







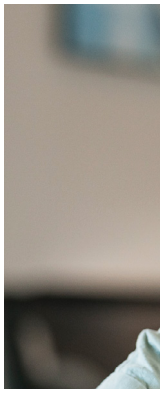


FOR SELF-FUNDED HEALTH PLANS WITH 150+ EMPLOYEES

2027 health plan guide

PREMERA BLUE CROSS

We care for our customers

The customer is at the center of all we do. That's why we offer plans that help you keep control of your expenses while giving your employees access to affordable, quality care.

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Why businesses choose Premera

As a not-for-profit health plan serving Washington state since 1933, we're committed to providing our clients affordable health plans, access to high-quality care networks, and an experience that meets members and employers where they are.

Affordability

Healthcare is expensive, and we take seriously our responsibility to make each dollar work harder, ensuring access to quality care at a fair price.

Pharmacy

We promote safe, lower-cost alternatives like generics and biosimilars—often as much as 40% cheaper. These are medications that are highly similar to an existing biologic drug and work the same way, with no meaningful differences in safety or effectiveness. We also supply members with tools to spot savings.

Provider access

We invested $30 million to expand the primary care workforce in Washington and Alaska. Partnerships with Kinwell primary care clinics in Washington improve access and are expected to reduce total cost of care by 4%.

System waste

We cut waste by preventing billing errors, fighting fraud, and using prior authorization to avoid unnecessary or duplicative treatments.

Right care, right time, right place

We offer options for members to seek care from high-quality, lower-cost settings that have proven results, such as Centers of Excellence providers or ambulatory surgery centers. This helps reduce costs while improving health outcomes.

Access

We work hard to connect members and their families to the care they need, when they need it, from providers who understand them.

Primary care

We're expanding access through Kinwell advanced primary care clinics. Kinwell clinics offer longer visits, faster scheduling, and integrated behavioral health care.

Rural care

We're expanding the rural healthcare workforce by investing in training and residency programs that build a stronger pipeline of providers in rural areas.

Behavioral health

Premera members have greater access to behavioral health providers through our expanded networks, virtual care, and personalized matching services like Matchmaker™ for Behavioral Health.

Experience

Enhanced case management

With one point of contact, secure chat, and built-in behavioral health support, members get coordinated, whole-person care that's easier to manage. Our Personal Health Support program builds on this approach with one-on-one concierge support to help members navigate care, understand their benefits, manage claims, and connect with the right providers.

Smarter digital tools

We're investing in smarter digital tools that make healthcare easier to access and understand. Our redesigned member portal, Find Care tool, and mobile app give members simple, self-service options to check benefits, find providers, and see cost estimates, all in one place. We also use Quest Analytics' BetterDoctor portal to keep our provider directory accurate and up to date.

Artificial intelligence (AI)

Premera uses AI to make healthcare faster and easier. AI helps approve claims and prior authorizations faster, reducing wait times and improving service. Through Premera Health Hub, AI also connects members to wellness and condition-management programs that fit their individual needs.[2]

[1]https://www.ama-assn.org/education/improve-gme/recipe-more-rural-physicians-more-exposure-residency-training
[2]Premera Health Hub is available to self-funded and OptiFlex groups.

CareCompass360

Our approach to population health ensures members receive the right support at the right time. CareCompass360 (CC360) is about looking at the whole person, identifying risk early, and proactively intervening.

Ensuring the right support at the right time

We identify rising risk early and escalate to the right level of clinical support.

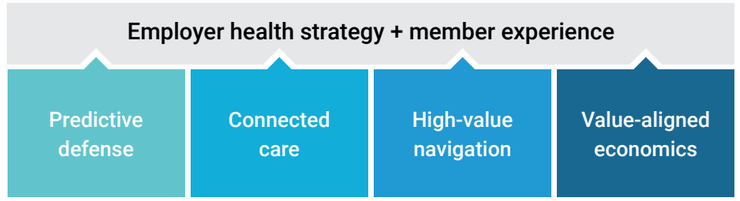
Delivering coordinated support that improves access, experience, and total cost of care.

Simplified design and better experience

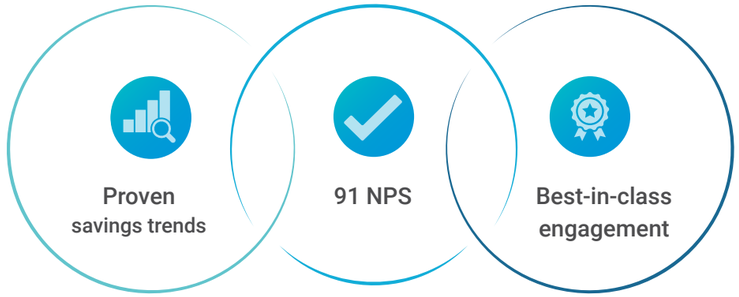
CC360 brings together our industry-leading, member-focused products into a unified core bundle that simplifies employer cost management and improves the member experience.

Driving the value and impact through a unified core

The CC360 core establishes a member environment that can prevent little problems from becoming bigger and costlier. By removing fragmented care caps, CC360 delivers employers the value they expect from Premera without sacrificing member experience.



Delivering on employer expectations



Estimate savings for clinical and UM programs vary by group.

Clinical outreach leads to meaningful engagement in 89% of targeted population.

Members rate PBC clinical services at 91 Net Promoter Score (NPS)

Did you know?

Enhanced Case Management combines predictive analysis (to identify at-risk members) with digital engagement to get members on the right care path sooner.

What's new for 2027

- Unified core design
- Simplified pricing
- Transparent utilization management pricing

PREMERA
Health Hub

Premera Health Hub

Premera Health Hub is a comprehensive virtual care network of solutions for wellness and health condition management. Premera Health Hub is designed to help members meet their health goals and lower the total cost of care by guiding members to virtual solutions for their unique needs.

Supporting your benefit strategy

Simplified employer administration	Premera manages vendor vetting, contracting, relationship management, and reporting.
Increased member engagement	Personalized digital communications optimize engagement with the hub.
Intervention-based approach	Proprietary clinical algorithms account for preference and need to best match members with a vendor.
Engagement- and outcomes-based payment model	Employers only pay when members are actively engaged or show positive health outcomes.
Greater access to care	Comprehensive digital solutions support wellness and chronic care management for all members, no matter where they are.

Did you know?

Offering a virtual program that covers a broad range of conditions **reduces costs**.[1]

2%–4%

reduction in estimated total plan claims cost

Where Premera Health Hub saves

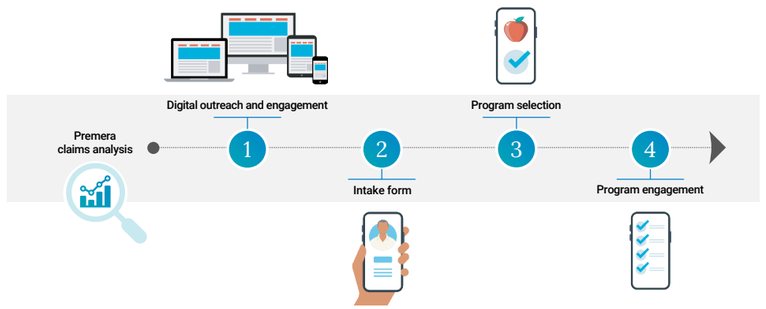
37% routine outpatient care

32% hospital & ER

31% pharmacy

Savings estimates are based on a study conducted by Solera Health

How members get started



A differentiated member experience

Premera Health Hub offers members more than just information. Members can use Premera Health Hub to help them manage their health conditions or achieve their health goals. With Premera Health Hub, members benefit from:

Personalized tools	A customized experience that matches members to a right-fit program and solution, making it easier for them to meet their health goals.
Clinically proven programs	Access to leading health and wellness programs that deliver effective results.
Convenient access	Digital resources available on demand for whenever and wherever members need them.
No extra costs	Programs and resources available to members at no additional out-of-pocket expense.

Premera Health Hub condition categories

- Achieve a healthy weight
- Manage diabetes
- Ease digestive symptoms
- Manage blood pressure
- Reduce joint or muscle pain
- Reduce or quit tobacco use
- Explore paths to parenthood
- Get support for women's health

[1]Solera Health, Inc. "The Network Effect: Proving the Value of Curated Digital Health," March 2026. PDF. Research was conducted using a dataset of 16,499 enrolled members. Independently reviewed by Accorded, Inc.

Premera pharmacy

A smarter way to manage pharmacy—built around your health plan strategy

Premera views pharmacy as an integrated benefit that can be leveraged to manage total cost of care without sacrificing member experience or access. Rising pharmacy costs, including specialty drugs and GLP 1s, require more than one solution. Your integrated pharmacy benefit can have the strongest impact through formulary design, coverage strategy, and clinical support.

Optimizing your pharmacy benefit to meet your needs

There's no one-size-fits-all approach for pharmacy. Premera assesses formulary design, coverage decisions, and personalized member support programs to help you develop a targeted pharmacy plan that complements your medical benefits.

When everything works together, employers gain

With an integrated approach, it becomes a proactive strategy to manage trends, support members, and control total cost of care—without unnecessary trade-offs.

More control over Rx spend

- Align cost share to value
- Guide to lower-cost, effective medications

Greater flexibility

- Adapt strategy as needs change
- Add Rx products that maximize benefit

Integrated pharmacy benefits

Better health outcomes

- Adherence and condition management
- Connect members to the right therapy sooner

Simpler member experience

- Clearer benefit design
- Predictable out-of-pocket costs

Expanded reporting and audit right options in development

A modern and more flexible formulary design

Premera offers a range of formulary options, including a new 6-tier structure, giving employers more precision in how they manage pharmacy spend and in alignment with their overall health plan strategy.

