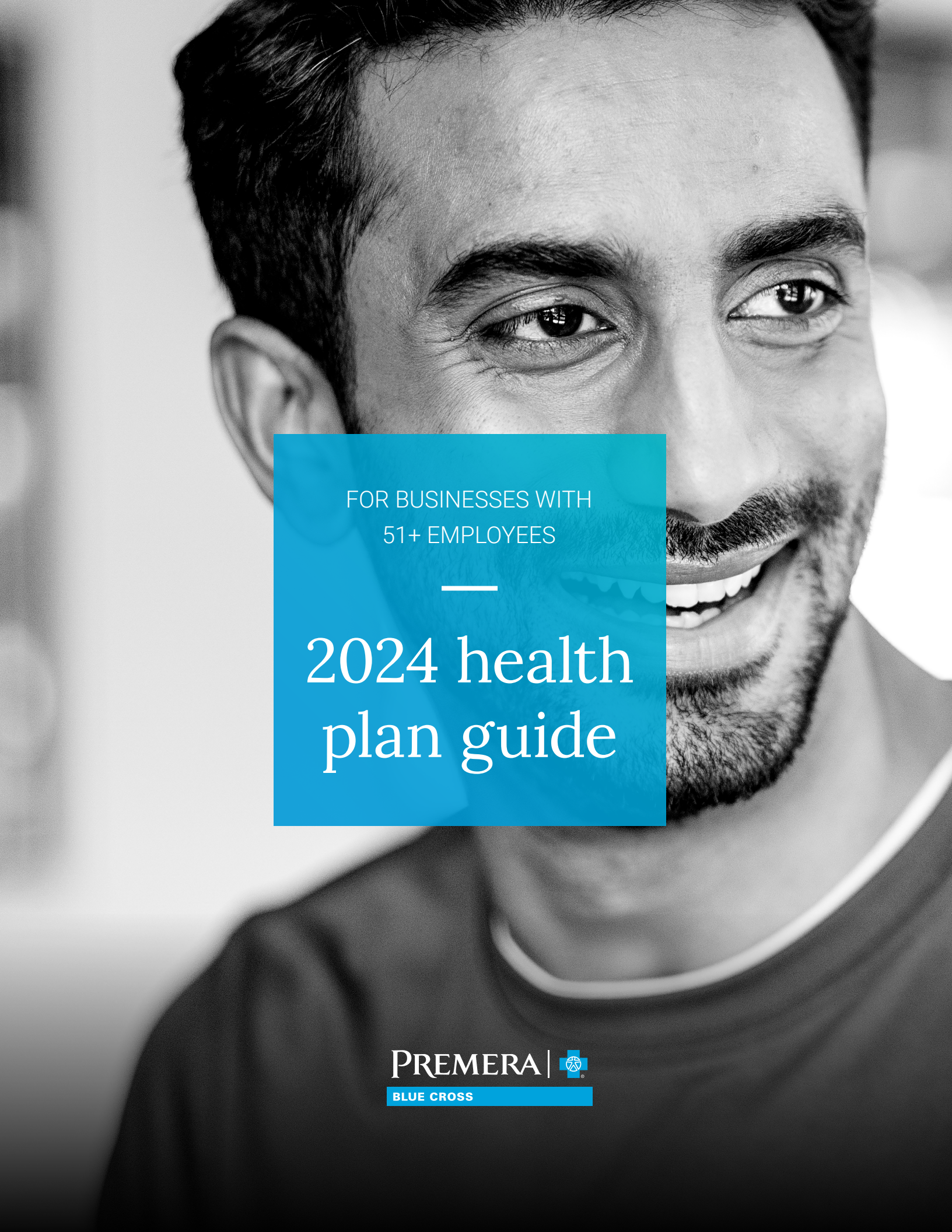


FOR BUSINESSES WITH
51+ EMPLOYEES

2024 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 affordable, quality care.

Table of contents

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.

Well-rounded benefits package

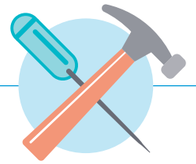
Choose from a range of plans to find the right balance that best fits the needs and budget for your business and your employees.

