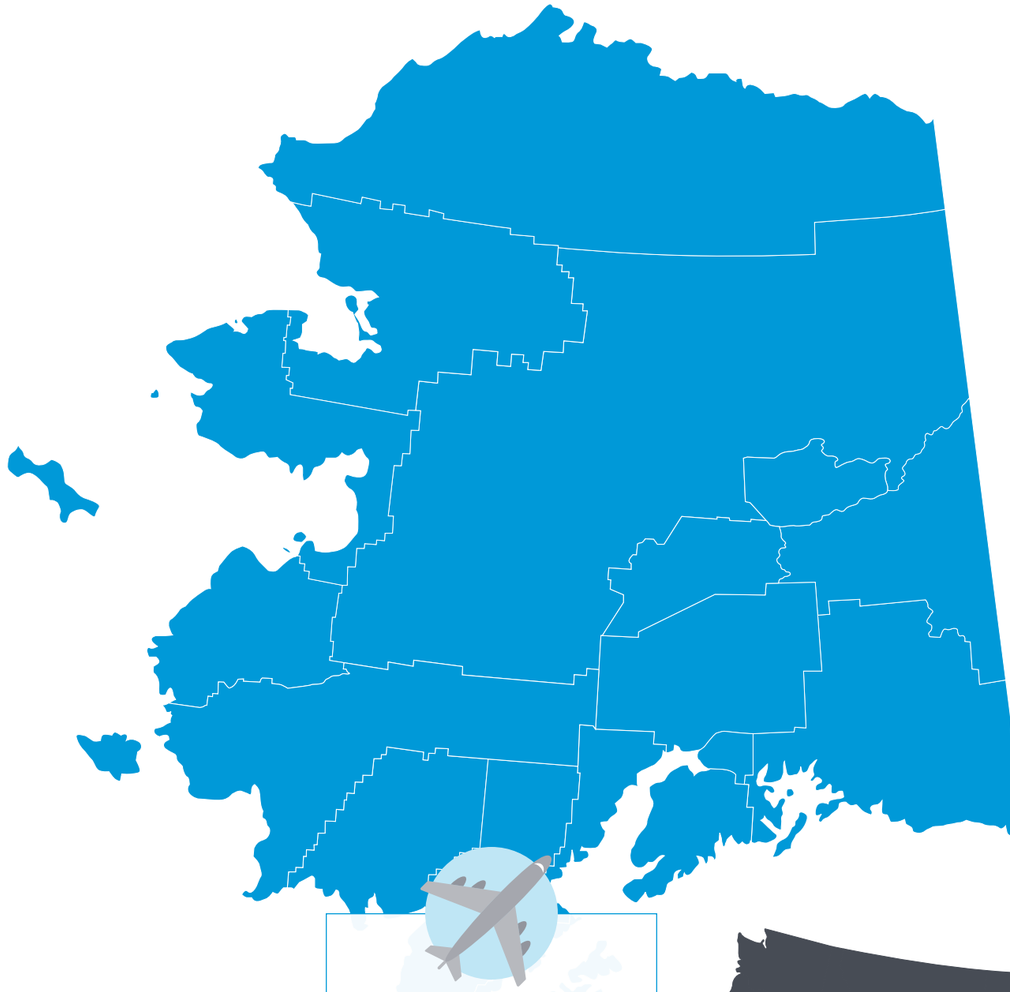


### Administrative ease and support

Integrated benefits with Premera make for a streamlined experience. We make it simple for you to promote components of your healthcare benefits with your employees or explain to them how to best use their plan.

### Meeting members where they are

With the broadest provider network in the state, Premera supports every member no matter where they are on their healthcare journey. From physical well-being to behavioral health and virtual care, we provide the support you need.





### Alaska medical transportation benefits

Premera plans include a variety of medical transportation benefits to support your employees and ensure they are getting the best care. Travel is available for various medical conditions, as well as for certain approved services for elective and non-emergent surgeries.

**We're in your corner**

Established since 1933, we're committed to having a positive impact in our communities. Through corporate giving, volunteering, and community engagement, we promote new partnerships and solutions to help make healthcare work better for the communities where we live and work.

# How you fund your health plan matters

You have three plan funding options that are designed to meet the needs of your business.

**Fully insured**

Group pays a fixed rate for employee health coverage. Premera pays all claims and assumes all risks for the group's health coverage.

GROUP PAYS FIXED RATE

PREMERA PAYS CLAIMS AND ASSUMES RISKS

**OptiFlex**

Group pays a fixed rate for employee health coverage but has more flexibility compared to fully insured funding.

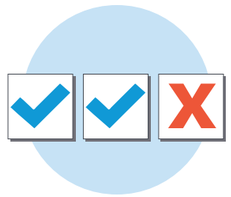
GROUP PAYS FIXED RATE

PLAN HAS PROTECTION AND FLEXIBILITY

**Self-funded**

Group assumes all the risk for providing healthcare benefits to its employees. This funding type offers the greatest amount of flexibility and plan customization.


GROUP ASSUMES HEALTHCARE RISK



PLAN HAS FLEXIBILITY AND CUSTOMIZATION

## OPTIONAL BENEFITS OFFERED BY PREMERA

### Stop-loss coverage

LifeWise Assurance Company* assists groups with creating just the right medical stop-loss level for their specific needs. Employers that elect to self-fund their medical plan can chose to have stop-loss coverage with a reinsurance contract to protect them from catastrophic losses.

### HSA, FSA, HRA options

Personal funding accounts offer an integrated system for implementing and administering a health savings account (HSA), flexible spending account (FSA), and health reimbursement agreement (HRA). These products can help manage healthcare costs by putting healthcare spending in the hands of your employees. By spending their own money, your employees pay more attention to their overall health and healthcare needs.

### HSA On Demand program

Provide your employees with peace of mind and get potential savings for your company with HSA On Demand. This is a new program that gives employees access to future HSA contributions. Ask your producer or Premera sales representative about HSA On Demand.

*LifeWise Assurance Company is an independent company that does not provide Blue Cross Blue Shield products or services.

**Where there's risk, there's stop-loss**

Self-funded and OptiFlex funded groups can use stop loss to protect themselves from higher than expected claims cost and avoid major losses. LifeWise Assurance Company* assists groups with creating the right medical stop-loss for their needs.

# Enhanced Case Management

FOR SELF FUNDED GROUPS

Mitigate rising healthcare costs with innovative predictive technology and robust digital tools with Enhanced Case Management.

## An integrated case management approach

Our core case management program at Premera focuses on the whole person, addressing members' physical and behavioral health challenges, social determinants of health, and barriers within the healthcare delivery system. The program identifies members with high-risk or complex health conditions who would benefit from intervention and, with guidance from a dedicated personal health support clinician, helps them navigate their healthcare journey.

**The benefits of Enhanced Case Management**

- Reduce future clinical costs
- Enhance the member experience
- Increase access to support

**Harnessing actionable data insights can maximize early intervention opportunities.**

87%

precision in predicting future high-cost claimants[1]

Studies indicate that using **digital member programs** with **case management intervention** leads to **improved member health outcomes**.[2]

[1] Foundation Model Overview, Prealize Health 2024
[2] A pragmatic methodology for the evaluation of digital care management in the context of multimorbidity, Journal of Medical Economics, Volume 24, 2021 — Issue 1

## A valuable member experience

Our Enhanced Case Management program includes a digital case management mobile app that provides your employees and their families with the following resources:

- **Secure chat** — flexibility for members to engage with their personal health support clinician when they want, using their preferred communication method.
- **Navigation support** — ability to identify healthcare needs for more members in your population and easily direct them to the right care programs, physicians, and high-value services.
- **Member resource center** — access to clinically reviewed health and wellness articles and extensive condition and self-management programs. Members can easily filter, scan, and find information they need.

**Download the flyer** and contact your Premera account representative to help you determine if Enhanced Case Management is the right solution for your employees and your benefit strategy.

# Chronic Condition Management Plus

Chronic conditions like diabetes and hypertension are costly and highly prevalent. Six in ten adults in the United States have at least one chronic condition.[1] Premera offers a full collection of virtual chronic condition management solutions to support members with pre-diabetes, diabetes, and hypertension.

## How Plus programs work

Programs and multi-condition support are based on the primary condition with highest severity

**PRIMARY CONDITION**

Members primary conditions are determined by their severity risk scores and diagnoses

- Diabetes
- Pre-diabetes
- Hypertension

RISK

**PRIMARY ENROLLMENT**

Members are enrolled in the program that matches their primary condition[2]

- Diabetes Management Plus
- Diabetes Prevention Plus
- Hypertension Plus

**MULTI-CONDITION SUPPORT**

Members are then enrolled in other Plus programs for additional diagnoses. Weight loss and mental health are available across all programs

- Diabetes Management Plus
- Diabetes Prevention Plus
- Hypertension Plus
- \+ Digital mental health
- \+ Standard weight managment

## Multi-faceted program design

Chronic Condition Management Plus takes a comprehensive approach. Whichever program a member is enrolled in, they will receive support for their primary condition and standard weight management and digital mental health services.

### Comprehensive support

Integrated support that goes beyond the primary condition specific program.

### Improved outcomes

Members who manage chronic conditions in one place can overcome care fragmentation and improve their health outcomes[3] to reduce total cost of care.

### Holistic approach

No matter what program the member is engaged with, digital mental health and weight support is embedded.

### Streamlined billing

New streamlined pricing offers a single price point for multiple chronic conditions based on a member's anchor condition.

### Chronic Condition Management Plus access

| | | |
|---|---|---|
| ✓ | **Fully insured:** | Diabetes Management Plus included as part of your plan |
| ✓ | **OptiFlex:** | Diabetes Management Plus included as part of your plan |
| ✓ | **Self-funded:** | Buy up, one or all Plus programs can be added to your plan |

[1]"Living with a Chronic Condition." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, www.cdc.gov/chronic-disease/living-with/index.html. Accessed 11 July 2024.
[2]If an employer hasn't purchased the Plus program that the member is eligible for based on their primary condition, they have no entry point. When employers purchase a program that is a member's anchor condition, the member can also access Plus programs for their other conditions even if the employer hasn't purchased the additional programs. Mental health is available across all programs.
[3]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10170908/#:~:text=Some%20promising%20research%20has%20shown%20that%20patient%E2%80%90centered%20care%2C,%28Joo%20%26%20Liu%2C%202017%3B%20McKay%20et%20al.%2C%202019%29

**Did you know?**

Employer groups who offer GLP-1 coverage for weight loss can offer Advanced Weight Management as a stand-alone program. Contact your Premera account representative for more information.

# Get the most from your pharmacy benefit

One in five Americans take prescribed medicine several times a day.[1] Health outcomes, member experience, and group savings are just some of the ways an integrated benefit design makes your health plan work better.