Where a 6-tier formulary design has impact

- Aligns member cost share to drug value
- Improves cost predictability over time
- Supports access to clinically effective treatments

ESSENTIALS FORMULARY

PLANS WITH 4 TIERS	
FIRST TIER	Preferred generic drugs
SECOND TIER	Preferred brand-name drugs
THIRD TIER	Preferred specialty* drugs
FOURTH TIER	Non-preferred drugs (generic, brand, and specialty)

PLANS WITH 6 TIERS	
FIRST TIER	Value generic
SECOND TIER	Preferred generic
THIRD TIER	Preferred brand
FOURTH TIER	Non-preferred generic and brand
FIFTH TIER	Preferred specialty
SIXTH TIER	Non-preferred specialty

PREFERRED FORMULARY

PLANS WITH 4 TIERS	
FIRST TIER	Generic drugs
SECOND TIER	Preferred brand-name drugs
THIRD TIER	Non-preferred brand-name drugs
FOURTH TIER	Specialty drugs*
PLANS WITH 3 TIERS	
FIRST TIER	Generic drugs
SECOND TIER	Preferred brand-name drugs
THIRD TIER	Non-preferred brand-name drugs
PLANS WITH 2 TIERS	
FIRST TIER	Generic drugs
SECOND TIER	Brand-name drugs

[1]Some ancillary pharmacy products may not be eligible based on the group's pharmacy model.

2Metallic and Essentials formularies excluded.

3Out-of-Pocket Protection Program is recommended for groups whose renewal aligns with their benefit year reset.

Premera pharmacy

Member pharmacy alerts and savings

Employers and members can save on prescription drugs with personalized alerts from Rx Savings Solutions (RxSS). RxSS identifies and notifies members of opportunities to spend less on their prescription drugs with little to no impact on the member's healthcare journey. Members can save by:

- Switching to another pharmacy
- Trying a new or different generic medication
- Changing to a therapeutic alternative

When a member acts on an alert, RxSS manages the entire process. All the member has to do is pick up their prescription.

Solutions that can enhance your pharmacy benefit

When paired with your pharmacy plan, the following solutions can help members and the group save more and manage costs.[1]

SOLUTION	FINANCIAL VALUE	HOW IT WORKS
Dispense as Written	Group	Instructs pharmacies on brand and generic dispensing requirements and affects how much a member pays out of pocket.
Exclusion Lists	Group	Pairs with a group's formulary.[2] Includes the High-Cost Low-Value exclusion list and the OTC exclusion.
Out-of-Pocket Protection	Group	Reduces drug manufacturer copay assistance impact on groups by excluding copay assistance dollars from counting toward members' out-of-pocket maximum accruals.[3]
Right Price	Member	Ensure your employees pay the lowest possible price under their plan for non-specialty retail generic prescriptions through use of the embedded discount card market price program.
Split Fill	Group, member	Eliminates waste and improves therapy adherence. The initial prescription is divided into two smaller days' supply. If the member has an interaction, for example, the second fill is not initiated.
Transition Fill	Group, member	Allows new members to maintain their prescriptions with a temporary fill while transitioning to their new Premera health plan.

NEW FOR 2027

Flexible GLP-1 options

GLP-1 medications are one of the fastest-growing cost drivers—and require intentional decision-making.

Premera offers flexible coverage pathways:

GLP-1 Clinical Select	Covers GLP 1s for medical conditions only
GLP-1 Access Select	Allows weight-loss coverage with defined criteria
Standard weight management	Broader access options, including benefit caps
Exclusion approaches	For tighter cost control

[1]Fleck, Anna, and Felix Richter. "Infographic: More than Half of Americans Take Prescribed Meds Daily." Statista Daily Data, 6 Nov. 2023, www.statista.com/chart/31183/us-respondents-who-are-taking-prescribed-medicine/.

[2]Metallic and Essentials formularies excluded.

[3]Out-of-Pocket Protection Program is recommended for groups whose renewal aligns with their benefit year reset.

[4]J Manag Care Spec Pharm. 2020 Jun;26(6):766-774. doi: 10.18553/jmcp.2020.19411. Epub 2020 Mar 10. Rx Savings Solutions is an independent company that does not provide Blue Cross Blue Shield products or services.

Medical and dental integration

Integrated medical and dental benefits go beyond network size and access. It's about creating a true whole-person health environment that provides total cost of care protection.

Fragmented benefit design costs more

Escalating claims severity	Unmanaged oral health drives higher medical utilization.
The stand-alone weak spot	Dental carve-outs isolate data, limiting early intervention and risk reduction.
Disengagement in silos	Carve-outs reduce preventive care use by ~25% compared to integrated medical-dental.[1]

Members with diabetes who forgo or skip dental care are at 120% increased risk of acute heart attacks and strokes. These events have real-dollar impacts on the health plans, from $25,000 to $130,000 per member.[2,3]

What whole-person cost protection looks like

- Automatic Enhanced Dental Care at 100% coverage for high-risk members
- Real-time clinical visibility into dental care gaps and benefits for case managers
- Zero-friction benefit activation without forms, waiting periods, or extra enrollment
- Full-spectrum digital outreach with positive reinforcement and targeted support
- Integrated reporting of engagement and utilization trends over time

Mitigating total medical spend + making it simple to operate = **value of whole-person care**

Enhanced Dental Care benefit

This benefit feature, exclusive to integrated medical and dental plan designs, can lower total medical costs and improve clinical outcomes for high-risk members.

High-risk covered conditions

- Cardiovascular disease
- Chronic obstructive pulmonary disease (COPD)
- Diabetes
- Oral cancers
- Pregnancy

Additional covered services

- Periodontal/routine evaluation[1]
- Routine cleanings and periodontal maintenance[2]
- Topical fluoride in dentist office[3]
- Periodontal scaling and root planing (new for 2027)[4]

Covers one extra service of each type per calendar year in addition to standard plan frequencies to reduce systemic medical risks.

Frictionless experience

- **Automatic enrollment**: Zero barriers—no forms or sign-ups required for high-risk members.
- **100% covered**: $0 out-of-pocket costs with all deductibles and co-insurance waived.
- **Fully embedded**: Standard on all Large Group Dental plans at no extra cost.
- **Immediate access**: No waiting periods for critical preventive care.

Protecting your total cost of care

Six in 10 adults in the United States are living with at least one chronic condition.[4] They are at risk of oral complications because of conditions like diabetes and cardiovascular disease.[5] Providing our members with access to one of the largest dental networks in the nation means that members with chronic illnesses can receive routine preventive care and oral treatment, possibly preventing them from becoming a high-cost claimant.

[1]The Dental Trade Alliance (DTA) Medical-Dental Integration Resource Matrix (Evaluating Integrated Care Models, 2026). https://cdn.ymaws.com/dentaltradealliance.org/resource/resmgr/DTA_MDI_Paper_2026.pdf

[2]Offenbacher S, Katz V, Fertik G, Collins J, Boyd D, Maynor G, et al. Periodontal infection as a potential risk factor for preterm low birth weight. J Periodontal. 1996;67(10S):1103-1113. doi:10.1902/jop.1996.67.10s.1103.

[3]American Academy of Periodontology; American OB/GYN Healthcare Coalition. "Joint clinical consensus tracking on maternal healthcare and neonatal intensive care unit (NICU) commercial cost drivers." Chicago, IL: AAP Publishing; 2025.

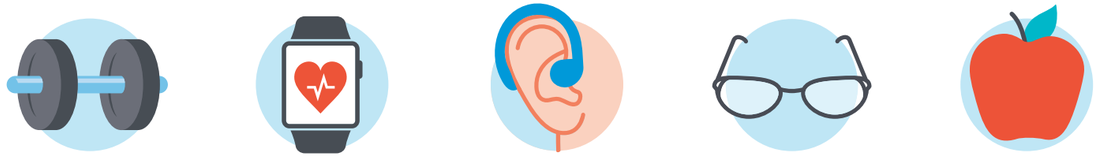
[4]Joo, J Y. "Fragmented Care and Chronic Illness Patient Outcomes: A Systematic Review." Nursing Open, U.S. National Library of Medicine, June 2023, https://pmc.ncbi.nlm.nih.gov/articles/PMC10170908/

[5]Fu, D, Shu, X, Zhou, G, et al. "Connection between oral health and chronic diseases." MedComm, 2025 Jan 14. https://pmc.ncbi.nlm.nih.gov/articles/PMC11731113/

Foster a healthy workforce with Blue365

Premera members can access Blue365—a health and wellness discount program offered through the Blue Cross Blue Shield (BCBS) system at no cost for the member or the group.

Health and wellness for less



Gym memberships | Fitness gear | Hearing aids | Prescription glasses | Healthy eating options

National access and well-known brands

Keep members healthy by connecting them to exclusive discounts.

- Gym memberships to more than 13,000 locations starting at $19/month
- Wearable devices from Fitbit, Garmin, Polar, and more
- LASIK eye surgery, hearing aids, and more

Reduce healthcare costs

$2.71

estimated return for every dollar spent on wellness programs[1]

Increase productivity

8.5%

increase in productivity when promoting wearables in the workplace[2]

How employers benefit

- Minimal setup
- Group discounts
- Access to healthy tips

Getting started is easy

Members can register at **blue365deals.com/premera** to browse their exclusive deals and discounts.

[1]Berry, Leonard L., et al. "What's the Hard Return on Employee Wellness Programs?" Harvard Business Review, Harvard Business Review, 1 Dec. 2010, hbr.org/2010/12/whats-the-hard-return-on-employeewellness-programs.

[2]Rajagopalan, Rajesh, and Venkataraman Krishnan. "Wearables: Are They Fit for the Workplace?" Cognizant, Feb. 2016, news.cognizant.com/download/The+Singapore+Engineer+May+2016.pdf.

Site-of-service expansion benefit

Value-based benefit design for elective surgeries and low-risk births

The Premera site-of-service benefit reduces member costs for high-value care at selected locations like ambulatory surgical centers (ASC) and freestanding birth centers. It encourages informed choices, ensures clinical oversight, and aligns cost sharing with care quality, while maintaining member-provider decision-making.

