PREMERA | BLUE CROSS

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 HSA QUALIFIED 3300 SILVER + FAMILY DENTAL**	
	HERITAGE AND DENTAL CHOICE IN-NETWORK	**OUT-OF-NETWORK**
Deductible (Family embedded deductible 2X Individual)	$3,300	$6,600
Coinsurance (lower coinsurance may apply to certain locations)	30%	50%
Out of Pocket Maximum (includes deductible, copays, coinsurance and pharmacy) (Family embedded OOP max 2X Individual)	$7,500	Unlimited
Office Visit Cost Share	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Annual Maximum	Unlimited	Unlimited
1 Ambulatory Patient Services		
Professional Office Visit	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Telemedicine by Traditional Provider – General Medical	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Urgent Care Office Visits	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Professional Services (see Ambulatory Surgery Center for lower cost option)	$3,300 Deductible, then 30% Coinsurance, applies to the $7,500 Out of Pocket Maximum	$6,600 Deductible, then 50% Coinsurance, applies to the Unlimited Out of Pocket Maximum
Ambulatory Surgery Center	$3,300 Deductible, then 20% Coinsurance, applies to the $7,500 Out of Pocket Maximum	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Contraceptive Management Services (Unlimited)	Covered in Full	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

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MEDICAL PLAN	CHOICE HSA QUALIFIED 3300 SILVER + FAMILY DENTAL	
	HERITAGE AND DENTAL CHOICE IN-NETWORK	**OUT-OF-NETWORK**
2 Emergency and Transportation Services		
Emergency Room - Facility	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum
Ambulance Service - Ground (Unlimited)	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum
Ambulance Service - Air (Unlimited)	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum
3 Hospitalization		
Inpatient Medical and Surgical Room and Board (Unlimited)	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 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)	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Hospice Inpatient Facility (Unlimited)	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Inpatient Professional Services	$3,300 Deductible, then 30% Coinsurance, applies to the $7,500 Out of Pocket Maximum	$6,600 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)	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 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)	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Outpatient Facility (Unlimited)	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Inpatient Facility (Unlimited)	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Office Visit (Unlimited)	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Facility (Unlimited)	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Inpatient Facility (Unlimited)	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
6 Prescription Drug		
Formulary Drug List	M1 No Tiers	Not Covered

MEDICAL PLAN	CHOICE HSA QUALIFIED 3300 SILVER + FAMILY DENTAL	
	HERITAGE AND DENTAL CHOICE IN-NETWORK	**OUT-OF-NETWORK**
Enhanced Preventive Drug List (PV Core)	Covered in Full	Not Covered
Prescription Drugs - Retail (Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days)	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	Not Covered
Prescription Drugs - Mail (Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days)	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	Not Covered
7 Rehabilitative & Habilitative Services & Devices		
Inpatient Rehabilitation (30 days PCY combined limit for inpatient services)	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Inpatient Habilitation (30 days PCY combined limit for inpatient services)	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 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)	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 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)	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Massage Therapy (25 visits PCY combined limit for outpatient services)	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Durable Medical Equipment (Unlimited)	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
8 Laboratory/Imaging Services		
Diagnostic Lab & Pathology	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Diagnostic Imaging - Basic	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Diagnostic Imaging - Major (MRI, CT, PET)	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Diagnostic Mammography	Covered in Full	$6,600 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	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Preventive Imaging	Covered in Full	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Preventive Mammography	Covered in Full	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
10 Pediatric Services, including Oral & Vision Care		

MEDICAL PLAN	CHOICE HSA QUALIFIED 3300 SILVER + FAMILY DENTAL	
	HERITAGE AND DENTAL CHOICE IN-NETWORK	**OUT-OF-NETWORK**
Pediatric Vision Exam (1 PCY Under age 19)	Waive Deductible, then 20% Coinsurance applies to $7,500 Out of Pocket Maximum	Waive Deductible, then 20% Coinsurance applies to $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 $6,600 Deductible, then 30% Coinsurance, applies to Unlimited Out of Pocket Maximum
Pediatric Dental - Basic	Medical $3,300 Deductible, then 20% Coinsurance, applies to $7,500 Out of Pocket Maximum	Medical $6,600 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Pediatric Dental - Major	Medical $3,300 Deductible, then 50% Coinsurance, applies to $7,500 Out of Pocket Maximum	Medical $6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chronic Condition Management Programs		
Diabetes Management Plus	Included	Included
Virtual Care Services		
Telemedicine – General Medical (Virtual Care Only)	$3,300 Deductible, then 30% Coinsurance, applies to $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)	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum
Routine Hearing Aids and Hardware ($1000 every 3 calendar years)	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum
Alternative Care		
Chiropractic (10 visits PCY)	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Acupuncture (12 visits PCY)	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Naturopath	$3,300 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,600 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%

MEDICAL PLAN	CHOICE HSA QUALIFIED 3300 SILVER + FAMILY DENTAL	
	HERITAGE AND DENTAL CHOICE IN-NETWORK	**OUT-OF-NETWORK**
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
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.
Звертайтесь 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。
ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር
Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
મુફત ભાષા સહાયિતા સેવાવાં અને ઉચિત સહાયિક ચીજાં અને સેવાવાં વાસતે કાલ કરો।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໃຫ້ເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ 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.

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