



Medical plan snapshots

PPO plans

PCP = Primary care provider
PCY = Per calendar year

BALANCE PPO PLANS Heritage Signature and Dental Choice Network											
	Balance 250 Platinum	Balance 500 Platinum	Balance 500 Gold	Balance 1000 Gold	Balance 1500 Gold	Balance 2000 Gold	Balance 2500 Gold	Balance 2000 Silver	Balance 3000 Silver	Balance 6500 Bronze	
Deductible Family = 2x Individual	\$250	\$500	\$500	\$1,000	\$1,500	\$2,000	\$2,500	\$2,000	\$3,000	\$6,500	
Coinsurance	15%		20%					30%			
Out-of-pocket maximum Family = 2x Individual	\$4,000	\$4,000	\$8,550	\$8,550	\$7,000	\$7,000	\$8,000	\$8,450	\$7,000	\$8,550	
Emergency room	\$100 copay, deductible/coinsurance		\$200 copay, deductible/coinsurance					\$250 copay, deductible/coinsurance			
Office visit	PCP designated = \$10 Specialist/ Non-designated PCP = \$25		PCP designated = \$25 Specialist/Non-designated PCP = \$55					PCP designated = \$35 Specialist/ Non-designated PCP = \$70	PCP designated = \$35 Specialist/ Non-designated PCP = \$65	PCP designated = \$60 Specialist/ Non-designated PCP = \$120	
Basic imaging and lab services	Deductible waived, then coinsurance		Deductible/Coinsurance	Deductible waived, then coinsurance					Deductible/Coinsurance		
Retail Rx 30-day supply cost (mail order copay = 3x retail)	\$10 / \$30 / \$70 / D25%		\$20 / \$50 / \$80 / D25%		\$20 / \$50 / \$80 / 25%			\$35 / \$75 / D30% / D30%	\$1,500 Rx Deductible \$25 ¹ / D25% D25% / D25%	\$1,000 Rx Deductible \$30 ¹ / D50% D50% / D50%	

¹ Deductible waived for tier 1 drugs (generics).

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CHOICE PPO PLANS Heritage and Dental Choice Network				
	Choice 750 Gold	Choice 1000 Gold	Choice 1500 Gold	Choice 2500 Silver
Deductible Family = 2x Individual	\$750	\$1,000	\$1,500	\$2,500
Coinsurance	20%			30%
Out-of-pocket maximum Family = 2x Individual	\$7,100	\$8,550	\$7,000	\$8,150
Emergency room	\$200 copay, Deductible/Coinsurance			\$250 copay, Deductible/Coinsurance
Office visit	PCP designated = \$25 Specialist/Non-designated PCP = \$55			PCP designated = \$35 Specialist/Non-designated PCP = \$65
Basic imaging and lab services	Deductible/Coinsurance	Deductible waived, then coinsurance		Deductible/Coinsurance
Retail Rx 30-day supply cost (mail order copay = 3x retail)	\$20 / \$50 / \$80 / D25%	\$20 / \$50 / \$80 / 25%		\$30 / \$70 / D30% / D30%



Medical plan snapshots continued

HSA-qualified plans

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	BALANCE HSA-QUALIFIED PLANS Heritage Signature and Dental Choice Network			CHOICE HSA-QUALIFIED PLANS Heritage and Dental Choice Network		
	Balance HSA-qualified 1500 Gold	Balance HSA-qualified 3000 Silver	Balance HSA-qualified 6200 Bronze	Choice HSA-qualified 1500 Gold	Choice HSA-qualified 3000 Silver	Choice HSA-qualified 6200 Bronze
Deductible Family = 2x Individual	\$1,500 (Aggregate)	\$3,000 (Embedded)	\$6,200 (Embedded)	\$1,500 (Aggregate)	\$3,000 (Embedded)	\$6,200 (Embedded)
Coinsurance	20%		30%	20%		30%
Out-of-pocket maximum Family = 2x Individual	\$3,900 (Aggregate)	\$6,700 (Embedded)	\$6,900 (Embedded)	\$3,900 (Aggregate)	\$6,700 (Embedded)	\$6,900 (Embedded)
Emergency room	Deductible/Coinsurance					
Office visit	Deductible/Coinsurance					
Basic imaging and lab services	Deductible/Coinsurance					
Retail Rx	Deductible/Coinsurance					

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.

Hearing (included in your plan)

	BALANCE/CHOICE PPO & EPO	BALANCE/CHOICE HSA-QUALIFIED	PEAK CARE
Exam Balance/Choice PPO (in and out of network) Balance EPO (in network only) Peak Care (in network only)	Specialist office visit copay (1 exam every 2 calendar years)	Deductible/Coinsurance (1 exam every 2 calendar years)	Specialist office visit copay (1 exam every 2 calendar years)
Hardware (in and out of network)	Covered in full (\$1,000 every 3 calendar years)	Deductible/Coinsurance (\$1,000 every 3 calendar years)	Covered in full (\$1,000 every 3 calendar years)

EPO plans

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	PEAK CARE PLANS: Pierce, Thurston, and Spokane counties Tahoma and Dental Choice Network			BALANCE EPO PLAN Heritage Signature and Dental Choice Network
	Peak Care 1000 Gold	Peak Care NOW 4000 Silver	Peak Care 6000 Bronze	Balance EPO 8550 Bronze
Deductible Family = 2x Individual	\$1,000	\$4,000	\$6,000	\$8,550
Coinsurance	20%	30%	35%	0%
Out-of-pocket maximum Family = 2x Individual	\$8,850	\$8,900	\$8,900	\$8,550
Emergency room	\$450 copay, then deductible/coinsurance			Deductible/Coinsurance
Office visit	PCP designated = \$25 Specialist/Non-designated PCP = \$55	PCP designated = \$0 Specialist/Non-designated PCP = \$65	PCP designated = \$55 Specialist/Non-designated PCP = \$120	Deductible/Coinsurance
Basic imaging and lab services	Waive deductible, subject to coinsurance	Subject to deductible/coinsurance		Deductible/Coinsurance
Retail Rx 30-day supply cost (mail order 3x retail)	\$15 / \$40 / \$80 / 25%	\$20 / \$50 / D50% / D30%	\$35 / D\$45 / D40% / D40%	Deductible/Coinsurance

Adult vision

	OPTIONAL BENEFIT RIDER
Vision exam* In and out of network	\$25 (1 exam PCY)
Vision hardware limit In and out of network	\$150 PCY

*Peak Care exams are covered in network only.