

Highlights of your Health Care Coverage

Effective Date: 01/01/2023

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.
 Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

MEDICAL PLAN		
CHOICE 750 GOLD + FAMILY DENTAL		
	HERITAGE AND DENTAL CHOICE IN-NETWORK	OUT-OF-NETWORK
Deductible (In-network only - Family embedded deductible 2X Individual)	\$750	\$1,500
Coinsurance	20%	50%
Out of Pocket Maximum (includes deductible, copays, coinsurance and pharmacy) (Family embedded OOP max 2X Individual)	\$7,100	Unlimited
Office Visit Cost Share	\$25 Copay designated PCP, applies to the \$7,100 Out of Pocket Maximum; \$55 Copay Specialist and non designated PCP, applies to the \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Annual Maximum	Unlimited	Unlimited
1 Ambulatory Patient Services		
Professional Office Visit	\$25 Copay designated PCP, applies to the \$7,100 Out of Pocket Maximum; \$55 Copay Specialist and non designated PCP, applies to the \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Telemedicine by Traditional Provider – General Medical	\$25 Copay designated PCP, applies to the \$7,100 Out of Pocket Maximum; \$55 Copay Specialist and non designated PCP, applies to the \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Urgent Care Office Visits	\$55 Copay Specialist and non designated PCP, applies to the \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Professional Services	\$750 Deductible, then 20% Coinsurance, applies to the \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to the Unlimited Out of Pocket Maximum

MEDICAL PLAN		CHOICE 750 GOLD + FAMILY DENTAL	
	HERITAGE AND DENTAL CHOICE IN-NETWORK	OUT-OF-NETWORK	
Contraceptive Management Services (Unlimited)	Covered in Full	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
2 Emergency and Transportation Services			
Emergency Room - facility	\$200 Copay then \$750 Deductible and 20% Coinsurance; all cost shares apply to the \$7,100 Out of Pocket Maximum	\$200 Copay then \$750 Deductible and 20% Coinsurance; all cost shares apply to the \$7,100 Out of Pocket Maximum	
Ambulance Service - ground (Unlimited)	\$750 Deductible, then 20% Coinsurance, applies to \$7,100 Out of Pocket Maximum	\$750 Deductible, then 20% Coinsurance, applies to \$7,100 Out of Pocket Maximum	
Ambulance Service - air (Unlimited)	\$750 Deductible, then 20% Coinsurance, applies to \$7,100 Out of Pocket Maximum	\$750 Deductible, then 20% Coinsurance, applies to \$7,100 Out of Pocket Maximum	
3 Hospitalization			
Inpatient Medical and Surgical Room and Board (Unlimited)	\$750 Deductible, then 20% Coinsurance, applies to \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$750 Deductible, then 20% Coinsurance, applies to \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Hospice Inpatient Facility (Unlimited)	\$750 Deductible, then 20% Coinsurance, applies to \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Inpatient Professional Services	\$750 Deductible, then 20% Coinsurance, applies to the \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to the Unlimited Out of Pocket Maximum	
Organ Transplants (Unlimited)	Covered as any other service	Not Covered	
4 Maternity & Newborn Care			
Prenatal, Delivery, Postnatal (Coverage for subscriber, spouse, dependent)	\$750 Deductible, then 20% Coinsurance, applies to \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
5 Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment			
Chemical Dependency Office Visit (Unlimited)	\$55 Copay Specialist and non designated PCP, applies to the \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Chemical Dependency Outpatient Facility (Unlimited)	\$750 Deductible, then 20% Coinsurance, applies to \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Chemical Dependency Inpatient Facility (Unlimited)	\$750 Deductible, then 20% Coinsurance, applies to \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Mental Health Office Visit (Unlimited)	\$55 Copay Specialist and non designated PCP, applies to the \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Mental Health Outpatient Facility (Unlimited)	\$750 Deductible, then 20% Coinsurance, applies to \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	