Pillars to our value-based benefit design

Improve member satisfaction with self-directed care

Provide cost-effective care without compromising quality

Reduce administrative burden

Lower total cost of care for members and employers

What's an ambulatory surgical center

Ambulatory surgical centers (ASC) are a type of outpatient surgical center. ASCs offer patients the convenience of having surgeries and procedures performed safely outside of a hospital outpatient department (HOPD).

What's a freestanding birth center

Freestanding birth centers are healthcare facilities that use a midwifery model of care to provide services during pregnancy, labor and delivery, and postpartum care. They often provide a more natural and family-centered approach to low-risk pregnancies.

Care starts with a member and their provider. An ASC or birthing center is not a good fit for all members. For any medical procedure, members should consult with their provider about the best place for them to receive their care.

ASCs deliver better outcomes at a lower cost

Like inpatient hospitals and HOPDs, ASCs are held to rigorous quality and safety standards. With a specialized focus on certain procedures, members often experience better outcomes along with lower costs.

Common ASC procedures and surgeries		
Joint and bone	**General**	**Stomach and colon**
• Total joint replacement	• Biopsies	• Colonoscopy
• ACL repair	• Appendix removal	• Endoscopy
• Hand or wrist procedures	• Gallbladder removal	• Hemorrhoid removal

Surgeries performed at ASCs can be

45-60%

less expensive than inpatient and outpatient hospital settings[1]

Freestanding birthing centers improve outcomes

Freestanding birth centers have become an increasingly popular option for low-risk pregnancies, and access to these centers has grown significantly in the United States. The midwifery care model used at birthing centers has consistently shown that women and babies have better outcomes, including lower rates of preterm and low-weight births, and higher breastfeeding rates.

Maternal and neonatal outcomes[2]		
	Birth centers	**National data**
Preterm birth %	**4.4**	9.9
Low birth weight %	**3.3**	8.2
Cesarean birth %	**12.3**	31.9
Breastfeeding initiation %	**92.2**	83.2

Freestanding birth centers often achieve higher patient satisfaction due to longer prenatal visits and individualized postpartum care.[3]

[1]Provista. "Huge Cost Savings and Other Benefits Boost Ambulatory Surgery Center Growth." Provista, https://www.provista.com/blog/blog-listing/huge-cost-savings-and-other-benefits-boost-ambulatory-surgery-center-growth. Accessed 20 June 2025.

[2]Gadzinski, Andrew J., et al. "Ambulatory Surgery Centers and Outpatient Urologic Surgery Among Medicare Beneficiaries." Urology Practice, vol. 9, no. 2, 2022, pp. 123–129. PubMed Central, https://pmc.ncbi.nlm.nih.gov/articles/PMC8827343/. Accessed 20 June 2025.

[3]Institute of Medicine (US) Committee on the Future of Emergency Care in the United States Health System. Hospital-Based Emergency Care: At the Breaking Point. National Academies Press (US), 2007. NCBI Bookshelf, https://www.ncbi.nlm.nih.gov/sites/books/NBK555483/. Accessed 20 June 2025.

Site-of-service, value-based benefit access

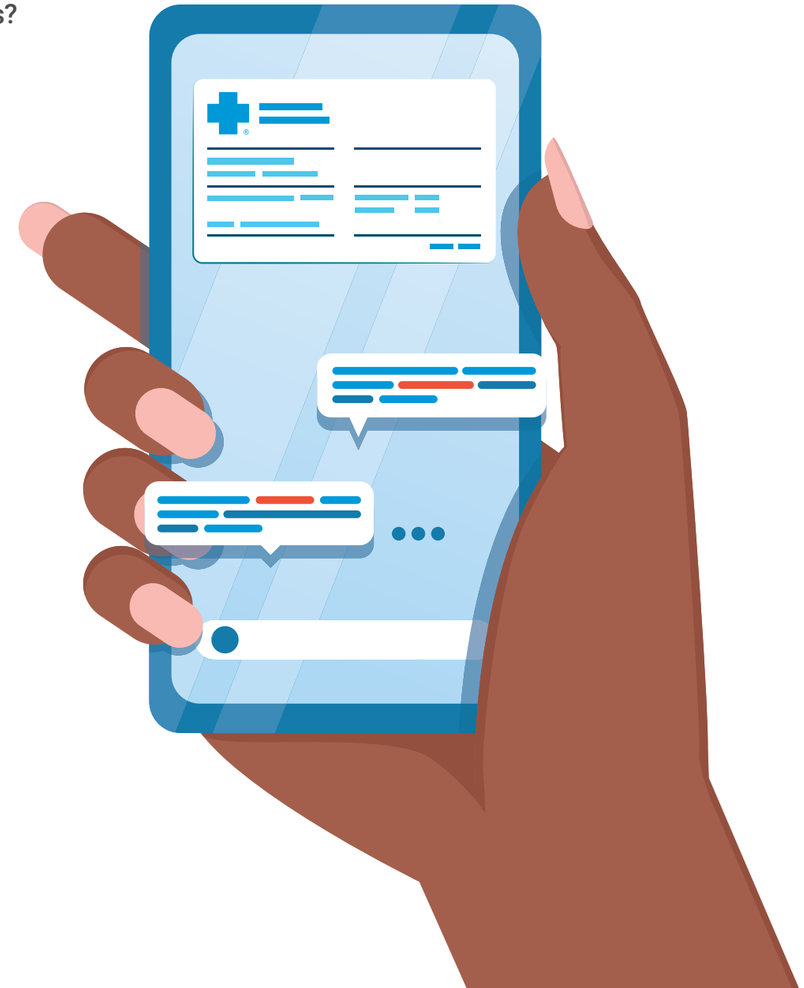
✓ **Self-funded:** an opt-in for flexible plans

Personalized messages at your fingertips

Premera Digital Health Messages are a way to reach our members and help them better understand their benefits, make personalized healthy choices, and more.

What are Digital Health Messages?

Digital Health Messages are text messages sent to members' mobile phones. These personalized messages point members to customized feeds that educate the member on primary care, seasonal health tips, and information about their health plan.



Interaction with Digital Health Messages

9% click-through rate to custom feed

22% average take-action rate

Digital Health Messages access

✓ **Self-funded:** included as part of your plan*

*Fee for Digital Health Messages is based on group size. Self-funded groups can opt out through customization.

Did you know?

The most successful Digital Health Message campaign was for Rx Savings Solutions (RxSS). RxSS offers members opportunities to save more on their prescriptions. **Learn more about RxSS**.

Advanced primary care starts here

Access to high-quality primary care and improved health outcomes go hand in hand.

> "It was amazing. She took the time to listen and answer all questions. I did not feel rushed. It was one of the best doctor appointments I've ever had. I'm so grateful that I made the switch. Definitely will recommend."
> – Kinwell patient

Kinwell clinics

With our health plans, you can be sure your employees have access to quality primary care from the broadest provider network. This network includes Kinwell, with 16 clinics across Washington and virtual care from anywhere in the state. Kinwell's advanced primary care integrates nutrition, physical activity, and behavioral health services exclusively for Premera Blue Cross members.

Scan QR code for Kinwell locations or visit **kinwellhealth.com/welcome**.

NET PROMOTER SCORE
85

TOTAL COST OF CARE
7% to 10% better than other in-network providers

TIMELY ACCESS
10% of patients seen same day
60% within 10 days
80% within 30 days

LOCATIONS
16 locations within **10** miles of **600,000** members

Did you know?

Every Premera medical plan includes access to our 24-Hour NurseLine. Members can call day or night to receive free and confidential health advice from a registered nurse.

Provider networks

We believe in working closely with providers and hospitals to ensure customers receive the best healthcare possible. That's why our provider networks are more than just a collection of contracts—they give members access to quality care, good experiences, and services at a fair price.

PREMERA BLUE CROSS

NETWORK	TOTAL PRACTITIONERS	PRIMARY CARE PROVIDERS	HOSPITALS
Heritage[1]	54,625	9,869	119
	Available with Your Choice, Your Future, Your Focus, and Essentials plans.		
Heritage Prime[1]	49,365	8,436	97
	Available with BlueHPN plans.		
Dental Choice[1,2]	Washington state	Nationwide providers	Nationwide locations
	3,980	122,000+	483,000+

[1]Network counts as of May 2026.
[2]Provider and location counts reflect inclusion of the Dental GRID+ network.

PROVIDER NETWORK OPTIONS

National, worldwide, and affordable network coverage with BlueCard

Premera Blue Cross health plans offer specific levels of healthcare benefits wherever your employees live or travel, across the country and worldwide.

Contact your producer or Premera representative for more details and to find out what level of BlueCard® healthcare benefits are included in your Premera health plan.

The power of choice

Whether your employees want access to the most providers in Washington state or the highest savings, give them the ability to choose their network. Talk with your producer or Premera account manager about the benefits of offering your employees the opportunity to choose from two medical plans.

Medical plans

You can choose from a range of plans to find the right balance between budgetary and healthcare needs for both your business and your employees. All our plans offer specified preventive screenings and services covered in full. They also include coverage for many professional and naturopathic services with no visit or dollar limits.

DECIDE WHICH PLAN IS RIGHT FOR YOU

Your Choice

This traditional preferred provider organization (PPO) plan offers coverage for a wide range of medical services. Your employees and their covered dependents can save money by using an in-network provider. Non-network providers are still covered, but at a higher cost.

Your Focus

This plan is an exclusive provider organization (EPO) plan. Services covered are the same for this plan as for the more traditional Your Choice plan; however, members of this EPO are not covered for care received outside the selected network. Members are encouraged to use the providers and hospitals within the selected network because there are no out-of-network benefits, except for emergency care.

Your Future

This plan is designed to be combined with an employee-owned health savings account (HSA) and offers the choice between an aggregate deductible, an embedded deductible, or an out-of-pocket maximum. **See page 36** to find more information on the difference between aggregate and embedded options.

Blue High Performance Network

This plan is an exclusive provider organization (EPO) plan. The BlueHPN plan design offers an average of 12% total cost of care savings over our industry-leading PPO and up to 20% savings in some markets.[1]

[1]Total cost of care savings based on Consortium Health Plans analysis, 2025. Savings are on average and assume 100% enrollment. Results will vary based on employer locations and implementations.