## Solutions that help you get more

Groups with integrated pharmacy can pull a variety of levers to exercise savings without sacrificing member experience.

| SOLUTION | FINANCIAL VALUE | HOW IT WORKS | FUNDING TYPE |
|---|---|---|---|
| **Dispense as Written** | Group | Instructs pharmacies on brand and generic dispensing requirements and impacts how much a member pays out of pocket. | All funding types |
| **Exclusion Lists** | Group | Pairs with a group's formulary.[2] Lists include High-cost Low-value and OTC exclusion. | Self-funded |
| **Out-of-Pocket Protection** | Group | This program excludes copay assistance dollars from counting toward members' out-of-pocket maximum accruals.[3] | Self-funded |
| **Right Price** | Member | Embedded discount card program ensures your employees pay the lowest possible price at the pharmacy counter. | Self-funded |
| **Rx Savings Solutions (RxSS)** | Group, Member | Personalized savings alerts including generic drugs, combination fills, pharmacy changes, and more. The RxSS concierge team can manage the change for the member, enabling a seamless transition. | All funding types |
| **Rx Rewards** | Group, Member | RxSS provides a financial incentive for members who switch to a lower cost alternative. | Self-funded |
| **Split Fill** | Group | Eliminates waste and improves therapy adherence. The initial prescription is divided into two smaller fills. If the member has an interaction, for example, the second fill is not initiated. | Self-funded |
| **Transition Fill** | Group, Member | New members can maintain their prescriptions with a temporary fill while transitioning to their new Premera health plan. | All funding types[4] |



## Premera as a partner in integrated benefits

- Dedicated account team
- Comprehensive utilization reviews
- Knowledge-based population health changes

## What integration looks like for our members

- Lower medical costs[5]
- Fewer hospitalizations[5]
- Fewer emergency room visits[5]

[1]Fleck, Anna, and Felix Richter. "Infographic: More than Half of Americans Take Prescribed Meds Daily." Statista Daily Data, 6 Nov. 2023, www.statista.com/chart/31183/us-respondents-who-are-taking-prescribed-medicine/.

[2]Metallic and Essentials formularies are excluded.

[3]The Out-of-Pocket Protection program is recommended for groups whose renewal aligns with their benefit year reset.

[4]Available to new groups only.

[5]J Manag Care Spec Pharm. 2020 Jun;26(6):766-774. doi: 10.18553/jmcp.2020.19411. Epub 2020 Mar 10.

Rx Savings Solutions is an independent company that does not provide Blue Cross Blue Shield products or services.

### Did you know?

The Premera Pharmacy and Therapeutics Committee consists of external physicians, pharmacists, and other professional leaders in our community, many of whom see patients at least part time.

# Helping you find a provider as unique as you

Two out of three employers rank employee mental health as a top health priority.[1] Premera has made it easier than ever for members to access behavioral health services virtually or in person.

## Matchmaker™ for Behavioral Health

Matchmaker for Behavioral Health is our commitment to improve access and lessen the hurdles members face when seeking behavioral health services. With Matchmaker for Behavioral Health, members receive a highly personalized list of behavioral health providers based on their plan, needs, and preferences.

**Member**

Member contacts Premera customer service or case management.

**CSR**

Premera representative completes member intake over the phone.

**Navigator team**

Matchmaker team curates a list of providers that is delivered to the member in three to four business days.

The Matchmaker for Behavioral Health intake asks members their preferences on:

- Religious affiliation
- In-person or virtual
- Gender, race, and ethnicity
- Language
- And more

Every Matchmaker for Behavioral Health list includes a minimum of two in-network providers.

### Matchmaker for Behavioral Health access

| | | |
|---|---|---|
| ✓ | **Fully insured:** | Included as part of your plan |
| ✓ | **OptiFlex:** | Included as part of your plan |
| ✓ | **Self-funded:** | Opt in, per list pricing |

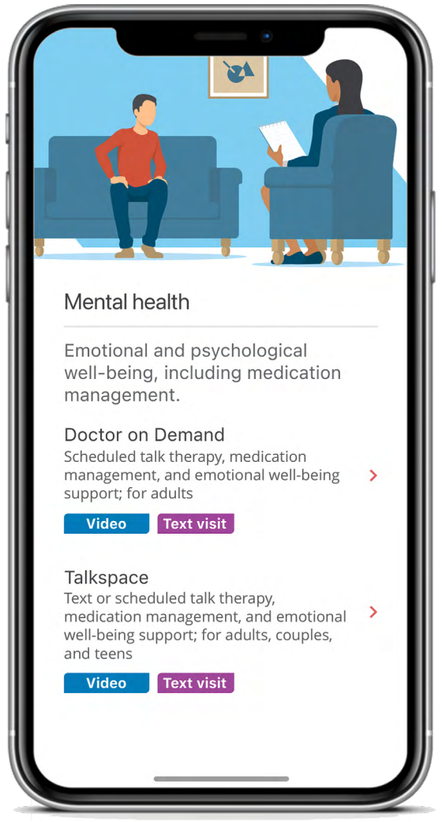
[1]2022 Best Practices in Healthcare Employer Survey, 2022 Global Benefit Attitudes Survey

[2]Medically assisted treatment (MAT) may be prohibited to certain U.S. states in order to meet federal in-person prescribing requirements.



## Behavioral health in the palm of your hand

Premera has partnered with industry-leading behavioral health virtual care vendors to ensure our members get the care they need, when they need it, and in a way that works for them.




**83%**

**of employers offer behavioral health services through virtual care.[1]**

Virtual behavioral health care can support members with:

- Generalized anxiety
- Depression
- Adjustment disorders
- And more

Members struggling with substance use disorder (SUD) have access to confidential and high-quality virtual care including medically assisted treatment (MAT).[2] **Contact your Premera account representative for more information.**

# Care when you need it

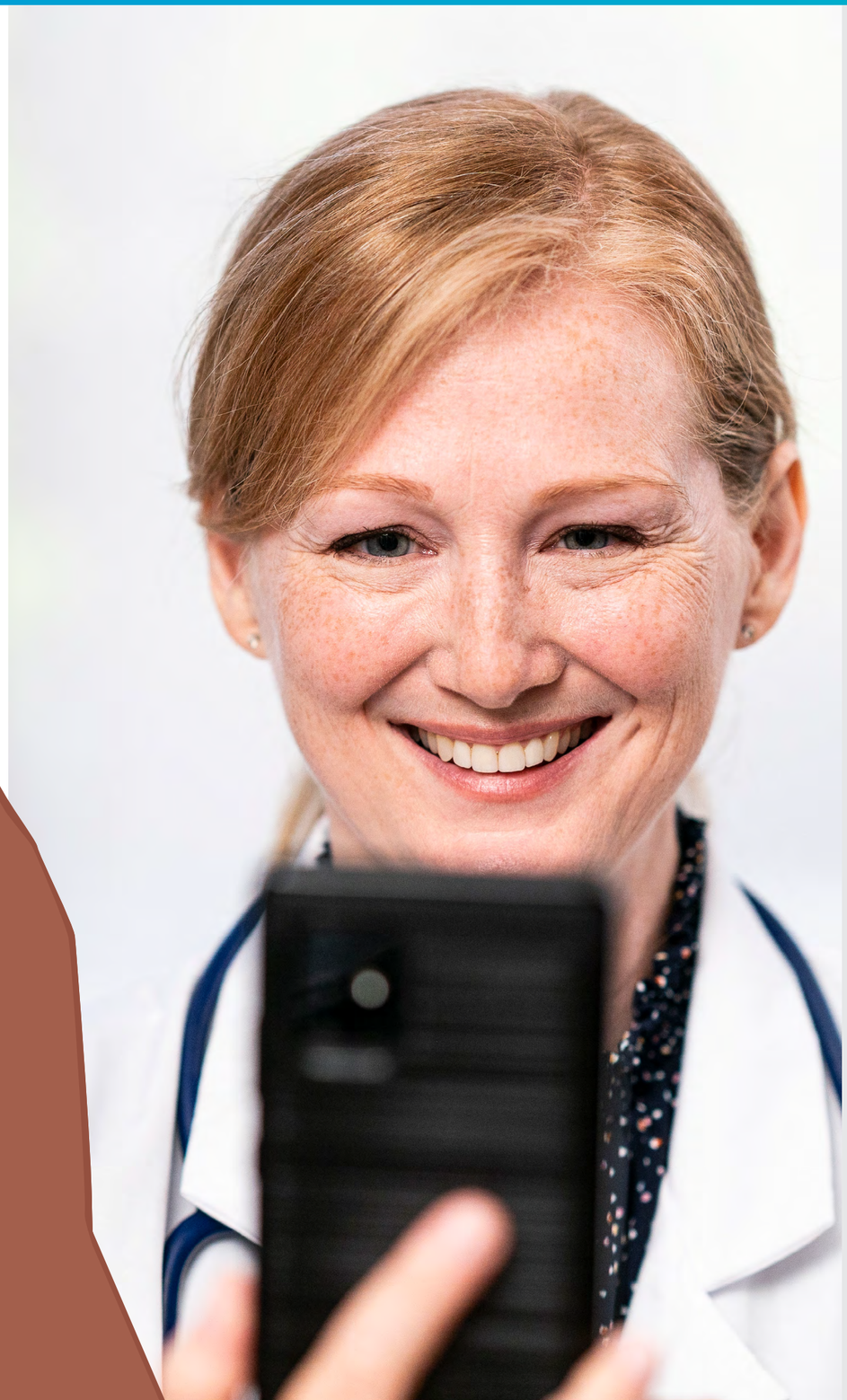
For the times when you can't wait for an in-person visit, virtual care is there. Virtual care providers offer secure text or video visits to treat a variety of primary care needs.

**Virtual care can help with:**

- Common colds
- COVID-19
- Follow-up visits with a physician
- Sinus infections
- Urinary tract infections (UTIs)

## Benefits

- **Improved employee experience**—Your employees no longer need to wait days or weeks for an appointment. Give them near-instant access to board-certified physicians, psychiatrists, therapists, and specialists who offer specialized care, from initial evaluation to an ongoing treatment plan. Your employees can conveniently access all these services from the safety and comfort of their homes.
- **Cost savings**—Virtual care costs less than in-person care, provides timely treatment to support condition management, and keeps employees within network.
- **Quality**—We deliver the highest quality care providers and innovative provider options for your employees. High-quality care improves continuity of care and retention, which is critical to the well-being of your employees.



### Did you know?

Every Premera medical plans includes our 24-Hour NurseLine at no extra cost. Members can call day or night to receive confidential health advice from a registered nurse.

# Networks that give you more

Our provider networks are more than just a collection of contracts. We work closely with providers and hospitals to give members access to quality care and good experiences.

### Heritage network

Our contracted providers and hospitals include over 6,063 preferred providers and 23 preferred hospitals across Alaska.

### Yukon network*

We designed a network that lowers costs by excluding dialysis providers that are not competitively priced. The Yukon network limits the financial impact of unanticipated dialysis costs for members and employers. It also reduces expenses when members require dialysis prior to qualifying for Medicare. For self-funded and OptiFlex employers, this network makes carving out dialysis coverage a reality.

### Healthcare that travels with you

Every Premera health plan includes the BlueCard® program. This program provides access to networks of contracted preferred and participating Blue Cross Blue Shield providers across the country. Just like here at home, these networks provide valuable discounts on billed charges. Plus, they have the added advantage of direct billing.