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	HERITAGE AND DENTAL CHOICE IN-NETWORK	OUT-OF-NETWORK	
Mental Health Inpatient Facility (Unlimited)	\$750 Deductible, then 20% Coinsurance, applies to \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
6 Prescription Drug			
Drug List	M4 Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = non-preferred generic and brand Tier 4 = specialty	Not Covered	
Prescription Drugs - Retail (Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days)	\$20/\$50/\$80, applies to OOP Max/ Subject to Deductible, then 25%	Not Covered	
Prescription Drugs - Mail (Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days)	\$60/\$150/\$240, applies to OOP Max/Subject to Deductible, then 25%	Not Covered	
7 Rehabilitative & Habilitative Services & Devices			
Inpatient Rehabilitation (30 days PCY combined limit for inpatient services)	\$750 Deductible, then 20% Coinsurance, applies to \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Inpatient Habilitation (30 days PCY combined limit for inpatient services)	\$750 Deductible, then 20% Coinsurance, applies to \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Rehab Outpatient Professional - physical, speech, occupational therapy (25 visits PCY combined limit for outpatient services)	\$55 Copay Specialist and non designated PCP, applies to the \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Habilitation Outpatient Professional - physical, speech, occupational therapy (25 visits PCY combined limit for outpatient services)	\$55 Copay Specialist and non designated PCP, applies to the \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Massage Therapy (Applies to rehab)	\$55 Copay Specialist and non designated PCP, applies to the \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Durable Medical Equipment (Unlimited)	\$750 Deductible, then 20% Coinsurance, applies to \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
8 Laboratory/Imaging Services			
Pathology	\$750 Deductible, then 20% Coinsurance, applies to \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Imaging - basic	\$750 Deductible, then 20% Coinsurance, applies to \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Imaging - major (MRI, CT, PET)	\$750 Deductible, then 20% Coinsurance, applies to \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Diagnostic Mammography	\$750 Deductible, then 20% Coinsurance, applies to \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
9 Preventive/Wellness Services & Chronic Disease Management			
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered	

MEDICAL PLAN		CHOICE 750 GOLD + FAMILY DENTAL	
	HERITAGE AND DENTAL CHOICE IN-NETWORK	OUT-OF-NETWORK	
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered	
Preventive Laboratory Screens	Covered in Full	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Preventive Imaging	Covered in Full	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Preventive Routine Mammography	Covered in Full	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
10 Pediatric Services, including Oral & Vision Care			
Pediatric Vision Exam (1 PCY Under age 19)	\$55 Copay Specialist and non designated PCP, applies to the \$7,100 Out of Pocket Maximum	\$55 Copay Specialist and non designated PCP, applies to the \$7,100 Out of Pocket Maximum	
Pediatric Eyewear (Under age 19: One pair of glasses PCY (frames & lenses). 12 month supply of contacts PCY, in lieu of glasses (frames & lenses).)	Covered in Full	Covered in Full	
Pediatric Dental (preventive)	Covered in Full	Medical \$1,500 Deductible, then 30% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Pediatric Dental (basic)	Waive Medical Deductible, then 20% Coinsurance, applies to \$7,100 Out of Pocket Maximum	Medical \$1,500 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Pediatric Dental (major)	Medical \$750 Deductible, then 50% Coinsurance, applies to \$7,100 Out of Pocket Maximum	Medical \$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Virtual Care Services			
Telemedicine – General Medical (Virtual Care Only)	\$25 Copay designated PCP, applies to the \$7,100 Out of Pocket Maximum; \$55 Copay Specialist and non designated PCP, applies to the \$7,100 Out of Pocket Maximum	Not Covered	
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered	
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	Not Covered	
Routine Hearing			
Routine Hearing Exam (1 every 2 calendar years)	\$55 Copay	\$55 Copay	
Routine Hearing Aids and Hardware (\$1000 every 3 calendar years)	Covered in Full	Covered in Full	
Alternative Care			
Chiropractic (10 visits PCY)	\$25 Copay, applies to the \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Acupuncture (12 visits PCY)	\$25 Copay, applies to the \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	

