

Highlights of your Health Care Coverage

Effective Date: 01/01/2025

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.
 Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

MEDICAL PLAN		
HMO CORE PLUS 2000 SILVER		
	SHERWOOD HMO AND DENTAL CHOICE IN-NETWORK	OUT-OF-NETWORK
Deductible (In-network only - Family embedded deductible 2X Individual)	\$2,000	Not Covered
Coinsurance (lower coinsurance may apply to certain locations)	30%	Not Covered
Out of Pocket Maximum (includes deductible, copays, coinsurance and pharmacy) (Family embedded OOP max 2X Individual)	\$8,550	Not Covered
Office Visit Cost Share	\$35 Copay PCP, applies to the \$8,550 Out of Pocket Maximum; \$70 Copay Specialist, applies to the \$8,550 Out of Pocket Maximum	Not Covered
Annual Maximum	Unlimited	Unlimited
1 Ambulatory Patient Services		
Professional Office Visit	\$35 Copay PCP, applies to the \$8,550 Out of Pocket Maximum; \$70 Copay Specialist, applies to the \$8,550 Out of Pocket Maximum	Not Covered
Telemedicine by Traditional Provider – General Medical	\$35 Copay PCP, applies to the \$8,550 Out of Pocket Maximum; \$70 Copay Specialist, applies to the \$8,550 Out of Pocket Maximum	Not Covered
Urgent Care Office Visits	\$70 Copay Specialist, applies to the \$8,550 Out of Pocket Maximum	\$70 Copay Specialist, applies to the \$8,550 Out of Pocket Maximum
Outpatient Professional Services (see Ambulatory Surgery Center for lower cost option)	\$2,000 Deductible, then 30% Coinsurance, applies to the \$8,550 Out of Pocket Maximum	Not Covered

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Ambulatory Surgery Center	\$2,000 Deductible, then 20% Coinsurance, applies to the \$8,550 Out of Pocket Maximum	Not Covered	
Contraceptive Management Services (Unlimited)	Covered in Full	Not Covered	
2 Emergency and Transportation Services			
Emergency Room - Facility	\$300 Copay then \$2,000 Deductible and 30% Coinsurance; all cost shares apply to the \$8,550 Out of Pocket Maximum	\$300 Copay then \$2,000 Deductible and 30% Coinsurance; all cost shares apply to the \$8,550 Out of Pocket Maximum	
Ambulance Service - Ground (Unlimited)	\$2,000 Deductible, then 30% Coinsurance, applies to \$8,550 Out of Pocket Maximum	\$2,000 Deductible, then 30% Coinsurance, applies to \$8,550 Out of Pocket Maximum	
Ambulance Service - Air (Unlimited)	\$2,000 Deductible, then 30% Coinsurance, applies to \$8,550 Out of Pocket Maximum	\$2,000 Deductible, then 30% Coinsurance, applies to \$8,550 Out of Pocket Maximum	
3 Hospitalization			
Inpatient Medical and Surgical Room and Board (Unlimited)	\$2,000 Deductible, then 30% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered	
Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$2,000 Deductible, then 30% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered	
Hospice Inpatient Facility (Unlimited)	\$2,000 Deductible, then 30% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered	
Inpatient Professional Services	\$2,000 Deductible, then 30% Coinsurance, applies to the \$8,550 Out of Pocket Maximum	Not Covered	
Organ Transplants (Unlimited)	Covered as any other service	Not Covered	
4 Maternity & Newborn Care			
Prenatal, Delivery, Postnatal (Coverage for subscriber, spouse, dependent)	\$2,000 Deductible, then 30% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered	
5 Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment			
Chemical Dependency Office Visit (Unlimited)	\$35 Copay PCP, applies to the \$8,550 Out of Pocket Maximum	Not Covered	
Chemical Dependency Outpatient Facility (Unlimited)	\$2,000 Deductible, then 30% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered	
Chemical Dependency Inpatient Facility (Unlimited)	\$2,000 Deductible, then 30% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered	
Mental Health Office Visit (Unlimited)	\$35 Copay PCP, applies to the \$8,550 Out of Pocket Maximum	Not Covered	
Mental Health Outpatient Facility (Unlimited)	\$2,000 Deductible, then 30% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered	

