Highlights of your Health Care Coverage

Alaska Municipal Health Trust

Prospect

Effective Date: 07/01/2021

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	**2021 TONGASS $0 PPO, a Alaska Municipal Health Trust**	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 2X Individual)	$0 PCY	$500 PCY
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$1,500 PCY	$45,000 PCY
Office Visit Cost Share	$25 Non Specialist; $50 Specialist, applies to the OOP Max	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 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: 40% Non-Preferred or 60% Non-Participating
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Health Education (HE) (Unlimited)	Covered in Full	Covered In Full
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Covered In Full
PROFESSIONAL CARE		
Professional Office Visit (Includes Telemedicine)	$25 Non Specialist; $50 Specialist, applies to the OOP Max	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
VIRTUAL CARE SERVICES		
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	Not Covered

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Telemedicine - Outpatient Rehab (Virtual Care Only)	Not Covered	Not Covered
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in Full	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Other Professional Diagnostic Imaging	Waive In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Other Professional Diagnostic Laboratory/Pathology	Waive In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Diagnostic Mammography	Waive In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
FACILITY CARE OPTIONS		
Inpatient Facility	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Inpatient Professional Services	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Outpatient Surgery Facility	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Skilled Nursing Facility (60 days PCY)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
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 & Professional: 40% Non-Preferred or 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%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Home Health Visits (130 visits PCY)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
MATERNITY & REPRODUCTIVE CARE		

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Contraceptive Management Services (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Sterilization - Female (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Sterilization - Male (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
PREMERA DESIGNATED CENTERS OF EXCELLENCE		
Centers of Excellence Packaged Services (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement), Spine & Gynecology)	Covered in Full	Covered as any other service
Travel and Care Coordination (See Elective Procedure Travel)	See Elective Procedure Travel	See Elective Procedure Travel
ALASKA MEDICAL TRANSPORTATION BENEFITS		
Medical Access Transportation (High Option 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%	In Network Deductible, then 20%
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
EMERGENCY CARE		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$300 Copay applies to the OOP Max, then Subject to Deductible, then 20%	$300 Copay applies to the OOP Max, then Subject to Deductible, then 20%
Emergency Room Physician	In Network Deductible, then 20%	In Network Deductible, then 20%
Urgent Care Center	$50 Specialist, applies to the OOP Max	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Ambulance Transportation (Unlimited)	$300 Copay applies to the OOP Max, then Subject to Deductible, then 20%	$300 Copay applies to the OOP Max, then Subject to Deductible, then 20%
Non-Emergent Ground Ambulance (Unlimited)	$300 Copay applies to the OOP Max, then Subject to Deductible, then 20%	$300 Copay applies to the OOP Max, then Subject to Deductible, then 20%
Air Ambulance (Unlimited)	$300 Copay applies to the OOP Max, then Subject to Deductible, then 20%	$300 Copay applies to the OOP Max, then Subject to Deductible, then 20%
Non-Emergent Air Ambulance (Unlimited)	$300 Copay applies to the Out of Pocket Maximum; then In Network Deductible, 20%	Out of Network Deductible, then 60%
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	$25 Non Specialist	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating

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Manipulations (Spinal and other) (12 visits PCY)	$25 Non Specialist	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Chemical Dependency Outpatient Professional Care (Unlimited)	$25 Non Specialist	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Mental Health Inpatient Facility Care (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Mental Health Outpatient Professional Care (Unlimited)	$25 Non Specialist	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab.; and Chronic Pain (45 visits PCY)	$50 Specialist, applies to the OOP Max	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
OTHER SERVICES		
Allergy/Therapeutic Injections	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Medical Supplies, Equipment, Prosthetics (MS: Unlimited, ME: Unlimited, Pro: Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 60% Non-Participating
Transplants (Unlimited; $75,000 donor and $7,500 travel and lodging limits)	Covered as any other service	Not Covered
PHARMACY		
Prescription Drugs – Retail (Specific preventative drugs and legend Retail: 90 day supply/Mail: 90 day supply/Specialty: 30 day supply)	Waive deductible all tiers, then 10%/20%/30%	Waive deductible all tiers, then 10%/20%/30%
Prescription Drugs – Mail (Specific preventative drugs and legend Retail: 90 day supply/Mail: 90 day supply/Specialty: 30 day supply)	Waive deductible all tiers, then 10%/20%/30%	Not Covered

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Drug List	Preferred B4 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands Tier 4 = specialty	Preferred B4 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands Tier 4 = specialty
Specialty Pharmacy (Mandatory – Exclusive)	Waive deductible, then 10%; $250 per script maximum	Not Covered
SUPPLEMENTAL BENEFITS		
Routine Vision Exam ($150 PCY)	Covered in Full	Out of Network Deductible, then Hospital & Professional: 40% Non-Preferred or 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 (Not Covered)	Not Covered	Not Covered
Hearing Hardware (Not Covered)	Not Covered	Not Covered
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited

*This benefit highlight is for members of the Alaska Municipal Health Trust medical plan. This plan is self-funded by Alaska Municipal Health Trust, which means that Alaska Municipal Health Trust is financially responsible for the payment of plan benefits. Alaska Municipal Health Trust has the final discretionary authority to determine eligibility for benefits and construe the terms used in this plan.

Alaska Municipal Health Trust has contracted with Premera Blue Cross Blue Shield of Alaska, an Independent Licensee of the Blue Cross Blue Shield Association, to perform administrative duties, including the processing of claims, under the plan. Premera Blue Cross Blue Shield of Alaska does not insure the benefits of this plan.

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 under which the program may be continued in force. This benefit highlight is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.