FOR BUSINESSES WITH
51+ EMPLOYEES

2023 health plan guide

PREMERA | BLUE CROSS

We care for our customers

The customer is at the center of all we do—that's why we offer plans that help you keep control of your expenses while giving your employees access to quality and affordable care.

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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.
- Our largest network, Heritage, offers the broadest access to hospitals and physicians across Washington state.

Well-rounded benefits package

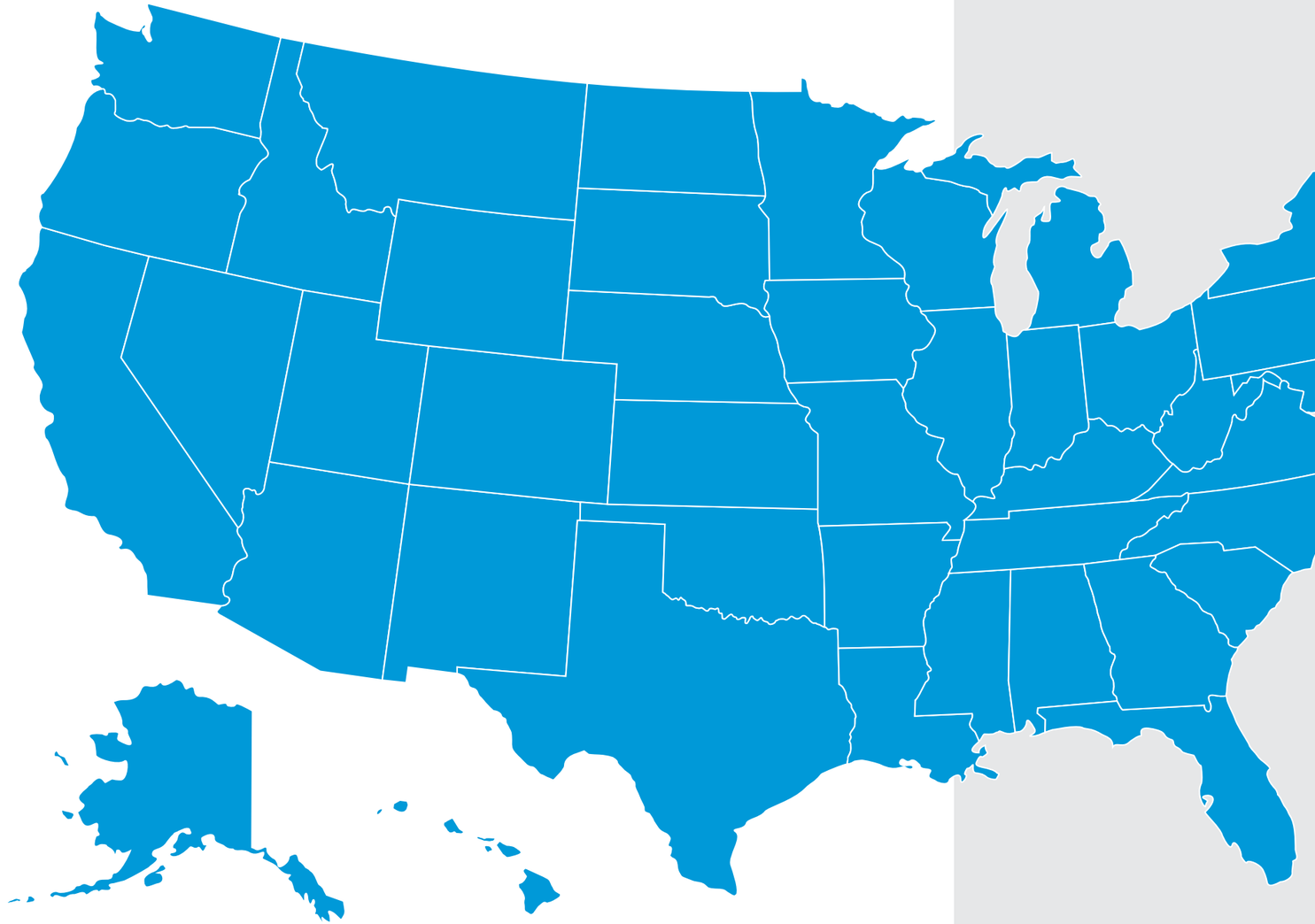
- We make it easy for you to attract and retain the best talent with appealing benefits packages that support the whole health of your employees.
- Choose from a range of plans to find the right balance that best fits the needs and budget for both your business and your employees.

Tools and programs for employees

- Our built-in support programs encourage your employees to engage in their healthcare, leading to healthier, happier employees.
- Online tools and apps help your employees find doctors, compare costs of services and medications, access pharmacy information, and review claims.

Administrative ease and support

- Integrate dental and pharmacy with your medical plans and simplify your work by dealing with only one health plan for all your healthcare administration.
- Effortlessly manage your health plans and pay bills online with our secure employer dashboard.
- Get ready-to-share resources that make benefits simple for you and your employees.



WE'RE IN YOUR CORNER

As a not-for-profit serving Washington 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.

The value of integration

When you combine medical, pharmacy, and dental plans, your employees benefit from whole-person care. You get deeper, real-time insights into your complete healthcare costs.

Here are a few other advantages of integrated care:

- Improved care coordination between providers results in earlier detection of chronic diseases.
- Greater adherence to doctor-recommended medication treatment plans.
- Increased use of preventive care services, which results in more effective management of conditions, fewer hospital admissions and emergency room visits, and lower claims costs.

SIMPLICITY	SAVINGS[1]	QUALITY OUTCOMES[1]
Combining benefits makes things easier for you and your employees.	Business with integrated benefits have the potential for significant medical cost savings.	You get quality health management and more control over employees' total care management.
1 CUSTOMER ID CARD CONTACT **EASIER ADMINISTRATION**	$333[1] **PER MEMBER, PER YEAR**	12% Improvement in medication adherence 19% Fewer hospital admissions 28% Fewer visits

[1] The Value of RX Integration. Blue Cross Blue Shield of North Carolina, June 2019, https://www.bluecrossnc.com/sites/default/files/U20694_TheValueOfRxIntegration.pdf.

Meeting members where they are, with programs to support their needs

Preventive health: Preventive healthcare services are part of every Premera plan. Our secure member website provides your employees with details about what is covered. It also includes suggested preventive routine exams, vaccinations, and screenings.

Virtual care: Our medical plans offer a variety of telehealth options, from video to call to text, that provide convenience and ease of use for your employees.

24-Hour NurseLine: Medical plans also include free, confidential health services from a registered nurse, available to your employees 24/7.

Wellness programs: Employees who feel better do better. Vivacity offers a variety of wellness program options like physical activity challenges, stress management programs, health assessments, wellness communications and many other tailored programs that align with varying workplace cultures and values. Discover more about **Vivacity.**

CareCompass360: This whole-person approach to health offers support services tailored to the unique needs of your employees who qualify.

Pregnancy and newborn support: Our maternity program supports healthy babies and parents with personalized tools, and it encourages early discovery of high-risk pregnancies. Our newborn program helps reduce costs associated with high-risk pregnancies, such as when newborns spend time in neonatal intensive care.

Mobile apps and online tools: Apps and digital tools give your employees more control when it comes to managing their healthcare. They can easily search for doctors, compare costs of services, track medications, review claims, and more.

Ready-to-share employee communications

We want to make your busy life a little less stressful. That's why we provide you with ready-to-share emails, flyers, and messages to share with your employees to help them understand their health plan benefits throughout their plan year.

Talk to your Premera representative or producer to determine which plans have the programs and services to best meet your needs.

The right care at the right time

Our members are truly at the center of all we do. Accessing care shouldn't be a challenge. We've built a robust provider network so our members can receive the care they need when they need it, delivered in a way that meets their needs without sacrificing quality.

Primary/Urgent care

Virtual text-based primary and urgent care from a doctor, 24/7

A robust variety of in-network providers for in-person care

Mental health care

Video and phone-based mental health therapy

In-network providers such as counselors, therapists, psychologists, and psychiatrists that offer in-person care

Substance use disorder

Virtual treatment for opioid use disorder and alcohol use disorder

Video visits and messaging with a therapist

Behavioral Health Navigator

Members can be matched with mental health care options based on their clinical needs, preferences, and health plan benefits

Kinwell clinics

Kinwell is an all-new primary care clinic specifically designed for Premera members.

Kinwell offers a wide range of services to meet the needs of every member on their journey to better health. Members benefit from an integrated care approach, more time with their providers and convenient online appointment scheduling.

Premera-Designated Centers of Excellence

Premera-Designated Centers of Excellence (PDCOEs) leverage performance data to connect members to enhanced benefits and providers who are committed to delivering predictable, high-value specialty care.

Quality maximized: Patients treated by PDCOE providers have better results, such as fewer complications and lower readmission rates.

Cost efficiency: PDCOE providers are also more cost efficient and drive more than 20% average savings per episode overall*.

Member experience: Enhanced care coordination and travel services help ensure a seamless member experience with higher quality outcomes.

Member statement: Eligibility for cost share waiver.

Learn more about our PDCOE offering

*AHRQ-sponsored Health Cost and Utilization Project (HCUP), 2014 (reflects all privately insured, BCBS, and non-BCBS).

Kinwell clinics are located to meet members where they are. Talk to your Premera representative or producer about how Kinwell can benefit your employees.

Provider networks

We believe in working closely with doctors and hospitals to ensure customers receive the best healthcare possible. That's why our provider networks are more than just a collection of contracts—they give members access to quality care, good experiences, and services at a fair price.

NETWORK	TOTAL PRACTITIONERS	PRIMARY CARE PROVIDERS	HOSPITALS
Heritage[1]	49,500	8,502	95
	Available with Your Choice, Your Future, and Your Focus plans.		
Heritage Prime[1]	40,799	6,985	74
	Available with Your Choice and Your Future plans.		
Tahoma[2] **(Pierce, Thurston and Spokane counties only**	7,364	1,390	5
	Available with Peak Care plans.		
Sherwood[2]	11,421	1,983	15
	Available with Premera HMO plans.		
Dental choice[1]	Washington State	Nationwide practitioners	Nationwide locations
	3,658	75,000	273,000

[1]Network counts as of July 2022.
[2]Network counts as of August 2022.