Programs for employees

Our built-in support programs encourage your employees to engage in their healthcare.

Digital tools

Our secure member portal and mobile apps help your employees find providers; view suggested preventive care; compare costs of services and medications; access pharmacy information; and review claims.

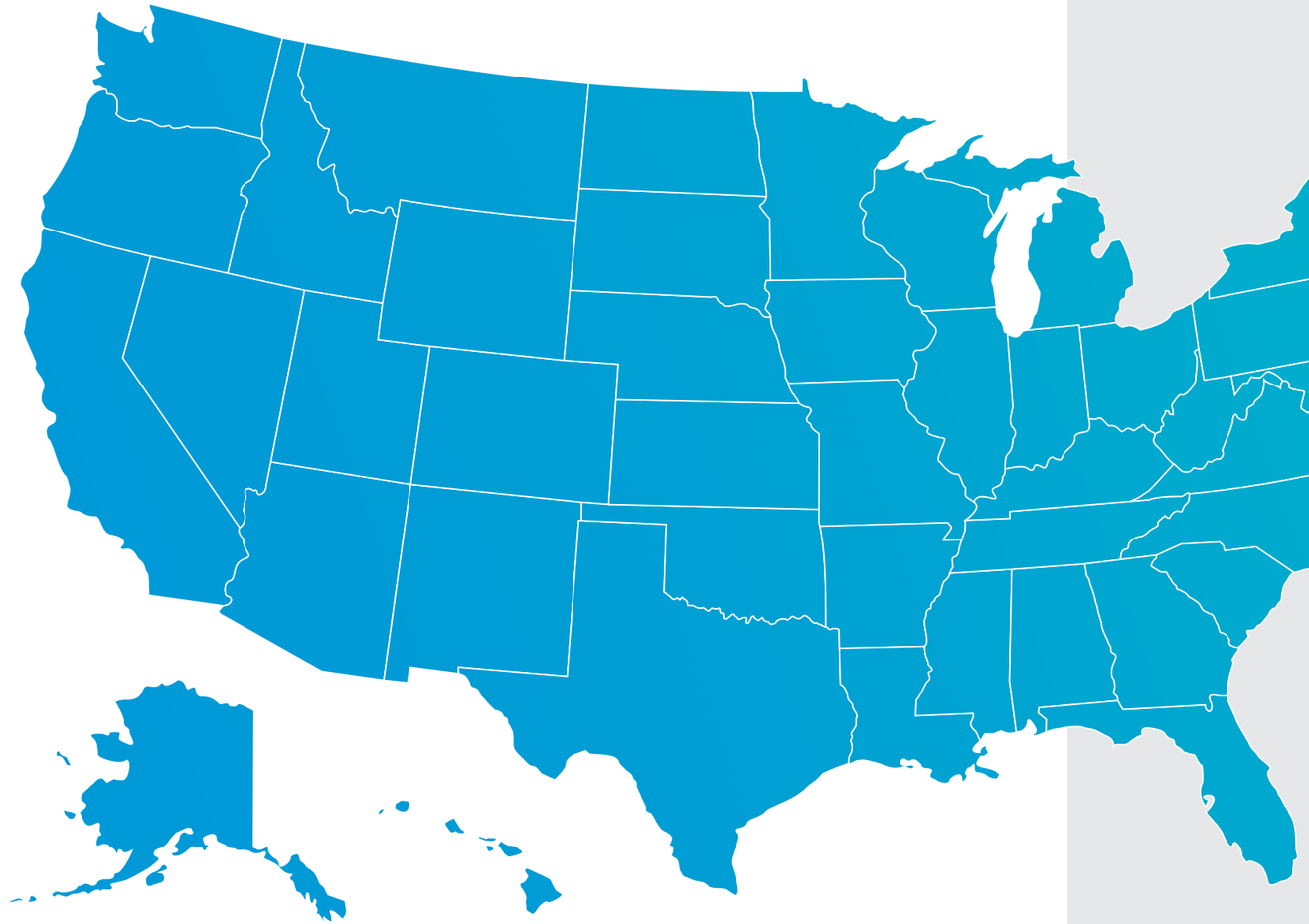


Administrative ease and support

Integrated benefits with Premera make for a streamlined experience for your employees when promoting components of your healthcare benefits or explaining plan utilization.

