PREMERA BLUE CROSS

Highlights of your Health Care Coverage

Effective Date: 01/01/2026

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 3400 SILVER + FAMILY DENTAL**	
	HERITAGE AND DENTAL CHOICE IN-NETWORK	**OUT-OF-NETWORK**
Deductible (Family embedded deductible 2X Individual)	$3,400	$6,800
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	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Annual Maximum	Unlimited	Unlimited
1 Ambulatory Patient Services		
Professional Office Visit	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Telemedicine by Traditional Provider – General Medical	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Urgent Care Office Visits	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Professional Services (see Ambulatory Surgery Center for lower cost option)	$3,400 Deductible, then 30% Coinsurance, applies to the $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to the Unlimited Out of Pocket Maximum
Ambulatory Surgery Center	$3,400 Deductible, then 20% Coinsurance, applies to the $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Contraceptive Management Services (Unlimited)	Covered in Full	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

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	HERITAGE AND DENTAL CHOICE IN-NETWORK	**OUT-OF-NETWORK**
2 Emergency and Transportation Services		
Emergency Room - Facility	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum
Ambulance Service - Ground (Unlimited)	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum
Ambulance Service - Air (Unlimited)	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum
3 Hospitalization		
Inpatient Medical and Surgical Room and Board (Unlimited)	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 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)	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Hospice Inpatient Facility (Unlimited)	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Inpatient Professional Services	$3,400 Deductible, then 30% Coinsurance, applies to the $7,500 Out of Pocket Maximum	$6,800 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		
Birth Center	$3,400 Deductible, then 20% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Prenatal, Delivery, Postnatal (Coverage for subscriber, spouse, dependent)	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Fertility Treatment & Assisted Reproduction Procedures (Artificial insemination in vivo covered; other assisted reproduction treatments excluded)	Cover as any other service	Cover as any other service
5 Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment		
Chemical Dependency Office Visit (Unlimited)	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Outpatient Facility (Unlimited)	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Inpatient Facility (Unlimited)	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Office Visit (Unlimited)	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Facility (Unlimited)	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Inpatient Facility (Unlimited)	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

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	HERITAGE AND DENTAL CHOICE IN-NETWORK	**OUT-OF-NETWORK**
6 Prescription Drug		
Formulary Drug List	M1 No Tiers	Not Covered
Enhanced Preventive Drug List (PV Core)	Covered in Full	Not Covered
Prescription Drugs - Retail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	Not Covered
Prescription Drugs - Mail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	Not Covered
7 Rehabilitative & Habilitative Services & Devices		
Inpatient Rehabilitation (30 days PCY)	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Rehabilitation - Physical, Occupational Therapy (25 visits PCY)	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Habilitation - Physical, Occupational Therapy (25 visits PCY)	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Massage Therapy (Applies to the outpatient rehab limit)	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Speech Therapy (Applies to the outpatient rehab limit)	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Inpatient Habilitation (30 days PCY)	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Durable Medical Equipment (Unlimited)	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
8 Laboratory/Imaging Services		
Diagnostic Laboratory & Pathology	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Diagnostic Imaging - Basic	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Diagnostic Imaging - Major (MRI, CT, PET)	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Diagnostic Mammography	Covered in Full	$6,800 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	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

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	HERITAGE AND DENTAL CHOICE IN-NETWORK	**OUT-OF-NETWORK**
Preventive Imaging	Covered in Full	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Preventive Mammography	Covered in Full	$6,800 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)	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	Waive Medical Deductible, then 30% Coinsurance, applies to Unlimited Out of Pocket Maximum
Pediatric Dental - Basic	Medical $3,400 Deductible, then 20% Coinsurance, applies to $7,500 Out of Pocket Maximum	Medical $6,800 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Pediatric Dental - Major	Medical $3,400 Deductible, then 50% Coinsurance, applies to $7,500 Out of Pocket Maximum	Medical $6,800 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)	$3,400 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 PCY)	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum
Routine Hearing Aids and Hardware (1 device per ear every 3 years)	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to $7,500 Out of Pocket Maximum	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to $7,500 Out of Pocket Maximum
Alternative Care		
Chiropractic (10 visits PCY)	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Acupuncture (Unlimited)	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 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	$3,400 Deductible, then 30% Coinsurance, applies to $7,500 Out of Pocket Maximum	$6,800 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
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

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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.
Зверніться 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 સેવાઓ અને ઉચિત સહાયિક ચીજો અને સેવાઓ વાસતે કાલ કરો।
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.

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