PROVIDER NETWORK OPTIONS

National and worldwide network coverage with BlueCard

When you choose a Premera Blue Cross health plan, it offers specific levels of healthcare benefits wherever your employees live or travel, across the country and worldwide.

Contact your producer or Premera representative for more details and to find out what level of BlueCard® healthcare benefits are included in your Premera health plan.

The power of choice

Whether your employees want access to the most providers in Washington state, or the highest savings, give them the ability to choose their network. Talk with your producer or Premera account manager about the benefits of offering your employees the opportunity to choose from two Premera medical plans like a Premera PPO plan and a Peak Care plan, or select from two dental plans like the Dental Optima or Willamette Dental plan.

NEW FOR 2023!

Medical plans

Premera is bringing you new plans in 2023. These plans meet the unique needs of your employees keeping them both happy and healthy.

DECIDE WHICH PLAN IS RIGHT FOR YOU

Premera HMO Core Plus

NEW FOR 2023

Starting January 1, 2023, the Premera HMO Core Plus plan will serve groups that want affordable healthcare for their employees, giving them the power of Plus with a forward-thinking health plan. This plan is designed for members living or working in Pierce, Thurston, and Spokane counties.

Blue High Performance Network

NEW FOR 2023

The Blue High Performance Network℠ (BlueHPN℠) provides national reach while being grounded in local market expertise—spanning 65+ major U.S. markets and covering millions of lives. BlueHPN members receive in-network-only access to high-performing, high-value care with an exclusive provider organization (EPO).

Looking to lower costs in 2023? We're in your corner.

Premera offers low-cost health plan options in 2023 to meet both the needs of your employees as well as your business. Ask your Premera representative or producer about how much you can save with some of our new plan options.

Curious about the HMO Core Plus health plan?

Fully-insured groups of 51 or more employees can purchase the Premera Blue Cross HMO plan. Contact your Premera representative or producer for more information.

premera.com

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.

DECIDE WHICH PLAN IS RIGHT FOR YOU

Your Choice

This traditional preferred provider organization (PPO) plan offers coverage for a wide range of medical services. Your employees and their covered dependents can save money by using an in-network provider. Non-network providers are still covered, but at a higher cost.

Your Focus

This plan is an exclusive provider organization (EPO) plan. Services covered are the same for this plan as for the more traditional Your Choice plan; however, members of this EPO are not covered for care received outside the selected network. Members are encouraged to use the doctors and hospitals within the selected network because there are no out-of-network benefits, except for emergency care.

Your Future

This plan is designed to be combined with an employee-owned health savings account (HSA) and offers the choice between an aggregate deductible, an embedded deductible, or an out-of-pocket maximum. See page 26, to find more information on the difference between aggregate or embedded options.

Peak Care

This is an exclusive provider organization (EPO) plan designed for Pierce, Thurston, or Spokane County-based employers. You save on health plan costs because benefits are provided only when your employees use in-network providers or when they are referred out-of-network by an in-network provider.

Essentials Medical

For businesses with hard decisions to make, the Essentials Medical health plan can offer you as much as 25% savings on premiums.* This plan will also help you maintain your Premera benefits and minimize disruption for your employees with a low-cost health plan option and free access to unlimited virtual care visits.

*When compared to Premera Heritage network preferred provider organization (PPO) plan pricing.

Curious about the Peak Care health plan?

For businesses with employees in the Pierce, Thurston, and Spokane county areas. Find out more about how Peak Care can lower costs for your bottom line at **peakcare.com/employer**.

NEW FOR 2023!

HMO Core Plus FOR FULLY INSURED GROUPS

Starting January 1, 2023, the Premera HMO Core Plus plan will serve groups that want affordable healthcare for their employees, giving them the power of Plus with a forward-thinking health plan. This plan is designed for members **living or working in Pierce, Thurston, and Spokane counties.**

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	OUT OF NETWORK
Individual deductible PCY	$500 $1,000 $1,500 $2,000 $2,500 $3,000 $3,500 $4,000, $4,500 $5,000	Not covered*
Family deductible PCY	2x Individual	
Coinsurance	0%, 10%, 20%, 30%, 40% or 50%	
Individual out-of-pocket maximum PCY (Includes deductible, coinsurance, and copay)	$3,000 $4,000 $5,000 $6,000 $7,000 $8,000 $9,000 $9,100	
Family out-of-pocket maximum PCY (Includes deductible, coinsurance, and copay)	2x Individual	
Fourth quarter deductible carryover	Excluded	
Office visit cost share	$0 PCP / $50 Specialist, $5 PCP / $60 Specialist, $10 PCP / $65 Specialist	
Inpatient cost share	In-network deductible and coinsurance	
Annual Plan Maximum	None	

Note: Coinsurance amounts based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
In-network and out-of-pocket maximum must not exceed the federally mandated maximum of $9,100 for an individual or $18,200 for a family.

Covered services

Benefits apply after calendar-year deductible is met, unless otherwise noted.
PCY = per calendar year

	BENEFIT LIMITS	IN NETWORK	OUT OF NETWORK
Preventive care and counseling visit	Subject to federal and state guidelines[1]	Covered in full[2]	Not covered
Preventive screenings			
Vaccinations (Including seasonal vaccinations received at a pharmacy or other mass vaccination location paid as in network)			
Professional office visit	No visit limits	Office visit cost share	Same as in-network
Urgent care		$25 copay	
Virtual care (General medicine)		PCP office visit copay	Not covered
Other outpatient professional services **Inpatient professional services**		In-network coinsurance	
Manipulations (Spinal and other)	12 or 24 visits PCY No visit limits	PCP office visit copay	
Acupuncture			
Naturopathic services	No visit limits	Office visit cost share	
Mammography (Non-preventive)	No visit limits	In-network coinsurance;	
Outpatient diagnostic imaging and laboratory services		Basic imaging & labs: In-network coinsurance (deductible waived), Major imaging: In-network coinsurance; Basic imaging & labs: $75 copay (deductible waived); Major imaging: $150 copay (deductible waived)	
Emergency room care (Copay waived if directly admitted to inpatient facility)	No maximum	In-network coinsurance PLUS copay of: $300	Same as in-network
Ambulance transportation (Air and ground)		In-network coinsurance	
Inpatient hospital care	No limit or visit maximum	Inpatient cost share	Not covered
Outpatient facility care		In-network coinsurance	
Skilled nursing facility	60, 90, 120, or 180 days PCY	Inpatient cost share	
Maternity care (Prenatal, delivery, and postnatal care)	No visit or day maximum; covered for: subscriber, spouse/domestic partner, and dependents	In-network coinsurance	
Mental health and chemical dependency treatment	No limit on number of days or visits	Outpatient: PCP office visit copay Inpatient: Inpatient cost share	
Rehabilitation (Including physical, occupational, speech, and massage therapy)	15 visits PCY / 30 days PCY, 25 visits PCY / 30 days PCY, 45 visits PCY / 30 days PCY, 60 visits PCY / 60 days PCY, or Unlimited/Unlimited	Outpatient: Specialist office visit copay Inpatient: Inpatient cost share	
(Including cardiac/pulmonary rehab and chronic pain)	No visit limits		
Supplies, equipment, prosthetics, and orthotics	No maximum, except $300 max PCY for foot orthotics that are not diabetes related	In-network coinsurance	
Temporomandibular joint disorders (TMJ)	No dollar maximum	Outpatient: Office visit cost share Inpatient: Inpatient cost share	
Home health agency services	130 visits PCY or no visit limit	In-network coinsurance	
Hospice care	Outpatient: No visit limits (within 6-month lifetime maximum) Respite: 240 hours (within 6-month lifetime maximum) Inpatient options: 10 days, 30 days, or No day limit (within 6-month lifetime maximum)	Outpatient and respite: In-network coinsurance or covered in full Inpatient: Inpatient cost share or covered in full	
Transplants (Organ and bone marrow)	No dollar maximums, except for $7,500, $10,000, or No limit for travel and lodging per transplant	Outpatient: Office visit cost share Inpatient: Inpatient cost share	Covered when approved

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
[1] A list of preventive benefits is available to members when they sign in to their secure member account on **premera.com**.
[2] Not subject to copay, deductible, or coinsurance.
This is only a brief summary of the major benefits provided by our plans. This is not a contract.
For information and details regarding general exclusions and limitations, please contact your Premera representative.

NEW FOR 2023!

BlueHPN (EPO)

BlueHPN provides national reach while being grounded in local market expertise. BlueHPN members receive in-network-only access to high-performing, high-value care using with the Heritage Prime 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	OUT OF NETWORK
Individual deductible PCY	$0 $100 $200 $250 $300 $500 $750 $1,000 $1,500 $2,000 $2,500 $3,000 $3,500 $4,000 $5,000 $6,350 $6,600 $7,900 $8,150, $8,550 $8,700 $9,100	Not covered*
Family deductible PCY	2x Individual, or 3x Individual	
Coinsurance	0%, 10%,15% 20%, or 30%	
Individual out-of-pocket maximum PCY (Includes deductible, coinsurance, and copay)	$1,000 $1,100 $1,200 $1,250 $1,300 $1,500 $1,750 $2,000 $2,100 $2,200 $2,250 $2,300 $2,500 $2,750 $3,000 $3,500 $4,000 $4,500 $5,000 $6,000, $6,350 $6,600 $6,850 $7,150 $7,350 $7,900 $8,150 $8,550 $8,700 $9,100	
Family out-of-pocket maximum PCY (Includes deductible, coinsurance, and copay)	2x Individual, or 3x Individual	
Fourth quarter deductible carryover	Included/Excluded	
Office visit cost share	In-network deductible and coinsurance, or copay options: $10, $15, $20, $25, $30, $35, $40	
Inpatient cost share	In-network deductible and coinsurance, $250 per admit, $250 per day up to 5 days per admit, or $100 per day	
Annual Plan Maximum	None	

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
In-network and out-of-pocket maximum must not exceed the federally mandated maximum of $9,100 for an individual or $18,200 for a family.
*Except for emergencies or as required by law.