Meeting members where they are

With the broadest provider network in the state, Premera supports every member no matter where they are on their healthcare journey. From physical wellbeing to behavioral health and virtual care, we provide the support you need.



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.

Integrated benefits make healthcare work better

An integrated approach to medical and pharmacy benefits simplifies administration; improves health and member experience; and manages total cost of care.

A single source to drive for operational success.

A coordinated approach to medical and pharmacy alleviates unnecessary barriers to care.

Care management teams (MD, RN, PharmD, and BH clinicians) work on behalf of our members.

Studies show significant savings per member per year (PMPY) with integrated benefits ($144–$228).*

Premera formulary design goes beyond cost

Our formularies are multi-faceted and take into account clinical efficacy, patient outcomes, and cost-effectiveness. We consult with our Pharmacy and Therapeutics Committee regularly to ensure we're providing the best possible formulary for our members while maintaining affordability. Our list of preferred or recommended drugs offers value and support to our members and their journey to better health.

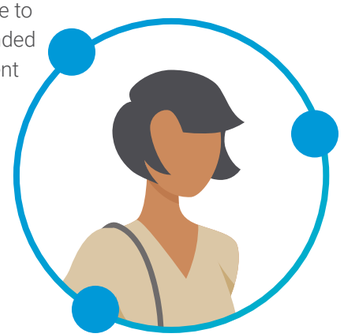
*HealthScape Advisors Integrated Pharmacy Value Analysis Technical Memo, Highmark Health, Feb 2021

Premera as a partner in integrated benefits

- Dedicated account team
- Comprehensive utilization reviews
- Knowledge-based population health changes

Putting the member at the center of integrated benefits

Improved adherence to provider-recommended medication treatment plans



Embedded care management teams work on behalf of our members

Increased use of preventive care services resulting in better management of chronic conditions

Did you know?

The Premera Pharmacy and Therapeutics Committee consists of external physicians, pharmacists, and other professional leaders in our community, many of whom see patients at least part time.

Mind over matter

Two out of three employers rank employee mental health as a top health priority.[1] Premera has made it easier than ever for members to access behavioral health services virtually or in person.

NEW FOR 2024!

Matchmaker™ for Behavioral Health

Matchmaker for Behavioral Health is an expansion of our commitment to improve access and lessen the hurdles members face when seeking behavioral health services. With Matchmaker for Behavioral Health, members receive a highly personalized list of behavioral health providers based on their plan, needs, and preferences.

Member	CSR	Navigator team
Member contacts Premera customer service or care management.	Premera representative completes member intake over the phone.	Matchmaker team curates a list of providers that is delivered to the member in three to four business days.

The Matchmaker for Behavioral Health intake asks members for their information and their appointment preferences:

- In-person or virtual attendance
- Language
- Gender, race, and ethnicity
- Religious affiliation
- And more

Every Matchmaker for Behavioral Health list includes a minimum of two in-network clinicians.

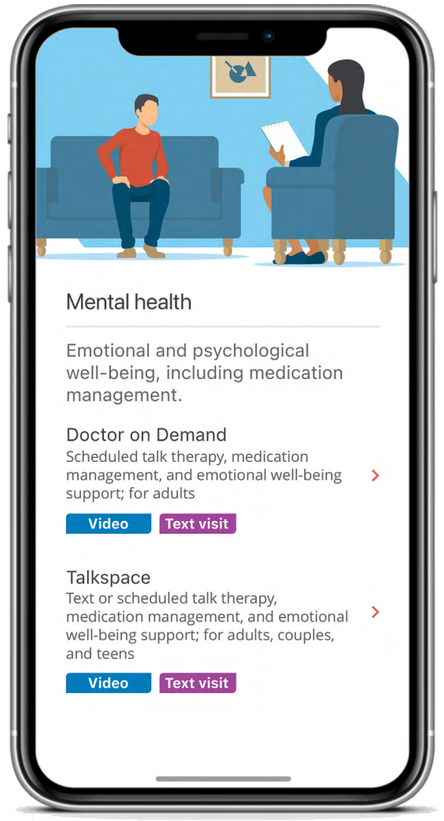
Matchmaker for Behavioral Health access

Fully insured:	included as part of your plan
OptiFlex:	included as part of your plan
Self-funded:	opt in, per list pricing

[1]2022 Best Practices in Healthcare Employer Survey, 2022 Global Benefit Attitudes Survey

Behavioral health in the palm of your hand

Premera has partnered with industry-leading behavioral health virtual care vendors to ensure our members get the care they need, when they need it, and in a way that works for them.



