

Highlights of your Health Care Coverage

Alaska Municipal Health Trust
Prospect

Effective Date: 07/01/2026

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

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

MEDICAL PLAN		2026 FAIRWEATHER \$250 PPO	
	YUKON IN-NETWORK	OUT-OF-NETWORK	
MEDICAL COST SHARES			
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$250 PCY	\$500 PCY	
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20% Preferred/40% Participating	Hospital & Professional: 60% Non-Participating	
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	\$2,000 PCY	\$45,000 PCY	
Non Specialist Office Visit Cost Share	\$25 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Specialist Office Visit Cost Share	\$50 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION			
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Health Education (HE) (Unlimited)	Covered in Full	Covered In Full	
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Covered In Full	
CHRONIC CONDITION MANAGEMENT PROGRAMS			
Diabetes Management Plus	Included	Included	
Diabetes Prevention Plus	Included	Included	
Hypertension Plus	Included	Included	
Weight Management	Excluded	Excluded	
PROFESSIONAL CARE			
Professional Office Visit (Includes Telemedicine)	Non Specialist: \$25 Copay, applies to the Out of Pocket Maximum; Specialist: \$50 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
APP-BASED VIRTUAL CARE SERVICES			

MEDICAL PLAN		2026 FAIRWEATHER \$250 PPO	
	YUKON IN-NETWORK	OUT-OF-NETWORK	
Telemedicine - General Medical (Virtual Care Only)	Covered in Full	Not Covered	
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered	
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit Cost Share	Not Covered	
DIAGNOSTIC SERVICES			
Preventive Imaging and Laboratory	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Diagnostic Laboratory	Waive In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Basic Diagnostic Imaging	Waive In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Major Diagnostic Imaging	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Preventive Mammography	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Diagnostic Mammography	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Supplemental Breast Exam	Covered in Full	Covered as any other service	
FACILITY CARE			
Inpatient Facility	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Inpatient Professional Services	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Hospital Outpatient Surgery Facility	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Ambulatory Surgery Center	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Outpatient Facility	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Skilled Nursing Facility (60 days PCY)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
HOSPICE & HOME HEALTH CARE			
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Hospice Care (Home Health and Respite) (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	

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Home Health Visits (130 visits PCY)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
MATERNITY & REPRODUCTIVE CARE			
Birth Center	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Contraceptive Management Services (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Sterilization - Female (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Sterilization - Male (Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
MEDICAL CARE COORDINATION AND TRAVEL SERVICES			
Centers of Excellence Packaged Services (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement), Spine & Gynecology)	Covered in Full	Covered as any other service	
Centers of Excellence Travel and Care Coordination (See Elective Procedure Travel)	See Elective Procedure Travel	See Elective Procedure Travel	
Medical Access Transportation (3 round trips PCY for patient (includes 3 round trips PCY for parent or guardian if pt. under 19 yrs of age))	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred	
Transplants (Unlimited; \$75,000 donor)	Covered as any other service	Not Covered	
Transplant Travel & Lodging (\$7,500 travel and lodging)	Subject to Deductible, then 0%	Subject to Deductible, then 0%	
Elective Procedure Travel (Prior Approval Required: Member & Medically Necessary Companion - Air: 1 round-trip per episode; Surface Transportation & Parking: \$35/day; Ferry Transportation \$50 per person each way; Lodging \$50/day per person)	Travel: Covered In Full; Medical Procedures: covered as any other service	Travel: Covered In Full; Medical Procedures: covered as any other service	
Medical Services from Elective Procedure Travel	Covered as any other service	Covered as any other service	
EMERGENCY CARE			
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	\$150 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$150 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	
Emergency Room Physician	In Network Deductible, then 20% Preferred	In Network Deductible, then 20% Preferred	
Urgent Care Center	\$50 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating	
Ambulance Transportation (Unlimited)	\$150 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$150 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	
Non-Emergent Ground Ambulance (Unlimited)	\$150 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$150 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	

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	YUKON IN-NETWORK	OUT-OF-NETWORK
Air Ambulance (Unlimited)	\$150 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred	\$150 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% Preferred
Non-Emergent Air Ambulance (Unlimited)	\$150 Copay applies to the Out of Pocket Maximum; then in Network Deductible, 20% Preferred/40% Participating	Out of Network Deductible, then 60% Non-Participating
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	\$25 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Manipulations (Spinal and other) (24 visits PCY)	\$25 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Chemical Dependency Outpatient Professional Care (Unlimited)	\$25 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Mental Health Inpatient Facility Care (Unlimited)	In Network Deductible, then 20% Preferred	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Mental Health Outpatient Professional Care (Unlimited)	\$25 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
REHABILITATION & NEURODEVELOPMENTAL THERAPY		
Inpatient Rehab (30 days PCY)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Rehab, Including Physical and Occupational Therapy; Cardiac and Pulmonary Rehab (Unlimited)	\$50 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Massage Therapy (Applies to the outpatient rehab limit)	\$50 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Outpatient Speech Therapy (Applies to the outpatient rehab limit)	\$50 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Inpatient Neurodevelopmental Therapy	30 days PCY	30 days PCY
OTHER SERVICES		
Allergy/Therapeutic Injections	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Medical Supplies, Equipment, Prosthetics (MS: Unlimited, ME: Unlimited, Pro: Unlimited)	In Network Deductible, then 20% Preferred/40% Participating	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
SUPPLEMENTAL BENEFITS		

MEDICAL PLAN	2026 FAIRWEATHER \$250 PPO	
	YUKON IN-NETWORK	OUT-OF-NETWORK
Routine Vision Exam (\$150 PCY)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 60% Non-Participating
Vision Hardware (\$300 PCY)	Covered in Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)	Covered in Full	Covered in Full
Pediatric Vision Hardware (Under age 19: One pair of glasses PCY (frames & lenses). 12 month supply of contacts PCY, in lieu of glasses (frames & lenses).)	Covered in Full	Covered in Full
Routine Hearing Exam (1 PCY)	Waive In Network Deductible, then 20%	Waive In Network Deductible, then 20%
Hearing Hardware (1 device per ear every 3 years)	Waive In Network Deductible, then 20%	Waive In Network Deductible, then 20%
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited

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

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

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

Copays are not subject to the deductible unless otherwise noted.

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

PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with 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.

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Below is a brief overview of your pharmacy benefit. For more information, please refer to your benefit booklet or sign into www.premera.com to find drug costs and coverages specific to your plan.

PHARMACY PLAN	2026 FAIRWEATHER \$250 PPO PHARMACY
PRESCRIPTION DRUGS	
Formulary Drug List	Preferred B4 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands Tier 4 = specialty
Annual Benefit Maximum	Unlimited
Individual Deductible PCY	\$0
Family Deductible PCY	No Family Deductible
Out of Network (Non-participating retail pharmacies)	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Enhanced Preventive Drug List	No Buy Up
Retail Cost Shares	10%/20%/30%/10% (\$250 maximum per script)
Mail Cost Shares	10%/20%/30%/10% (\$250 maximum per script)
Day Supply	Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days
Mandatory Home Delivery for Maintenance Drugs	Excluded
Specialty Pharmacy	Mandatory - Exclusive

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