

# 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
<b>Deductible</b> (Family embedded deductible 2X Individual)	\$3,300	\$6,600
<b>Coinsurance (lower coinsurance may apply to certain locations)</b>	30%	50%
<b>Out of Pocket Maximum (includes deductible, copays, coinsurance and pharmacy)</b> (Family embedded OOP max 2X Individual)	\$7,500	Unlimited
<b>Office Visit Cost Share</b>	\$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
<b>Annual Maximum</b>	Unlimited	Unlimited
<b>1 Ambulatory Patient Services</b>		
<b>Professional Office Visit</b>	\$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
<b>Telemedicine by Traditional Provider – General Medical</b>	\$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
<b>Urgent Care Office Visits</b>	\$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
<b>Outpatient Professional Services (see Ambulatory Surgery Center for lower cost option)</b>	\$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
<b>Ambulatory Surgery Center</b>	\$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
<b>Contraceptive Management Services</b> (Unlimited)	Covered in Full	\$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

<b>MEDICAL PLAN</b>	<b>CHOICE HSA QUALIFIED 3300 SILVER + FAMILY DENTAL</b>	
	<b>HERITAGE AND DENTAL CHOICE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>2 Emergency and Transportation Services</b>		
<b>Emergency Room - Facility</b>	\$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
<b>Ambulance Service - Ground</b> (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
<b>Ambulance Service - Air</b> (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
<b>3 Hospitalization</b>		
<b>Inpatient Medical and Surgical Room and Board</b> (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
<b>Skilled Nursing Facility</b> (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
<b>Hospice Inpatient Facility</b> (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
<b>Inpatient Professional Services</b>	\$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
<b>Organ Transplants</b> (Unlimited)	Covered as any other service	Not Covered
<b>4 Maternity &amp; Newborn Care</b>		
<b>Prenatal, Delivery, Postnatal</b> (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
<b>5 Mental Health &amp; Substance Use Disorder Services, including Behavioral Health Treatment</b>		
<b>Chemical Dependency Office Visit</b> (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
<b>Chemical Dependency Outpatient Facility</b> (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
<b>Chemical Dependency Inpatient Facility</b> (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
<b>Mental Health Office Visit</b> (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
<b>Mental Health Outpatient Facility</b> (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
<b>Mental Health Inpatient Facility</b> (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
<b>6 Prescription Drug</b>		
<b>Formulary Drug List</b>	M1 No Tiers	Not Covered

<b>MEDICAL PLAN</b>		
<b>CHOICE HSA QUALIFIED 3300 SILVER + FAMILY DENTAL</b>		
	<b>HERITAGE AND DENTAL CHOICE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Enhanced Preventive Drug List</b> (PV Core)	Covered in Full	Not Covered
<b>Prescription Drugs - Retail</b> (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
<b>Prescription Drugs - Mail</b> (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
<b>7 Rehabilitative &amp; Habilitative Services &amp; Devices</b>		
<b>Inpatient Rehabilitation</b> (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
<b>Inpatient Habilitation</b> (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
<b>Rehab Outpatient Professional - Physical, Speech, Occupational Therapy</b> (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
<b>Habilitation Outpatient Professional - Physical, Speech, Occupational Therapy</b> (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
<b>Massage Therapy</b> (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
<b>Durable Medical Equipment</b> (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
<b>8 Laboratory/Imaging Services</b>		
<b>Diagnostic Lab &amp; Pathology</b>	\$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
<b>Diagnostic Imaging - Basic</b>	\$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
<b>Diagnostic Imaging - Major (MRI, CT, PET)</b>	\$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
<b>Diagnostic Mammography</b>	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$7,500 Out of Pocket Maximum	\$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Supplemental Breast Exam</b>	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$7,500 Out of Pocket Maximum	Covered as any other service
<b>9 Preventive/Wellness Services</b>		
<b>Preventive Office Visit</b> (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered
<b>Immunizations</b> (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered
<b>Preventive Laboratory Screens</b>	Covered in Full	\$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Preventive Imaging</b>	Covered in Full	\$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