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	OUT OF NETWORK
Preventive care and counseling visit	Subject to federal and state guidelines[1]	Covered in full[2]	Not covered
Preventive screenings			
Vaccinations (Including seasonal vaccinations received at a pharmacy or other mass vaccination location paid as in network)			
Professional office visit (including urgent care)	No visit limits	Office visit cost share	
Urgent care		Office visit cost share	HPN product area: Not covered; Non-HPN product area: Same as in-network cost share
Virtual care (General medicine)		$10 copay, or In-network coinsurance	Not covered
Other outpatient professional services **Inpatient professional services**		In-network coinsurance	
Manipulations (Spinal and other)	12 or 24 visits PCY No visit limits	Office visit cost share	
Acupuncture			
Naturopathic services	No visit limits		
Mammography (Non-preventive)	No visit limits	In-network coinsurance; In-network coinsurance (deductible waived); Basic imaging & labs: In-network coinsurance (deductible waived), Major imaging: In-network coinsurance; Covered in full[2]	
Outpatient diagnostic imaging and laboratory services			
Emergency room care (Copay waived if directly admitted to inpatient facility)	No maximum	In-network coinsurance, or In-network coinsurance PLUS copay of $50, $75, $100, $150, $200, $250, or $300	Same as in network
Ambulance transportation (Air and ground)	No trip or dollar maximum	$50 copay, In-network coinsurance, or In-network coinsurance (deductible waived)	
Inpatient hospital care	No limit on number of days or visits	Inpatient cost share	Not covered
Outpatient facility care		In-network coinsurance	
Skilled nursing facility	60, 90, 120, or 180 days PCY	Inpatient cost share	
Maternity care (Prenatal, delivery, and postnatal care)	No visit or day maximum; covered for: subscriber, spouse/domestic partner, and dependents	In-network coinsurance	
Mental health and chemical dependency treatment	No limit on number of days or visits	Outpatient: Office visit cost share Inpatient: Inpatient cost share	
Rehabilitation (Including physical, occupational, speech, and massage therapy)	15 visits PCY / 30 days PCY, 25 visits PCY / 30 days PCY, 45 visits PCY / 30 days PCY, 60 visits PCY / 60 days PCY, or Unlimited/Unlimited		
(Including cardiac/pulmonary rehab and chronic pain)	No visit limits		
Supplies, equipment, prosthetics, and orthotics	No maximum, except $300 max PCY for foot orthotics that are not diabetes related	In-network coinsurance	
Temporomandibular joint disorders (TMJ)	No dollar maximum	Outpatient: Office visit cost share Inpatient: inpatient cost share	
Home health agency services	130 visits PCY or Unlimited	In-network coinsurance or covered in full	
Hospice care	Outpatient: No visit limits (within 6-month lifetime maximum) Respite: 240 hours (within 6-month lifetime maximum) Inpatient options: 10 days, 30 days, or No day limit (within 6-month lifetime maximum)	Outpatient and respite: In-network coinsurance or covered in full Inpatient: Inpatient cost share or covered in full	
Transplants (Organ and bone marrow)	No dollar maximums, except for $7,500, $10,000, or No limit for travel and lodging per transplant	Outpatient: Office visit cost share Inpatient: inpatient cost share	Covered when approved

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
[1] A list of preventive benefits is available to members when they sign in to their secure member account on **premera.com**.
[2] Not subject to copay, deductible, or coinsurance.
This is only a brief summary of the major benefits provided by our plans. This is not a contract.
For information and details regarding general exclusions and limitations, please contact your Premera representative.

Your Choice

Your Choice offers a familiar preferred provider organization (PPO) plan with coverage for a wide range of medical services.

You can select from a range of deductible options. You can also split copay options, with a lower copay for a nonspecialist office visit and a higher copay when your employee or their covered dependent sees a specialist.

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	OUT OF NETWORK
Individual deductible PCY	$0 $100 $200 $250 $300 $500 $750 $1,000 $1,500 $2,000 $2,500 $3,000 $3,500 $4,000 $5,000 $6,350 $6,600 $7,900 $8,150 $8,550 $8,700 $9,100	Shared with in network, 2x Individual in network, or 3x Individual in network
Family deductible PCY	2x Individual or 3x Individual	
Coinsurance	0%, 10%, 15%, 20%, or 30%	30%, 40%, or 50%
Individual out-of-pocket maximum PCY (Includes deductible, coinsurance, and copay)	$1,000 $1,100 $1,200 $1,250 $1,300 $1,500 $1,750 $2,000 $2,100 $2,200 $2,250 $2,300 $2,500 $2,750 $3,000 $3,500 $4,000 $4,500 $5,000 $6,000 $6,350 $6,600 $6,850 $7,150 $7,350 $7,900 $8,150 $8,550 $8,700 $9,100	Shared with in network, 2x Individual in network, 3x Individual in network, or None
Family out-of-pocket maximum PCY (Includes deductible, coinsurance, and copay)	2x Individual or 3x Individual	
Fourth quarter deductible carryover	Included/Excluded	
Office visit cost share	Split copay options: $20 nonspecialist / $30 specialist, $20 nonspecialist / $40 specialist, $25 nonspecialist / $35 specialist, $25 nonspecialist / $40 specialist, $25 nonspecialist / $50 specialist, $30 nonspecialist / $45 specialist, or $35 nonspecialist / $45 specialist In-network deductible and coinsurance; Single copay options: $10, $15, $20, $25, $30, $35, or $40	Out-of-network deductible and coinsurance
Inpatient cost share	In-network deductible and coinsurance, $250 per admit, $250 per day up to 5 days per admit, or $100 per day	

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
In-network and out-of-pocket maximum must not exceed the federally mandated maximum of $9,100 for an individual or $18,200 for a family.

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	OUT OF NETWORK
Preventive care and counseling visit	Subject to federal and state guidelines[1]	Covered in full[2]	Not covered, Out-of-network coinsurance, Out-of-network coinsurance (deductible waived), or Covered in full
Preventive screenings			
Vaccinations (Including seasonal vaccinations received at a pharmacy or other mass vaccination location paid as in network)			
Professional office visit	No visit limits	Office visit cost share	Out-of-network coinsurance
Urgent care		Split copay: Specialist copay All others: Office visit cost share	
Virtual care (General medicine)		$10 copay, or in-network coinsurance	
Other outpatient professional services **Inpatient professional services**		In-network coinsurance	
Manipulations[3] (Spinal and other)	12 visits PCY, 24 visits PCY, or No visit limits	Office visit cost share[3]	Out-of-network coinsurance
Acupuncture[3]			
Naturopathic services	No visit limits		
Mammography (Non-preventive)	No visit limits	In-network coinsurance;	Out-of-network coinsurance
Outpatient diagnostic imaging and laboratory services		In-network coinsurance (deductible waived); Basic imaging & labs: In-network coinsurance (deductible waived), Major imaging: In-network coinsurance; Covered in full[2]	
Emergency room care (Copay waived if directly admitted to inpatient facility)	No maximum	In-network coinsurance, or In-network coinsurance PLUS copay of: $50, $75, $100, $150, $200, $250, or $300	Same as in network
Ambulance transportation (Air and ground)	No trip or dollar maximum	$50 copay, In-network coinsurance, or In-network coinsurance (deductible waived)	
Inpatient hospital care	No limit on number of days or visits	Inpatient cost share	Out-of-network coinsurance
Outpatient facility care		In-network coinsurance	
Skilled nursing facility	60 days PCY, 90 days PCY, 120 days PCY, or 180 days PCY	Inpatient cost share	
Maternity care (Prenatal, delivery, and postnatal care)	No visit or day maximum; covered for: subscriber, spouse/domestic partner, and dependents	In-network coinsurance	Out-of-network coinsurance
Mental health and chemical dependency treatment	No visit or day maximums	Outpatient: Office visit cost share[3] Inpatient: Inpatient cost share	Out-of-network coinsurance
Rehabilitation (Including physical, occupational, speech, and massage therapy)	15 visits / 30 days PCY, 25 visits / 30 days PCY, 45 visits / 30 days PCY, 60 visits / 60 days PCY, or Unlimited/Unlimited		
(Including cardiac/pulmonary rehab and chronic pain)	No visit limits		
Supplies, equipment, prosthetics, and orthotics	No maximum, except $300 max PCY for foot orthotics that are not diabetes related	In-network coinsurance	
Temporomandibular joint disorders (TMJ)	No dollar maximum	Outpatient: Office visit cost share Inpatient: Inpatient cost share	
Home health agency services	130 visits PCY, or No visit limit	In-network coinsurance or covered in full	
Hospice care	Outpatient: No visit limits (within 6-month lifetime maximum) Respite: 240 hours (within 6-month lifetime maximum) Inpatient options: 10 days, 30 days, or No day limit (within 6-month lifetime maximum)	Outpatient and respite: In-network coinsurance or covered in full Inpatient: Inpatient cost share or covered in full	
Transplants (Organ and bone marrow)	No dollar maximums, except for $7,500, $10,000, or No limit for travel and lodging per transplant	Outpatient: Office visit cost share Inpatient: Inpatient cost share	Covered same as in network when approved

Your Focus

This plan is an exclusive provider organization (EPO) plan. Services covered are the same for this plan as the more traditional Your Choice plan; however, members of this EPO are not covered for care received outside the selected network.

Therefore, members are encouraged to use the doctors and hospitals within the selected network, potentially saving both you and them money. There are no out-of-network benefits.

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	OUT OF NETWORK
Individual deductible PCY	$0 $100 $200 $250 $300 $500 $750 $1,000 $1,500 $2,000 $2,500 $3,000 $3,500 $4,000 $5,000 $6,350 $6,600 $7,900 $8,150, $8,550 $8,700 $9,100	Not covered*
Family deductible PCY	2x Individual, or 3x Individual	
Coinsurance	0%, 10%, 15%, 20%, or 30%	
Individual out-of-pocket maximum PCY (Includes deductible, coinsurance, and copay)	$1,000 $1,100 $1,200 $1,250 $1,300 $1,500 $1,750 $2,000 $2,100 $2,200 $2,250 $2,300 $2,500 $2,750 $3,000 $3,500 $4,000 $4,500 $5,000 $6,000, $6350 $6,600 $6,850 $7,150 $7,350 $7,900 $8,150 $8,550 $8,700 $9,100	
Family out-of-pocket maximum PCY (Includes deductible, coinsurance, and copay)	2x Individual, or 3x Individual	
Fourth quarter deductible carryover	Included/Excluded	
Office visit cost share	In-network deductible and coinsurance, or copay options: $10, $15, $20, $25, $30, $35, $40	
Inpatient cost share	In-network deductible and coinsurance, $250 per admit, $250 per day up to 5 days per admit, or $100 per day	
Annual Plan Maximum	None	

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
In-network and out-of-pocket maximum must not exceed the federally mandated maximum of $9,100 for an individual or $18,200 for a family.
*Except for emergencies or as required by law.