83%

of employers offer behavioral health services through virtual care.[1]

Virtual behavioral health care can support members with the following:

- Generalized anxiety
- Depression
- Adjustment disorders
- And more

Members struggling with substance use disorder (SUD) have access to confidential and high-quality virtual care including medically assisted treatment (MAT) depending on their location. **Contact your Premera account representative for more information.**

Advanced primary care starts here

Access to high-quality primary care and improved health outcomes go hand in hand. With a Premera health plan, you can be sure your employees have access to primary care with the broadest provider network in the state and access to primary care clinics designed just for Premera members.

Creating access

In 2022, Premera invested in the Kinwell Medical Group to aid the expansion and access to high-quality primary care across Washington. Kinwell now has 16 clinics located across the state with more than 300,000 members located within five miles of their local Kinwell.

Providing an integrated care model

Kinwell cares for patients from head to toe. The integrated care model makes it possible for primary care providers (PCP) and behavioral health providers to connect quickly and easily when a patient presents with physical symptoms that may be a manifestation of mental illness.

Kinwell

Curious about Kinwell?

Scan the QR code to find out more.

1 Bellingham
2 Federal Way
3 Lynnwood
4 Mill Creek
5 Olympia
6 Pasco
7 Poulsbo
8 Redmond
9 Renton
10 Seattle—Ballard
11 Seattle—Denny Way
12 Seattle—Westlake
13 Spokane—West 6th
14 Spokane—North Country Homes
15 Spokane Valley
16 Wenatchee

Care when you need it

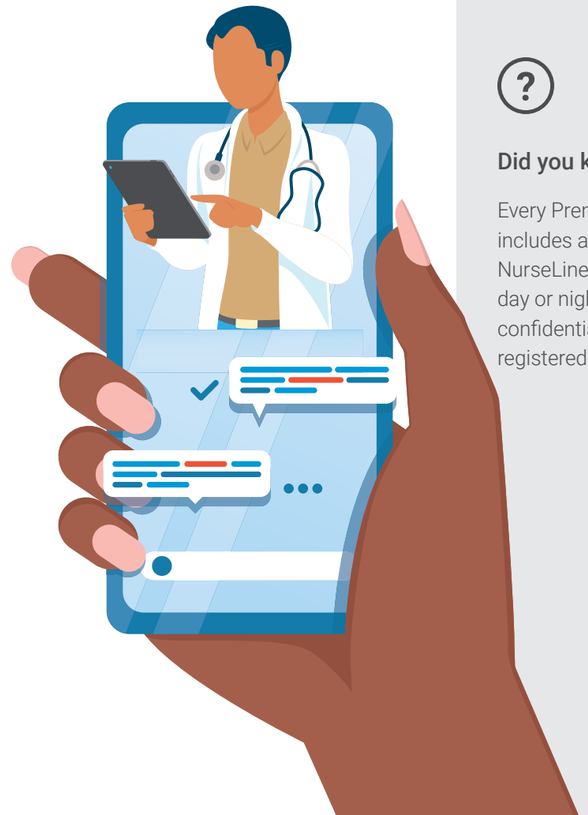
For the times when you can't wait for an in-person visit, virtual care is there. Premera virtual care providers offer secure text or video visits to treat a variety of primary care needs.

Virtual care can help with the following:

- Common cold symptoms
- COVID-19 treatments
- Follow-up visits with a physician
- Sinus infections
- Urinary tract infections (UTIs)

Urgent care to your doorstep

DispatchHealth is an expansion of our provider network and a unique medical service that brings care to our members' front doors. Head, shoulders, knees, toes, and nearly everything in between can be treated at home with the DispatchHealth care team that includes a physician assistant or nurse practitioner and a medical technician. Keep your members healthy and out of the emergency room with DispatchHealth.