The BlueCard program includes worldwide coverage with Blue Cross Blue Shield Global Core. Members have access to an international network of participating providers and hospitals for a broad range of medical care services. This access means they can feel safe wherever they go.

### Affordable quality care

Going beyond network access, Blue Distinction Centers and Blue Distinction Centers+ offer members access to facilities that surpass quality metrics and offer cost-effective procedures for certain specialty care.

*Network selection specific to self-funded and OptiFlex employer groups.



### Extending our network reach

Virtual care for primary and urgent care services has become the norm for our members. Premera has partnered with a variety of vendors to ensure members get care when it's convenient for them.

### The power of choice

Whether your employees want access to the most providers in Alaska, or the highest savings, give them the ability to choose their network. Talk with your producer about the benefits of offering your employees two or three Premera medical plan options.

# Medical plans

You can choose from a range of plans to find the right balance between budgetary and healthcare needs for both your business and your employees. All of our plans offer specified preventive screenings and services covered in full. They also include coverage for many professional and naturopathic services with no visit or dollar limits.

### PPO plans

All of the medical plans outlined in this guide are preferred provider organization (PPO) plans. PPO plans work with a network of participating and preferred providers to offer you savings on your health plan.

Your employees save money when they get care from our broad list of providers within the Heritage network.

## Plus plan vs. Select plan

Plus plans give your employees the highest benefit level when they use preferred providers and hospitals.

Select plans offer the flexibility for your employees to see the provider of their choice with the same benefit level—whether the provider is in the Premera network or not.

## HSA-qualified plans

Health savings account (HSA)-qualified plans offer valuable benefits for covered services, and they are qualified to work in combination with an employee-owned, tax-advantaged HSA. These plans offer the option for you to use our vendor, an independent company that administers HSA accounts on behalf of Premera customers at a federally insured bank.

## Split Copay plans

Split Copay plans offer options with a lower copay for non-specialist office visits—and a higher copay when a member sees a specialist.

| Plan highlights | PLUS | PLUS SPLIT COPAY | PLUS HSA | SELECT | SELECT HSA |
|---|---|---|---|---|---|
| **NETWORK** | | | | | |
| Heritage | ● | ● | ● | ● | ● |
| Yukon | ● | ● | ● | ● | ● |
| **PLAN TYPE** | | | | | |
| PPO plan | ● | ● | ● | ● | ● |
| Split Copay | | ● | | | |
| HSA-qualified with the option of our financial vendor | | | ● | | ● |

# Plus

An Alaska Plus plan offers you savings on your health plan costs and provides the highest benefit level to your employees and their covered dependents when they use in-network preferred providers and hospitals. In-network care can be found using the Find a Doctor tool on **premera.com**.

## Cost-share options

**Cost-share amounts represent customers' costs. Not all plan option combinations are offered.**
See your Premera representative for clarification.
PCY = per calendar year

| | IN NETWORK<br>Preferred/Participating | OUT OF NETWORK<br>Non-participating |
|---|---|---|
| **Individual deductible** | $0–$9,200 (increments of $50) | Shared with in network<br>2x Individual or 3x Individual in-network deductible |
| **Family deductible** PCY | 2x Individual 3x Individual | |
| **Coinsurance** | Preferred 0%–30% (increments of 5%)<br>Participating 30%–50% (increments of 5%) | 20%–60% (increments of 5%) |
| **Individual out-of-pocket maximum**<br>PCY (Includes deductible, coinsurance, and copay) | $0–$9,200 (increments of $50) | $45,000 or Unlimited |
| **Family out-of-pocket maximum**<br>PCY (Includes deductible, coinsurance, and copay) | 2x Individual 3x Individual | None |
| **Fourth quarter deductible carryover** | Excluded or Included | |
| **Office visit cost share** | In-network deductible and coinsurance<br>Preferred copay of $20 or $25 | Out-of-network deductible and coinsurance |
| **Inpatient cost share** | In-network deductible and coinsurance<br>Preferred $100 copay per admission<br>Participating 30%–50% (increments of 5%) | |
| **Annual plan maximum** | Unlimited | |

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracted with Premera Blue Cross Blue Shield of Alaska.



## Covered services

**Benefits apply after calendar-year deductible is met, unless otherwise noted.**
PCY = per calendar year
MD = Medical doctor DO = Doctor of osteopathy DC = Doctor of chiropractic

| | BENEFIT LIMITS | IN NETWORK<br>Preferred | IN NETWORK<br>Participating | OUT OF NETWORK<br>Non-participating |
|---|---|---|---|---|
| **Preventive office visit**<br>**Preventive screenings**[1]<br>**Vaccinations** | Unlimited[1] | Covered in full[2] | | 20%–60% (increments of 5%) |
| **Seasonal vaccinations** (Provider office or pharmacy)<br>**Health education and training**<br>**Diabetes education and training** | | | | Covered in full[1] |
| **Professional office visit** | Unlimited | Office visit cost share | | 20%–60% (increments of 5%) |
| **Virtual care** (General medicine) | | Covered in full | | Not applicable |
| **Urgent care** (Freestanding clinics) | | $0–$150 (increments of $5) | | 20%–60% (increments of 5%) |
| **Other outpatient professional services**<br>**Inpatient professional services** | | Preferred coinsurance | Participating coinsurance | |
| **Manipulations** (Spinal and other) | 10–34, or unlimited visits PCY | Office visit cost share | | 40%, 50%, or 60% |
| **Acupuncture** | 10–34, or unlimited visits PCY | | | |
| **Naturopathic services** | Unlimited | | | |
| **Mammography** (Non-preventive) | | Deductible waived, then coinsurance; Deductible, then coinsurance; Covered in full | | 20%–60% (increments of 5%) |
| **Outpatient diagnostic imaging and laboratory services** | | Deductible waived, then coinsurance; Deductible, then coinsurance | | |
| **Emergency care**<br>(Copay waived if directly admitted to inpatient facility) | | Deductible, then preferred coinsurance; $50–$500 copay, then deductible and preferred coinsurance | | |
| **Ambulance transportation**<br>(Air and surface) | | Emergent: Preferred coinsurance; $50–$500 copay (increments of $25) copay, then deductible and preferred coinsurance<br>Non-emergent surface: Same as emergent<br>Non-emergent air: Coinsurance; $50–$500 (increments of $25) copay, then deductible and coinsurance | | Emergent: Same as in network<br>Non-emergent surface: Same as in network<br>Non-emergent air: 20%–60% (increments of 5%) |
| **Inpatient facility care** | | Preferred inpatient cost share | Participating inpatient cost share | 20%–60% (increments of 5%) |
| **Outpatient facility care** | | Preferred coinsurance | Participating coinsurance | |
| **Skilled nursing facility** | 60, 100, or 120 days PCY | Preferred inpatient cost share | Participating inpatient cost share | |
| **Premera-Designated Centers of Excellence** | Unlimited | Covered in full | | |
| **Maternity care** (Prenatal, delivery, and postnatal care) | | Preferred coinsurance | Participating coinsurance | |
| **Mental health and chemical dependency treatment** | Unlimited outpatient and inpatient | Inpatient: Preferred inpatient cost share; Outpatient: Preferred office visit cost share | | |
| **Rehabilitation** (Including cardiac/pulmonary rehab; chronic pain; and physical, occupational, speech, and massage therapy. Massage therapy must be billed by MD, DO, or DC) | 15–90 visits (increments of 5 visits)/15–90 days (increments of 5 days); Unlimited/Unlimited | Inpatient: Preferred inpatient cost share; Outpatient: Preferred office visit cost share | Inpatient: Participating inpatient cost share; Outpatient: Preferred office visit cost share | |
| **Supplies, equipment, prosthetics, and orthotics** | Unlimited except foot orthotics $300 PCY or Unlimited | Preferred coinsurance | Participating coinsurance | |
| **Home health care** | 120, 130, or unlimited home health visits PCY | | | |
| **Hospice care** | Inpatient: 10, 30, or unlimited days; Respite: 240 hours; Home visits: unlimited (6-month lifetime maximum for all services) | Home visits and respite: Preferred coinsurance; Inpatient: Preferred inpatient cost share | Home visits and respite: Participating coinsurance; Inpatient: Participating inpatient cost share | |
| **Transplants** (Organ and bone marrow) | $75,000 donor and $7,500 travel and lodging limits per transplant | Inpatient: Preferred inpatient cost share; Outpatient: Preferred office visit cost share | Inpatient: Participating inpatient cost share; Outpatient: Preferred office visit cost share | Not covered |

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if provider is not contracted with Premera Blue Cross Blue Shield of Alaska.
This is only a brief summary of the major benefits provided by the Plus plan. It is not a contract.
[1]A list of preventive screenings and services, with their suggested frequency guidelines and limits, is available on **premera.com** on the Miscellaneous Form page.
[2]Benefits provided at 100% of allowable charges; not subject to deductible or coinsurance.

# Plus Split Copay

The Plus Split Copay plan provides lower copays for non-specialist office visits and a higher copay when your employee sees a specialist. This plan gives the highest benefit level to your employees and their covered dependents when they use in-network preferred providers and hospitals. In-network care can be found using the Find a Doctor tool on **premera.com**.

## Cost-share options

**Cost-share amounts represent customers' costs. Not all plan option combinations are offered.**
See your Premera representative for clarification.
PCY = per calendar year

| | IN NETWORK<br>Preferred/Participating | OUT OF NETWORK<br>Non-participating |
|---|---|---|
| **Individual deductible** | $0–$9,200 (increments of $50) | Shared with in-network<br>2x Individual or 3x Individual in-network deductible |
| **Family deductible** PCY | 2x Individual 3x Individual | |
| **Coinsurance** | Preferred 0%–30% (increments of 5%)<br>Participating 30%–50% (increments of 5%) | 20%–60% (increments of 5%) |
| **Individual out-of-pocket maximum**<br>PCY (Includes deductible, coinsurance, and copay) | $0–$9,200 (increments of $50) | $45,000 or Unlimited |
| **Family out-of-pocket maximum**<br>PCY (Includes deductible, coinsurance, and copay) | 2x Individual 3x Individual | None |
| **Fourth quarter deductible carryover** | Excluded or Included | |
| **Office visit copay** | Non-specialist: $0–$45 (increments of $5)<br>Specialist: $20–$80 (increments of 5%) | Out-of-network deductible and coinsurance |
| **Inpatient cost share** | In-network deductible and coinsurance<br>Preferred $100 copay per admission<br>Participating 30%–50% (increments of 5%) | |
| **Annual plan maximum** | Unlimited | |

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracted with Premera Blue Cross Blue Shield of Alaska.



