PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Highlights of your Health Care Coverage

University of Alaska
Group Number: 1000033

Effective Date: 07/01/2024

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	**2024 $1,600 HDHP**	
	CUSTOM YUKON IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARE OPTIONS		
Individual Deductible PPY (Family aggregate deductible 2x Individual)	$1,600 PPY/$3,200 PPY	Shared with In-Network
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	MD, DO, DPM, Hospital and Hospital-Based CD Programs: 40% Non-Participating; Other Facilities and Professionals: Same as In-Network
Individual Out of Pocket Maximum PPY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$5,000 individual embedded PPY / $6,850 family max PPY	Unlimited
Office Visit Cost Share	In Network Deductible, then 20%	Out of Network Deductible, then MD, DO, DPM: 40%; Other Professionals: Same as In-Network (highest benefit level)
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited, not subject to internal and/or regulatory guidelines)	Covered in Full	Covered in Full
Immunizations (Unlimited, not subject to internal and/or regulatory guidelines)	Covered in Full	Covered in Full
Health Education (HE) (Covered in Full)	Covered in full	OON Ded,then MD, DO, DPM,Hospital & Hospital-Based CD Programs:40%;Other Facil & Profess:Same as INN
Diabetes Health Education (DE) (Covered in Full)	Covered in full	OON Ded,then MD, DO, DPM,Hospital & Hospital-Based CD Programs:40%;Other Facil & Profess:Same as INN
CHRONIC CONDITION MANAGEMENT PROGRAMS		
Diabetes Prevention	Included	Included
Diabetes Management	Included	Included
Hypertension Management	Included	Included
Weight Management	Included	Included
PROFESSIONAL CARE		

MEDICAL PLAN	2024 $1,600 HDHP	
	CUSTOM YUKON IN-NETWORK	**OUT-OF-NETWORK**
Professional Office Visit (Includes Telemedicine)	In Network Deductible, then 20%	Out of Network Deductible, then MD, DO, DPM: 40%; Other Professionals: Same as In-Network (highest benefit level)
APP-BASED VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	In Network Deductible, then 20%	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	Not Covered
Telemedicine - Outpatient Rehab (Virtual Care Only) (Shared with Rehab Outpatient Care)	Subject to Rehab Outpatient Care In-Network Cost Share	Not Covered
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in Full	Covered in Full
Other Professional Diagnostic Imaging	In Network Deductible, then 20%	OON Ded,then MD, DO, DPM,Hospital & Hospital-Based CD Programs:40%;Other Facil & Profess:Same as INN
Other Professional Diagnostic Laboratory/Pathology	In Network Deductible, then 20%	OON Ded,then MD, DO, DPM,Hospital & Hospital-Based CD Programs:40%;Other Facil & Profess:Same as INN
Diagnostic Mammography	INN Deductible, then 20%	OON Ded,then MD,DO,DPM,Hospital & Hospital- Based CD Programs: 40%;Other Fac and Prof Same as INN
FACILITY CARE OPTIONS		
Inpatient Facility	In Network Deductible, then 20%	Out of Network Deductible, then Hospital and Hospital-Based CD Programs: 40%; Other Facilities: Same as In-Network
Inpatient Professional Services	In Network Deductible, then 20%	Out of Network Deductible, then MD, DO, DPM, Hospital and Hospital-Based CD Programs: 40% Non-Participating; Other Facilities and Professionals: Same as In-Network
Outpatient Surgery Facility	In Network Deductible, then 20%	Out of Network Deductible, then MD, DO, DPM, Hospital and Hospital-Based CD Programs: 40% Non-Participating; Other Facilities and Professionals: Same as In-Network

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Outpatient Facility	In Network Deductible, then 20%	Out of Network Deductible, then MD, DO, DPM, Hospital and Hospital-Based CD Programs: 40% Non-Participating; Other Facilities and Professionals: Same as In-Network
Skilled Nursing Facility (100 days PPY)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital and Hospital-Based CD Programs: 40%; Other Facilities: Same as In-Network
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital and Hospital-Based CD Programs: 40%; Other Facilities: Same as In-Network
Hospice Care (Home Health and Respite) (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	In Network Deductible, then 20%	Out of Network Deductible, then MD, DO, DPM, Hospital and Hospital-Based CD Programs: 40% Non-Participating; Other Facilities and Professionals: Same as In-Network
Home Health Visits (130 visits PPY)	In Network Deductible, then 20%	Out of Network Deductible, then MD, DO, DPM, Hospital and Hospital-Based CD Programs: 40% Non-Participating; Other Facilities and Professionals: Same as In-Network
MATERNITY & REPRODUCTIVE CARE		
Contraceptive Management Services (Unlimited)	Covered in Full	Out of Network Deductible, then MD, DO, DPM: 40%; Other Professionals: Same as In-Network (highest benefit level)
Sterilization - Female (Unlimited)	Covered in Full	Out of Network Deductible, then MD, DO, DPM, Hospital and Hospital-Based CD Programs: 40% Non-Participating; Other Facilities and Professionals: Same as In-Network
Sterilization - Male (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then MD, DO, DPM, Hospital and Hospital-Based CD Programs: 40% Non-Participating; Other Facilities and Professionals: Same as In-Network
MEDICAL CARE COORDINATION AND TRAVEL SERVICES		
Centers of Excellence Packaged Services (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement), Spine & Gynecology)	In Network Deductible, then 0%	Covered as any other service
Centers of Excellence Travel and Care Coordination (See Elective Procedure Travel)	See Elective Procedure Travel	See Elective Procedure Travel