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	OUT OF NETWORK
Preventive care and counseling visit	Subject to federal and state guidelines[1]	Covered in full[2]	Not covered
Preventive screenings			
Vaccinations (Including seasonal vaccinations received at a pharmacy or other mass vaccination location paid as in network)			
Professional office visit (Including urgent care)	No visit limits	Office visit cost share	
Virtual care (General medicine)		$10 copay, or In-network coinsurance	
Other outpatient professional services **Inpatient professional services**		In-network coinsurance	
Manipulations (Spinal and other)	12 visits PCY, 24 visits PCY, or No visit limits	Office visit cost share	
Acupuncture			
Naturopathic services	No visit limits		
Mammography (Non-preventive)	No visit limits	In-network coinsurance;	
Outpatient diagnostic imaging and laboratory services		In-network coinsurance (deductible waived); Basic imaging & labs: In-network coinsurance (deductible waived), Major imaging: In-network coinsurance; Covered in full[2]	
Emergency room care (Copay waived if directly admitted to inpatient facility)	No maximum	In-network coinsurance, or In-network coinsurance PLUS copay of: $50, $75, $100, $150, $200, $250, or $300	Same as in network
Ambulance transportation (Air and ground)	No trip or dollar maximum	$50 copay, In-network coinsurance, or In-network coinsurance (deductible waived)	
Inpatient hospital care	No limit on number of days or visits	Inpatient cost share	Not covered
Outpatient facility care		In-network coinsurance	
Skilled nursing facility	60 days PCY, 90 days PCY, 120 days PCY, or 180 days PCY	Inpatient cost share	
Maternity care (Prenatal, delivery, and postnatal care)	No visit or day maximum; covered for: subscriber, spouse/domestic partner, and dependents	In-network coinsurance	
Mental health and chemical dependency treatment	No limit on number of days or visits	Outpatient: Office visit cost share Inpatient: Inpatient cost share	
Rehabilitation (Including physical, occupational, speech, and massage therapy)	15 visits / 30 days PCY, 25 visits / 30 days PCY, 45 visits / 30 days PCY, 60 visits / 60 days PCY, or Unlimited/Unlimited		
(Including cardiac/pulmonary rehab and chronic pain)	No visit limits		
Supplies, equipment, prosthetics, and orthotics	No maximum, except $300 max PCY for foot orthotics that are not diabetes related	In-network coinsurance	
Temporomandibular joint disorders (TMJ)	No dollar maximum	Outpatient: Office visit cost share Inpatient: Inpatient cost share	
Home health agency services	130 visits PCY, or no visit limit	In-network coinsurance or covered in full	
Hospice care	Outpatient: No visit limits (within 6-month lifetime maximum) Respite: 240 hours (within 6-month lifetime maximum) Inpatient options: 10 days, 30 days, or No day limit (within 6-month lifetime maximum)	Outpatient and respite: In-network coinsurance or covered in full Inpatient: Inpatient cost share or covered in full	
Transplants (Organ and bone marrow)	No dollar maximums, except for $7,500, $10,000, or No limit for travel and lodging per transplant	Outpatient: Office visit cost share Inpatient: Inpatient cost share	Covered when approved

Your Future

The HSA-qualified Your Future plan is designed to work with an employee-owned, tax-advantaged health savings account (HSA).

You can choose between an aggregate or embedded deductible.

Deductible options

Aggregate deductible	The aggregate deductible amount is different depending on whether a subscriber enrolls alone or with dependents. When dependents are enrolled, the full amount of the aggregate deductible must be met before benefits can begin for any covered family member.
Embedded deductible	An embedded deductible works like a traditional health plan deductible. Benefits begin for a single family member after either the member's own expenses equal the individual deductible or the expenses from a combination of family members equals the family maximum.

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
INN = in network
OON = out of network

		IN NETWORK													OUT OF NETWORK
Individual/ family deductible PCY	**Aggregate**	$2,000 / $4,000[1]	$2,000 / $4,000[1]	$1,500 / $3,000[2]	$1,700 / $3,400[2]	$2,500 / $5,000[2]	$3,000 / $6,000[2]	$1,500 / $3,000[2]	$2,500 / $5,000[2]	N/A	N/A	N/A	N/A	N/A	N/A	See below[1]
	Embedded	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$3,000 / $6,000[2]	$3,500 / $7,000[2]	$4,000 / $8,000[2]	$5,000 / $10,000[1]	$6,050 / $12,100[2]	$6,450 / $12,900[1]	
Coinsurance		0%	20%	20%	20%	20%	20%	15%	15%	20%	20%	20%	0%	0%	0%	40% or 50%
Individual/ family out-of-pocket maximum PCY	**Aggregate**	$2,000 / $4,000	$3,000 / $6,000	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Unlimited
	Embedded	N/A	N/A	$4,000 / $8,000	$4,200 / $8,400	$5,000 / $10,000	$6,000 / $12,000	$4,500 / $9,000	$6,000 / $12,000	$5,100 / $10,200	$6,000 / $12,000	$6,000 / $12,000	$5,000 / $10,000	$6,050 / $12,100	$6,450 / $12,900	
Fourth quarter deductible carryover		Excluded														Excluded
Office visit cost share		In-network deductible and coinsurance														OON deductible and coinsurance
Inpatient cost share																OON deductible and coinsurance
Annual plan maximum		Unlimited														

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
[1] Out-of-network deductible is 2x the in-network deductible.
[2] Out-of-network deductible can either be shared with in-network or be 2x the in-network deductible.

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	OUT OF NETWORK
Preventive care and counseling visit	Subject to federal and state guidelines[1]	Covered in full[2]	Not covered
Preventive screenings			40% or 50%
Vaccinations (Including seasonal vaccinations received at a pharmacy or other mass vaccination location paid as in network)			40% or 50% (deductible waived) Covered in full
Professional office visit (including urgent care)	No visit limits	In-network coinsurance	40% or 50%
Virtual care (General medicine)			Not covered
Other outpatient professional services **Inpatient professional services**			40% or 50%
Manipulations (Spinal and other)	12 or 24 visits PCY No visit limits	In-network coinsurance	40% or 50%
Acupuncture			
Naturopathic services	No visit limits		
Mammography (Non-preventive)	No visit limits		
Outpatient diagnostic imaging and laboratory services			
Emergency room care (Copay waived if directly admitted to inpatient facility)	No maximum	In-network coinsurance	
Ambulance transportation (Air and ground)			
Inpatient hospital care	No limit or visit maximum	In-network coinsurance	40% or 50%
Outpatient facility care			
Skilled nursing facility	60, 90, 120, or 180 days PCY		
Maternity care (Prenatal, delivery, and postnatal care)	No visit or day maximum; covered for: subscriber, spouse/domestic partner, and dependents		
Mental health and chemical dependency treatment	No limit on number of days or visits	In-network coinsurance	40% or 50%
Rehabilitation (Including physical, occupational, speech, and massage therapy)	15 visits PCY / 30 days PCY, or 25 visits PCY / 30 days PCY, or 45 visits PCY / 30 days PCY, or 60 visits PCY / 60 days PCY, or Unlimited/Unlimited		
(Including cardiac/pulmonary rehab and chronic pain)	No visit limits		
Supplies, equipment, prosthetics, and orthotics	No maximum, except $300 max PCY for foot orthotics that are not diabetes related		
Temporomandibular joint disorders (TMJ)	No dollar maximum		
Home health agency services	130 visits PCY or Unlimited		
Hospice care	Outpatient: No visit limits (within 6-month lifetime maximum) Respite: 240 hours (within 6-month lifetime maximum) Inpatient options: 10 days, 30 days, or No day limit (within 6-month lifetime maximum)	In-network coinsurance or Deductible, then 0%	
Transplants (Organ and bone marrow)	No dollar maximums, except for $7,500, $10,000, or No limit for travel and lodging per transplant	In-network coinsurance	Covered when approved
Certain generic preventive drugs retail and mail order	90-day supply, except Specialty Rx: 30-day supply	Covered in full[2]	
Retail pharmacy (Subject to medical deductible)		In-network coinsurance, or Deductible then $10 / $35 / $70, or Deductible then $10 / $35 / $70 / 30%	
Mail-order pharmacy (Subject to medical deductible)		In-network coinsurance, or Deductible then $25 / $87 / $175, or Deductible then $25 / $87 / $70 / 30%	Not covered

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
[1] A list of preventive benefits is available to members when they sign in to their secure member account on **premera.com**.
[2] Not subject to copay, deductible, or coinsurance.
This is only a brief summary of the major benefits provided by our plans. This is not a contract.
For information and details regarding general exclusions and limitations, please contact your Premera representative.
Please see our Personal Funding Accounts brochure for more details on health savings accounts.

Peak Care FOR FULLY INSURED GROUPS*

Peak Care is an exclusive provider organization (EPO) plan **designed for Pierce, Thurston, and Spokane County-based employers.** Offer Peak Care to your employees in combination with a Premera PPO medical plan to give them the opportunity to choose the best plan to meet their needs.

An EPO is a hybrid health plan in which a primary care provider referral is not required when seeking specialty care, but care must be provided within network. With an EPO plan, your employees receive care at a lower cost of coverage versus other plan types.** Peak Care plans provide your employees with a smooth healthcare experience, allowing them to focus on their health.

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
Individual deductible PCY	$0 $100 $200 $250 $300 $500 $750 $1,000 $1,500 $2,000 $2,500 $3,000 $3,500 $4,000 $5,000 $6,350 $6,600 $6,850 $7,900 $8,150 $8,500 $8,700 $9,100
Family deductible PCY	2x Individual or 3x Individual
Coinsurance	0%, 10%, 15%, 20%, or 30%
Individual out-of-pocket maximum PCY (Includes deductible, coinsurance, and copay)	$1,000 $1,100 $1,200 $1,250 $1,300 $1,500 $1,750 $2,000 $2,100 $2,200 $2,250 $2,300 $2,500 $2,750 $3,000 $3,500 $4,000 $4,500 $5,000 $6,000 $6,350 $6,600 $6,850 $7,150 $7,900 $8,150 $8,500 $8,700 $9,100
Family out-of-pocket maximum PCY (Includes deductible, coinsurance, and copay)	2x Individual or 3x Individual
Fourth quarter deductible carryover	Included/Excluded
Office visit cost share	In-network deductible and coinsurance, or copay options of: $10, $15, $20, $25, $30, $35, $40
Inpatient cost share	In-network deductible and coinsurance, $250 per admit – no day maximum, $250 per day – up to 5 days per admit, or $100 per day – no day maximum
Annual Plan Maximum	None

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

In-network and out-of-pocket maximum must not exceed the federally mandated maximum of $9,100 for an individual or $18,200 for a family.