Preventive health

Preventive healthcare services are part of every Premera Blue Cross plan. Our secure member website provides suggested preventive routine exams, vaccinations, and screenings.

Your Choice

Your Choice offers a familiar preferred provider organization (PPO) plan with coverage for a wide range of medical services.

You can select from a range of deductible options. You can also split copay options, with a lower copay for a nonspecialist office visit and a higher copay when your employee or their covered dependent sees a specialist.

Cost-share options

Cost-share amounts represent customers' costs. Not all plan option combinations are offered.
See your Premera representative for clarification.
PCY = per calendar year

	IN NETWORK	OUT OF NETWORK
Individual deductible PCY	$0–$12,000 (increments of $50)	Shared with in network, 2x Individual in network, or 3x Individual in network
Family deductible PCY	2x Individual or 3x Individual	
Coinsurance	0%–50% (increments of 5%)	20%–60% (increments of 5%)
Individual out-of-pocket maximum PCY (includes deductible, coinsurance, and copay)	$1,000–$12,000 (increments of $50)	Shared with in network, 2x Individual in network, 3x Individual in network, or None
Family out-of-pocket maximum PCY (includes deductible, coinsurance, and copay)	2x Individual or 3x Individual	
Fourth-quarter deductible carryover	Included/Excluded	
Office visit cost share **Split copay** (nonspecialist/specialist)	Nonspecialist: $0–$45/Specialist: $20–$80 (increments of $5) In-network deductible and coinsurance Single copay options: $10–$40 (increments of $5)	Out-of-network deductible and coinsurance
Inpatient cost share	In-network deductible and coinsurance; $250 per admit; $250 per day up to 5 days per admit; or $100 per day	
Annual plan maximum	None	

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
In-network and out-of-pocket maximum must not exceed the federally mandated maximum of $12,000 for an individual or $24,000 for a family.

Covered services

Benefits apply after calendar-year deductible is met, unless otherwise noted.
Benefits subject to medical necessity except for preventive care.
PCY = per calendar year

	BENEFIT LIMITS	IN NETWORK	OUT OF NETWORK
Preventive care and counseling visit	Subject to federal and state guidelines[1]	Covered in full[2]	Not covered; Out-of-network coinsurance; Out-of-network coinsurance (deductible waived); or Covered in full
Preventive screenings			
Vaccinations (including seasonal vaccinations received at a pharmacy or other mass vaccination location paid as in network)			
Professional office visit	No visit limits	Office visit cost share	Out-of-network coinsurance
Urgent care		Split copay: Specialist copay; All others: Office visit cost share	
Virtual care (general medicine)		$10 copay, or in-network coinsurance	
Other outpatient professional services; Inpatient professional services		In-network coinsurance	
Manipulations[3] (spinal and other)	10–34 visits PCY or Unlimited	Office visit cost share[3]	Out-of-network coinsurance
Acupuncture[3]			
Naturopathic services	No visit limits		
Breast cancer screening (including mammogram)	No visit limits	Covered in full[2]	Out-of-network coinsurance
Outpatient diagnostic imaging and laboratory services		Basic imaging and labs: In-network coinsurance; In-network coinsurance (deductible waived); Major imaging: In-network coinsurance; Covered in full[2] Basic/Major imaging and lab: first $400 covered in full, then in-network coinsurance	
Emergency room care (copay waived if directly admitted to inpatient facility)	No maximum	In-network coinsurance, or in-network coinsurance **plus** copay of: $75–$500 (increments of $25)	Same as in network
Ambulance transportation (air and ground)	No trip or dollar maximum	$50 copay, in-network coinsurance, or in-network coinsurance (deductible waived)	
Inpatient hospital care	No limit on number of days or visits	Inpatient cost share	Out-of-network coinsurance
Outpatient facility care		In-network coinsurance	
Skilled nursing facility	60–180 days (increments of 10 days) or Unlimited	Inpatient cost share	
Maternity care (prenatal, delivery, and postnatal care)	No visit or day maximum; covered for: subscriber, spouse/domestic partner, and dependents	In-network coinsurance	Out-of-network coinsurance
Mental health and substance use treatments	No visit or day maximums	Outpatient: Office visit cost share[3]; Inpatient: Inpatient cost share	Out-of-network coinsurance
Rehabilitation (including physical, occupational, speech, and massage therapy)	15–90 visits (increments of 5 visits)/ 15–90 days (increments of 5 days) Unlimited/Unlimited		
(including cardiac/pulmonary rehab and chronic pain)	No visit limits		
Supplies, equipment, prosthetics, and orthotics	No maximum, except $100–$600 (increments of $100) max PCY for foot orthotics that are not diabetes related	In-network coinsurance	
Temporomandibular joint disorders (TMJ)	No dollar maximum	Outpatient: Office visit cost share; Inpatient: Inpatient cost share	
Home health agency services	130 visits PCY, or No visit limit	In-network coinsurance or covered in full	
Hospice care	Outpatient: No visit limits (within 6-month lifetime maximum) or Unlimited; Respite: 240 hours (within 6-month lifetime maximum) or Unlimited; Inpatient options: 10 days or Unlimited	Outpatient and respite: In-network coinsurance or covered in full; Inpatient: Inpatient cost share or covered in full	
Transplants (organ and bone marrow)	No dollar maximums, except for $7,500, $10,000, or No limit for travel and lodging per transplant	Outpatient: Office visit cost share; Inpatient: Inpatient cost share	Covered same as in network when approved

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
[1]A list of preventive benefits is available to members when they sign in to their secure member account on **premera.com**.
[2]Not subject to copay, deductible, or coinsurance.
[3]With the split copay option, this benefit is subject to the nonspecialist copay.
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Your Focus

This plan is an exclusive provider organization (EPO) plan. Services covered are the same for this plan as the more traditional Your Choice plan; however, members of this EPO are not covered for care received outside the selected network.

Therefore, members are encouraged to use the providers and hospitals within the selected network, potentially saving both you and them money. There are no out-of-network benefits.

Cost-share options

Cost-share amounts represent customers' costs. Not all plan option combinations are offered.
See your Premera representative for clarification.
PCY = per calendar year

	IN NETWORK	OUT OF NETWORK
Individual deductible PCY	$0–$12,000 (increments of $50)	Not covered*
Family deductible PCY	2x Individual or 3x Individual	
Coinsurance	0%–50% (increments of 5%)	
Individual out-of-pocket maximum PCY (includes deductible, coinsurance, and copay)	$1,000–$12,000 (increments of $50)	
Family out-of-pocket maximum PCY (includes deductible, coinsurance, and copay)	2x Individual or 3x Individual	
Fourth-quarter deductible carryover	Included/Excluded	
Office visit cost share	In-network deductible and coinsurance, or copay options: $10–$40 (increments of $5)	
Inpatient cost share	In-network deductible and coinsurance; $250 per admit; $250 per day up to 5 days per admit; or $100 per day	
Annual plan maximum	None	

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
In-network and out-of-pocket maximum must not exceed the federally mandated maximum of $12,000 for an individual or $24,000 for a family.
*Except for emergencies or as required by law.

Covered services

Benefits apply after calendar-year deductible is met, unless otherwise noted.
Benefits subject to medical necessity except for preventive care.
PCY = per calendar year

	BENEFIT LIMITS	IN NETWORK	OUT OF NETWORK
Preventive care and counseling visit	Subject to federal and state guidelines[1]	Covered in full[2]	Not covered
Preventive screenings			
Vaccinations (including seasonal vaccinations received at a pharmacy or other mass vaccination location paid as in network)			
Professional office visit (including urgent care)	No visit limits	Office visit cost share	
Virtual care (general medicine)		$10 copay, or in-network coinsurance	
Other outpatient professional services; Inpatient professional services		In-network coinsurance	
Manipulations (spinal and other)	10–34 visits PCY or Unlimited	Office visit cost share	
Acupuncture			
Naturopathic services	No visit limits		
Breast cancer screening (including mammogram)	No visit limits	Covered in full[2]	
Outpatient diagnostic imaging and laboratory services		Basic imaging and labs: In-network coinsurance, in-network coinsurance (deductible waived); Major imaging: In-network coinsurance; Covered in full[2] Basic/Major imaging and lab: first $400 covered in full, then in-network coinsurance	
Emergency room care (copay waived if directly admitted to inpatient facility)	No maximum	In-network coinsurance, or in-network coinsurance **plus** copay of: $75–$500 (increments of $25)	Same as in network
Ambulance transportation (air and ground)	No trip or dollar maximum	$50 copay; In-network coinsurance; or in-network coinsurance (deductible waived)	
Inpatient hospital care	No limit on number of days or visits	Inpatient cost share	Not covered
Outpatient facility care		In-network coinsurance	
Skilled nursing facility	60–180 days (increments of 10 days) or Unlimited	Inpatient cost share	
Maternity care (prenatal, delivery, and postnatal care)	No visit or day maximum; covered for: subscriber, spouse/domestic partner, and dependents	In-network coinsurance	
Mental health and substance use treatments	No limit on number of days or visits	Outpatient: Office visit cost share; Inpatient: Inpatient cost share	
Rehabilitation (including physical, occupational, speech, and massage therapy)	15–90 visits (increments of 5 visits)/ 15–90 days (increments of 5 days) Unlimited/Unlimited		
(including cardiac/pulmonary rehab and chronic pain)	No visit limits		
Supplies, equipment, prosthetics, and orthotics	No maximum, except $100–$600 (increments of $100) max PCY for foot orthotics that are not diabetes related	In-network coinsurance	
Temporomandibular joint disorders (TMJ)	No dollar maximum	Outpatient: Office visit cost share; Inpatient: Inpatient cost share	
Home health agency services	130 visits PCY, or no visit limit	In-network coinsurance or covered in full	
Hospice care	Outpatient: No visit limits (within 6-month lifetime maximum) or Unlimited; Respite: 240 hours (within 6-month lifetime maximum) or Unlimited; Inpatient options: 10 days, 30 days, or No day limit (within 6-month lifetime maximum) or Unlimited	Outpatient and respite: In-network coinsurance or covered in full; Inpatient: Inpatient cost share or covered in full	
Transplants (organ and bone marrow)	No dollar maximums, except for $7,500, $10,000, or No limit for travel and lodging per transplant	Outpatient: Office visit cost share; Inpatient: Inpatient cost share	Covered when approved

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
[1]A list of preventive benefits is available to members when they sign in to their secure member account on **premera.com**.
[2]Not subject to copay, deductible, or coinsurance.
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BlueHPN

Blue High Performance Network℠ is an exclusive provider organization (EPO) with a network that was developed to include the right providers in the right markets. BlueHPN aims to deliver better outcomes, value, and high quality care with the Heritage Prime network.