Preventive health

Preventive healthcare services are part of every Premera plan. Our secure member website provides suggested preventive routine exams, vaccinations, and screenings.

Did you know?

Every Premera medical plan includes access to our 24-Hour NurseLine. Members can call day or night to receive free and confidential health advice from a registered nurse.

Provider networks

We believe in working closely with providers 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]	47,560	9,381	95
	Available with Your Choice, Your Future, and Your Focus plans.		
Heritage Prime[1]	42,468	7,662	74
	Available with Your Choice, Your Focus, Your Future, Premera Pathfinder, and BlueHPN plans.		
Dental Choice[1]	Washington state	Nationwide practitioners	Nationwide locations
	3,541	74,456	267,089

[1]Network counts as of July 2023.

PROVIDER NETWORK OPTIONS

National, worldwide, and affordable 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 medical plans like a Premera Blue Cross PPO plan and a Premera Blue Cross HMO plan, or select from two dental plans like the Dental Optima or Willamette Dental plan.

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 providers 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 34** to find more information on the difference between aggregate or embedded options.

Premera Pathfinder

Introducing our cost-effective, primary care focused, exclusive provider organization (EPO) plan. Premera Pathfinder is designed to remove financial barriers to care while reinforcing the value of the primary care relationship. With $0 primary care office visit copays, Premera Pathfinder supports primary care usage and overall better physical and financial health for your business and your workforce.

Premera Pathfinder

For fully insured Washington employers

Delivering a balance of savings, access, and flexibility

Introducing our cost-effective, primary care focused, exclusive provider organization (EPO) plan. Premera Pathfinder is designed to remove financial barriers to care while reinforcing the value of the primary care relationship. With $0 primary care office visit copays, Premera Pathfinder supports primary care usage and overall better physical and financial health for your business and your workforce.

Value of a primary care focused plan

- Provide $0 in-person and virtual office visit copays with a designated primary care provider (PCP)
- Promote primary care visits for better long-term health outcomes
- Bring affordable primary care to your workforce without required referrals
- Offer the flexibility of broad, statewide access to care and coverage

Heritage Prime + Kinwell

Premera Pathfinder uses the Heritage Prime network, which offers easy access to care throughout Washington state. It includes access to national BlueCard® providers, and advanced primary care with Kinwell clinics just for Premera members (**see page 10**). At Kinwell, the enhanced patience experience includes great perks for members:

- Timely appointments (many same-day and next-day)
- Longer appointment times (up to 60 minutes)
- Coordinated virtual and in-person care options
- Preventive and behavioral health care that work together

SAVE UP TO

10%

over a traditional Premera PPO plan[1]

$0

in-person and virtual office visit copays with a designated PCP

Nationwide coverage with the BlueCard Program

Care wherever your employees are—work, home, or when traveling

[1] Savings based on Premera underwriting and actuarial calculations, 2023.

NEW FOR 2024!

Premera Pathfinder

Premera Pathfinder is a cost-effective, primary care-focused, exclusive provider organization (EPO) plan. With $0 primary care office visit copays, Premera Pathfinder supports primary care usage and overall better physical and financial health for your business and your workforce.

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	$250 $500 $750 $1,000 $1,500 $2,000 $2,500 $3,000 $3,500 $4,000 $5,000 $6,000 $6,500	Not covered*
Family deductible PCY	2x Individual or 3x Individual	
Coinsurance	10%, 20%, or 30%	
Individual out-of-pocket maximum PCY (includes deductible, coinsurance, and copay)	$4,000 $4,500 $5,000 $5,500 $6,000 $6,500 $7,000 $7,500 $8,000 $8,500 $9,000	
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 (designated PCP/Specialist and non-designated PCP)	$0/$20 $0/$25 $0/$30 $0/$35 $0/$40 $0/$50	
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 $9,450 for an individual or $18,900 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	No visit limits	Office visit cost share	Same as in network
Urgent care		Specialist office visit cost share	
Virtual care (general medicine)		Office visit cost share	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 cost share	
Acupuncture			
Naturopathic services	No visit limits	Office visit cost share	
Mammography (non-preventive)	No visit limits	Covered in full[2]	
Outpatient diagnostic imaging and laboratory services		In-network coinsurance	
Emergency room care (copay waived if directly admitted to inpatient facility)	No maximum	In-network coinsurance **plus** copay of $150	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 treatments	No limit on number of days or visits	Outpatient: Specialist 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 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