*Other funding types may be eligible for Peak Care. Contact your producer or Premera representative.
**Compared to Premera preferred provider organization plan pricing.

MultiCare

Peak Care is the result of a first-of-its-kind alliance between Premera Blue Cross and MultiCare. This collaboration promises a simple and easy customer experience while ensuring patients receive the care they need at a lower cost.

Speak with your Premera representative or producer to find out more about **Peak Care**.

Covered services

Benefits apply after calendar-year deductible is met, unless otherwise noted.
PCY = per calendar year

	BENEFIT LIMITS	COST SHARES
Preventive care and counseling visit	Subject to federal and state guidelines[1]	Covered in full[2]
Preventive screenings		
Vaccinations (Including seasonal vaccinations received at a pharmacy or other mass vaccination location paid as in network)		
Professional office visit (Including urgent care)	No visit limits	Office visit cost share
Virtual care (General medicine)		$10 copay
Other outpatient professional services **Inpatient professional services**		In-network coinsurance
Manipulations (Spinal and other)	12 visits PCY, 24 visits PCY, or No visit limits	Office visit cost share
Acupuncture		
Naturopathic services	No visit limits	
Mammography (Non-preventive)	No visit limits	In-network coinsurance; In-network coinsurance (deductible waived); Basic imaging & labs: In-network coinsurance (deductible waived), Major imaging: In-network coinsurance; Covered in full[2]
Outpatient diagnostic imaging and laboratory services		
Emergency room care (Copay waived if directly admitted to inpatient facility)	No maximum	In-network coinsurance, or In-network coinsurance PLUS copay of: $50, $75, $100, $150, $200, or $300
Ambulance transportation (Air and ground)	No trip or dollar maximum	$50 copay, In-network coinsurance, or In-network coinsurance (deductible waived)
Inpatient hospital care	No limit on number of days or visits	Inpatient cost share
Outpatient facility care		In-network coinsurance
Skilled nursing facility	60 days PCY, 90 days PCY, 120 days PCY, or 180 days PCY	Inpatient cost share
Maternity care (Prenatal, delivery, and postnatal care)	No visit or day maximum; covered for: subscriber, spouse/domestic partner, and dependents	In-network coinsurance
Mental health and chemical dependency treatment	No limit on number of days or visits	Outpatient: Office visit cost share Specialist Inpatient: Inpatient cost share
Rehabilitation (Including physical, occupational, speech, and massage therapy)	15 visits / 30 days PCY, 25 visits / 30 days PCY, 45 visits / 30 days PCY, 60 visits / 60 days PCY, or Unlimited/Unlimited	
(Including cardiac/pulmonary rehab and chronic pain)	No visit limits	
Supplies, equipment, prosthetics, and orthotics	No maximum, except $300 max PCY for foot orthotics that are not diabetes related	In-network coinsurance
Temporomandibular joint disorders (TMJ)	No dollar maximum	Outpatient: Office visit cost share Inpatient: Inpatient cost share
Home health agency services	130 visits PCY or no visit limit	In-network coinsurance or covered in full
Hospice care	Outpatient: No visit limits (within 6-month lifetime maximum) Respite: 240 hours (within 6-month lifetime maximum) Inpatient options: 10 days, 30 days, or no day limit (within 6-month lifetime maximum)	Outpatient and respite: In-network coinsurance or covered in full Inpatient: Inpatient cost share or covered in full
Transplants (Organ and bone marrow)	No dollar maximums, except $7,500, $10,000, or No limit for travel and lodging per transplant	Outpatient: Office visit cost share Inpatient: inpatient cost share

Peak Care NOW

We have partnered with MultiCare to power a digital and physical hybrid offering that provides a low-cost option to access MultiCare's primary and retail care. Using convenience-centric touchpoints members are referred to nearby MultiCare locations. When a member is outside the MultiCare territory, a high-quality provider partner is recommended.

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
Individual deductible PCY	$500 $1,000 $1,500 $2,000, $2,500 $3,000 $3,500 $4,000
Family deductible PCY	2x Individual
Coinsurance	20%
Individual out-of-pocket maximum PCY (Includes deductible, coinsurance, and copay)	$8,550
Family out-of-pocket maximum PCY (Includes deductible, coinsurance, and copay)	2x Individual
Fourth quarter deductible carryover	Excluded
Virtual care	Covered in Full
Office visit cost share	$0 non-specialist/$50 specialist
Inpatient cost share	In-network deductible and coinsurance
Annual Plan Maximum	None

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
In-network and out-of-pocket maximum must not exceed the federally mandated maximum of $9,100 for an individual or $18,200 for a family.
*Except for emergencies or as required by law.

Covered services

Benefits apply after calendar-year deductible is met, unless otherwise noted.
PCY = per calendar year

	BENEFIT LIMITS	COST SHARES
Preventive care and counseling visit	Subject to federal and state guidelines[1]	Covered in full[2]
Preventive screenings		
Vaccinations (Including seasonal vaccinations received at a pharmacy or other mass vaccination location paid as in network)		
Professional office visit	No visit limits	Office visit cost share
Urgent care		Covered in full[2]
Virtual care (General medicine)		
Other outpatient professional services **Inpatient professional services**		In-network coinsurance
Manipulations (Spinal and other)	12 visits PCY	In-network coinsurance
Acupuncture		
Naturopathic services	No visit limits	
Mammography (Non-preventive)	No visit limits	In-network coinsurance
Outpatient diagnostic imaging and laboratory services		
Emergency room care (Copay waived if directly admitted to inpatient facility)	No maximum	In-network coinsurance PLUS $450 copay
Ambulance transportation (Air and ground)	No trip or dollar maximum	In-network coinsurance
Inpatient hospital care	No limit on number of days or visits	Inpatient cost share
Outpatient facility care		In-network coinsurance
Skilled nursing facility	60 days PCY	Inpatient cost share
Maternity care (Prenatal, delivery, and postnatal care)	No visit or day maximum; covered for: subscriber, spouse/domestic partner, and dependents	In-network coinsurance
Mental health and chemical dependency treatment	No limit on number of days or visits	Outpatient: Non-specialist office visit copay Inpatient: Inpatient cost share
Rehabilitation (Including physical, occupational, speech, and massage therapy)	45 visits / 30 days PCY	Outpatient: In-network coinsurance Inpatient: Inpatient cost share
(Including cardiac/pulmonary rehab and chronic pain)	No visit limits	
Supplies, equipment, prosthetics, and orthotics	No maximum, except $300 max PCY for foot orthotics that are not diabetes related	In-network coinsurance
Temporomandibular joint disorders (TMJ)	No dollar maximum	Outpatient: Office visit cost share Inpatient: Inpatient cost share
Home health agency services	130 visits PCY or No visit limit	In-network coinsurance
Hospice care	Outpatient: No visit limits (within 6-month lifetime maximum) Respite: 240 hours (within 6-month lifetime maximum) Inpatient options: 10 days (within 6-month lifetime maximum)	Outpatient and respite: In-network coinsurance Inpatient: Inpatient cost share
Transplants (Organ and bone marrow)	No dollar maximums, except $7,500 for travel and lodging per transplant	Outpatient: Office visit cost share Inpatient: Inpatient cost share
Retail pharmacy	Up to 30-day supply per Rx	Preferred generic: $20 Preferred brand: $50 Preferred specialty: 30% Non-preferred drugs: 50%
Mail-order pharmacy	Up to 90-day supply per Rx (except Specialty Rx)	Preferred generic: $60 Preferred brand: $150 Preferred specialty: 30% Non-preferred drugs: 50%
Drug list	Essentials	

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
[1]A list of preventive benefits is available to members when they sign in to their secure member account on **premera.com**.
[2]Not subject to copay, deductible, or coinsurance.
This is only a brief summary of the major benefits provided by our plans. This is not a contract.
For information and details regarding general exclusions and limitations, please contact your Premera representative.

Peak Care HSA

The HSA-qualified Peak Care plan is designed to work with an employee-owned, tax-advantaged health savings account (HSA).

You can choose between an aggregate or embedded deductible.

Deductible options

Aggregate deductible	The aggregate deductible amount is different depending on whether a subscriber enrolls alone or with dependents. When dependents are enrolled, the full amount of the aggregate deductible must be met before benefits can begin for any covered family member.
Embedded deductible	An embedded deductible works like a traditional health plan deductible. Benefits begin for a single family member after either the member's own expenses equal the individual deductible or the expenses from a combination of family members equals the family maximum.

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													
Individual/family deductible PCY	**Aggregate**	$2,000 / $4,000	$2,000 / $4,000	$1,500 / $3,000	$1,700 / $3,400	$2,500 / $5,000	$3,000 / $6,000	$1,500 / $3,000	$2,500 / $5,000	N/A	N/A	N/A	N/A	N/A	N/A
	Embedded	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$3,000 / $6,000	$3,500 / $7,000	$4,000 / $8,000	$5,000 / $10,000	$6,050 / $12,100	$6,450 / $12,900
Coinsurance		0%	20%	20%	20%	20%	20%	15%	15%	20%	20%	20%	0%	0%	0%
Individual/family out-of-pocket maximum PCY	**Aggregate**	$2,000 / $4,000	$3,000 / $6,000	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Embedded	N/A	N/A	$4,000 / $8,000	$4,200 / $8,400	$5,000 / $10,000	$6,000 / $12,000	$4,500 / $9,000	$6,000 / $12,000	$5,100 / $10,200	$6,000 / $12,000	$6,000 / $12,000	$5,000 / $10,000	$6,050 / $12,100	$6,450 / $12,900
Fourth quarter deductible carryover		Excluded													
Office visit cost share		In-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 contracting with Premera Blue Cross.