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Medical Access Transportation (3 round trips PPY; INN and OON: In Network Deductible, then 20%)	3 round trips PPY; INN and OON: In Network Deductible, then 20%	3 round trips PPY; INN and OON: In Network Deductible, then 20%
Transplants (Unlimited; Deductible/Coinsurance. Donor limit: Unlimited)	Covered as any other service	Not Covered
Transplant Travel & Lodging ($7,500 travel and lodging)	Subject to Deductible, then 0%	Subject to Deductible, then 0%
Elective Procedure Travel (Prior Approval Required: Member & Medically Necessary Companion - Air: 1 round-trip per episode; Surface Transportation & Parking: $35/day; Ferry Transportation $50 per person each way; Lodging $50/day per person)	$1,600 PPY/$3,200 PPY Deductible, then 0%	$1,600 PPY/$3,200 PPY Deductible, then 0%
Medical Services from Elective Procedure Travel	Covered as any other service	Covered as any other service
EMERGENCY CARE		
Emergency Care	In Network Deductible, then 20%	In Network Deductible, then 20%
Emergency Room Physician	In Network Deductible, then 20%	In Network Deductible, then 20%
Urgent Care Center	In Network Deductible, then 20%	Out of Network Deductible, then MD, DO, DPM: 40%; Other Professionals: Same as In-Network (highest benefit level)
Ambulance Transportation (Unlimited)	In Network Deductible, then 20%	In Network Deductible, then 20%
Non-Emergent Ground Ambulance (Unlimited)	In Network Deductible, then 20%	In Network Deductible, then 20%
Air Ambulance (Unlimited)	In Network Deductible, then 20%	In Network Deductible, then 20%
Non-Emergent Air Ambulance (Unlimited)	In Network Deductible, then 20%	In Network Deductible, then 20%
ALTERNATIVE CARE		
Acupuncture (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then MD, DO, DPM: 40%; Other Professionals: Same as In-Network (highest benefit level)
Manipulations (Spinal and other) (26 visits PPY (ability to request exception if medically necessary when maxed))	In Network Deductible, then 20%	Out of Network Deductible, then MD, DO, DPM: 40%; Other Professionals: Same as In-Network (highest benefit level)
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital and Hospital-Based CD Programs: 40%; Other Facilities: Same as In-Network
Chemical Dependency Outpatient Professional Care (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then MD, DO, DPM: 40%; Other Professionals: Same as In-Network (highest benefit level)
Mental Health Inpatient Facility Care (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital and Hospital-Based CD Programs: 40%; Other Facilities: Same as In-Network

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Mental Health Outpatient Professional Care (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then MD, DO, DPM: 40%; Other Professionals: Same as In-Network (highest benefit level)
PHARMACY		
Drug List	E1	E1
Enhanced Preventive Drug List (PV Core Plus (Buy-Up))	Covered in Full	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Prescription Drugs - Retail (Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days)	In Network Deductible, then 20%	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Prescription Drugs - Mail (Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days)	In Network Deductible, then 20%	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital and Hospital-Based CD Programs: 40%; Other Facilities: Same as In-Network
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab.; and Chronic Pain (45 visits PPY. Massage Therapy is not included in rehab and has a separate 26 visit limit PPY)	In Network Deductible, then 20%	Out of Network Deductible, then MD, DO, DPM: 40%; Other Professionals: Same as In-Network (highest benefit level)
OTHER SERVICES		
Allergy/Therapeutic Injections	In Network Deductible, then 20%	Out of Network Deductible, then MD, DO, DPM, Hospital and Hospital-Based CD Programs: 40% Non-Participating; Other Facilities and Professionals: Same as In-Network
Medical Supplies, Equipment, Prosthetics (ME, MS, Pro: Unlimited. $350 PPY max on wigs. Ded/coinsurance both INN and OON)	In Network Deductible, then 20%	Out of Network Deductible, then MD, DO, DPM, Hospital and Hospital-Based CD Programs: 40% Non-Participating; Other Facilities and Professionals: Same as In-Network
SUPPLEMENTAL BENEFITS		
Routine Vision Exam (Not Covered)	Not Covered	Not Covered
Vision Hardware (Not Covered)	Not Covered	Not Covered
Pediatric Vision Exam (Not Covered)	Not Covered	Not Covered
Pediatric Vision Hardware (Not Covered)	Not Covered	Not Covered
Routine Hearing Exam (1 exam PPY)	INN Deductible, then covered in full	INN Deductible, then covered in full
Hearing Hardware ($3,000 every 3 consecutive plan years.)	INN Deductible, then covered in full	INN Deductible, then covered in full
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited

Benefits provided at 100% of allowable charges; not subject to deductible or coinsurance.
Seasonal immunizations provided at a pharmacy will be covered in full up to maximum allowable amount.
Autism: Mental Health, Psychological & Neuropsychological Testing, Outpatient Professional & Facility Care covered as any other service.

Copays are not subject to the deductible unless otherwise noted.
Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.
PPY = Per Plan Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross Blue Shield of Alaska. Members are responsible for amounts in excess of the allowable charge.

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