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	HERITAGE AND DENTAL CHOICE IN-NETWORK	OUT-OF-NETWORK
Naturopath (Unlimited)	\$25 Copay designated PCP, applies to the \$7,100 Out of Pocket Maximum; \$55 Copay Specialist and non designated PCP, applies to the \$7,100 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Premera Designated Centers of Excellence		
Centers of Excellence Packaged Services (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement))	Designated Provider: Covered in Full; Non-Designated Provider: Not Covered	Not Covered
Travel and Care Coordination (Limited to IRS Guidelines)	Covered in Full	Covered in Full
Centers of Excellence for Radiology (Member Outreach Included)	Covered as any other service	Covered as any other service
Adult Dental Services		
Individual Deductible	\$50	\$50
Preventive Cost Share	Covered In Full	Deductible Waived, then 30%
Basic Cost Share	Deductible, then 20%	Deductible, then 40%
Major Cost Share	Deductible, then 50%	Deductible, then 50%
Dental Annual Maximum	\$1,000 PCY	Shared with In Network
Diagnostic / Preventive		
Routine Oral Exams (2 PCY)	Preventive Cost Share	Preventive Cost Share
Routine X-Rays (1 complete series every 60 months)	Preventive Cost Share	Preventive Cost Share
Cleanings (2 PCY)	Preventive Cost Share	Preventive Cost Share
Basic		
Non-Routine / Problem-Focused Exams (1 PCY)	Basic Cost Share	Basic Cost Share
Fillings (Once every 24 months)	Basic Cost Share	Basic Cost Share
Pulp Cap (Pulp Cap: Direct only; Pulp Therapy: Not Covered)	Basic Cost Share	Basic Cost Share
Endodontics (Once per tooth per Lifetime)	Basic Cost Share	Basic Cost Share
Full Mouth Debridement (Once per lifetime)	Basic Cost Share	Basic Cost Share
Periodontal Maintenance (4 PCY)	Basic Cost Share	Basic Cost Share
Periodontal Scaling and Root Planing (Scaling and Root Planing 1 every 24 months)	Basic Cost Share	Basic Cost Share
Simple Extractions	Basic Cost Share	Basic Cost Share
Surgical Extractions	Basic Cost Share	Basic Cost Share
General Anesthesia	Basic Cost Share	Basic Cost Share
Emergency Palliative Treatment	Basic Cost Share	Basic Cost Share
Limited Occlusal Adjustment (1 per 24 months)	Basic Cost Share	Basic Cost Share
Major		
Installation of Crowns (Porcelain, ceramic and metal crowns only 1 every 7 years)	Major Cost Share	Major Cost Share
Build-Ups (Once every 7 years)	Major Cost Share	Major Cost Share

MEDICAL PLAN	CHOICE 750 GOLD + FAMILY DENTAL	
	HERITAGE AND DENTAL CHOICE IN-NETWORK	OUT-OF-NETWORK
Re-Cementing/Repair of Crowns (Crowns only 1 every 24 months, 6 months after placement)	Major Cost Share	Major Cost Share

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

PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross. Members are responsible for amounts in excess of the allowable charge.

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms of the plan. This benefit highlight is not a contract and may change. Please see your benefit booklet or call Customer Service for full coverage information including a description of waiting periods, limitations, and exclusions.

Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at <https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx>.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).

注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-722-1471 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.

Телефонуйте за номером 800-722-1471 (телетайп: 711).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតលុយ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471 (TTY:711) まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው፡ 711)።

XIYYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajjila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).

ໂປດອຸບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ຄ່າສິ່ງຄ່າ, ຄວນມີພ້ອມໃຫ້ທ່ານ. ໂທ 800-722-1471 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sévis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).

توجہ: اگر بہ زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.