Please see our Personal Funding Accounts brochure for more details on health savings accounts (HSAs)

Covered services

Benefits apply after calendar-year deductible is met, unless otherwise noted.
PCY = per calendar year

	BENEFIT LIMITS	COST SHARES
Preventive care and counseling visit	Subject to federal and state guidelines[1]	Covered in full[2]
Preventive screenings		
Vaccinations (Including seasonal vaccinations received at a pharmacy or other mass vaccination location paid as in network)		
Professional office visit (Including urgent care)	No visit limits	In-network coinsurance
Virtual care (General medicine)		
Other outpatient professional services **Inpatient professional services**		
Manipulations (Spinal and other)	12 visits PCY, 24 visits PCY, or No visit limits	In-network coinsurance
Acupuncture		
Naturopathic services	No visit limits	
Mammography (Non-preventive)	No visit limits	In-network coinsurance
Outpatient diagnostic imaging and laboratory services		
Emergency room care (Copay waived if directly admitted to inpatient facility)	No maximum	In-network coinsurance
Ambulance transportation (Air and ground)		
Inpatient hospital care	No limit on number of days or visits	In-network coinsurance
Outpatient facility care		
Skilled nursing facility	60 days PCY, 90 days PCY, 120 days PCY, or 180 days PCY	
Maternity care (Prenatal, delivery, and postnatal care)	No visit or day maximum; covered for: subscriber, spouse/domestic partner, and dependents	In-network coinsurance
Mental health and chemical dependency treatment	No limit on number of days or visits	In-network coinsurance
Rehabilitation (Including physical, occupational, speech, and massage therapy)	15 visits / 30 days PCY, 25 visits / 30 days PCY, 45 visits / 30 days PCY, 60 visits / 60 days PCY, or Unlimited/Unlimited	
(Including cardiac/pulmonary rehab and chronic pain)	No visit limits	
Supplies, equipment, prosthetics, and orthotics	No maximum, except $300 max PCY for foot orthotics that are not diabetes related	
Temporomandibular joint disorders (TMJ)	No dollar maximum	
Home health agency services	130 visits PCY	
Hospice care	Outpatient: No visit limits (within 6-month lifetime maximum) Respite: 240 hours (within 6-month lifetime maximum) Inpatient options: 10 days, 30 days, or No day limit (within 6-month lifetime maximum)	In-network coinsurance or deductible, then 0%
Transplants (Organ and bone marrow)	No dollar maximums, except $7,500, $10,000, or No limit for travel and lodging per transplant	In-network coinsurance
Certain generic preventive drugs (retail and mail order)	90-day supply, except Specialty Rx: 30-day supply	Covered in full[2]
Retail pharmacy (Subject to medical deductible)		In-network coinsurance, or Deductible then $10 / $35 / $70, or Deductible then $10 / $35 / $70 / 30%
Mail-order pharmacy (Subject to medical deductible)		In-network coinsurance, or Deductible then $25 / $87 / $175, or Deductible then $25 / $87 / $70 / 30%

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
[1] A list of preventive benefits is available to members when they sign in to their secure member account on **premera.com**.
[2] Not subject to copay, deductible, or coinsurance.
This is only a brief summary of the major benefits provided by our plans. This is not a contract.
For information and details regarding general exclusions and limitations, please contact your Premera representative.

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.

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
Individual deductible PCY	$8,550
Family deductible PCY	2x Individual
Coinsurance	0%
Individual out-of-pocket maximum PCY (Includes deductible, coinsurance, and copay)	$8,550
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
Inpatient cost share	In-network deductible and coinsurance
Annual Plan Maximum	None

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
In-network and out-of-pocket maximum must not exceed the federally mandated maximum of $9,100 for an individual or $18,200 for a family.
*Except for emergencies or as required by law.

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
Preventive care and counseling visit	Subject to federal and state guidelines[1]	Covered in full[2]
Preventive screenings		
Vaccinations (Including seasonal vaccinations received at a pharmacy or other mass vaccination location paid as in network)		
Professional office visit (Including urgent care)	No visit limits	In-network coinsurance
Virtual care (General medicine)		Covered in full[2]
Other outpatient professional services **Inpatient professional services**		
Manipulations (Spinal and other)	12 visits PCY	In-network coinsurance
Acupuncture		
Naturopathic services	No visit limits	
Mammography (Non-preventive)	No visit limits	
Outpatient diagnostic imaging and laboratory services		
Emergency room care (Copay waived if directly admitted to inpatient facility)	No maximum	
Ambulance transportation (Air and ground)	No trip or dollar maximum	
Inpatient hospital care	No limit on number of days or visits	
Outpatient facility care		
Skilled nursing facility	60 days PCY	
Maternity care (Prenatal, delivery, and postnatal care)	No visit or day maximum; covered for: subscriber, spouse/domestic partner, and dependents	
Mental health and chemical dependency treatment	No limit on number of days or visits	
Rehabilitation (Including physical, occupational, speech, and massage therapy)	45 visits / 30 days PCY	
(Including cardiac/pulmonary rehab and chronic pain)	No visit limits	
Supplies, equipment, prosthetics, and orthotics	No maximum, except $300 max PCY for foot orthotics that are not diabetes related	
Temporomandibular joint disorders (TMJ)	No dollar maximum	
Home health agency services	130 visits PCY	
Hospice care	Outpatient: No visit limits (within 6-month lifetime maximum) Respite: 240 hours (within 6-month lifetime maximum) Inpatient options: 10 days (within 6-month lifetime maximum)	
Transplants (Organ and bone marrow)	No dollar maximums, except for $7,500 for travel and lodging per transplant	
Retail pharmacy	Up to 30-day supply per Rx	
Mail-order pharmacy	Up to 90-day supply per Rx (except Specialty Rx)	
Drug list	Essentials	

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
[1]A list of preventive benefits is available to members when they sign in to their secure member account on **premera.com**.
[2] Not subject to copay, deductible, or coinsurance.
This is only a brief summary of the major benefits provided by our plans. This is not a contract.
For information and details regarding general exclusions and limitations, please contact your Premera representative.

Pharmacy plans

Premera uses cost-saving incentives to encourage our customers to use generic or preferred brand-name drugs. They will enjoy even greater savings if they use the mail-order service.

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

The options listed on this page are available for all plans except health savings account (HSA) plans:

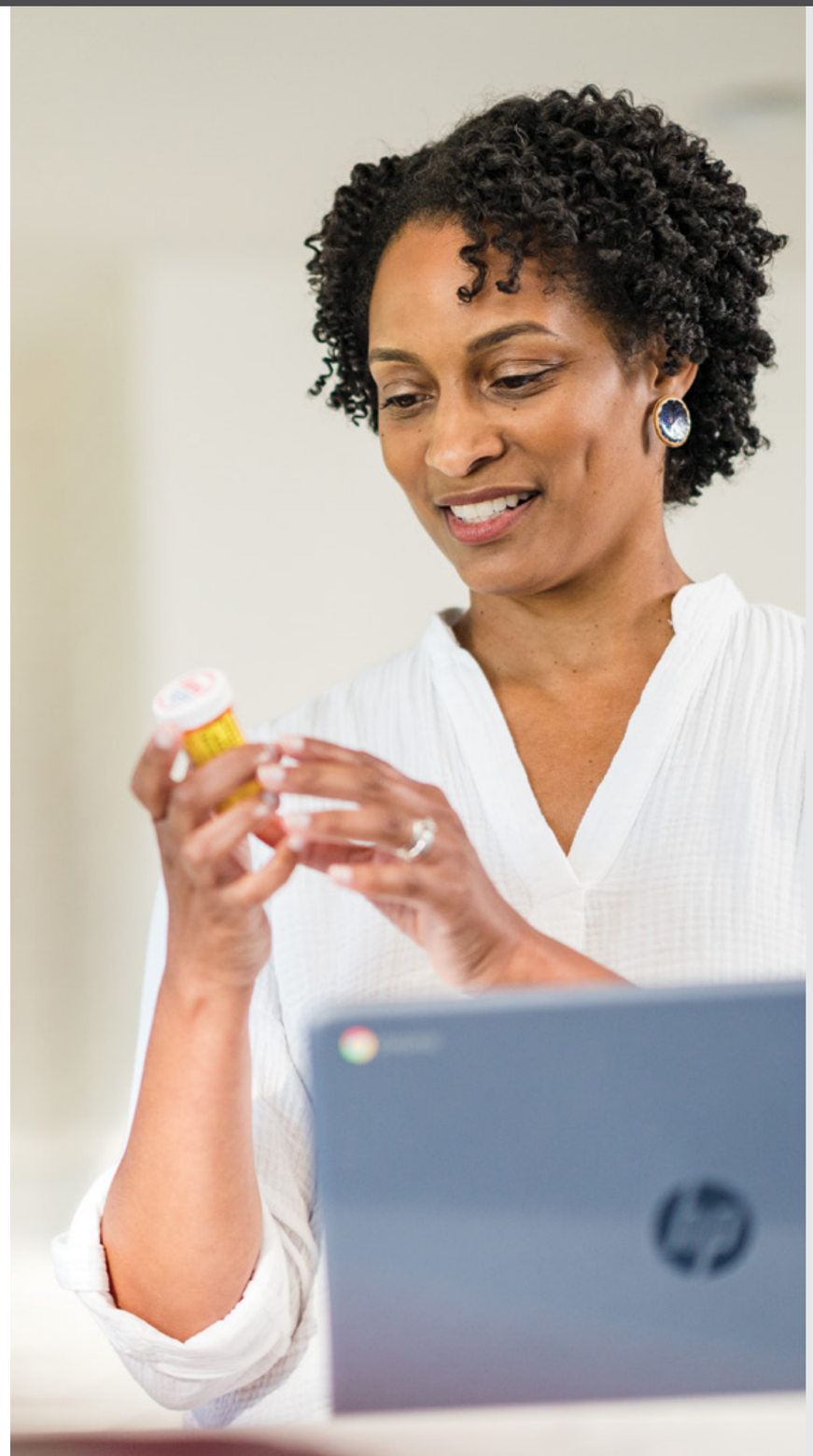
HSA plans include prescription drug coverage as well as a zero cost share for certain generic cardiovascular and oral diabetic medications on the preventive drug list. Please see the HSA plan summary pages on premera.com for more details.