<b>MEDICAL PLAN</b>		
<b>CHOICE HSA QUALIFIED 3300 SILVER + FAMILY DENTAL</b>		
	<b>HERITAGE AND DENTAL CHOICE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Preventive Mammography</b>	Covered in Full	\$6,600 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>10 Pediatric Services, including Oral &amp; Vision Care</b>		
<b>Pediatric Vision Exam</b> (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
<b>Pediatric Eyewear</b> (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
<b>Pediatric Dental - Preventive</b>	Covered in Full	Medical \$6,600 Deductible, then 30% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Pediatric Dental - Basic</b>	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
<b>Pediatric Dental - Major</b>	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
<b>Chronic Condition Management Programs</b>		
<b>Diabetes Management Plus</b>	Included	Included
<b>Virtual Care Services</b>		
<b>Telemedicine – General Medical (Virtual Care Only)</b>	\$3,300 Deductible, then 30% Coinsurance, applies to \$7,500 Out of Pocket Maximum	Not Covered
<b>Telemedicine - Mental Health (Virtual Care Only)</b>	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered
<b>Telemedicine - Chemical Dependency (Virtual Care Only)</b>	Subject to Chemical Dependency Outpatient Office Visit	Not Covered
<b>Routine Hearing</b>		
<b>Routine Hearing Exam</b> (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
<b>Routine Hearing Aids and Hardware</b> (\$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
<b>Alternative Care</b>		
<b>Chiropractic</b> (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
<b>Acupuncture</b> (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
<b>Naturopath</b>	\$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
<b>Adult Dental Services</b>		

<b>MEDICAL PLAN</b>		<b>CHOICE HSA QUALIFIED 3300 SILVER + FAMILY DENTAL</b>	
	<b>HERITAGE AND DENTAL CHOICE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>Individual Deductible</b>	\$50	\$50	
<b>Preventive Cost Share</b>	Covered In Full	Deductible Waived, then 30%	
<b>Basic Cost Share</b>	Deductible, then 20%	Deductible, then 40%	
<b>Major Cost Share</b>	Deductible, then 50%	Deductible, then 50%	
<b>Dental Annual Maximum</b>	\$1,000 PCY	Shared with In Network	
<b>Office Visit</b>			
<b>Routine Oral Exams (2 PCY)</b>	Preventive Cost Share	Preventive Cost Share	
<b>Non-Routine / Problem-Focused Exams (1 PCY)</b>	Basic Cost Share	Basic Cost Share	
<b>Diagnostic / Preventive</b>			
<b>Cleanings (2 PCY)</b>	Preventive Cost Share	Preventive Cost Share	
<b>Routine X-Rays (1 complete series every 60 months)</b>	Preventive Cost Share	Preventive Cost Share	
<b>Restorative</b>			
<b>Fillings (Once every 24 months)</b>	Basic Cost Share	Basic Cost Share	
<b>Installation of Crowns (Porcelain, ceramic and metal crowns only 1 every 7 years)</b>	Major Cost Share	Major Cost Share	
<b>Re-Cementing/Repair of Crowns (Crowns only 1 every 24 months, 6 months after placement)</b>	Major Cost Share	Major Cost Share	
<b>Build-Ups (Once every 7 years)</b>	Major Cost Share	Major Cost Share	
<b>Endodontics</b>			
<b>Pulp Cap (Pulp Cap: Direct only; Pulp Therapy: Not Covered)</b>	Basic Cost Share	Basic Cost Share	
<b>Endodontics (Once per tooth per Lifetime)</b>	Basic Cost Share	Basic Cost Share	
<b>Periodontics</b>			
<b>Periodontal Maintenance (4 PCY)</b>	Basic Cost Share	Basic Cost Share	
<b>Full Mouth Debridement (Once per lifetime)</b>	Basic Cost Share	Basic Cost Share	
<b>Periodontal Scaling and Root Planing (Scaling and Root Planing 1 every 24 months)</b>	Basic Cost Share	Basic Cost Share	
<b>Oral Surgery</b>			
<b>Simple Extractions</b>	Basic Cost Share	Basic Cost Share	
<b>Surgical Extractions</b>	Basic Cost Share	Basic Cost Share	
<b>General Services</b>			
<b>General Anesthesia</b>	Basic Cost Share	Basic Cost Share	
<b>Limited Occlusal Adjustment (1 per 24 months)</b>	Basic Cost Share	Basic Cost Share	
<b>Emergency Palliative Treatment</b>	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。

ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ ማሳሰቢያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር

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](mailto: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>.