Cost-share options

Cost-share amounts represent customers' costs. Not all plan option combinations are offered.
See your Premera representative for clarification.
PCY = per calendar year

	IN NETWORK	OUT OF NETWORK
Individual deductible PCY	$0–$12,000 (increments of $50)	Not covered*
Family deductible PCY	2x Individual or 3x Individual	
Coinsurance	0%–50% (increments of $50)	
Individual out-of-pocket maximum PCY (includes deductible, coinsurance, and copay)	$1,000–$12,000 (increments of $50)	
Family out-of-pocket maximum PCY (includes deductible, coinsurance, and copay)	2x Individual or 3x Individual	
Fourth-quarter deductible carryover	Included/Excluded	
Office visit cost share	In-network deductible and coinsurance, or copay options: $10–$40 (increments of $5)	
Inpatient cost share	In-network deductible and coinsurance; $250 per admit; $250 per day up to 5 days per admit; or $100 per day	
Annual plan maximum	None	

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross. In-network and out-of-pocket maximum must not exceed the federally mandated maximum of $12,000 for an individual or $24,000 for a family.
*Except for emergencies or as required by law.

Covered services

Benefits apply after calendar-year deductible is met, unless otherwise noted.
Benefits subject to medical necessity except for preventive care.
PCY = per calendar year

	BENEFIT LIMITS	IN NETWORK	OUT OF NETWORK
Preventive care and counseling visit	Subject to federal and state guidelines[1]	Covered in full[2]	Not covered
Preventive screenings			
Vaccinations (including seasonal vaccinations received at a pharmacy or other mass vaccination location paid as in network)			
Professional office visit (including urgent care)	No visit limits	Office visit cost share	
Urgent care		Office visit cost share	HPN product area: Not covered; Non-HPN product area: Same as in-network cost share
Virtual care (general medicine)		$10 copay, or in-network coinsurance	Not covered
Other outpatient professional services; Inpatient professional services		In-network coinsurance	
Manipulations (spinal and other)	10–34 visits PCY, or Unlimited	Office visit cost share	
Acupuncture			
Naturopathic services	No visit limits		
Breast cancer screening (including mammogram)	No visit limits	Covered in full[2]	
Outpatient diagnostic imaging and laboratory services		Basic imaging and labs: In-network coinsurance, in-network coinsurance (deductible waived); Major imaging: In-network coinsurance; Covered in full[2] Basic/Major imaging and lab: first $400 covered in full, then in-network coinsurance	
Emergency room care (copay waived if directly admitted to inpatient facility)	No maximum	In-network coinsurance, or in-network coinsurance **plus** copay of $75–$500 (increments of $25)	Same as in network
Ambulance transportation (air and ground)	No trip or dollar maximum	$50 copay; In-network coinsurance; or in-network coinsurance (deductible waived)	
Inpatient hospital care	No limit on number of days or visits	Inpatient cost share	Not covered
Outpatient facility care		In-network coinsurance	
Skilled nursing facility	60–180 days (increments of 10 days), or Unlimited	Inpatient cost share	
Maternity care (prenatal, delivery, and postnatal care)	No visit or day maximum; covered for: subscriber, spouse/domestic partner, and dependents	In-network coinsurance	
Mental health and substance use treatments	No limit on number of days or visits	Outpatient: Office visit cost share; Inpatient: Inpatient cost share	
Rehabilitation (including physical, occupational, speech, and massage therapy)	15–90 visits (increments of 5 visits)/ 15–90 days (increments of 5 days); or Unlimited/Unlimited		
(including cardiac/pulmonary rehab and chronic pain)	No visit limits		
Supplies, equipment, prosthetics, and orthotics	No maximum, except $100–$600 (increments of $100) max PCY for foot orthotics that are not diabetes related	In-network coinsurance	
Temporomandibular joint disorders (TMJ)	No dollar maximum	Outpatient: Office visit cost share; Inpatient: Inpatient cost share	
Home health agency services	130 visits PCY or Unlimited	In-network coinsurance or covered in full	
Hospice care	Outpatient: No visit limits (within 6-month lifetime maximum) or Unlimited; Respite: 240 hours (within 6-month lifetime maximum) or Unlimited; Inpatient options: 10 days, 30 days, or No day limit (within 6-month lifetime maximum) or Unlimited	Outpatient and respite: In-network coinsurance or covered in full; Inpatient: Inpatient cost share or covered in full	
Transplants (organ and bone marrow)	No dollar maximums, except for $7,500, $10,000, or No limit for travel and lodging per transplant	Outpatient: Office visit cost share; Inpatient: Inpatient cost share	Covered when approved

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
[1]A list of preventive benefits is available to members when they sign in to their secure member account on **premera.com**.
[2]Not subject to copay, deductible, or coinsurance.
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BlueHPN HSA

BlueHPN HSA combines the benefits of a cost-effective EPO health plan with an employee-owned, tax-advantaged health savings account (HSA).

You can choose between an aggregate or an embedded deductible.

Deductible options

Aggregate deductible	The aggregate deductible amount is different depending on whether a subscriber enrolls alone or with dependents. When dependents are enrolled, the full amount of the aggregate deductible must be met before benefits can begin for any covered family member.
Embedded deductible	An embedded deductible works like a traditional health plan deductible. Benefits begin for a single family member after either the member's own expenses equal the individual deductible or the expenses from a combination of family members equals the family maximum.

Cost-share options

Cost-share amounts represent customers' costs. Not all plan option combinations are offered.
See your Premera representative for clarification.
PCY = per calendar year
INN = in network
OON = out of network

		IN NETWORK		OUT OF NETWORK
Individual/ Family deductible PCY	**Aggregate**	$1,750/$3,500—$4,350/$8,700 (increments of $50)	N/A	Not covered
	Embedded	N/A	$3,500/$7,000—$8,700/$17,400 (increments of $50)	
Coinsurance		0%–50% (increments of 5%)		
Individual/ Family out-of-pocket maximum PCY	**Aggregate**	$1,750/$3,500—$4,350/$8,700 (increments of $50)	N/A	
	Embedded	$3,500/$7,000—$8,700/$17,400 (increments of $50)		
Fourth-quarter deductible carryover		Excluded		
Office visit cost share		In-network deductible and coinsurance		
Inpatient cost share				
Annual plan maximum		Unlimited		

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.

Covered services

Benefits apply after calendar-year deductible is met, unless otherwise noted.
Benefits subject to medical necessity except for preventive care.
PCY = per calendar year

	BENEFIT LIMITS	IN NETWORK	OUT OF NETWORK
Preventive care and counseling visit	Subject to federal and state guidelines[1]	Covered in full[2]	Not covered
Preventive screenings			
Vaccinations (including seasonal vaccinations received at a pharmacy or other mass vaccination location paid as in-network)			
Professional office visit (including urgent care)	No visit limits	In-network coinsurance	HPN product area: Not covered; Non-HPN product area: Same as in-network cost share
Urgent care			
Virtual care (general medicine)			
Other outpatient professional services; Inpatient professional services			Not covered
Manipulations (spinal and other)	10–34 visits PCY, or Unlimited		
Acupuncture			
Naturopathic services	No visit limits		
Breast cancer screening (including mammogram)	No visit limits	Covered in full[2]	
Outpatient diagnostic imaging and laboratory services		In-network coinsurance	
Emergency room care (copay waived if directly admitted to inpatient facility)	No maximum	In-network coinsurance, or $300 copay then in-network coinsurance	
Ambulance transportation (air and ground)			
Inpatient hospital care	No limit or visit maximum	In-network coinsurance	Not covered
Outpatient facility care			
Skilled nursing facility	60–180 days (increments of 10 days), or Unlimited		
Maternity care (prenatal, delivery, and postnatal care)	No visit or day maximum; covered for: subscriber, spouse/domestic partner, and dependents		
Mental health and substance use treatments	No limit on number of days or visits		
Rehabilitation (including physical, occupational, speech, and massage therapy)	15–90 visits (increments of 5 visits)/ 15–90 days (increments of 5 days) Unlimited/Unlimited		
(including cardiac/pulmonary rehab and chronic pain)	No visit limits		
Supplies, equipment, prosthetics, and orthotics	No maximum, except $100–$600 (increments of $100) max PCY for foot orthotics that are not diabetes related		
Temporomandibular joint disorders (TMJ)	No dollar maximum		
Home health agency services	130 visits PCY or Unlimited		
Hospice care	Outpatient: No visit limits (within 6-month lifetime maximum) or Unlimited; Respite: 240 hours (within 6-month lifetime maximum) or Unlimited; Inpatient options: 10 days, 30 days, or No day limit (within 6-month lifetime maximum) or Unlimited	In-network coinsurance or deductible, then 0%	
Transplants (organ and bone marrow)	No dollar maximums, except for $7,500, $10,000, or No limit for travel and lodging per transplant	In-network coinsurance	Covered when approved
Certain generic preventive drugs retail and mail order	90-day supply, except Specialty Rx: 30-day supply	Covered in full[2]	
Retail pharmacy (subject to medical deductible)		In-network coinsurance	
Mail-order pharmacy (subject to medical deductible)		In-network coinsurance	Not covered

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
[1]A list of preventive benefits is available to members when they sign in to their secure member account on **premera.com**.
[2]Not subject to copay, deductible, or coinsurance.
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Your Future

The HSA-qualified Your Future plan is designed to work with an employee-owned, tax-advantaged health savings account (HSA).