Choose from options for your pharmacy plan:

Essentials is a restricted list of prescription drugs that meets basic pharmacy needs 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 a comprehensive drug list and provides access to a full spectrum of brand-name medications.

* Projected savings based on actuary data of Premera groups with Essentials from 2018 through 2020. Approximated savings for fully insured groups was 5% on prescription premiums. Approximated savings for self-funded groups was up to 5% on prescription claims.



SAVE UP TO

5%*

Fully insured and self-funded group with Essentials

Contact your producer or Premera account manager to see what the savings and drug discounts can look like for your business with Essentials.

See how the pharmacy options compare

ESSENTIALS

PLANS WITH 4 TIERS	
FIRST TIER	Preferred generic drugs
SECOND TIER	Preferred brand-name drugs
THIRD TIER	Preferred specialty[1] drugs
FOURTH TIER	Non-preferred drugs (generic, brand, specialty)

PREFERRED

PLANS WITH 4 TIERS	
FIRST TIER	Generic drugs
SECOND TIER	Preferred brand-name drugs
THIRD TIER	Non-preferred brand-name drugs
FOURTH TIER	Specialty drugs[1]
PLANS WITH 3 TIERS	
FIRST TIER	Generic drugs
SECOND TIER	Preferred brand-name drugs
THIRD TIER	Non-preferred brand-name drugs
PLANS WITH 2 TIERS	
FIRST TIER	Generic drugs
SECOND TIER	Brand-name drugs

[1] Specialty Pharmacy program: Both Essentials and Preferred pharmacy options include benefits for specialty drugs. Specialty drugs are used for treating complex or rare conditions and require special handling, storage, administration, or patient monitoring. Coverage requires these prescriptions be filled through our Specialty Pharmacy program, which uses pharmacies dedicated to supporting specialty drugs and those who need them. Employers can choose between our specialty pharmacy providers.

Benefits for Essentials and Preferred pharmacy plans

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

	4-TIER ESSENTIALS					
Retail pharmacy Up to 30-day supply per Rx	$10 / $25 / $45 / 30%	$10 / $30 / $30 / 30%	$10 / $30 / $50 / 30%	$15 / $30 / $50 / 30%	$15 / $60 / $100 / 50%	$20 / $50 / 30% / 50%
Mail order Up to 90-day supply per Rx	$25 / $62.50 / $45[1] / 30%	$25 / $75 / $30[1] / 30%	$25 / $75 / $50[1] / 30%	$37.50 / $75 / $50[1] / 30%	$37.50 / $150 / $100[1] / 50%	$50 / $125 / 30% / 50%
Rx individual deductible[2] PCY (Separate from medical deductible)	None, $150, $300, $500					
Rx family deductible[2] PCY	None, or same as medical[3]					
Individual out-of-pocket maximum PCY	Participating pharmacy cost shares accrue to the in-network medical out-of-pocket maximum.					
Drug list	Essentials E4					
	4-TIER PREFERRED					
Retail pharmacy Up to 30-day supply per Rx	$15 / 35% / 50% / 30%			$20 / $50 / 50% / 30%		
Mail order Up to 90-day supply per Rx	$37.50 / 35% / 50% / 30%			$50 / $125 / 50% / 30%		
Rx individual deductible[2] PCY (Separate from medical deductible)	None, $150, $300, $500					
Rx family deductible[2] PCY	None, or same as medical[3]					
Individual out-of-pocket maximum PCY	Participating pharmacy cost shares accrue to the out-of-pocket maximum for in-network medical.					
Drug list	Preferred B4					
	3-TIER PREFERRED					
	Standard Copay Plans		**Configurable Copay Plans**			
Retail pharmacy Up to 30-day supply per Rx	$10 / $25 / $45[1]	$10 / $30 / $50[1]	$10 / $20 / $40[1]	$15 / $25 / $40[4]	$15 / $30 / $50[4]	
Mail order[4] Up to 90-day supply per Rx	$25 / $62 / $112[1]	$25 / $75 / $125[1]	$20 / $40 / $80 $25 / $50 / $100[1]	$30 / $50 / $80 $37 / $62 / $100[1]	$30 / $60 / $100 $37 / $75 / $125[1]	
Rx individual deductible[2] PCY (Separate from medical plan deductible)	None, $150, $300, $500					
Rx family deductible[2] PCY	None	None, same as medical[3]	None, or same as medical[3]			
Individual out-of-pocket maximum PCY	Participating pharmacy cost shares accrue to the out-of-pocket maximum for in-network medical.					
Drug list	Preferred B3					
	2-TIER PREFERRED					
	Standard Coinsurance Plan		**Configurable Copay Plans**			
Retail pharmacy Up to 30-day supply per Rx	$10 / 50%		$10 / $30	$15 / $35		
Mail order Up to 90-day supply per Rx	$25 / 45%		$20 / $60 or $25 / $75	$30 / $70 or $37 / $87		
Rx individual deductible[2] PCY (Separate from medical plan deductible)	None / $150 / $300 / $500					
Rx family deductible[2] PCY	None, or same as medical[3]					
Individual out-of-pocket maximum PCY	Participating pharmacy cost shares accrue to the out-of-pocket maximum for in-network medical.					
Drug list	Preferred A2					

[1] Up to 30-day supply for specialty drugs only from a Premera specialty pharmacy provider.
[2] Deductible waived for generics and preferred generics on Essentials.
[3] Family deductible is separate from medical deductible; value uses same multiplier as medical deductible.
[4] Buy-up options are available to extend certain generic preventive drugs to be covered in full. Ask your sales representative for more details.
This is only a brief summary of the major benefits provided by our plans. This is not a contract.
For information and details regarding general exclusions and limitations, please contact your Premera representative.

Dental plans

Good oral health is important to your employee's 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**

9.5% **overall rate cap**

Better health outcomes

Medical and dental integration can lead to early detection of dental conditions that can increase risk of certain diseases. It also provides better care management and lower healthcare costs[2].

90% **of diseases first show symptoms in the mouth[3]**

Broad network access

Your employees gain access to more than 273,000 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.

75K **dentists nationwide**

273K **locations nationwide**

Easy experience

Simplify your work by dealing with 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.
[2]Ries, Julia. "How Regular Dental Visits Can Help Reduce Health Care Costs for People with Diabetes and Heart Disease." Health, Health, 21 June 2022, https://www.health.com/news/dental-visits-reduce-healthcare-costs-diabetes-heart-disease#:~:text=The%20study%20found%20that%20people,a%20dentist%20saved%20about%20%24866.
[3]Academy of General Dentistry: Know Your Teeth.
January 2012. "Warning Signs in the Mouth Can Save Lives." http://www.knowyourteeth.com/infobites/abc/article/?iid=320&aid=1291&chapt=1

Choose from five dental plan options

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

- Access to any in-network dentist or any out-of-network[1] dentist 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 or chronic conditions

Plan highlights	DENTAL OPTIMA	DENTAL OPTIMA FLEX	DENTAL OPTIMA VOLUNTARY	ESSENTIALS DENTAL
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	●	●		
Employee-funded plan option[3]			●	

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

Want to offer your employees even more choice?

Consider offering your employees a Premera dental plan or one of our Willamette dental plan options. Let them choose which plan best suits their needs! Ask your producer about the benefits of **Willamette Dental presented by Premera**.

Dental Optima

With Dental Optima™, you can choose from several cost share options—giving your employees and their covered dependents choice and control over their spending. 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 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 customers' cost share.
PCY = per calendar year
CY = calendar year(s)

		OPTIMA	OPTIMA Shared Family Maximum Plan
		COST SHARES	
Annual deductible PCY	**INDIVIDUAL**	$0 / $25 / $50	$50
	FAMILY	$0 / $75 / $150	$150
Maximum allowance per person, PCY		$1,000 $1,500 $1,750 $2,000 $2500	$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 limited to 2 PCY		0%, 10%, 20%	0%
Emergency exams unlimited			
Routine x-rays bitewing x-rays unlimited; complete series or panoramic x-ray limited to once per 36 consecutive months			
Cleanings limited to 2 PCY			
Fluoride treatments limited to 2 applications PCY for customers under the age of 19			
Sealants replacements limited to once every 24 consecutive months for customers under age 19; limited to permanent molars only			
Space maintainers for customers under age 19			
BASIC			
Fillings limited to once per tooth surface every 24 consecutive months		10%, 20%	20%
Repair and recementing of crowns, inlays, bridgework, and dentures when performed 6 or more months after placement			
Endodontic (root canal) treatment limited to once per tooth every 24 consecutive months			
Periodontal maintenance limited to 4 visits PCY			
Periodontal scaling limited to once per quadrant every 24 consecutive months			
Periodontal surgery limited to once per quadrant every 36 consecutive months			
Oral surgery including simple and surgical extractions			
General anesthesia limited to covered dental procedures at a dental-care provider's office when dentally necessary			
MAJOR			
Inlays, onlays, and crowns replacements limited to once per tooth every 5 CY		40%, 50%	50%
Implants replacements limited to once every 5 CY			
Dentures, partials, and fixed bridges replacements limited to once every 5 CY			

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
[1] Annual deductible waived for diagnostic and preventive services.

Dental Optima Flex

Dental Optima Flex, allows you to choose from different in and out-of-network cost-share options. Your employees and their covered dependents can save money by using an in-network provider. Non-network providers are still covered, but you may have more 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.

