Highlights of your Health Care Coverage

UIC (Ukpeagvik Inupiat Corporation)
Group Number: 4002747

Effective Date: 01/01/2026

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 HP HDHP $5,000/30%/$6,000 - ESSENTIALS**	
	YUKON IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARES		
Individual Deductible PCY (Family aggregate deductible 2x Individual)	$5,000 PCY/$10,000 PCY	Shared with In-Network
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	30% Preferred/40% Participating	Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$6,000 PCY	Shared with In-Network
Office Visit Cost Share	In Network Deductible, then 30% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
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	Included - Standard	Included - Standard
PROFESSIONAL CARE		
Professional Office Visit (Includes Telemedicine)	In Network Deductible, then 30% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
APP-BASED VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	In Network Deductible, then 30% Preferred	Not Covered

MEDICAL PLAN	2026 HP HDHP $5,000/30%/$6,000 - ESSENTIALS	
	YUKON IN-NETWORK	**OUT-OF-NETWORK**
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
Telemedicine - Outpatient Rehab (Virtual Care Only) (Shared with Rehab Outpatient Care)	Subject to Rehab Outpatient Care In-Network Cost Share	Not Covered
DIAGNOSTIC SERVICES		
Preventive Imaging and Laboratory	Covered in Full	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
Diagnostic Laboratory	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
Basic Diagnostic Imaging	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
Major Diagnostic Imaging	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
Preventive Mammography	Covered in Full	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
Diagnostic Mammography	In Network Deductible, then 0%	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
Supplemental Breast Exam	In Network Deductible, then 0%	Covered as any other service
FACILITY CARE		
Inpatient Facility	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
Inpatient Professional Services	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
Outpatient Surgery Facility	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
Outpatient Facility	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
MEDICAL PLAN	**2026 HP HDHP $5,000/30%/$6,000 - ESSENTIALS**	

	YUKON IN-NETWORK	OUT-OF-NETWORK
Skilled Nursing Facility (100 days PCY)	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (Inpatient: Unlimited; Respite: 240 hours; 6 month limit)	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: 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 30% Preferred/40% Participating	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
Home Health Visits (130 visits PCY)	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
MATERNITY & REPRODUCTIVE CARE		
Contraceptive Management Services (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
Sterilization - Female (Unlimited)	Covered in Full	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
Sterilization - Male (Unlimited)	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: 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
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 30% Preferred	In Network Deductible, then 30% 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)	$5,000 PCY/$10,000 PCY Deductible, then 0%	$5,000 PCY/$10,000 PCY Deductible, then 0%
Medical Services from Elective Procedure Travel	Covered as any other service	Covered as any other service
EMERGENCY CARE		
MEDICAL PLAN	**2026 HP HDHP $5,000/30%/$6,000 - ESSENTIALS**	

	YUKON IN-NETWORK	OUT-OF-NETWORK
Emergency Care	In Network Deductible, then 30% Preferred	In Network Deductible, then 30% Preferred
Emergency Room Physician	In Network Deductible, then 30% Preferred	In Network Deductible, then 30% Preferred
Urgent Care Center	In Network Deductible, then 30% preferred & participating	Same as In-Network
Ambulance Transportation (Unlimited)	In Network Deductible, then 30%	In Network Deductible, then 30%
Non-Emergent Ground Ambulance (Unlimited)	In Network Deductible, then 30%	In Network Deductible, then 30%
Air Ambulance (Unlimited)	In Network Deductible, then 30%	In Network Deductible, then 30%
Non-Emergent Air Ambulance (Unlimited)	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then 50%
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	In Network Deductible, then 30% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
Manipulations (Spinal and other) (20 visits PCY)	In Network Deductible, then 30% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	In Network Deductible, then 30% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
Chemical Dependency Outpatient Professional Care (Unlimited)	In Network Deductible, then 30% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
Mental Health Inpatient Facility Care (Unlimited)	In Network Deductible, then 30% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
Mental Health Outpatient Professional Care (Unlimited)	In Network Deductible, then 30% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
PHARMACY		
Formulary Drug List	E4 Essentials Formulary Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = preferred specialty Tier 4 = non-preferred all drugs	E4 Essentials Formulary Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = preferred specialty Tier 4 = non-preferred all drugs
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
MEDICAL PLAN	**2026 HP HDHP $5,000/30%/$6,000 - ESSENTIALS**	

	YUKON IN-NETWORK	OUT-OF-NETWORK
Prescription Drugs - Retail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	Tier 1 = Subject to Deductible, then $10 Tier 2 = Subject to Deductible, then $30 Tier 3 = Subject to Deductible, then $50 Tier 4 = Subject to Deductible, then 30% (cost shares apply to the OOP Max)	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Prescription Drugs - Mail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	Tier 1 = Subject to Deductible, then $25 Tier 2 = Subject to Deductible, then $75 Tier 3 = Subject to Deductible, then $50 Tier 4 = Subject to Deductible, then 30% (cost shares apply to the OOP Max)	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (100 visits PCY)	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab.; and Chronic Pain (45 days PCY)	In Network Deductible, then 30% Preferred	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
OTHER SERVICES		
Allergy/Therapeutic Injections	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
Medical Supplies, Equipment, Prosthetics (Unlimited)	In Network Deductible, then 30% Preferred/40% Participating	Out of Network Deductible, then Hospital/CD & Professional: 50%; ARP/Certified ABA: Same as In-Network
SUPPLEMENTAL BENEFITS		
Routine Hearing Exam (I PCY)	Exam & Test: INN Deductible, then 30% Preferred/40% Participating	OON Deductible, then 50%
Hearing Hardware ($800 limit every 3 consecutive years)	In Network Deductible, then 30%	In Network Deductible, then 30%
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.