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 $9,450	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 $9,450	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** (non-specialist/specialist)	$20 / $30 $20 / $40 $25 / $35 $25 / $40 $25 / $50 $30 / $45 $35 / $45 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	
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 $9,450 for an individual or $18,900 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 **Preventive screenings** **Vaccinations** (including seasonal vaccinations received at a pharmacy or other mass vaccination location paid as in network)	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
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) **Acupuncture**[3]	12 visits PCY, 24 visits PCY, or No visit limits	Office visit cost share[3]	Out-of-network coinsurance
Naturopathic services	No visit limits		
Mammography (non-preventive)	No visit limits	Covered in full[2]	Out-of-network coinsurance
Outpatient diagnostic imaging and laboratory services		In-network coinsurance; In-network coinsurance (deductible waived); Basic imaging and 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 treatments	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

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.
[3] With the split copay option, this benefit is subject to the non-specialist copay.
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 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 providers 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 $9,450	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 $9,450	
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, or $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 $9,450 for an individual or $18,900 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	Covered in full[2]	
Outpatient diagnostic imaging and laboratory services		In-network coinsurance; In-network coinsurance (deductible waived); Basic imaging and 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 treatments	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

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.
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BlueHPN

Blue High Performance Network℠ (BlueHPN) is an exclusive provider organization (EPO) health plan. BlueHPN provides national reach while being grounded in local market expertise. BlueHPN members received in-network only access to high-performing, high-value care using 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 $9,450	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 $9,450	
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, or $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 $9,450 for an individual or $18,900 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	HPN product area: Not covered; Non-HPN product area: Same as in-network cost share
Urgent care		Office visit 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	Covered in full[2]	
Outpatient diagnostic imaging and laboratory services		In-network coinsurance; In-network coinsurance (deductible waived); Basic imaging and 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, 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 treatments	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.
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NEW FOR 2024!

BlueHPN HSA

BlueHPN HSA combines the benefits of a cost-effective EPO health plan with an employee-owned, tax-advantaged health savings account.

You can choose between an aggregate or an 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	$2,000 / $4,000	$1,600 / $3,200	$1,700 / $3,400	$2,500 / $5,000	$3,000 / $6,000	$1,600 / $3,200	$2,500 / $5,000	N/A	N/A	N/A	N/A	N/A	N/A	Not covered
	Embedded	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$3,200 / $6,400	$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.

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	In-network coinsurance	HPN product area: Not covered; Non-HPN product area: Same as in-network cost share
Urgent care			
Virtual care (general medicine)			Not covered
Other outpatient professional services; Inpatient professional services			
Manipulations (spinal and other)	12 or 24 visits PCY No visit limits		
Acupuncture			
Naturopathic services	No visit limits		
Mammography (non-preventive)	No visit limits	IRS minimum deductible, then 0%	
Outpatient diagnostic imaging and laboratory services		In-network coinsurance	
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	Not covered
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 treatments	No limit on number of days or visits		
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		
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; Deductible then $10 / $35 / $70; or Deductible then $10 / $35 / $70 / 30%	
Mail-order pharmacy (subject to medical deductible)		In-network coinsurance; 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.
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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 an 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]	$1,600 / $3,200[2]	$1,700 / $3,400[2]	$2,500 / $5,000[2]	$3,000 / $6,000[2]	$1,600 / $3,200[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	$3,200 / $6,400[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; 40% or 50%; 40% or 50% (deductible waived); 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 (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		
Acupuncture			
Naturopathic services	No visit limits		
Mammography (non-preventive)	No visit limits	IRS minimum deductible, then 0%	
Outpatient diagnostic imaging and laboratory services		In-network coinsurance	
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 treatments	No limit on number of days or visits		
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		
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; Deductible then $10 / $35 / $70; or Deductible then $10 / $35 / $70 / 30%	
Mail-order pharmacy (subject to medical deductible)		In-network coinsurance; 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.
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Please see our Personal Funding Accounts brochure for more details on health savings accounts.

