

Highlights of your Health Care Coverage

Effective Date: 01/01/2025

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 (lower coinsurance may apply to certain locations)	20%	50%
Out of Pocket Maximum (includes deductible, copays, coinsurance and pharmacy) (Family embedded OOP max 2X Individual)	\$7,500	Unlimited
Office Visit Cost Share	\$25 Copay designated PCP, applies to the \$7,500 Out of Pocket Maximum; \$55 Copay Specialist and non designated PCP, applies to the \$7,500 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 \$7,500 Out of Pocket Maximum; \$55 Copay Specialist and non designated PCP, applies to the \$7,500 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 \$7,500 Out of Pocket Maximum; \$55 Copay Specialist and non designated PCP, applies to the \$7,500 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 \$7,500 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

MEDICAL PLAN		
CHOICE 750 GOLD + FAMILY DENTAL		
	HERITAGE AND DENTAL CHOICE IN-NETWORK	OUT-OF-NETWORK
Outpatient Professional Services (see Ambulatory Surgery Center for lower cost option)	\$750 Deductible, then 20% Coinsurance, applies to the \$7,500 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to the Unlimited Out of Pocket Maximum
Ambulatory Surgery Center	\$750 Deductible, then 10% Coinsurance, applies to the \$7,500 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
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 \$7,500 Out of Pocket Maximum	\$200 Copay then \$750 Deductible and 20% Coinsurance; all cost shares apply to the \$7,500 Out of Pocket Maximum
Ambulance Service - Ground (Unlimited)	\$750 Deductible, then 20% Coinsurance, applies to \$7,500 Out of Pocket Maximum	\$750 Deductible, then 20% Coinsurance, applies to \$7,500 Out of Pocket Maximum
Ambulance Service - Air (Unlimited)	\$750 Deductible, then 20% Coinsurance, applies to \$7,500 Out of Pocket Maximum	\$750 Deductible, then 20% Coinsurance, applies to \$7,500 Out of Pocket Maximum
3 Hospitalization		
Inpatient Medical and Surgical Room and Board (Unlimited)	\$750 Deductible, then 20% Coinsurance, applies to \$7,500 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 \$7,500 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 \$7,500 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 \$7,500 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 \$7,500 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 \$7,500 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Outpatient Facility (Unlimited)	Waive Deductible, then 20% Coinsurance, applies to \$7,500 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 \$7,500 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

MEDICAL PLAN		
CHOICE 750 GOLD + FAMILY DENTAL		
	HERITAGE AND DENTAL CHOICE IN-NETWORK	OUT-OF-NETWORK
Mental Health Office Visit (Unlimited)	\$55 Copay Specialist and non designated PCP, applies to the \$7,500 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Facility (Unlimited)	Waive Deductible, then 20% Coinsurance, applies to \$7,500 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Inpatient Facility (Unlimited)	\$750 Deductible, then 20% Coinsurance, applies to \$7,500 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
6 Prescription Drug		
Formulary 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)	Tier 1 = \$20 Tier 2 = \$50 Tier 3 = \$80 Tier 4 = Subject to Deductible, then 25% (cost shares apply to the OOP Max)	Not Covered
Prescription Drugs - Mail (Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days)	Tier 1 = \$60 Tier 2 = \$150 Tier 3 = \$240 Tier 4 = Subject to Deductible, then 25% (cost shares apply to the OOP Max)	Not Covered
7 Rehabilitative & Habilitative Services & Devices		
Inpatient Rehabilitation (30 days PCY combined limit for inpatient services)	\$750 Deductible, then 20% Coinsurance, applies to \$7,500 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 \$7,500 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 \$7,500 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 \$7,500 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Massage Therapy (25 visits PCY combined limit for outpatient services)	\$55 Copay Specialist and non designated PCP, applies to the \$7,500 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 \$7,500 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
8 Laboratory/Imaging Services		

MEDICAL PLAN		
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Diagnostic Lab & Pathology	Waive Deductible, then 20% Coinsurance, applies to \$7,500 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Diagnostic Imaging - Basic	Waive Deductible, then 20% Coinsurance, applies to \$7,500 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Diagnostic Imaging - Major (MRI, CT, PET)	\$750 Deductible, then 20% Coinsurance, applies to \$7,500 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Diagnostic Mammography	Covered in Full	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Supplemental Breast Exam	Covered in Full	Covered as any other service
9 Preventive/Wellness Services		
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered
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 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 \$7,500 Out of Pocket Maximum	\$55 Copay Specialist and non designated PCP, applies to the \$7,500 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 \$7,500 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 \$7,500 Out of Pocket Maximum	Medical \$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chronic Condition Management Programs		
Diabetes Management Plus	Included	Included
Virtual Care Services		

MEDICAL PLAN		CHOICE 750 GOLD + FAMILY DENTAL	
	HERITAGE AND DENTAL CHOICE IN-NETWORK	OUT-OF-NETWORK	
Telemedicine – General Medical (Virtual Care Only)	\$25 Copay designated PCP, applies to the \$7,500 Out of Pocket Maximum; \$55 Copay Specialist and non designated PCP, applies to the \$7,500 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 \$7,500 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 \$7,500 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Naturopath	\$25 Copay designated PCP, applies to the \$7,500 Out of Pocket Maximum; \$55 Copay Specialist and non designated PCP, applies to the \$7,500 Out of Pocket Maximum	\$1,500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
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	
Office Visit			
Routine Oral Exams (2 PCY)	Preventive Cost Share	Preventive Cost Share	
Non-Routine / Problem-Focused Exams (1 PCY)	Basic Cost Share	Basic Cost Share	
Diagnostic / Preventive			
Cleanings (2 PCY)	Preventive Cost Share	Preventive Cost Share	
Routine X-Rays (1 complete series every 60 months)	Preventive Cost Share	Preventive Cost Share	
Restorative			
Fillings (Once every 24 months)	Basic Cost Share	Basic Cost Share	
Installation of Crowns (Porcelain, ceramic and metal crowns only 1 every 7 years)	Major Cost Share	Major Cost Share	
Re-Cementing/Repair of Crowns (Crowns only 1 every 24 months, 6 months after placement)	Major Cost Share	Major Cost Share	

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Build-Ups (Once every 7 years)	Major Cost Share	Major Cost Share	
Endodontics			
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	
Periodontics			
Periodontal Maintenance (4 PCY)	Basic Cost Share	Basic Cost Share	
Full Mouth Debridement (Once per lifetime)	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	
Oral Surgery			
Simple Extractions	Basic Cost Share	Basic Cost Share	
Surgical Extractions	Basic Cost Share	Basic Cost Share	
General Services			
General Anesthesia	Basic Cost Share	Basic Cost Share	
Limited Occlusal Adjustment (1 per 24 months)	Basic Cost Share	Basic Cost Share	
Emergency Palliative Treatment	Basic Cost Share	Basic 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.

Notice of availability and nondiscrimination 800-722-1471 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.

Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.

呼吁提供免费的语言援助服务和适当的辅助设备及服务。

呼籲提供免費的語言援助服務和適當的輔助設備及服務。

Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.

무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.

Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.

Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.

Звертайте за безкоштовною мовною підтримкою та відповідними додатковими послугами.

សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។

無料言語支援サービスと適切な補助器具及びサービスをお求めください。

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Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta’an argachuuf bilbilaa.

ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।

Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.

ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.

Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.

Appelez pour obtenir des services gratuits d’assistance linguistique et des aides et services auxiliaires appropriés.

Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.

Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.

Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.

اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.

برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

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, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our 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, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TTY: 711, Fax: 425-918-5592, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our 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>.