You can choose between an aggregate or an embedded deductible.

Deductible options

Aggregate deductible	The aggregate deductible amount is different depending on whether a subscriber enrolls alone or with dependents. When dependents are enrolled, the full amount of the aggregate deductible must be met before benefits can begin for any covered family member.
Embedded deductible	An embedded deductible works like a traditional health plan deductible. Benefits begin for a single family member after either the member's own expenses equal the individual deductible or the expenses from a combination of family members equals the family maximum.

Cost-share options

Cost-share amounts represent customers' costs. Not all plan option combinations are offered.
See your Premera representative for clarification.
PCY = per calendar year
INN = in network
OON = out of network

		IN NETWORK		OUT OF NETWORK
Individual/ Family deductible PCY	**Aggregate**	$1,750/$3,500—$4,350/$8,700 (increments of $50)	N/A	Shared with in-network, or 2x individual in-network
	Embedded	N/A	$3,500/$7,000—$8,700/$17,400 (increments of $50)	
Coinsurance		0%–50% (increments of 5%)		20%–60% (increments of 5%)
Individual/ Family out-of-pocket maximum PCY	**Aggregate**	$3,500/$7,000—$8,700/$17,400 (increments of $50)	N/A	Unlimited or 2x in-network
	Embedded	$3,500/$7,000—$8,700/$17,400 (increments of $50)		
Fourth-quarter deductible carryover		Excluded		Excluded
Office visit cost share		In-network deductible and coinsurance		OON deductible and coinsurance
Inpatient cost share				OON deductible and coinsurance
Annual plan maximum		Unlimited		

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
[1]Out-of-network deductible is 2x the in-network deductible.
[2]Out-of-network deductible can either be shared with in-network or be 2x the in-network deductible.

Covered services

Benefits apply after calendar-year deductible is met, unless otherwise noted.
Benefits subject to medical necessity except for preventive care.
PCY = per calendar year

	BENEFIT LIMITS	IN NETWORK	OUT OF NETWORK
Preventive care and counseling visit	Subject to federal and state guidelines[1]	Covered in full[2]	Not covered; 40% or 50%; 40% or 50% (deductible waived); Covered in full
Preventive screenings			
Vaccinations (including seasonal vaccinations received at a pharmacy or other mass vaccination location paid as in-network)			
Professional office visit (including urgent care)	No visit limits	In-network coinsurance	20%–60% (increments of 5%)
Virtual care (general medicine)			Not covered
Other outpatient professional services; Inpatient professional services			20%–60% (increments of 5%)
Manipulations (spinal and other)	10–34 visits PCY, or Unlimited		
Acupuncture			
Naturopathic services	No visit limits		
Breast cancer screening (including mammogram)	No visit limits	Covered in full[2]	
Outpatient diagnostic imaging and laboratory services		In-network coinsurance	
Emergency room care (copay waived if directly admitted to inpatient facility)	No maximum	In-network coinsurance, or $300 copay then in-network coinsurance	
Ambulance transportation (air and ground)			
Inpatient hospital care	No limit or visit maximum	In-network coinsurance	20%–60% (increments of 5%)
Outpatient facility care			
Skilled nursing facility	60–180 days (increments of 10 days), or Unlimited		
Maternity care (prenatal, delivery, and postnatal care)	No visit or day maximum; covered for: subscriber, spouse/domestic partner, and dependents		
Mental health and substance use treatments	No limit on number of days or visits		
Rehabilitation (including physical, occupational, speech, and massage therapy)	15–90 visits (increments of 5 visits)/ 15–90 days (increments of 5 days) Unlimited/Unlimited		
(including cardiac/pulmonary rehab and chronic pain)	No visit limits		
Supplies, equipment, prosthetics, and orthotics	No maximum, except $100–$600 (increments of $100) max PCY for foot orthotics that are not diabetes related		
Temporomandibular joint disorders (TMJ)	No dollar maximum		
Home health agency services	130 visits PCY or Unlimited		
Hospice care	Outpatient: No visit limits (within 6-month lifetime maximum) or Unlimited; Respite: 240 hours (within 6-month lifetime maximum) or Unlimited; Inpatient options: 10 days, 30 days, or No day limit (within 6-month lifetime maximum) or Unlimited	In-network coinsurance or deductible, then 0%	
Transplants (organ and bone marrow)	No dollar maximums, except for $7,500, $10,000, or No limit for travel and lodging per transplant	In-network coinsurance	Covered when approved
Certain generic preventive drugs retail and mail order	90-day supply, except Specialty Rx: 30-day supply	Covered in full[2]	
Retail pharmacy (subject to medical deductible)		In-network coinsurance; Deductible then $10 / $35 / $70; or Deductible then $10 / $35 / $70 / 30%	
Mail-order pharmacy (subject to medical deductible)		In-network coinsurance; Deductible then $30/$105/$210; or Deductible then $30/$105/$210/30%	20%–60% (increments of 5%)

[1]A list of preventive benefits is available to members when they sign in to their secure member account on **premera.com**.
[2]Not subject to copay, deductible, or coinsurance.
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Learn more about **personal funding accounts**..

Essentials Medical

Essentials Medical gives you everything you need and nothing you don't. Essentials Medical is a low-cost health plan option that offers you savings on premiums.

Cost-share options

Cost-share amounts represent customers' costs.
Not all plan option combinations are offered.
See your Premera representative for clarification.
PCY = per calendar year.

	IN NETWORK	OUT OF NETWORK
Individual deductible PCY	$8,550	Not covered*
Family deductible PCY	2x Individual	
Coinsurance	0%	
Individual out-of-pocket maximum PCY (includes deductible, coinsurance, and copay)	$8,550	
Family out-of-pocket maximum PCY (includes deductible, coinsurance, and copay)	2x Individual	
Fourth-quarter deductible carryover	Excluded	
Office visit cost share	In-network deductible and coinsurance	
Inpatient cost share	In-network deductible and coinsurance	
Annual plan maximum	None	

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
In-network and out-of-pocket maximum must not exceed the federally mandated maximum of $12,000 for an individual or $24,000 for a family.
*Except for emergencies or as required by law.

Covered services

Benefits apply after calendar-year deductible is met, unless otherwise noted.
Benefits subject to medical necessity except for preventive care.
PCY = per calendar year

	BENEFIT LIMITS	IN NETWORK	OUT OF NETWORK
Preventive care and counseling visit	Subject to federal and state guidelines[1]	Covered in full[2]	Not covered
Preventive screenings			
Vaccinations (including seasonal vaccinations received at a pharmacy or other mass vaccination location paid as in-network)			
Professional office visit (including urgent care)	No visit limits	In-network coinsurance	
Virtual care (general medicine)		Covered in full[2]	
Other outpatient professional services; Inpatient professional services		In-network coinsurance	
Manipulations (spinal and other)	12 visits PCY		
Acupuncture			
Naturopathic services	No visit limits		
Breast cancer screening (including mammogram)	No visit limits	Covered in full[2]	
Outpatient diagnostic imaging and laboratory services		In-network coinsurance	
Emergency room care (copay waived if directly admitted to inpatient facility)	No maximum		Same as in network
Ambulance transportation (air and ground)	No trip or dollar maximum		
Inpatient hospital care	No limit on number of days or visits		Not covered
Outpatient facility care			
Skilled nursing facility	60 days PCY		
Maternity care (prenatal, delivery, and postnatal care)	No visit or day maximum; covered for: subscriber, spouse/ domestic partner, and dependents		
Mental health and substance use treatments	No limit on number of days or visits		
Rehabilitation (including physical, occupational, speech, and massage therapy)	45 visits/30 days PCY		
(including cardiac/pulmonary rehab and chronic pain)	No visit limits		
Supplies, equipment, prosthetics, and orthotics	No maximum, except $300 max PCY for foot orthotics that are not diabetes related		
Temporomandibular joint disorders (TMJ)	No dollar maximum		
Home health agency services	130 visits PCY		
Hospice care	Outpatient: No visit limits (within 6-month lifetime maximum) or Unlimited; Respite: 240 hours (within 6-month lifetime maximum) or Unlimited; Inpatient options: 10 days (within 6-month lifetime maximum) or Unlimited		
Transplants (organ and bone marrow)	No dollar maximums, except for $7,500 for travel and lodging per transplant		
Retail pharmacy	Up to 90-day supply per Rx		
Mail-order pharmacy	Up to 90-day supply per Rx (except Specialty Rx)		
Formulary drug list	Essentials		

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
[1]A list of preventive benefits is available to members when they sign in to their secure member account on **premera.com**.
[2] Not subject to copay, deductible, or coinsurance.
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Pharmacy benefits

Premera Blue Cross uses cost-saving incentives to encourage our customers to use generic or preferred brand-name drugs. They will enjoy even greater savings if they use the mail-order service.

Important: All medical plans are required to include a pharmacy plan.

The options listed on this page are available for all plans except health savings account (HSA) plans:

HSA plans include prescription drug coverage as well as a zero cost share for certain generic cardiovascular and oral diabetic medications on the preventive drug list. Please see the HSA plan summary pages on **premera.com** for more details.

Choose from options for your pharmacy plan:

Essentials is a restricted list of prescription drugs that meets basic pharmacy needs and has a new benefit structure, which follows. Essentials keeps costs as low as possible by focusing on high-value drugs that are approved by the U.S. Food and Drug Administration (FDA).

Preferred is a comprehensive drug list and provides access to a full spectrum of brand-name medications.