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 $9,450 for an individual or $18,900 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		In-network coinsurance
Manipulations (spinal and other)	12 visits PCY	
Acupuncture		
Naturopathic services	No visit limits	
Mammography (non-preventive)	No visit limits	Covered in full[2]
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 treatments	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	In-network coinsurance
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.
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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.

Fully insured and self-funded groups with Essentials

SAVE UP TO

5%[2]

Solutions to save more on pharmacy

Premera offers a variety of solutions to supplement your pharmacy benefit making it possible for you and your employees to spend less.

SOLUTION	
Rx Savings Solutions	Members receive personalized alerts regarding savings opportunities including generic drugs, combination fills, pharmacy changes, and more. The RxSS concierge team can manage the change on behalf of the member, by request, enabling a seamless transition to the new prescription.
Right Price	Embedded discount program ensures your employees are paying the lowest possible price at the pharmacy counter.
Split Fill	Designed to eliminate waste and improve therapy adherence, the initial prescription is divided into two smaller days supply. If the member has an interaction, for example, the second split fill is not initiated. This results in more savings and less waste.
Exclusion lists	Available to pair with a group's formulary selection,[1] the High-cost Low-value and Legend to OTC exclusion lists can save groups more on their pharmacy benefit.

Ancillary pharmacy products are subject to installation, group size, and funding type. Contact your Premera representative for more information.

1 Metallic and Essentials formularies excluded.
2 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.

Rx Savings Solutions is an independent company that does not provide Blue Cross Blue Shield products or services.

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 FORMULARY

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

PREFERRED FORMULARY

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*
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

*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, or $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, or $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, or $500					
Rx family deductible[2] PCY	None	None or 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, or $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 for 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**

11% **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 267,000 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.

74K **dentists nationwide**

267K **locations nationwide**

[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 will receive the following:

- 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 include 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 options?