## Covered services

**Benefits apply after calendar-year deductible is met, unless otherwise noted.**
PCY = per calendar year
MD = Medical doctor DO = Doctor of osteopathy DC = Doctor of chiropractic

| | BENEFIT LIMITS | IN NETWORK<br>Preferred | IN NETWORK<br>Participating | OUT OF NETWORK<br>Non-participating |
|---|---|---|---|---|
| **Preventive office visit**<br>**Preventive screenings**[1]<br>**Vaccinations** | Unlimited[1] | Covered in full[2] | | 20%–60% (increments of 5%) |
| **Seasonal vaccinations**<br>(Provider office or pharmacy)<br>**Health education and training**<br>**Diabetes education and training** | | | | Covered in full[2] |
| **Professional office visit** | Unlimited | Office visit cost share | | 20%–60% (increments of 5%) |
| **Virtual care** (General medicine) | | Covered in full | | |
| **Urgent care** (Freestanding clinics) | | $0–$150 copay (increments of 5%) | | |
| **Other outpatient professional services**<br>**Inpatient professional services** | | Preferred coinsurance | Participating coinsurance | |
| **Manipulations** (Spinal and other) | 10–34 visits PCY or unlimited | Office cost share | | |
| **Acupuncture** | 10–34 visits PCY or unlimited | | | |
| **Naturopathic services** | Unlimited | | | |
| **Mammography** (Non-preventive) | | Deductible waived, then coinsurance; Deductible, then coinsurance; Covered in full | | |
| **Outpatient diagnostic imaging and laboratory services** | | Deductible waived, then coinsurance; Deductible, then coinsurance; Covered in full | | |
| **Emergency care** (Copay waived if directly admitted to inpatient facility) | | Deductible, then preferred coinsurance; $50–$500 copay (increments of $25) copay, then deductible and preferred coinsurance | | |
| **Ambulance transportation**<br>(Air and surface) | | Emergent: Preferred coinsurance; $50–$500 copay (increments of $25), then deductible and preferred coinsurance<br>Non-emergent surface: Same as emergent<br>Non-emergent air: Coinsurance; $50–$500 copay (increments of $25) copay, then deductible and coinsurance | | Emergent: Same as in network<br>Non-emergent surface: Same as in network<br>Non-emergent air: 20%–60% (increments of 5%) |
| **Inpatient facility care** | | Preferred inpatient cost share | Participating inpatient cost share | 20%–60% (increments of 5%) |
| **Outpatient facility care** | | Preferred coinsurance | Participating coinsurance | |
| **Skilled nursing facility** | 60–120 days PCY (increments of 10 days) or unlimited | Preferred inpatient cost share | Participating inpatient cost share | |
| **Premera-Designated Centers of Excellence** | Unlimited | Covered in full | | |
| **Maternity care**<br>(Prenatal, delivery, and postnatal care) | | Preferred coinsurance | Participating coinsurance | |
| **Mental health and chemical dependency treatment** | Unlimited outpatient and inpatient | Inpatient: Preferred inpatient cost share; Outpatient: Nonspecialist office visit cost share | | |
| **Rehabilitation**<br>(Including cardiac/pulmonary rehab; chronic pain; and physical, occupational, speech, and massage therapy. Massage therapy must be billed by MD, DO, or DC.) | 15–90 visits (increments of 5 visits)<br>15–90 days (increments of 5 days)<br>Unlimited/Unlimited | Inpatient: Preferred inpatient cost share; Outpatient: Specialist office visit cost share | Inpatient: Participating inpatient cost share; Outpatient: Preferred office visit cost share | |
| **Supplies, equipment, prosthetics, and orthotics** | Unlimited except foot orthotics $300 PCY or Unlimited | Preferred coinsurance | Participating coinsurance | |
| **Home health care** | 120, 130, or unlimited home health visits PCY | | | |
| **Hospice care** | Inpatient: 10, 30, or unlimited days; Respite: 240 hours; Home visits: unlimited (6-month lifetime maximum for all services) | Home visits and respite: Preferred coinsurance; Inpatient: Preferred inpatient cost share | Home visits and respite: Participating coinsurance; Inpatient: Participating inpatient cost share | |
| **Transplants** (Organ and bone marrow) | $75,000 donor and $7,500 travel and lodging limits per transplant | Inpatient: Preferred inpatient cost share; Outpatient: Preferred office visit cost share | Inpatient: Participating inpatient cost share; Outpatient: Preferred office visit cost share | Not covered |

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if provider is not contracted with Premera Blue Cross Blue Shield of Alaska.
This is only a brief summary of the major benefits provided by the Plus Split Copay plan. It is not a contract.
[1]A list of preventive screenings and services, with their suggested frequency guidelines and limits, is available on **premera.com** on the Miscellaneous Form page.
[2]Benefits are provided at 100% of allowable charges; not subject to deductible or coinsurance.

# Plus HSA

The Alaska Plus HSA plan offers you savings on your health plan costs and valuable benefits to your employees and their covered dependents for covered services when they use preferred providers and hospitals. This plan is also qualified to work in combination with an employee-owned, tax-advantaged HSA. In-network care can be found using the Find a Doctor tool on **premera.com**.

**Cost-share amounts represent customers' costs. Not all plan option combinations are offered.** See your Premera representative for clarification.
PCY = per calendar year

| DEDUCTIBLE OPTIONS | | | |
|---|---|---|---|
| **Aggregate deductible** | | With an aggregate deductible, there is one deductible for the subscriber (individual) and their family that must be met first before benefits are paid for anyone in the family. | |
| **Embedded deductible** | | An embedded deductible works like a traditional PPO health plan deductible. Benefits begin for a single family member once the individual deductible for that person has been met or once the family deductible is met—whichever comes first. | |
| **COST-SHARE OPTIONS** | | | |
| **Individual/Family[1] deductible** PCY | **Aggregate** | $1,650/$3,300 – $4,150/$8,300 (increments of $50) | N/A |
| | **Embedded** | N/A | $3,300/$6,000 – $8,300/$16,600 (increments of $50) |
| **Coinsurance percentage[2]** (Preferred / Participating) | | Preferred 0%–30% (increments of 5%)<br>Participating 30%–50% (increments of 5%) | |
| **Out of network** | | 20%–60% (increments of 5%) | |
| **Individual/Family[1] out-of-pocket max.** PCY (Includes deductible and coinsurance) | **Aggregate** | $1,650/$3,300 – $4,150/$8,300 (increments of $50) | N/A |
| | **Embedded** | $3,300/$6,600 – $8,300/$16,600 (increments of $50) | |
| **Annual plan maximum** | | Unlimited | |

| PRESCRIPTION DRUGS | BENEFIT LIMITS | IN NETWORK | | OUT OF NETWORK |
|---|---|---|---|---|
| | | Preferred | Participating | Non-participating |
| **Enhanced preventive drug list[3]** | 90-day supply except Specialty Rx 30-day supply | Covered in full[4] | | |
| **Retail pharmacy** (Subject to medical deductible) | | In-network coinsurance | Medical deductible, $10 / $30 / $50 / 30% (Copay = 30 days; up to 90-day supply per Rx) | Same as in network |
| **Mail-order pharmacy** (Subject to medical deductible) | | | Medical deductible, $25 / $75 / $50 / 30% (Copay = 30 days; up to 90-day supply per Rx) | Not covered |
| **Drug list** | | A1 or E1 | E4 | Same as in network |

Note: Out-of-pocket costs for out-of-network providers do not accrue toward out-of-pocket maximum. Out-of-pocket maximum = deductible + your coinsurance maximum.
N/A = Not available in this plan choice.
[1]Family = Subscriber and one or more dependents. [2]All coinsurance amounts are based on a percentage of allowable charges. Preferred and participating providers are in network.
[3]Buy-up option available. Contact your Premera sales representative or producer for more information. [4]Benefits are provided at 100% of allowable charges; not subject to deductible or coinsurance.



## Covered services

**Benefits apply after calendar-year deductible is met, unless otherwise noted.**
PCY = per calendar year
MD = Medical doctor DO = Doctor of osteopathy DC = Doctor of chiropractic

| | BENEFIT LIMITS | IN NETWORK | | OUT OF NETWORK |
|---|---|---|---|---|
| | | Preferred | Participating | Non-participating |
| **Preventive office visit**<br>**Preventive screenings[1]**<br>**Vaccinations** | Unlimited[1] | Covered in full[2] | | 20%–60% (increments of 5%) |
| **Seasonal vaccinations** (Provider office or pharmacy)<br>**Health education and training**<br>**Diabetes education and training** | | | | Covered in full[2] |
| **Professional office visit** | Unlimited | Preferred coinsurance | | 20%–60% (increments of 5%) |
| **Virtual care designated provider** | | Preferred coinsurance | | Not covered |
| **Urgent care** (Freestanding clinics) | | | | 20%–60% (increments of 5%) |
| **Other outpatient professional services**<br>**Inpatient professional services** | | Preferred coinsurance | Participating coinsurance | |
| **Manipulations** (Spinal and other) | 10–34 visits PCY for each or unlimited | Preferred coinsurance | | |
| **Acupuncture** | | | | |
| **Naturopathic services** | Unlimited | | | |
| **Mammography** (Non-preventive) | | Preferred coinsurance, or Preferred deductible, 0$ | Participating coinsurance | |
| **Outpatient diagnostic imaging and laboratory services** | | Preferred coinsurance | | |
| **Emergency care** | | Deductible and preferred coinsurance | | |
| **Ambulance transportation** (Air and surface) | | Emergent: Preferred coinsurance<br>Non-emergent surface: Same as emergent<br>Non-emergent air: Coinsurance | | Emergent: Same as in network<br>Non-emergent surface: Same as in network<br>Non-emergent air: 50% or 60% |
| **Inpatient facility care** | | Preferred coinsurance | Participating coinsurance | 20%–60% (increments of 5%) |
| **Outpatient facility care** | | | | |
| **Skilled nursing facility** | Unlimited for 60–180 days (increments of 10 days) or unlimited | | | |
| **Premera-Designated Centers of Excellence** | Unlimited | Deductible, then 0% | | |
| **Maternity care** (Prenatal, delivery, and postnatal care) | | Preferred coinsurance | Participating coinsurance | |
| **Mental health and chemical dependency treatment** | Unlimited outpatient and inpatient | Preferred coinsurance | | |
| **Rehabilitation** (Including cardiac/pulmonary rehab; chronic pain; and physical, occupational, speech, and massage therapy. Massage therapy must be billed by MD, DO, or DC.) | 45 visits/30 days PCY<br>60 visits/60 days PCY<br>Unlimited/Unlimited | Preferred coinsurance | Inpatient: Participating inpatient cost share<br>Outpatient: Preferred office visit cost share | |
| **Supplies, equipment, prosthetics, and orthotics** | Unlimited except foot orthotics $300 PCY | | Participating coinsurance | |
| **Home health care** | 120, 130, or unlimited home health visits PCY | | | |
| **Hospice care** | Inpatient: 10, 30, or unlimited days;<br>Respite: 240 hours;<br>Home visits: unlimited (6-month lifetime maximum for all services) | | Home visits and respite: Participating coinsurance<br>Inpatient: Participating inpatient cost share | |
| **Transplants** (Organ and bone marrow) | $75,000 donor and $7,500 travel and lodging limits per transplant | | Inpatient: Participating inpatient cost share<br>Outpatient: Preferred office visit cost share | Not covered |

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if provider is not contracted with Premera Blue Cross Blue Shield of Alaska.
This is only a brief summary of the major benefits provided by the Plus HSA plan. It is not a contract.
[1]A list of preventive screenings and services, with their suggested frequency guidelines and limits, is available on **premera.com** on the Miscellaneous Form page.
[2]Benefits are provided at 100% of allowable charges; not subject to deductible or coinsurance.