Preventive services such as routine oral exams and cleanings are covered and there's no waiting period for major services such as crowns, implants, and dentures. 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 customers' cost share.
PCY = per calendar year
CY = calendar year(s)

		OPTIMA FLEX		OPTIMA FLEX Shared Family Maximum Plan	
		COST SHARES			
Annual deductible PCY	**INDIVIDUAL**	$0 / $25 / $50		$50	
	FAMILY	$0 / $75 / $150		$150	
Maximum allowance per person, PCY		$1,000 $1,500 $1,750 $2,000 $2,500		$1,500 $2,000 Shared family maximum - up to 3x Individual	
		IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
DIAGNOSTIC AND PREVENTIVE[1]					
Routine oral exams limited to 2 PCY		0%, 10%, 20%	0%, 10%, 20%	0%	10%
Emergency exams unlimited					
Routine x-rays bitewing x-rays unlimited; complete series					
Cleanings limited to 2 PCY					
Fluoride treatments limited to 2 applications PCY for customers under the age of 19					
Sealants limited to once every 24 consecutive months for customers under age 19; limited to permanent molars only					
Space maintainers for customers under age 19					
BASIC					
Fillings limited to once per tooth surface every 24 consecutive months		10%, 20%	20%, 30%	20%	30%
Repair and recementing of crowns, inlays, bridgework, and dentures when performed 6 or more months after placement					
Endodontic (root canal) treatment limited to once per tooth every 24 consecutive months					
Periodontal maintenance limited to 4 visits PCY					
Periodontal scaling limited to once per quadrant every 24 consecutive months					
Periodontal surgery limited to once per quadrant once every 36 consecutive months					
Oral surgery including simple and surgical extractions					
General anesthesia limited to covered dental procedures at a dental-care provider's office when dentally necessary					
MAJOR					
Inlays, onlays, and crowns replacements limited to once per tooth every 5 CY		40%, 50%	50%, 60%	50%	60%
Implants replacements limited to once every 5 CY					
Dentures, partials, and fixed bridges replacements limited to once every 5 CY					

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
[1] Annual deductible waived for diagnostic and preventive services.

Dental Optima Voluntary

Premera Optima Voluntary™ dental plans require no employer contribution, and employee contributions can be made on a pre-tax basis. Employees also appreciate being able to use any licensed dentist, although they many elect to access in-network dentists to maximize the purchasing power of their benefits dollar. Plus, additional periodontal maintenance procedures can help at-risk members receive the extra care they need to stay healthy.

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 = calendar year(s)

		COST SHARES
Annual deductible PCY	**INDIVIDUAL**	$50
	FAMILY	$150
Maximum allowance per person, PCY		$1,000 / $1,500
		IN AND OUT OF NETWORK
DIAGNOSTIC AND PREVENTIVE[1]		0%
Routine oral exams limited to 2 PCY		
Emergency exams unlimited		
Routine x-rays bitewing x-rays unlimited; complete series or panoramic x-ray limited to once per 36 consecutive months		
Cleanings limited to 2 PCY		
Fluoride treatments limited to 2 applications PCY for customers under the age of 19		
Sealants replacements limited to once every 24 consecutive months for customers under age 19; limited to permanent molars only		
Space maintainers for customers under age 19		
BASIC		20%
Fillings limited to once per tooth surface every 24 consecutive months		
Repair and recementing of crowns, inlays, bridgework, and dentures when performed 6 or more months after placement		
Periodontal maintenance limited to 4 visits PCY		
Periodontal scaling limited to once per quadrant every 24 consecutive months		
Oral surgery including simple and surgical extractions		
General anesthesia limited to covered dental procedures at a dental-care provider's office when dentally necessary		
MAJOR[2]		50%
Endodontic (root canal) treatment limited to once per tooth every 24 consecutive months		
Periodontal surgery limited to once per quadrant every 36 consecutive months		
Inlays, onlays, and crowns replacements limited to once per tooth every 5 CY		
Dentures, partials, and fixed bridges replacements limited to once every 5 CY		

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

Essentials Dental

With Essentials Dental, businesses with hard decisions to make, can choose from the Essentials Dental plan that offers savings on premiums. This plan will also help you maintain your Premera benefits and minimize disruption for your employees with a new, low-cost dental plan option that includes coverage for most preventive dental services and many other common dental services such as fillings, root canals, non-surgical periodontal care, and crowns.

Covered services

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

		COST SHARES			
Annual deductible PCY	**INDIVIDUAL**	$50[1]		$50	
	FAMILY	$150[1]		$150	
Maximum allowance per person, PCY		$1,000		$1,000	
		IN NETWORK	**OUT OF NETWORK**	**IN NETWORK**	**OUT OF NETWORK**
DIAGNOSTIC AND PREVENTIVE		0%	10%	20%	30%
Routine oral exams limited to 2 PCY					
Routine x-rays bitewing x-rays 1 PCY; complete series once per 60 consecutive months					
Cleanings limited to 2 PCY					
Fluoride treatments limited to 1 application PCY for customers under the age of 19; limited to permanent molars only					
Sealants replacements limited to once every 24 consecutive months for customers under age 19					
Space maintainers for customers under age 19					
BASIC		30%	50%	40%	50%
Emergency exams unlimited					
Panoramic x-ray once per 60 consecutive months					
Fillings limited to once per tooth surface every 24 consecutive months					
Recementing of crowns, inlays, bridgework, and dentures limited to once per tooth every 24 consecutive months, 6 or more months after initial placement					
Endodontic (root canal) treatment limited to per lifetime					
Periodontal maintenance limited to 4 visits PCY					
Periodontal scaling limited to once per quadrant every 24 consecutive months					
Simple and surgical extractions					
MAJOR		50%			
Crowns replacements limited to once per tooth every 5 CY					

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
[1] Annual deductible waived for diagnostic and preventive services.

Willamette Dental presented by Premera

Willamette Dental Group is the Northwest's largest multi-specialty group dental practice. With about 50 locations throughout the Pacific Northwest, your employees will most likely find a Willamette Dental Group office in their area.

The dentists at Willamette Dental Group practice proactive dental care. Proactive dental care at Willamette Dental Group builds on two fundamental beliefs: healthy teeth should last a lifetime and proper care doesn't always mean invasive treatment. It's about practicing dentistry responsibly—with honesty, integrity, and a dentist-patient partnership focused on promoting long-term health.

That's what sets Willamette Dental Group apart. The participating providers use the latest scientific evidence, combined with their own clinical experience, to develop an individualized, evidence-based treatment plan. By providing treatment that directly promotes long-term health, participating providers will help your employees maintain or regain a healthy mouth for a lifetime of smiles.

Predictable out-of-pocket costs

Our Willamette Dental plans offer your employees a predictable schedule of covered dental services and copayments including orthodontic care.* Your employees and their families will never be surprised by unknown costs.

	GROUPS 51+			
	Plan 1	Plan 2	Plan 3	Out of network
	In network			
Annual maximum	No annual maximum			N/A
Deductible	No deductible			N/A
Waiting periods	No waiting periods			N/A

Dental coverage when needed, as often as needed

Your employees will never exhaust their dental coverage and will never need to satisfy a deductible before they can receive benefits. Each of our Willamette Dental plans feature:

- No deductible
- No annual maximum
- No waiting periods

More dental options

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.

Covered services

	DENTAL OPTIMA	DENTAL OPTIMA FLEX	DENTAL OPTIMA VOLUNTARY	ESSENTIALS DENTAL
BENEFIT ENHANCEMENT OPTIONS	Optional		Optional	N/A
Preventive services do not count toward maximum allowance				
ORTHODONTIA[1]	0%[2] 50% (up to lifetime maximum)		N/A	
Diagnostic services and active/retention treatment Including appliances				
Monthly orthodontic adjustments Including retention treatment				
Lifetime maximum Per person	$1,000, $1,500, or $2,000			
Age limit	None Under the age of 19			

[1]Not available for a voluntary plan.
[2]Benefits not subject to deductible or coinsurance.

* This option is limited to certain plan types and coinsurance options.

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

		BENEFIT LIMITS	COVERAGE PLANS		
			Your Choice	Your Future/PeakCare HSA	Peak Care
Vision Adult	**Exam only**	1 Routine exam, PCY	Covered in full or deductible / coinsurance or copay only	Covered in full or deductible / coinsurance or $25 copay or $10 copay	*Covered in full, or copay only
	Exam and eyewear	1 Routine exam PCY; Hardware: $150 PCY; $150 every 2 consecutive CY; $200 every 2 consecutive CY; $300 PCY; $300 every 2 consecutive CY	Exam: covered in full or deductible / coinsurance or copay only Hardware: Covered in full	Exam: covered in full or deductible / coinsurance or $25 copay or $10 copay Hardware: Covered in full	Exam: Covered in full, or copay only Hardware: Covered in full
Vision Pediatric (Pediatric exam and cost shares count toward the out-of-pocket maximum)	**Exam only**	1 Routine exam, PCY	Office visit cost share, or covered in full	Office visit cost share, $25 copay, or covered in full	*Office visit Cost share or waive deductible, then coinsurance, or covered in full
	Exam and eyewear	1 Routine exam PCY; Hardware: 1 pair of glasses PCY (frames and lenses); 12-month supply of contacts PCY, in lieu of glasses (frames and lenses)	Exam: Office visit cost share or waive deductible, then coinsurance, or covered in full Eyeware: Covered in full	Exam: Office visit cost share, $25 copay, or covered in full Eyeware: Covered in full	Exam: Office visit cost share or waive deductible, then coinsurance, or covered in full Eyeware: Covered in full
Hearing	**Exam only**	1 Exam PCY or 1 exam every 2 CY	Covered in full or deductible / coinsurance or copay only	N/A	*Covered in full, or copay only
	Exam and hardware	1 Exam PCY or 1 exam every 2 CY; Hardware: $1,000 every 3 CY, $3,000 every 3 CY, $5,000 every 3 CY, or $5,000 PCY	Exam: covered in full or deductible / coinsurance or copay only Hardware: Covered in full	Deductible / coinsurance	Exam: Covered in full, or copay only Hardware: Covered in full

*Select covered services for EPO plans are in-network only.
This is only a brief summary of the major benefits provided by our plans.
This is not a contract. For information and details regarding general exclusions and limitations, please contact your Premera representative.

More optional benefits

Stop-loss coverage

LifeWise Assurance Company[1] assists groups with creating the right medical stop loss for their needs. If you elect to self fund your medical plan, this product provides a reinsurance contract to protect your group from catastrophic losses.

HSA, FSA, HRA options

Employers can take advantage of an integrated system for implementing and administering a health savings account (HSA), flexible spending account (FSA), and health reimbursement arrangement (HRA). These products can help manage healthcare costs by putting healthcare spending in the hands of employees. By spending their own money, employees pay more attention to their health and healthcare.

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

Adding benefits from Premera beyond medical and dental coverage can help give your business a competitive advantage. Consider how you benefit from adding:

Stop-loss
Life and Disability coverage

Personal funding accounts

Find out more

Visit **premera.com/wa/employer**

Talk with your producer or general agency partner.

PREMERA BLUE CROSS

An Independent Licensee of the Blue Cross Blue Shield Association

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