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 2 PCY		0%, 10%, 20%	0%
Emergency exams			
Bitewing X-rays			
Complete series or panoramic X-ray once per 36 consecutive months			
Cleanings 2 PCY			
Fluoride treatments 2 applications PCY under the age of 19			
Sealants once every 24 consecutive months under age 19; limited to permanent molars only			
Space maintainers under age 19			
BASIC			
Fillings 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 once per tooth every 24 consecutive months			
Periodontal maintenance 4 visits PCY			
Periodontal scaling and root planning once per quadrant every 24 consecutive months			
Periodontal surgery once per quadrant every 36 consecutive months			
Oral surgery including simple and surgical extractions			
Intravenous or general anesthesia for covered dental procedures at a dental-care provider's office when dentally necessary			
MAJOR			
Inlays, onlays, and crowns once per tooth every 5 CY		40%, 50%	50%
Implants once every 5 CY			
Dentures, partials, and fixed bridges 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 2 PCY		0%, 10%, 20%	0%, 10%, 20%	0%	10%
Emergency exams					
Bitewing X-rays					
Complete series or panoramic X-ray once per 36 consecutive months					
Cleanings 2 PCY					
Fluoride treatments 2 applications PCY under the age of 19					
Sealants once every 24 consecutive months under age 19; limited to permanent molars only					
Space maintainers under age 19					
BASIC					
Fillings 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 once per tooth every 24 consecutive months					
Periodontal maintenance 4 visits PCY					
Periodontal scaling and root planning once per quadrant every 24 consecutive months					
Periodontal surgery once per quadrant once every 36 consecutive months					
Oral surgery including simple and surgical extractions					
Intravenous or general anesthesia for covered dental procedures at a dental-care provider's office when dentally necessary					
MAJOR					
Inlays, onlays, and crowns once per tooth every 5 CY		40%, 50%	50%, 60%	50%	60%
Implants once every 5 CY					
Dentures, partials, and fixed bridges 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]		
Routine oral exams 2 PCY		0%
Emergency exams		
Bitewing X-rays		
Complete series or panoramic X-ray once per 36 consecutive months		
Cleanings limited to 2 PCY		
Fluoride treatments 2 applications PCY under the age of 19		
Sealants once every 24 consecutive months under age 19; limited to permanent molars only		
Space maintainers under age 19		
BASIC		
Fillings once per tooth surface every 24 consecutive months		20%
Repair and recementing of crowns, inlays, bridgework, and dentures when performed 6 or more months after placement		
Periodontal maintenance 4 visits PCY		
Periodontal scaling and root planning once per quadrant every 24 consecutive months		
Oral surgery including simple and surgical extractions		
Intravenous or general anesthesia for covered dental procedures at a dental-care provider's office when dentally necessary		
MAJOR[2]		
Endodontic (root canal) treatment once per tooth every 24 consecutive months		50%
Periodontal surgery once per quadrant every 36 consecutive months		
Inlays, onlays, and crowns once per tooth every 5 CY		
Dentures, partials, and fixed bridges 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**
DIAGNOSTIC AND PREVENTIVE			
Routine oral exams 2 PCY		0%	10%
Bitewing X-rays 1 PCY			
Complete series once per 60 consecutive months			
Cleanings 2 PCY			
Fluoride treatments 1 application PCY under the age of 19; limited to permanent molars only			
Sealants once every 24 consecutive months under age 19			
Space maintainers under age 19			
BASIC			
Emergency exams		30%	50%
Panoramic X-ray once per 60 consecutive months			
Fillings once per tooth surface every 24 consecutive months			
Recementing of crowns, inlays, bridgework, and dentures once per tooth every 24 consecutive months, 6 or more months after initial placement			
Endodontic (root canal) treatment once per lifetime			
Periodontal maintenance 4 visits PCY			
Periodontal scaling and root planning once per quadrant every 24 consecutive months			
Simple and surgical extractions			
MAJOR		50%	
Crowns 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 nearly 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 the following:

- 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.

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 an 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		COVERAGE PLANS	
			Your Choice / Your Focus* / BlueHPN*	Your Future / BlueHPN HSA*	HMO Core Plus / Premera Pathfinder*	Essentials Medical*
Vision Adult	**Exam only**	1 routine exam PCY	Covered in full or deductible / coinsurance or copay only*	Covered in full or deductible / coinsurance, $25 copay, $20 copay, or $10 copay*	$25 copay*	Not covered
	Exam and eyewear	1 routine exam PCY; Hardware: $150 PCY; $150 every 2 consecutive CY; $200 PCY; $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, $25 copay, $20 copay, or $10 copay; Hardware: Covered in full	Exam: $25 copay* 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*	$25 copay*	
	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; Eyewear: Covered in full	Exam: Office visit cost share, $25 copay, or covered in full; Eyewear: Covered in full	Exam: $25 copay* Eyewear: Covered in full	
Hearing	**Exam and hardware**	1 exam PCY; 1 every 36 months[1]; Hardware: $3,000 per ear with hearing loss every 36 months[1]	Exam: Covered in full or deductible / coinsurance or copay only; Hardware: Covered in full	Exam: Deductible/Coinsurance;* Hardware: IRS minimum deductible, then 0%	Exam: $25 copay* Hardware: Covered in full	Exam: Deductible/Coinsurance* Hardware: Covered in full

*Select covered services for Premera Blue Cross EPO or Premera Blue Cross HMO Core Plus 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.

[1] Embedded within the medical plan

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, and 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. With greater visibility of their healthcare costs, employees can delegate their funds with ease.

Be well, work better

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**

Ways to fund your health plan

Fully insured

Group pays a fixed rate for employee health coverage. Premera pays all claims and assumes all risks for the group's health coverage.

OptiFlex

Group pays a fixed rate for employee health coverage, but has more flexibility compared to fully insured funding.

Self-funded

Group assumes all the risk for providing healthcare benefits to its employees. This funding type offers the greatest amount of flexibility and plan customization.

[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 these features:

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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