# Essentials Medical

For businesses with hard decisions to make, the Essentials Medical health plan can offer you savings on premiums. This plan will also help you maintain your Premera benefits and minimize disruptions for your employees with a new, low-cost health plan option.

## ESSENTIALS 7550

### Cost-share options

**Cost-share amounts represent customers' costs. Not all plan option combinations are offered.**
See your Premera representative for clarification.
PCY = per calendar year

| | IN NETWORK<br>Preferred/Participating | OUT OF NETWORK<br>Non-participating |
|---|---|---|
| **Individual deductible** PCY | $7,550 | $15,100 |
| **Family deductible** PCY | 2x Individual | |
| **Coinsurance** | Preferred 30%<br>Participating 40% | 60% |
| **Individual out-of-pocket maximum**<br>PCY (Includes deductible, coinsurance, and copay) | $8,550 | Unlimited |
| **Family out-of-pocket maximum**<br>PCY (Includes deductible, coinsurance, and copay) | 2x Individual | |
| **Fourth quarter deductible carryover** | Excluded | |
| **Office visit cost share** | In-network deductible and coinsurance | Out-of-network deductible and coinsurance |
| **Inpatient cost share** | | |
| **Annual plan maximum** | Unlimited | |

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracted with Premera Blue Cross Blue Shield of Alaska.

### Covered services

| | IN NETWORK<br>Preferred/Participating | OUT OF NETWORK<br>Non-participating |
|---|---|---|
| **Retail pharmacy**<br>**Up to 90-day supply per Rx**<br>(copay per 30 days) | $30 copay, deductible waived; Deductible, then 30% coinsurance; Deductible, then 30% coinsurance; Deductible then 50% coinsurance | Same as in network |
| **Mail-order pharmacy**<br>**Up to 90-day supply per Rx** | $90 copay, deductible waived; Deductible, then 30% coinsurance; Deductible, then 30% coinsurance; Deductible then 50% coinsurance | Not covered |
| **Drug list** | Essentials E4 formulary | |



### Covered services

**Benefits apply after calendar-year deductible is met, unless otherwise noted.**
**Benefits subject to medical necessity except for preventive care.** PCY = per calendar year

| | BENEFIT LIMITS | IN NETWORK<br>Preferred | IN NETWORK<br>Participating | OUT OF NETWORK<br>Non-participating |
|---|---|---|---|---|
| **Preventive office visit**<br>**Preventive screenings**<br>**Vaccinations** | Unlimited | Covered in full | | 60% |
| **Seasonal vaccinations**<br>(Provider office or pharmacy)<br>**Health education and training**<br>**Diabetes education and training** | | | | Covered in full |
| **Professional office visit** | | Preferred coinsurance | Participating coinsurance | 60% |
| **Virtual care** (General medicine) | | Covered in full | | Not applicable |
| **Urgent care** (Freestanding clinics) | | Preferred coinsurance | | 60% |
| **Other outpatient professional services**<br>**Inpatient professional services** | | Preferred coinsurance | Participating coinsurance | |
| **Manipulations** (Spinal and other) | Not covered | Not covered | | Not covered |
| **Acupuncture** | | | | |
| **Naturopathic services** | Unlimited | See office visit | | 60% |
| **Mammography** (Non-preventive) | | Preferred coinsurance or covered in full | Participating coinsurance | |
| **Outpatient diagnostic imaging and laboratory services** | | Preferred coinsurance | | |
| **Emergency care**<br>(Copay waived if directly admitted to inpatient facility) | | Preferred coinsurance and copay of $450 after deductible | | Same as in network |
| **Ambulance transportation**<br>(Air and surface) | | Emergent: Preferred coinsurance; $450 copay, then deductible and preferred coinsurance<br>Non-emergent surface: Same as emergent<br>Non-emergent air: Coinsurance; $450 copay, then deductible and coinsurance | | Emergent: Same as in network<br>Non-emergent surface: Same as in network<br>Non-emergent air: 60% |
| **Inpatient facility care** | | Preferred inpatient cost share | Participating inpatient cost share | 60% |
| **Outpatient facility care** | | Preferred coinsurance | Participating coinsurance | |
| **Skilled nursing facility** | 60 days PCY | Preferred inpatient cost share | Participating inpatient cost share | |
| **Premera-Designated Centers of Excellence** | Unlimited | Covered in full | | |
| **Maternity care**<br>(Prenatal, delivery, and postnatal care) | No visit or day maximum; covered for: subscriber, spouse/ domestic partner, and dependents | Preferred coinsurance | Participating coinsurance | |
| **Mental health and chemical dependency treatment** | Unlimited | Inpatient: Preferred inpatient cost share;<br>Outpatient: Preferred office visit cost share | | |
| **Rehabilitation**<br>(Including cardiac/pulmonary rehab; chronic pain; and physical, occupational, speech, and massage therapy. Massage therapy must be billed by MD, DO, or DC.) | 45 visits/30 days PCY | Inpatient: Preferred inpatient cost share;<br>Outpatient: Preferred office visit cost share | Inpatient: Participating cost share;<br>Outpatient: Preferred office visit cost share | |
| **Supplies, equipment, prosthetics, and orthotics** | No maximum, except $300 max PCY for foot orthotics that are not diabetes related | Preferred coinsurance | Participating coinsurance | |
| **Home health care** | 130 visits PCY | | | |
| **Hospice care** | Outpatient: No visit limits (within 6-month lifetime maximum)<br>Respite: 240 hours (within 6-month lifetime maximum); Inpatient options: 10 days (within 6-month lifetime maximum) | Home visits and respite: Preferred coinsurance;<br>Inpatient: Preferred inpatient cost share | Home visits and respite: Participating coinsurance;<br>Inpatient: Participating inpatient cost share | |
| **Transplants** (Organ and bone marrow) | $75,000 donor and $7,500 travel and lodging limits per transplant | Inpatient: Preferred inpatient cost share;<br>Outpatient: Preferred office visit cost share | Inpatient: Participating inpatient cost share;<br>Outpatient: Preferred office visit cost share | Not covered |

# Essentials Medical

## ESSENTIALS 8550

### Cost-share options

**Cost-share amounts represent customers' costs. Not all plan option combinations are offered.**
See your Premera representative for clarification.
PCY = per calendar year

| | IN NETWORK Preferred/Participating | OUT OF NETWORK Non-participating |
|---|---|---|
| **Individual deductible** PCY | $8,550 | $17,100 |
| **Family deductible** PCY | 2x Individual | |
| **Coinsurance** | 0% | 60% |
| **Individual out-of-pocket maximum** PCY (Includes deductible, coinsurance, and copay) | $8,550 | Unlimited |
| **Family out-of-pocket maximum** PCY (Includes deductible, coinsurance, and copay) | 2x Individual | |
| **Fourth quarter deductible carryover** | Excluded | |
| **Office visit cost share** | In-network deductible and coinsurance | Out-of-network deductible and coinsurance |
| **Inpatient cost share** | | |
| **Annual plan maximum** | Unlimited | |

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracted with Premera Blue Cross Blue Shield of Alaska.

### Covered services

| | IN NETWORK Preferred/Participating | OUT OF NETWORK |
|---|---|---|
| **Retail pharmacy up to 90-day supply per Rx** | All tiers - Deductible, then 0% coinsurance | Same as in network |
| **Mail-order up to 90-day supply per Rx** | | Not covered |
| **Drug list** | Essentials E1 formulary | |



### Covered services

**Benefits apply after calendar-year deductible is met, unless otherwise noted.**
**Benefits subject to medical necessity except for preventive care.** PCY = per calendar year

| | BENEFIT LIMITS | IN NETWORK Preferred | IN NETWORK Participating | OUT OF NETWORK Non-participating |
|---|---|---|---|---|
| **Preventive office visit**<br>**Preventive screenings**<br>**Vaccinations** | Unlimited | Covered in full | | 60% |
| **Seasonal vaccinations**<br>(Provider office or pharmacy)<br>**Health education and training**<br>**Diabetes education and training** | | | | Covered in full |
| **Professional office visit** | | 0% | | 60% |
| **Virtual care** (General medicine) | | Covered in full | | Not applicable |
| **Urgent care** (Freestanding clinics) | | 0% | | 60% |
| **Other outpatient professional services**<br>**Inpatient professional services** | | | | |
| **Manipulations** (Spinal and other) | Not covered | Not covered | | Not covered |
| **Acupuncture** | | | | |
| **Naturopathic services** | Unlimited | See office visit | | 60% |
| **Mammography** (Non-preventive) | | Preferred coinsurance or covered in full | Participating coinsurance | |
| **Outpatient diagnostic imaging and laboratory services** | | 0% | | |
| **Emergency care**<br>(Copay waived if directly admitted to inpatient facility) | | Deductible, then 0% | | |
| **Ambulance transportation**<br>(Air and surface) | | Emergent: Preferred coinsurance; deductible then 0%<br>Non-emergent surface: Same as emergent<br>Non-emergent air: Deductible, then 0% | | Emergent: Same as in network<br>Non-emergent surface: Same as in network<br>Non-emergent air: 60% |
| **Inpatient facility care** | | 0% | | 60% |
| **Outpatient facility care** | | | | |
| **Skilled nursing facility** | 60 days PCY | | | |
| **Premera-Designated Centers of Excellence** | Unlimited | Covered in full | | |
| **Maternity care**<br>(Prenatal, delivery, and postnatal care) | No visit or day maximum; covered for: subscriber, spouse/ domestic partner, and covered dependents | 0% | | |
| **Mental health and chemical dependency treatment** | Unlimited | Inpatient: 0%;<br>Outpatient: 0% | | |
| **Rehabilitation**<br>(Including cardiac/pulmonary rehab; chronic pain; and physical, occupational, speech, and massage therapy. Massage therapy must be billed by MD, DO, or DC.) | 45 visits/30 days PCY | Inpatient: 0%;<br>Outpatient: 0% | | |
| **Supplies, equipment, prosthetics, and orthotics** | No maximum, except $300 max PCY for foot orthotics that are not diabetes related | 0% | | |
| **Home health care** | 130 visits PCY | Preferred coinsurance | Participating coinsurance | |
| **Hospice care** | Outpatient: No visit limits (within 6-month lifetime maximum)<br>Respite: 240 hours (within 6-month lifetime maximum); Inpatient options: 10 days (within 6-month lifetime maximum) | Home visits and respite: 0%;<br>Inpatient: 0% | | |
| **Transplants** (Organ and bone marrow) | $75,000 donor and $7,500 travel and lodging limits per transplant | Inpatient: 0%;<br>Outpatient: 0% | | Not covered |

# Select

Choosing the Alaska Select plan allows your employees and their covered dependents to see the provider of their choice at the same benefit level, whether or not the provider is within the Premera provider network.