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Mental Health Inpatient Facility (Unlimited)	\$2,000 Deductible, then 30% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
6 Prescription Drug		
Formulary Drug List	M4 Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = non-preferred generic and brand Tier 4 = specialty	Not Covered
Prescription Drugs - Retail (Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days)	Tier 1 = \$35 Tier 2 = \$75 Tier 3 = Subject to Deductible, then 30% Tier 4 = Subject to Deductible, then 30% (cost shares apply to the OOP Max)	Not Covered
Prescription Drugs - Mail (Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days)	Tier 1 = \$105 Tier 2 = \$225 Tier 3 = Subject to Deductible, then 30% Tier 4 = Subject to Deductible, then 30% (cost shares apply to the OOP Max)	Not Covered
7 Rehabilitative & Habilitative Services & Devices		
Inpatient Rehabilitation (30 days PCY combined limit for inpatient services)	\$2,000 Deductible, then 30% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Inpatient Habilitation (30 days PCY combined limit for inpatient services)	\$2,000 Deductible, then 30% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Rehab Outpatient Professional - Physical, Speech, Occupational Therapy (25 visits PCY combined limit for outpatient services)	\$70 Copay Specialist, applies to the \$8,550 Out of Pocket Maximum	Not Covered
Habilitation Outpatient Professional - Physical, Speech, Occupational Therapy (25 visits PCY combined limit for outpatient services)	\$70 Copay Specialist, applies to the \$8,550 Out of Pocket Maximum	Not Covered
Massage Therapy (25 visits PCY combined limit for outpatient services)	\$70 Copay Specialist, applies to the \$8,550 Out of Pocket Maximum	Not Covered
Durable Medical Equipment (Unlimited)	\$2,000 Deductible, then 30% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
8 Laboratory/Imaging Services		
Diagnostic Lab & Pathology	\$2,000 Deductible, then 30% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Diagnostic Imaging - Basic	\$2,000 Deductible, then 30% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Diagnostic Imaging - Major (MRI, CT, PET)	\$2,000 Deductible, then 30% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Diagnostic Mammography	Covered in Full	Not Covered
Supplemental Breast Exam	Covered in Full	Not Covered

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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	Not Covered	
Preventive Imaging	Covered in Full	Not Covered	
Preventive Mammography	Covered in Full	Not Covered	
10 Pediatric Services, including Oral & Vision Care			
Pediatric Vision Exam (1 PCY Under age 19)	\$70 Copay Specialist, applies to the \$8,550 Out of Pocket Maximum	Not Covered	
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	Not Covered	
Pediatric Dental - Basic	Waive Medical Deductible, then 20% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered	
Pediatric Dental - Major	Medical \$2,000 Deductible, then 50% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered	
Chronic Condition Management Programs			
Diabetes Management Plus	Included	Included	
Virtual Care Services			
Telemedicine – General Medical (Virtual Care Only)	\$35 Copay PCP, applies to the \$8,550 Out of Pocket Maximum	Not Covered	
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered	
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	Not Covered	
Routine Hearing			
Routine Hearing Exam (1 every 2 calendar years)	\$70 Copay	Not Covered	
Routine Hearing Aids and Hardware (\$1000 every 3 calendar years)	Covered in Full	Covered in Full	
Alternative Care			
Chiropractic (10 visits PCY)	\$25 Copay, applies to the \$8,550 Out of Pocket Maximum	Not Covered	
Acupuncture (12 visits PCY)	\$25 Copay, applies to the \$8,550 Out of Pocket Maximum	Not Covered	

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Naturopath	\$35 Copay PCP, applies to the \$8,550 Out of Pocket Maximum; \$70 Copay Specialist, applies to the \$8,550 Out of Pocket Maximum	Not Covered	

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 HMO. Members are responsible for amounts in excess of the allowable charge.

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms of the plan. This benefit highlight is not a contract and may change. Please see your benefit booklet or call Customer Service for full coverage information including a description of waiting periods, limitations, and exclusions.

Notice of availability and nondiscrimination 844-722-4661 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.

Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.

呼吁提供免费的语言援助服务和适当的辅助设备及服务。

呼籲提供免費的語言援助服務和適當的輔助設備及服務。

Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.

무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.

Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.

Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.

Звертайте за безкоштовною мовною підтримкою та відповідними додатковими послугами.

សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។

無料言語支援サービスと適切な補助器具及びサービスをお求めください。

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

Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.

ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।

Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.

ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.

Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.

Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.

Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.

Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.

Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.

اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.

برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

Discrimination is against the law. Premera Blue Cross HMO 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 Blue Cross HMO does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera Blue Cross HMO 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 Blue Cross HMO 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 Blue Cross HMO 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>.