Self-funded groups with Essentials

SAVE UP TO

5%[1]

ESSENTIALS FORMULARY

PLANS WITH 4 TIERS	
FIRST TIER	Preferred generic drugs
SECOND TIER	Preferred brand-name drugs
THIRD TIER	Preferred specialty* drugs
FOURTH TIER	Non-preferred drugs (generic, brand, and specialty)

PLANS WITH 6 TIERS	
FIRST TIER	Value generic
SECOND TIER	Preferred generic
THIRD TIER	Preferred brand
FOURTH TIER	Non-preferred generic and brand
FIFTH TIER	Preferred specialty
SIXTH TIER	Non-preferred specialty

PREFERRED FORMULARY

PLANS WITH 4 TIERS	
FIRST TIER	Generic drugs
SECOND TIER	Preferred brand-name drugs
THIRD TIER	Non-preferred brand-name drugs
FOURTH TIER	Specialty drugs*

PLANS WITH 3 TIERS	
FIRST TIER	Generic drugs
SECOND TIER	Preferred brand-name drugs
THIRD TIER	Non-preferred brand-name drugs

PLANS WITH 2 TIERS	
FIRST TIER	Generic drugs
SECOND TIER	Brand-name drugs

Projected savings based on actuary analysis of claim experience for Premera groups with 4-Tier Essentials formulary. Approximated savings for self-funded groups was up to 5% on prescription claims.

*Specialty Pharmacy program: Both Essentials and Preferred pharmacy options include benefits for specialty drugs. Specialty drugs are used for treating complex or rare conditions and require special handling, storage, administration, or patient monitoring. Coverage requires these prescriptions be filled through our Specialty Pharmacy program, which uses pharmacies dedicated to supporting specialty drugs and those who need them. Employers can choose between our specialty pharmacy providers.

Essentials formulary

ESSENTIALS	4-TIER ESSENTIALS						
Retail pharmacy Up to 30-day supply per Rx	$10/$25/ $45/30%	$10/$30 / $30/30%	$10/$30/ $50/30%	$15/$30/ $50/30%	$15/$60/ $100/50%	$20/$50/ 30%/50%	$5/$20/$75/20% ($90 min, $175 max per script)/30% ($250 max per script)/ 50%
Mail order Up to 90-day supply per Rx	2.5X or 3X retail copays						
Rx individual deductible[2] PCY (separate from medical deductible)	None, $150, $300, or $500						
Rx family deductible[2] PCY	None or same as medical[3]						
Individual out-of-pocket maximum PCY	Participating pharmacy cost shares accrue to the in-network medical out-of-pocket maximum.						
Formulary Drug list	Essentials E4						
	6-TIER ESSENTIALS						
Retail pharmacy (Copay = 30 days; up to 90-day supply per Rx)	$5/$15/$35/$70/ 30%/50%[1]	$5/$15/$35/20%/ 30%/50%[1]	$5/$20/$40/$75/ 30%/50%[1]	$7/$25/$50/$100/ 30%/50%[1]	$5/$20/$75/20% ($90 min, $175 max per script)/30% ($250 max per script)/ 50%		
Mail order pharmacy[2] (Copay = 90 days; up to 90-day supply per Rx)	2.5X or 3X retail copays						
Rx individual deductible[2] PCY (separate from medical deductible)	None, $150[3], $300[3], or $500[3]						
Individual out-of-pocket maximum PCY	Participating pharmacy cost shares accrue to the out-of-pocket maximum for in-network medical.						
Formulary Drug list	Essentials E6						

W

Preferred formulary

Copays and coinsurance represent customers' cost
PCY = per calendar year
Rx = pharmacy

	4-TIER PREFERRED				
Retail pharmacy Up to 30-day supply per Rx	$15/35%/50%/30%		$20/$50/50%/30%		
Mail order Up to 90-day supply per Rx	$37.50/35%/50%/30%		$50/$125/50%/30%		
Rx individual deductible[2] PCY (separate from medical deductible)	None, $150, $300, or $500				
Rx family deductible[2] PCY	None or same as medical[3]				
Individual out-of-pocket maximum PCY	Participating pharmacy cost shares accrue to the out-of-pocket maximum for in-network medical.				
Formulary Drug list	Preferred B4				
	3-TIER PREFERRED				
	Standard copay plans		**Configurable copay plans**		
Retail pharmacy Up to 30-day supply per Rx	$10/$25/$45[1]	$10/$30/$50[1]	$10/$20/$40[1]	$15/$25/$40[4]	$15/$30/$50[4]
Mail order[4] Up to 90-day supply per Rx	$25/$62/$112[1]	$25/$75/$125[1]	$20/$40/$80; $25/$50/$100[1]	$30/$50/$80; $37/$62/$100[1]	$30/$60/$100; $37/$75/$125[1]
Rx individual deductible[2] PCY (separate from medical plan deductible)	None, $150, $300, or $500				
Rx family deductible[2] PCY	None	None or same as medical[3]	None or same as medical[3]		
Individual out-of-pocket maximum PCY	Participating pharmacy cost shares accrue to the out-of-pocket maximum for in-network medical.				
Formulary Drug list	Preferred B3				
	2-TIER PREFERRED				
	Standard coinsurance plan		**Configurable copay plans**		
Retail pharmacy Up to 30-day supply per Rx	$10/50%		$10/$30	$15/$35	
Mail order Up to 90-day supply per Rx	$25/45%		$20/$60 or $25/$75	$30/$70 or $37/$87	
Rx individual deductible[2] PCY (separate from medical plan deductible)	None, $150, $300, or $500				
Rx family deductible[2] PCY	None or same as medical[3]				
Individual out-of-pocket maximum PCY	Participating pharmacy cost shares accrue to the out-of-pocket maximum for in-network medical.				
Formulary Drug list	Preferred A2				

[1]Up to 30-day supply for specialty drugs only from a Premera specialty pharmacy provider.
[2]Deductible waived for generics and preferred generics on Essentials.
[3]Family deductible is separate from medical deductible; value uses same multiplier as medical deductible.
[4]Buy-up options are available to extend certain generic preventive drugs to be covered in full. Ask your sales representative for more details.
This is only a brief summary of the major benefits provided by our plans. This is not a contract.
For information and details regarding general exclusions and limitations, please contact your Premera representative.

Dental plans

Good oral health is important for your employees' overall health. Here's why: Regular preventive oral health visits assist with early detection and management of diseases. When you offer your employees both dental and medical benefits from Premera, you help encourage healthy habits.

Broad network access

Your employees gain access to more than 483,000 in-network provider locations nationwide with our expanded dental network. This is great for your employees who live or travel outside of Washington or Alaska.

122k dentists nationwide

483k locations nationwide

Did you know?

Premera dental plans may include additional preventive benefits. Detecting and treating minor issues early can prevent more serious and expensive claims for members with certain at-risk conditions.

[1]Discount and rate cap are subject to review.

Choose from three dental plans

With any Premera dental plan, your employees and their covered dependents will receive the following:

- Access to any in-network dentist or any out-of-network[1] dentist nationwide
- Freedom to choose any licensed dental provider, but they will pay less out of pocket if they choose an in-network dental provider
- Preventive and diagnostic services such as routine oral exams, cleanings, and x-rays covered with no deductibles
- Benefits for periodontal maintenance include up to four visits per year to help manage gum disease or chronic conditions

Plan highlights	DENTAL OPTIMA	DENTAL OPTIMA FLEX	DENTAL OPTIMA VOLUNTARY
Comprehensive benefits for major services	●	●	●
Employer-funded plan option[2]	●	●	
Access to nationwide Choice dental network	●	●	●
Optional orthodontia coverage available for groups with 26 or more enrolled employees	●	●	
Employee-funded plan option[3]			●

[1]Balance billing may apply with out-of-network dentists. Note: For a summary of plan benefits and limitations, see plan details to follow.
[2]Employer contributes 50%–100% of premium. Minimum enrollment is 50% of eligible employees.
[3]Employer contributes 0%–49% of premium. Minimum enrollment is 30% of eligible employees.

Dental Optima

With Dental Optima™ you can choose from several cost-share options, giving your employees and their covered dependents choice and control over their spending. You can decide to have routine diagnostic and preventive services that won't count toward the annual maximum on the plan.

To help encourage regular oral health maintenance, preventive services such as routine exams and cleanings are covered. Additionally, there's no waiting period for major services such as crowns, implants, and dentures, so your employees can get the care they need as soon as their coverage starts.

Covered services

Benefits apply after calendar year deductible is met, unless otherwise noted.
Deductible and coinsurance represent customers' cost share.
PCY = per calendar year
CY = calendar year(s)

		OPTIMA	OPTIMA Shared family maximum plan
		COST SHARES	
Annual deductible PCY	**INDIVIDUAL**	$0/$25/$50	$50
	FAMILY	$0/$75/$150	$150
Maximum allowance per person, PCY		$1,000–$3,000 (increments of $250)	$1,500, $2,000 Shared family maximum, up to 3x Individual
		IN AND OUT OF NETWORK	**IN AND OUT OF NETWORK**
DIAGNOSTIC AND PREVENTIVE[1]			
Routine oral exams 2 PCY		0%–30% (increments of 5%)	0%
Emergency exams			
Bitewing x-rays			
Complete series or panoramic x-ray once per 36 consecutive months			
Cleanings 2 PCY			
Fluoride treatments 2 applications PCY under the age of 19			
Sealants once every 24 consecutive months under age 19; limited to permanent molars only			
Space maintainers under age 19			
BASIC			
Fillings once per tooth surface every 24 consecutive months		0%–50% (increments of 5%)	20%
Repair and recementing of crowns, inlays, bridgework, and dentures when performed 6 or more months after placement			
Endodontic (root canal) treatment once per tooth every 24 consecutive months			
Periodontal maintenance 4 visits PCY			
Periodontal scaling and root planing once per quadrant every 24 consecutive months			
Periodontal surgery once per quadrant every 36 consecutive months			
Oral surgery including simple and surgical extractions			
Intravenous or general anesthesia for covered dental procedures at a dental-care provider's office when dentally necessary			
MAJOR			
Inlays, onlays, and crowns once per tooth every 5 CY		0%–60% (increments of 5%)	50%
Implants once every 5 CY			
Dentures, partials, and fixed bridges once every 5 CY			

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
[1]Annual deductible waived for diagnostic and preventive services.