## Cost-share options

**Cost-share amounts represent customers' costs. Not all plan option combinations are offered.**
See your Premera representative for clarification.
PCY = per calendar year

| | IN NETWORK<br>Preferred/Participating | OUT OF NETWORK<br>Non-participating |
|---|---|---|
| **Individual deductible** PCY | $0–$9,200 (increments of $50) | Shared with in network<br>2x Individual or 3x Individual in network deductible |
| **Family deductible** PCY | 2x Individual 3x Individual | |
| **Coinsurance** | Preferred 0%–30% (increments of 5%)<br>Participating 30%–50% (increments of 5%) | 20%–60% (increments of 5%) hospital-based |
| **Individual out-of-pocket maximum**<br>PCY (Includes deductible, coinsurance, and copay) | $0–$9,200 (increments of $50) | $45,000 or unlimited |
| **Family out-of-pocket maximum**<br>PCY (Includes deductible, coinsurance, and copay) | 2x Individual 3x Individual | None |
| **Fourth quarter deductible carryover** | Excluded or Included | |
| **Office visit cost share** | In-network deductible and preferred coinsurance<br>Copay: $20 $25 | |
| **Inpatient cost share** | In-network deductible and coinsurance<br>Preferred $100 copay per admission / participating 40% | Out-of-network deductible and coinsurance |
| **Annual plan maximum** | Unlimited | |

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracted with Premera Blue Cross Blue Shield of Alaska.



## Covered services

**Benefits apply after calendar-year deductible is met, unless otherwise noted.**
PCY = per calendar year
MD = Medical doctor DO = Doctor of osteopathy DC = Doctor of chiropractic

| | BENEFIT LIMITS | IN NETWORK<br>Preferred | IN NETWORK<br>Participating | OUT OF NETWORK<br>Non-participating |
|---|---|---|---|---|
| **Preventive office visit**<br>**Preventive screenings**[1]<br>**Vaccinations** | Unlimited[1] | Covered in full[2] | | Covered in full[2] |
| **Seasonal vaccinations**<br>(Provider office or pharmacy)<br>**Health education and training** | | | | Hospital-based services: 20%–60% (increments of 5%); Other facilities and professionals: covered in full[2] |
| **Diabetes education and training** | | | | Covered in full[2] |
| **Professional office visit** | Unlimited | Office visit cost share | | |
| **Virtual care** (General medicine) | | Covered in full | | Not applicable |
| **Urgent care** (Freestanding clinics) | | $0–$150 copay (increments of $5) | | |
| **Other outpatient professional services**<br>**Inpatient professional services** | | Preferred coinsurance | | Hospital-based services: 20%–60% (increments of 5%) Other facilities and professionals: preferred coinsurance |
| **Manipulations** (Spinal and other) | 10–34 or unlimited visits PCY | Office visit cost share | | |
| **Acupuncture** | 10–34 or unlimited visits PCY | | | |
| **Naturopathic services** | Unlimited | | | |
| **Mammography** (Non-preventive) | Unlimited | Deductible waived, then coinsurance; Deductible, then coinsurance; Covered in full | | Hospital-based services: 20%–60% (increments of 5%) Other facilities and professionals: Preferred cost share |
| **Outpatient diagnostic imaging and laboratory services** | | | | |
| **Emergency care** | | Deductible, then preferred coinsurance; $50–$500 copay (increments of $25) copay, then deductible and preferred coinsurance | | |
| **Ambulance transportation**<br>(Air and surface) | | Emergent: Preferred coinsurance; $50–$500 copay (increments of $25) copay, then deductible and preferred coinsurance<br>Non-emergent surface: Same as emergent<br>Non-emergent air: Coinsurance; $50–$500 copay (increments of $25) copay, then deductible and coinsurance | | Emergent: Same as in network<br>Non-emergent surface: Same as in network<br>Non-emergent air: 50% or 60% |
| **Inpatient facility care** | | Preferred inpatient cost share | Participating inpatient cost share | Hospital-based services: 20%–60% (increments of 5%); Other facilities and professionals: Preferred cost share |
| **Outpatient facility care** | | Preferred coinsurance | Participating coinsurance | |
| **Skilled nursing facility** | 60–120 days PCY (increments of 10 days) or unlimited | Preferred inpatient cost share | Participating inpatient cost share | |
| **Premera-Designated Centers of Excellence** | Unlimited | Covered in full | | |
| **Maternity care**<br>(Prenatal, delivery, and postnatal care) | | Preferred coinsurance | Participating coinsurance | |
| **Mental health and chemical dependency treatment** | Unlimited outpatient and inpatient | Inpatient: Preferred inpatient cost share; Outpatient: Preferred office visit cost share | | Inpatient: Hospital-based services: 20%–60% (increments of 5%); Other facilities and professionals: Preferred cost share; Outpatient: Preferred cost share |
| **Rehabilitation**<br>(Including cardiac/pulmonary rehab; chronic pain; and physical, occupational, speech, and massage therapy. Massage therapy must be billed by MD, DO, or DC.) | 15–90 visits (increments of 5 visits)/15–90 days (increments of 5 days); Unlimited / Unlimited | Inpatient: Preferred inpatient cost share; Outpatient: Preferred office visit cost share | Inpatient: Participating inpatient cost share; Outpatient: Preferred cost share | |
| **Supplies, equipment, prosthetics, and orthotics** | Unlimited except foot orthotics $300 PCY or unlimited | Preferred coinsurance | Participating coinsurance | Hospital-based services: 20%–60%; Other facilities and professionals: Preferred coinsurance |
| **Home health care** | 120, 130, or unlimited home health visits PCY | | | |
| **Hospice care** | Inpatient: 10, 30, or unlimited days; Respite: 240 hours; Home visits: unlimited (6-month lifetime maximum for all services) | Home visits and respite: Preferred coinsurance; Inpatient: Preferred inpatient cost share | Home visits and respite: Participating coinsurance; Inpatient: Participating inpatient cost share | |
| **Transplants** (Organ and bone marrow) | $75,000 donor and $7,500 travel and lodging limits per transplant | Inpatient: Preferred inpatient cost share; Outpatient: Preferred office visit cost share | Inpatient: Participating inpatient cost share; Outpatient: Preferred cost share | Not covered |

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if provider is not contracted with Premera Blue Cross Blue Shield of Alaska.
This is only a brief summary of the major benefits provided by the Select plan. It is not a contract.
[1]A list of preventive screenings and services, with their suggested frequency guidelines and limits, is available on **premera.com** on the Miscellaneous Form page.
[2]Benefits are provided at 100% of allowable charges; not subject to deductible or coinsurance.

# Select HSA

Choosing the HSA-qualified Alaska Select HSA™ plan gives your employees and their covered dependents the same benefits whether or not their provider is within the Premera network.

**Cost-share amounts represent customers' costs. Not all plan option combinations are offered.**
See your Premera representative for clarification.
PCY = per calendar year

| DEDUCTIBLE OPTIONS | | | |
|---|---|---|---|
| **Aggregate deductible** | | With an aggregate deductible, there is one deductible for the subscriber (individual) and their family that must be met first before benefits are paid for anyone in the family. | |
| **Embedded deductible** | | An embedded deductible works like a traditional PPO health plan deductible. Benefits begin for a single family member once the individual deductible for that person has been met or once the family deductible is met—whichever comes first. | |
| **COST-SHARE OPTIONS** | | | |
| **Individual/Family[1] deductible** PCY | **Aggregate** | $1,650/$3,300 – $4,150/$8,300 (increments of $50) | N/A |
| | **Embedded** | N/A | $3,300/$6,600 – $8,300/$16,600 (increments of $50) |
| **Coinsurance percentage[2]** (Preferred / Participating) | | Preferred 0%–30% (increments of 5%)<br>Participating 30%–50% (increments of 5%) | |
| **Out of network** | | 20%–60% (increments of 5%) | |
| **Individual/Family[1] out-of-pocket maximum** PCY (Includes deductible and coinsurance) | **Aggregate** | $1,650/$3,300 – $4,150/$8,300 (increments of $50) | N/A |
| | **Embedded** | $3,300/$6,600 – $8,300/$16,600 (increments of $50) | |
| **Annual plan maximum** | | Unlimited | |

| PRESCRIPTION DRUGS | BENEFIT LIMITS | IN NETWORK | | OUT OF NETWORK |
|---|---|---|---|---|
| **Enhanced preventive drug list[3]** | 90-day supply except Specialty Rx 30-day supply | Covered in full[4] | | |
| **Retail pharmacy** (Subject to medical deductible) | | In-network coinsurance | Medical deductible, $10 / $30 / $50 / 30% (Copay = 30 days; up to 90-day supply per Rx) | Same as in network |
| **Mail-order pharmacy** (Subject to medical deductible) | | | Medical deductible, $25 / $75 / $50 / 30% (Copay = 30 days; up to 90-day supply per Rx) | Not covered |
| **Drug list** | | A1 or E1 | E4 | Same as in network |

Note: Out-of-pocket costs for out-of-network providers do not accrue toward out-of-pocket maximum. Out-of-pocket maximum = deductible + coinsurance maximum.
N/A = Not available in this plan choice.
[1]Family = Subscriber and one or more covered dependents.
[2]All coinsurance amounts are based on a percentage of allowable charges. Preferred and participating providers are in network.
[3]Buy-up option available. Contact your Premera sales representative or producer for more information.
[4]Benefits are provided at 100% of allowable charges; not subject to deductible or coinsurance.



## Covered services

**Benefits apply after calendar-year deductible is met, unless otherwise noted.**
PCY = per calendar year
MD = Medical doctor DO = Doctor of osteopathy DC = Doctor of chiropractic

