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 3000 SILVER** | |
|---|---|---|
| | **HERITAGE AND DENTAL CHOICE IN-NETWORK** | **OUT-OF-NETWORK** |
| **Deductible** (In-network only - Family embedded deductible 2X Individual) | $3,000 | $6,000 |
| **Coinsurance (lower coinsurance may apply to certain locations)** | 35% | 50% |
| **Out of Pocket Maximum (includes deductible, copays, coinsurance and pharmacy)** (Family embedded OOP max 2X Individual) | $9,000 | Unlimited |
| **Designated PCP Office Visit Cost Share** | $40 Copay, applies to the $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Specialist and non designated PCP Office Visit Cost Share** | $75 Copay, applies to the $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Annual Maximum** | Unlimited | Unlimited |
| **1 Ambulatory Patient Services** | | |
| **Professional Office Visit** | Designated PCP: $40 Copay, applies to the $9,000 Out of Pocket Maximum; Specialist and non designated PCP: $75 Copay, applies to the $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Telemedicine by Traditional Provider – General Medical** | Designated PCP: $40 Copay, applies to the $9,000 Out of Pocket Maximum; Specialist and non designated PCP: $75 Copay, applies to the $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Urgent Care Office Visits** | $75 Copay, applies to the $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |


Independent Licensee of the Blue Cross Blue Shield Association

| MEDICAL PLAN | CHOICE 3000 SILVER | |
|---|---|---|
| | **HERITAGE AND DENTAL CHOICE IN-NETWORK** | **OUT-OF-NETWORK** |
| **Outpatient Professional Services (see Ambulatory Surgery Center for lower cost option)** | $3,000 Deductible, then 35% Coinsurance, applies to the $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to the Unlimited Out of Pocket Maximum |
| **Ambulatory Surgery Center** | $3,000 Deductible, then 25% Coinsurance, applies to $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Contraceptive Management Services** (Unlimited) | Covered in Full | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **2 Emergency and Transportation Services** | | |
| **Emergency Room - Facility** | $350 Copay then $3,000 Deductible and 35% Coinsurance; all cost shares apply to the $9,000 Out of Pocket Maximum | $350 Copay then $3,000 Deductible and 35% Coinsurance; all cost shares apply to the $9,000 Out of Pocket Maximum |
| **Ambulance Service - Ground** (Unlimited) | $3,000 Deductible, then 35% Coinsurance, applies to $9,000 Out of Pocket Maximum | $3,000 Deductible, then 35% Coinsurance, applies to $9,000 Out of Pocket Maximum |
| **Ambulance Service - Air** (Unlimited) | $3,000 Deductible, then 35% Coinsurance, applies to $9,000 Out of Pocket Maximum | $3,000 Deductible, then 35% Coinsurance, applies to $9,000 Out of Pocket Maximum |
| **3 Hospitalization** | | |
| **Inpatient Medical and Surgical Room and Board** (Unlimited) | $3,000 Deductible, then 35% Coinsurance, applies to $9,000 Out of Pocket Maximum | $6,000 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) | $3,000 Deductible, then 35% Coinsurance, applies to $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Hospice Inpatient Facility** (Unlimited) | $3,000 Deductible, then 35% Coinsurance, applies to $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Inpatient Professional Services** | $3,000 Deductible, then 35% Coinsurance, applies to the $9,000 Out of Pocket Maximum | $6,000 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** | $3,000 Deductible, then 25% Coinsurance, applies to $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Prenatal, Delivery, Postnatal** (Coverage for subscriber, spouse, dependent) | $3,000 Deductible, then 35% Coinsurance, applies to $9,000 Out of Pocket Maximum | $6,000 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) | $75 Copay, applies to the $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Chemical Dependency Outpatient Facility** (Unlimited) | $3,000 Deductible, then 35% Coinsurance, applies to $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |

| MEDICAL PLAN | CHOICE 3000 SILVER | |
|---|---|---|
| | **HERITAGE AND DENTAL CHOICE IN-NETWORK** | **OUT-OF-NETWORK** |
| **Chemical Dependency Inpatient Facility** (Unlimited) | $3,000 Deductible, then 35% Coinsurance, applies to $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Mental Health Office Visit** (Unlimited) | $75 Copay, applies to the $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Mental Health Outpatient Facility** (Unlimited) | $3,000 Deductible, then 35% Coinsurance, applies to $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Mental Health Inpatient Facility** (Unlimited) | $3,000 Deductible, then 35% Coinsurance, applies to $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **6 Prescription Drug** | | |
| **Formulary Drug List** | M4<br>Tier 1 = preferred generic<br>Tier 2 = preferred brand<br>Tier 3 = non-preferred generic and brand<br>Tier 4 = specialty | Not Covered |
| **Prescription Drugs - Retail** (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days) | Tier 1 = $30<br>Tier 2 = $75<br>Tier 3 = Subject to Deductible, then 35%<br>Tier 4 = Subject to Deductible, then 40%<br>(cost shares apply to the OOP Max) | Not Covered |
| **Prescription Drugs - Mail** (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days) | Tier 1 = $90<br>Tier 2 = $225<br>Tier 3 = Subject to Deductible, then 35%<br>Tier 4 = Subject to Deductible, then 40%<br>(cost shares apply to the OOP Max) | Not Covered |
| **7 Rehabilitative & Habilitative Services & Devices** | | |
| **Inpatient Rehabilitation** (30 days PCY) | $3,000 Deductible, then 35% Coinsurance, applies to $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Outpatient Rehabilitation - Physical, Occupational Therapy** (25 visits PCY) | $75 Copay, applies to the $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Outpatient Habilitation - Physical, Occupational Therapy** (25 visits PCY) | $75 Copay, applies to the $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Outpatient Massage Therapy** (Applies to the outpatient rehab limit) | $75 Copay, applies to the $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Outpatient Speech Therapy** (Applies to the outpatient rehab limit) | $75 Copay, applies to the $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Inpatient Habilitation** (30 days PCY) | $3,000 Deductible, then 35% Coinsurance, applies to $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Durable Medical Equipment** (Unlimited) | $3,000 Deductible, then 35% Coinsurance, applies to $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **8 Laboratory/Imaging Services** | | |


Independent Licensee of the Blue Cross Blue Shield Association

| MEDICAL PLAN | CHOICE 3000 SILVER | |
|---|---|---|
| | **HERITAGE AND DENTAL CHOICE IN-NETWORK** | **OUT-OF-NETWORK** |
| **Diagnostic Laboratory & Pathology** | $3,000 Deductible, then 35% Coinsurance, applies to $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Diagnostic Imaging - Basic** | $3,000 Deductible, then 35% Coinsurance, applies to $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Diagnostic Imaging - Major (MRI, CT, PET)** | $3,000 Deductible, then 35% Coinsurance, applies to $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Diagnostic Mammography** | Covered in Full | $6,000 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 | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Preventive Imaging** | Covered in Full | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Preventive Mammography** | Covered in Full | $6,000 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) | $75 Copay, applies to the $9,000 Out of Pocket Maximum | $75 Copay, applies to the $9,000 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** | Waive Medical Deductible, then 20% Coinsurance, applies to $9,000 Out of Pocket Maximum | Medical $6,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Pediatric Dental - Major** | Medical $3,000 Deductible, then 50% Coinsurance, applies to $9,000 Out of Pocket Maximum | Medical $6,000 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)** | Designated PCP: $40 Copay, applies to the $9,000 Out of Pocket Maximum; Specialist and non designated PCP: $75 Copay, applies to the $9,000 Out of Pocket Maximum | Not Covered |


Independent Licensee of the Blue Cross Blue Shield Association

| MEDICAL PLAN | CHOICE 3000 SILVER | |
|---|---|---|
| | **HERITAGE AND DENTAL CHOICE IN-NETWORK** | **OUT-OF-NETWORK** |
| **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) | $75 Copay, applies to the $9,000 Out of Pocket Maximum | $75 Copay, applies to the $9,000 Out of Pocket Maximum |
| **Routine Hearing Aids and Hardware** (1 device per ear every 3 years) | Covered in Full | Covered in Full |
| **Alternative Care** | | |
| **Chiropractic** (10 visits PCY) | $40 Copay, applies to the $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Acupuncture** (Unlimited) | $40 Copay, applies to the $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Naturopath** | Designated PCP: $40 Copay, applies to the $9,000 Out of Pocket Maximum; Specialist and non designated PCP: $75 Copay, applies to the $9,000 Out of Pocket Maximum | $6,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |

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.*


Independent Licensee of the Blue Cross Blue Shield Association

## 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.

An Independent Licensee of the Blue Cross Blue Shield Association
037397 (07-05-2024)

PREMERA | BLUE CROSS