Dental Optima Flex

Dental Optima Flex™ allows you to choose from different in-network and out-of-network cost-share options. Your employees and their covered dependents can save money by using an in-network provider. Non-network providers are still covered, but you may have more out-of-pocket cost. You can decide to have routine diagnostic and preventive services that won't count toward the annual maximum on the plan.

Preventive services such as routine oral exams and cleanings are covered and there's no waiting period for major services such as crowns, implants, and dentures. Your employees can get the care they need as soon as their coverage starts.

Covered services

Benefits apply after calendar year deductible is met, unless otherwise noted.
Deductible and coinsurance represent customers' cost share.
PCY = per calendar year
CY = calendar year(s)

		OPTIMA FLEX		OPTIMA FLEX Shared family maximum plan	
		COST SHARES			
Annual deductible PCY	**INDIVIDUAL**	$0/$25/$50		$50	
	FAMILY	$0/$75/$150		$150	
Maximum allowance per person, PCY		$1,000–$3,000 (increments of $250)		$1,500, $2,000 Shared family maximum, up to 3x Individual	
		IN NETWORK	**OUT OF NETWORK**	**IN NETWORK**	**OUT OF NETWORK**
DIAGNOSTIC AND PREVENTIVE[1]					
Routine oral exams 2 PCY		0%–30% (increments of 5%)	0%–30% (increments of 5%)	0%	10%
Emergency exams					
Bitewing x-rays					
Complete series or panoramic x-ray once per 36 consecutive months					
Cleanings 2 PCY					
Fluoride treatments 2 applications PCY under the age of 19					
Sealants once every 24 consecutive months under age 19; limited to permanent molars only					
Space maintainers under age 19					
BASIC					
Fillings once per tooth surface every 24 consecutive months		0%–50% (increments of 5%)	0%–50% (increments of 5%)	20%	30%
Repair and recementing of crowns, inlays, bridgework, and dentures when performed 6 or more months after placement					
Endodontic (root canal) treatment once per tooth every 24 consecutive months					
Periodontal maintenance 4 visits PCY					
Periodontal scaling and root planing once per quadrant every 24 consecutive months					
Periodontal surgery once per quadrant once every 36 consecutive months					
Oral surgery including simple and surgical extractions					
Intravenous or general anesthesia for covered dental procedures at a dental-care provider's office when dentally necessary					
MAJOR					
Inlays, onlays, and crowns once per tooth every 5 CY		0%–50% (increments of 5%)	0%–50% (increments of 5%)	50%	60%
Implants once every 5 CY					
Dentures, partials, and fixed bridges once every 5 CY					

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
[1]Annual deductible waived for diagnostic and preventive services.

Dental Optima Voluntary

Premera Optima Voluntary™ dental plans require no employer contribution, and employee contributions can be made on a pretax basis. Employees also appreciate being able to use any licensed dentist, although they may elect to access in-network dentists to maximize the purchasing power of their benefits dollar. Plus, additional periodontal maintenance procedures can help at-risk members receive the extra care they need to stay healthy.

Covered services

Benefits apply after calendar year deductible is met, unless otherwise noted.
Deductible and coinsurance represent customer's cost share.
PCY = per calendar year
CY = calendar year(s)

		COST SHARES
Annual deductible PCY	**INDIVIDUAL**	$50
	FAMILY	$150
Maximum allowance per person, PCY		$1,000, $1,500, $2,000
		IN AND OUT OF NETWORK
DIAGNOSTIC AND PREVENTIVE[1]		
Routine oral exams 2 PCY		0%
Emergency exams		
Bitewing x-rays		
Complete series or panoramic x-ray once per 36 consecutive months		
Cleanings limited to 2 PCY		
Fluoride treatments 2 applications PCY under the age of 19		
Sealants once every 24 consecutive months under age 19; limited to permanent molars only		
Space maintainers under age 19		
BASIC		
Fillings once per tooth surface every 24 consecutive months		20%
Repair and recementing of crowns, inlays, bridgework, and dentures when performed 6 or more months after placement		
Periodontal maintenance 4 visits PCY		
Periodontal scaling and root planing once per quadrant every 24 consecutive months		
Oral surgery including simple and surgical extractions		
Intravenous or general anesthesia for covered dental procedures at a dental-care provider's office when dentally necessary		
MAJOR[2]		
Endodontic (root canal) treatment once per tooth every 24 consecutive months		50%
Periodontal surgery once per quadrant every 36 consecutive months		
Inlays, onlays, and crowns once per tooth every 5 CY		
Dentures, partials, and fixed bridges once every 5 CY		

Note: Coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross.
[1]Annual deductible waived for diagnostic and preventive services.
[2]A 12-month waiting period for major services applies to customers who have not had continuous comparable dental coverage under the group's prior dental plan.

Dental plan enhancements

Shared family maximum

Unexpected dental care can be expensive. Choosing the right dental plan with an annual maximum that meets the needs of your employees is an important decision.

A shared family maximum may be the best choice for your employees and their covered dependents. This option allows employees to share their dental annual maximum to help maximize their family's dental coverage. The shared family maximum does not apply to preventive dental services.

Benefit enhancements

	DENTAL OPTIMA	DENTAL OPTIMA FLEX	DENTAL OPTIMA VOLUNTARY
BENEFIT ENHANCEMENT OPTIONS			
Preventive services do not count toward maximum allowance	Optional		Optional
ORTHODONTIA[1]			
Diagnostic services and active/retention treatment Including appliances	50%–100% (increments of 10%) up to lifetime maximum		N/A
Monthly orthodontic adjustments Including retention treatment			
Lifetime maximum per person	$1,000, $1,500, or $2,000		
Age limit	None; Up to age 19; Up to age 26		

[1]Not available for a voluntary plan.
[2]Benefits not subject to deductible or coinsurance.

* This option is limited to certain plan types and coinsurance options.

Vision and hearing plans

Offering vision and hearing benefits along with your employees' medical and dental coverage is easier to manage for both your business and your employees.

In fact, routine eye and hearing exams can lead to earlier diagnosis of chronic diseases.

Plus, offering all of your employees' benefits with Premera means you get the ease of dealing with just one health plan. It also means that your employees and their covered dependents enjoy the simplicity of one card, one customer service phone number, and one website.

You can choose between an exam-only or an exam-plus-hardware plan. Adult vision coverage (19 and older) also includes pediatric coverage (18 and younger). See the grid below. When a group offers vision coverage as a separate option, benefits for customers younger than 19 are the same as benefits for adults.

Covered services

PCY = per calendar year
CY = calendar year

		BENEFIT LIMITS	COVERAGE PLANS		
			Your Choice / Your Focus* / BlueHPN*	Your Future / BlueHPN HSA*	Essentials Medical*
Vision Adult	**Exam only**	1 routine exam PCY	Covered in full or deductible/ coinsurance or copay only*	Covered in full or deductible/ coinsurance, $25 copay, $20 copay, or $10 copay*	Not covered
	Exam and eyewear	1 routine exam PCY; Hardware: $150–$500 PCY or CY (increments of $25)	Exam: Covered in full or deductible/ coinsurance or $5–$40 copay (increments of $5); Hardware: Covered in full	Exam: Covered in full or deductible/ coinsurance, $5–$40 copay (increments of $5) Hardware: Covered in full	
Vision Pediatric (pediatric exam and cost shares count toward the out-of-pocket maximum)	**Exam only**	1 routine exam PCY	Office visit, cost share, or covered in full*	Office visit, cost share, $25 copay, or covered in full*	
	Exam and eyewear	1 routine exam PCY; Hardware: 1 pair of glasses PCY (frames and lenses); 12-month supply of contacts PCY, in lieu of glasses (frames and lenses)	Exam: Office visit cost share or waive deductible, then coinsurance, or covered in full; Eyewear: Covered in full	Exam: Office visit cost share, $25 copay, or covered in full; Eyewear: Covered in full	
Hearing	**Exam and hardware**	1 exam PCY; 1 device per ear with hearing loss every 3 years	Exam: Deductible/coinsurance or $10–$40 copay (increments of $5); Hardware: Covered in full	Exam: Deductible/Coinsurance;* Hardware: IRS minimum deductible, then 0%	Exam: Deductible/Coinsurance* Hardware: Covered in full

*Select covered services for Premera Blue Cross EPO plans are in-network only.
This is only a brief summary of the major benefits provided by our plans.
This is not a contract. For information and details regarding general exclusions and limitations, please contact your Premera representative.

[1]Embedded within the medical plan

Did you know?

Your Premera account manager can help you build a well-rounded benefits package that includes ancillary offerings like long- and short-term disability, accident, and employee assistance programs.

More optional benefits

Stop-loss coverage

LifeWise Assurance Company[1] assists groups with creating the right medical stop loss for their needs. If you elect to self-fund your medical plan, this product provides a reinsurance contract to protect your group from catastrophic losses.

HSA, FSA, and HRA options

Employers can take advantage of an integrated system for implementing and administering a health savings account (HSA), flexible spending account (FSA), and health reimbursement arrangement (HRA). These products can help manage healthcare costs by putting healthcare spending in the hands of employees. With greater visibility of their healthcare costs, employees can delegate their funds with ease. Personal funding accounts are available to Your Choice, Your Focus, Your Future, and BlueHPN HSA plans only.

Ancillary products for a well-rounded offering

Adding benefits from beyond medical, pharmacy, and dental coverage can help give your business a competitive advantage. Considering offering life, long- and short-term disability, hospital indemnity, and other coverage options with Connexion.

Synergie Gene Therapy + Risk Protection

Large group employers with LifeWise Assurance Company stop loss can avoid major rate increases and potential lasers due to a gene therapy hitting their stop-loss coverage.

[1] LifeWise Assurance Company is an independent company that does not provide Blue Cross Blue Shield products or services.

Adding benefits from Premera beyond medical and dental coverage can help give your business a competitive advantage. Consider how you benefit from adding these features:

Stop loss

Life and disability coverage

Personal funding accounts

Find out more:

premera.com/wa/employer

Talk with your producer or general agency partner.

PREMERA BLUE CROSS

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