| | BENEFIT LIMITS | IN NETWORK | | OUT OF NETWORK |
|---|---|---|---|---|
| | | Preferred | Participating | Non-participating |
| **Preventive office visit**<br>**Preventive screenings[1]**<br>**Vaccinations** | Unlimited[1] | Covered in full[2] | | Covered in full[2] |
| **Seasonal vaccinations** (Provider's office or pharmacy)<br>**Health education and training**<br>**Diabetes education and training** | | | | Hospital-based services: 20%–60% (increments of 5%); Other facilities and professionals: Covered in full[2] |
| **Professional office visit** | Unlimited | Preferred coinsurance | | |
| **Virtual care** (General medicine) | | Preferred coinsurance | | Not covered |
| **Urgent care** (Freestanding clinics) | | Preferred coinsurance | | |
| **Other outpatient professional services**<br>**Inpatient professional services** | | Preferred coinsurance | Participating coinsurance | Hospital-based services: 20%–60% (increments of 5%); Other facilities and professionals: Preferred coinsurance |
| **Manipulations** (Spinal and other) | 10–34 visits PCY for each or unlimited | Preferred coinsurance | | |
| **Acupuncture** | | | | |
| **Naturopathic services** | Unlimited | | | |
| **Mammography** (Non-preventive) | | Preferred coinsurance or Preferred deductible, 0% | Participating coinsurance | Hospital-based services: 20%–60% (increments of 5%); Other facilities and professionals: Preferred cost share |
| **Outpatient diagnostic imaging and laboratory services** | | Preferred coinsurance | | |
| **Emergency care** | | Deductible and preferred coinsurance | | |
| **Ambulance transportation** (Air and surface) | | Emergent: Preferred coinsurance<br>Non-emergent surface: Same as emergent<br>Non-emergent air: Preferred coinsurance | | Emergent: Same as in network<br>Non-emergent surface: Same as in network<br>Non-emergent air: 50% or 60% |
| **Inpatient facility care** | | Preferred coinsurance | Participating coinsurance | Hospital-based services: 20%–60% (increments of 5%); Other facilities and professionals: Preferred coinsurance |
| **Outpatient facility care** | | | | |
| **Skilled nursing facility** | 60–180 days (increments of 10 days) or unlimited | | | |
| **Premera-Designated Centers of Excellence** | Unlimited | Deductible, then 0% | | |
| **Maternity care** (Prenatal, delivery, and postnatal care) | | Preferred coinsurance | Participating coinsurance | |
| **Mental health and chemical dependency treatment** | Unlimited outpatient and inpatient | Inpatient: Preferred inpatient cost share; Outpatient: Preferred office visit cost share | | Inpatient: Hospital-based services: 20%–60% (increments of 5%); Other facilities and professionals: Preferred cost share; Outpatient: Preferred cost share |
| **Rehabilitation** (Including cardiac/pulmonary rehab; chronic pain; and physical, occupational, speech, and massage therapy. Massage therapy must be billed by MD, DO, or DC) | 45 visits/30 days PCY<br>60 visits/60 days PCY<br>Unlimited/Unlimited | Inpatient: Preferred inpatient cost share; Outpatient: Preferred office visit cost share | Inpatient: Participating inpatient cost share; Outpatient: Preferred office visit cost share | |
| **Supplies, equipment, prosthetics, and orthotics** | Unlimited except foot orthotics $300 PCY | Preferred coinsurance | Participating coinsurance | Hospital-based services: 20%–60% (increments of 5%); Other facilities and professionals: Preferred coinsurance |
| **Home health care** | 120, 130, or unlimited home health visits PCY | | | |
| **Hospice care** | Inpatient: 10, 30, or unlimited days; Respite: 240 hrs; Home visits: Unlimited (6-month lifetime maximum for all services) | | | |
| **Transplants** (Organ and bone marrow) | $75,000 donor and $7,500 travel and lodging limits per transplant | Inpatient: Preferred coinsurance; Outpatient: preferred coinsurance | Inpatient: Participating inpatient coinsurance; Outpatient: preferred coinsurance | Not covered |

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if provider is not contracted with Premera Blue Cross Blue Shield of Alaska.
This is only a brief summary of the major benefits provided by the Select HSA plan. It is not a contract.
[1]A list of preventive screenings and services, with their suggested frequency guidelines and limits, is available on **premera.com** on the Miscellaneous Form page.
[2]Benefits are provided at 100% of allowable charges; not subject to deductible or coinsurance.

# Pharmacy plans

## What our pharmacy plans offer

**Important:** All medical plans are required to include a pharmacy plan.

**The options listed on this page are available for all plans except HSA plans.**

## Choose from three options for your pharmacy plan:

**Essentials** is a list of prescription drugs that meets the pharmacy requirement and has a new benefit structure, outlined below. Essentials keeps costs as low as possible by focusing on high-value drugs that are approved by the U.S. Food and Drug Administration (FDA).

**Preferred** is more comprehensive and provides access to a full spectrum of generic and brand-name medications.

## Select HSA and Plus HSA

These plans include prescription drug coverage as well as zero cost shares for certain generic cardiovascular and oral diabetic medications on the enhanced preventive drug list.

## See how the pharmacy options compare

| ESSENTIALS TIERS AND CUSTOMER COST SHARES | |
|---|---|
| FIRST TIER | Preferred generic drugs |
| SECOND TIER | Preferred brand-name drugs |
| THIRD TIER | Preferred specialty[2] drugs |
| FOURTH TIER | Non-preferred drugs (generic, brand, specialty) |

| PREFERRED TIERS AND CUSTOMER COST SHARES | |
|---|---|
| FIRST TIER | Generic drugs |
| SECOND TIER | Preferred brand-name drugs |
| THIRD TIER | Non-preferred brand-name drugs |
| FOURTH TIER | Specialty drugs[2] |

[1]Metallic and Essentials formularies are excluded.
[2]Up to 30-day supply for specialty drugs only from the Premera specialty pharmacy provider.



# Benefits for Essentials and Preferred pharmacy plans

**Copays and coinsurance represent customers' cost**
PCY = per calendar year

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **4-TIER ESSENTIALS** | | | | | | |
| | Standard Copay/Coinsurance Plans | | | | | | |
| **Retail pharmacy** (Copay = 30 days; up to 90-day supply per Rx) | 10% / 20% / 30% / 40%[1] | $10 / $25 / $45 / 30%[1]* | $10 / $30 / $30 / 30%[1] | $10 / $30 / $50 / 30%[1]* | $15 / $30 / $50 / 30%[1] | $15 / $60 / $100 / 50%[1] | $20 / $50 / 30% / 50%[1] |
| **Mail-order pharmacy[2]** (Copay = 90 days; up to 90-day supply per Rx) | 10% / 20% / 30% / 40%[1] | $25 / $62.50 / $45 / 30%[1] | $25 / $75 / $30 / 30%[1] | $25 / $75 / $50 / 30%[1] | $37.50 / $75 / $50 / 30%[1] | $37.50 / $150 / $100 / 50%[1] | $50 / $125 / 30% / 50%[1] |
| **Rx individual deductible[2] PCY** (Separate from medical deductible) | None, $150,[3] $300,[3] or $500[3] | | | | | | |
| **Individual out-of-pocket maximum PCY** | Participating pharmacy cost-shares accrue to the in-network, out-of-pocket maximum | | | | | | |
| **Formulary drug list option** | Essentials E4 | | | | | | |
| | **4-TIER** | | | | | | |
| **Retail pharmacy** (Copay = 30 days; up to 90-day supply per Rx) | $10 / $30 / $30 / 30%* | | $10 / $30 / $50 / 30%[1] | | $15 / $30 / $50 / 30%* | | $20 / $50 / 50% / 30%[1] |
| **Mail-order pharmacy[2]** (Copay = 90 days; up to 90-day supply per Rx) | $25 / $75 / $75 / 30%[1] | | $25 / $75 / $125 / 30%[1] | | $37 / $75 / $125 / 30%[1] | | $50 / $125 / 45% / 30%[1] |
| **Rx individual deductible[4]** (Separate from medical deductible) | None | | None | | None / $150 / $300 / $500[5] | | None |
| **Individual out-of-pocket maximum PCY** | Accrues to the medical out-of-pocket cost | | | | | | |
| **Formulay drug list option** | Preferred B4 | | | | | | |
| | **3-TIER** | | | | | | |
| **Retail pharmacy** (Copay = 30 days; up to 90-day supply per Rx) | $10 / $25 / $40 | $10 / $20 / $40 | $10 / 25% / 50% | $10 / $30 / $50 | $10 / $25 / $45 | $15 / $25 / $50 | $20 / $50 / 50% |
| **Mail-order pharmacy[2]** (Copay = 90 days; up to 90-day supply per Rx) | $25 / $62 / $100 | $25 / $50 / $100 | $25 / 20% / 45% | $25 / $75 / $125 | $25 / $62 / $112 | $37 / $62 / $125 | $50 / $125 / 45% |
| **Rx individual deductible[4]** (Separate from medical deductible) | None or $150 | None | None | None | $300 | None or $150 | None |
| **Individual out-of-pocket maximum** PCY | Accrues to the medical out-of-pocket cost | | | | | | |
| **Formulary drug list option** | Preferred B3 | | | | | | |
| | **2-TIER** | | | | | | |
| **Retail pharmacy** (Copay = 30 days; up to 90-day supply per Rx) | $10 / $25 | | | | $10 / $30 | | |
| **Mail-order pharmacy[1]** (Copay = 90 days; up to 90-day supply per Rx) | $25 / $62 | | | | $25 / $75 | | |
| **Rx individual deductible[2]** (Separate from medical deductible) | None or $150 | | | | None | | |
| **Individual out-of-pocket maximum** PCY | Accrues to the medical out-of-pocket cost | | | | | | |
| **Formulary drug list option** | Preferred A2 | | | | | | |

Note: Specialty drugs are used to treat complex or rare conditions such as rheumatoid arthritis, hepatitis C, or multiple sclerosis. Coverage requires that these prescriptions be filled through our Specialty Pharmacy Program, which employs pharmacists dedicated to supporting specialty drugs and those who require them.

*A buy-up option is available with this plan to allow certain generic preventive drugs to be covered in full. Ask your Premera sales representative or producer for more information.
[1]Up to 30-day supply for specialty drugs only through Premera specialty pharmacy provider.
[2]Coverage for mail service is only available through Express Scripts Home Delivery.
[3]Deductible waived for preferred generics (Tier 1).
[4]Family=2x or 3x individual.
[5]Deductible is waived for generics.

# Dental plans

Good oral health is important to your employees' overall health. Here's why—regular preventive oral health visits assist with early detection and management of diseases. When you offer your employees both dental and medical benefits from Premera, you help encourage healthy habits.

## Attractive savings

When you purchase a **fully insured** Premera medical and dental plan together, you will receive the savings and value of an integrated approach.[1]

1% **premium discount**

11% **overall rate cap**

## Broad network access

Your employees gain access to more than 267,000 in-network provider locations nationwide with our expanded dental network. This is great for your employees who live or travel outside of Washington or Alaska.

71K **dentists nationwide**

254K **locations nationwide**

## Easy experience

Simplify your work by having only one health plan for medical and dental. Your employees will enjoy a streamlined experience: one ID card, one customer service number, and one secure account for managing their healthcare.

1 **card for medical and dental**

[1]Discount and rate cap are subject to review.

## Take the anxiety out of going to the dentist

There's many reasons why you may experience mild anxiety when visiting your dentist. That's why Premera Blue Cross Blue Shield of Alaska now provides coverage for nitrous oxide in conjunction with covered dental services for our group dental business.  Our mission is to provide our members with peace of mind and encourage good oral health that can lead to better overall health and well being.

# Choose from two dental plans

**With any Premera dental plan, your employees and their covered dependents get many perks:**

- Access to in-network dentists or out-of-network[1] dentists nationwide
- Freedom to choose any licensed dental provider, but they will pay less out of pocket if they choose an in-network dental provider
- Preventive and diagnostic services such as routine oral exams, cleanings, and x-rays covered with no deductibles
- Benefits for periodontal maintenance up to four visits per year to help manage gum disease

| Plan highlights | DENTAL OPTIMA | DENTAL OPTIMA VOLUNTARY |
|---|---|---|
| **Optional TMJ coverage available** (see page 40) | ● | |
| **Comprehensive benefits for major services** | ● | ● |
| **Employer-funded plan option**[2] | ● | |
| **Access to nationwide Choice dental network** | ● | ● |
| **Optional orthodontia coverage available for groups with 26 or more enrolled employees** (see page 40) | ● | |
| **Benefit enhancement options** (see page 40) | ● | |
| **Employee-funded plan option**[3] | | ● |

Note: For a summary of plan benefits and limitations, see plan details to follow.
[1] Balance billing may apply with out-of-network dentists.
[2] Employer contributes 50%-100% of premium. Minimum enrollment is 50% of eligible employee.
[3] Employer contributes 0%-49% of premium. Minimum enrollment is 30% of eligible employees.

# Dental Optima

With Dental Optima, you have the freedom to choose from an in- or out-of-network dental provider at the same coinsurance. Using an in-network provider may reduce your out-of-pocket cost. You can decide to have routine diagnostic and preventive services that won't count toward the annual maximum on the plan.

To help encourage regular oral health maintenance, preventive services such as routine oral exams and cleanings are covered. Additionally, there's no waiting period for major services such as crowns, implants, and dentures, so your employees can get the care they need as soon as their coverage starts.

## Covered services

Benefits apply after calendar-year deductible is met, unless otherwise noted. Deductible and coinsurance represent customer's cost share.
PCY = per calendar year

| | | DENTAL OPTIMA | DENTAL OPTIMA (SHARED FAMILY MAXIMUM) |
|---|---|---|---|
| **Annual deductible PCY** | **Individual** | $0 / $50 | $50 |
| | **Family** | $0 / $150 | $150 |
| **Maximum allowance per person, PCY** | | $1,000, $1,500, $2,000, $2,500, or $3,000 | $1,500, $2,000 Shared family maximum — up to 3x Individual |
| | | IN AND OUT OF NETWORK | IN AND OUT OF NETWORK |
| **DIAGNOSTIC AND PREVENTIVE[1]** | | | |
| **Routine oral exams** 2 PCY | | 0% / 10% / 20% | 0% |
| **Problem-focused (including emergency) oral evaluations** 2 PCY | | | |
| **Bitewing x-rays**<br>**Complete series or panoramic x-ray** once per 36 consecutive months | | | |
| **Cleanings** 2 PCY | | | |
| **Fluoride treatments** 2 applications PCY for customers under the age of 20 | | | |
| **Sealants** permanent molars only, under the age of 20; replacements limited to 24 consecutive months | | | |
| **Space maintainers** under age 20 | | | |
| **BASIC** | | | |
| **Fillings** once per tooth surface every 24 consecutive months | | 20% | 20% |
| **Recementing and repair of crowns, inlays, bridgework, and dentures** when performed 6 or more months after placement | | | |
| **Periodontal maintenance** 4 visits PCY | | | |
| **Oral surgery** including simple and surgical extractions | | | |
| **General anesthesia or intravenous sedation** for covered dental procedures at a dental-care provider's office when dentally necessary | | | |
| **Nitrous oxide** | | | |
| **Occlusal (night) guard** once every 36 consecutive months | | | |
| **MAJOR** | | | |
| **Endodontic (root canal) treatment** once per tooth in a 24 consecutive months | | 50% | 50% |
| **Periodontal scaling** once per quadrant every 24 consecutive months | | | |
| **Periodontal surgery** once per quadrant every 36 consecutive months | | | |
| **Inlays, onlays, and crowns** once per tooth every 5 calendar years | | | |
| **Implants** once every 5 calendar years | | | |
| **Dentures, partials, and fixed bridges** once every 5 calendar years | | | |

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera.
*Shared family maximum option, see page 36.
[1]Annual deductible is waived for diagnostic and preventive services.



# Dental Optima Voluntary

With Dental Optima Voluntary™, you can offer dental coverage at little or no cost to you. Choose between letting your employees and their covered dependents pay the full cost of their monthly health plan bills or funding up to 50% of the plan cost.

To help encourage regular oral health maintenance, preventive services such as cleanings and x-rays are covered in full.

## Covered services

Benefits apply after calendar-year deductible is met, unless otherwise noted.
Deductible and coinsurance represent customer's cost share
PCY = per calendar year
CY = per calender year(s)

| | | DENTAL OPTIMA VOLUNTARY |
|---|---|---|
| **Annual deductible PCY** | **Individual** | $50 |
| | **Family** | $150 |
| **Maximum allowance per person, PCY** | | $1,000 or $1,500 |
| | | IN AND OUT OF NETWORK |
| **DIAGNOSTIC AND PREVENTIVE[1]** | | |
| **Routine oral exams** 2 PCY | | 0% |
| **Bitewing x-rays**<br>**Complete series or panoramic x-ray** once per 36 consecutive months | | |
| **Cleanings** 2 PCY | | |
| **Fluoride treatments** 2 applications PCY, under the age of 20 | | |
| **Sealants** permanent molars only, under the age of 20; replacements limited to 24 consecutive months | | |
| **BASIC** | | |
| **Problem-focused (including emergency) oral evaluations** 2 PCY | | 20% |
| **Space maintainers** under age 20 | | |
| **Fillings** once per tooth surface every 24 consecutive months | | |
| **Recementing and repair of crowns, inlays, bridgework, and dentures** when performed 6 or more months after placement | | |
| **Periodontal maintenance** 4 visits PCY | | |
| **Simple and surgical extractions** | | |
| **Nitrous oxide** | | |
| **Occlusal (night) guard** once every 36 consecutive months | | |
| **MAJOR[2]** | | |
| **Endodontic (root canal) treatment** once per tooth in a 24 consecutive months | | 50% |
| **Periodontal scaling** once per quadrant every 24 consecutive months | | |
| **Periodontal surgery** once per quadrant every 36 consecutive months | | |
| **Inlays, onlays, and crowns replacements** once per tooth every 5 calendar years | | |
| **Dentures, partials, and fixed bridges** once every 5 calendar years | | |
| **Oral surgery** | | |
| **General anesthesia or intravenous sedation** for covered dental procedures at a dental care provider's office when dentally necessary | | |

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera.
[1] Annual deductible is waived for diagnostic and preventive services.
[2] A 12-month waiting period applies to customers who have not had continuous comparable dental coverage under the group's prior dental plan.

# Dental plan enhancements

## Shared family maximum

Unexpected dental care can be expensive. Choosing the right dental plan with an annual maximum that meets you and your family's needs is an important decision.

A shared family maximum may be the best choice for you and your family. This option allows you to share your dental annual maximum to help maximize your family's dental coverage. The shared family maximum does not apply to preventive dental services, ensuring that everyone in your family has access to preventive dental care.

For more information and specific details regarding the shared annual maximum please contact your Premera representative.

## Benefit enhancements

| | DENTAL OPTIMA | DENTAL OPTIMA VOLUNTARY |
|---|---|---|
| **BENEFIT ENHANCEMENTS** | | |
| **Endodontic (root canal), periodontal scaling, and surgical periodontal treatment** | Optional | N/A |
| **Routine diagnostic and preventive services** (Does not accrue toward the maximum allowance) | | Optional |
| **ORTHODONTIA** | | |
| **Diagnostic services and active/retention treatment** (Including appliances) | Covered in full[1] / 50% (up to lifetime maximum) | N/A |
| **Monthly orthodontic adjustments** (Including retention treatment) | | |
| **Lifetime maximum** (Choose one. Limit is per person.) | $1,000, $1,500, or $2,000 | |
| **Age limit** | Up to age 20 | |
| **TEMPOROMANDIBULAR JOINT DISORDERS[2]** | | |
| **TMJ exams, x-rays, splints, surgical procedures, and manipulations under anesthesia** | Deductible and coinsurance apply | N/A |
| **Annual benefit maximum** | $1,000 | |
| **Lifetime maximum** (Limit is per person) | $5,000 | |

[1]Benefits are provided at 100% of allowable charges; not subject to deductible or coinsurance.
[2]Option is available only with Optima plans with 200 or more employees. Balance billing may apply if a provider is not contracting with Premera.

# Vision and hearing plans

Offering vision and hearing benefits along with your employees' medical and dental coverage is easier to manage for both your business and your employees.

In fact, routine eye and hearing exams can lead to earlier diagnosis of chronic diseases.

Plus, offering all of your employees' benefits with Premera means you get the ease of dealing with just one health plan. It also means that your employees and their covered dependents enjoy the simplicity of one card, one customer service phone number, and one website.

You can choose between an exam-only or exam-plus-hardware plan. Adult vision coverage (19 and older) also includes pediatric coverage (18 and younger). See the grid below. When a group offers vision coverage as a separate option, benefits for customers younger than 19 are the same as benefits for adults.

## Covered services

**PCY** = per calendar year
**CY** = calendar year
**PY** = plan year and **PPY** = per plan year

| | | SELECT AND PLUS PLANS | | HSA PLANS | |
|---|---|---|---|---|---|
| | | **Benefit limits** | **Coverage options** | **Benefit limits** | **Coverage options** |
| **Vision** (Adult) | **Exam only** | 1 exam | Exam $25 copay or covered in full | 1 exam PCY | Covered in full or $25 copay[1] |
| | **Exam and eyewear** | 1 exam PCY and hardware<br>$150 PCY, $200 PCY, $300 every 2 CY,<br>$200 every 2 CY, $30 every PCY,<br>or 1 pair of lenses PCY; Frames every 2 CY | Exam $25 copay or covered in full;<br>Hardware covered in full | 1 exam PCY and hardware<br>$150 PCY or $200 PCY or $300 every 2 CY | Exam $25 copay[1];<br>Hardware covered in full |
| | | 1 exam PCY and 1 pair lenses PCY,<br>1 pair frames every 2 CY to $90 retail max;<br>Contact lenses to $170 max;<br>Vision exam and hardware annual max $350[2] | Exam 10% (deductible waived);<br>Hardware covered in full | 1 exam PCY and 1 pair lenses PCY,<br>1 pair frames every 2 CY to $90 retail max;<br>Contact lenses to $170 max;<br>Vision exam and hardware annual max $350[2] | Exam 10% (deductible waived);<br>Hardware covered in full |
| **Vision** (Pediatric) | **Exam only** | 1 exam PCY | Covered in full or deductible waived,<br>then coinsurance or office visit cost share[3] | 1 exam PCY | Covered in full or office<br>visit cost share[3] |
| | **Exam and eyewear** | 1 pair frames and lens or contacts PCY | Covered in full | 1 pair frames and lens or contacts PCY | Deductible, then coinsurance or covered in full |
| **Hearing** | **Exam** | 1 routine exam PPY or<br>1 routine exam every 2 PY | Office visit cost share or covered in full<br>or 20% coinsurance<br>(deductible waived)[4] | 1 exam/test per 2 PY;<br>Aids and hardware $3,000 every 3 PY | Deductible and 20% coinsurance |
| | **Exam with aids and hardware** | $3,000 every 3 PY | Waive deductible, subject to plan's coinsurance<br>(can vary by % they select),<br>Covered in full or 20% coinsurance<br>(deductible waived)[4] | | |

[1] Copay will apply toward out-of-pocket maximum for HSA plans.
[2] This is an Alaska state-mandated offering.
[3] Pediatric vision office visit cost shares apply toward out-of-pocket maximum.
[4] This option is only available as an exam plus hardware combination.

## Find out more

Visit **premera.com/ak/employer**

Talk with your Premera representative or producer.

PREMERA BLUE CROSS BLUE SHIELD OF ALASKA

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This brochure is not a contract. It is only a summary of the major benefits provided by these plans. For full coverage provisions, including a description of waiting periods, limitations, and exclusions, please contact your producer.

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