Medical plan snapshots

Preferred provider organization (PPO) plans

PCP = Primary care provider
PCY = Per calendar year
D = Deductible

	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 5000 Silver**	**Balance 6500 Bronze**
Deductible Family = 2x individual	$250	$500	$500	$1,000	$1,500	$2,000	$2,500	$2,000	$3,000	$5,000	$6,500
Coinsurance	10%		20%					30%			40%
Out-of-pocket maximum Family = 2x individual	$4,000		$8,000					$8,550			$9,100
Emergency room	$100 copay, deductible/coinsurance		$200 copay, deductible/coinsurance					$300 copay, deductible/coinsurance			Deductible/ coinsurance
Office visit	PCP designated $10; Specialist/ non-designated PCP $25	PCP designated $15; Specialist/ non-designated PCP $25	PCP designated $25; Specialist/non-designated PCP $55			PCP designated $20; Specialist/non-designated PCP $50		PCP designated $35; Specialist/non-designated PCP $70			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 3x retail)	$10 / $30 / $70 / D25%		$20 / $50 / $80 / D25%				$15 / $45 / $80 / D25%	$35 / $75 / D30% / D30%	$30 / $75 / D30% / D30%		$30* / D40% D40% / D50%

* Deductible waived for tier 1 drugs (generics).

PCP = Primary care provider
PCY = Per calendar year
D = Deductible

	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	$8,000			$8,550
Emergency room	$200 copay, deductible/coinsurance			$300 copay, deductible/coinsurance
Office visit	PCP designated $25; Specialist/non-designated PCP $55			PCP designated $35; Specialist/non-designated PCP $70
Basic imaging and lab services	Deductible/coinsurance	Deductible waived, then coinsurance		Deductible/coinsurance
Retail Rx 30-day supply cost (mail order 3x retail)	$20 / $50 / $80 / D25%			$30 / $75 / D30% / D30%

Medical plan snapshots continued

HSA-qualified plans

PCP = Primary care provider
PCY = Per calendar year
D = Deductible

	BALANCE HSA-QUALIFIED PLANS Heritage Signature and Dental Choice Network			CHOICE HSA-QUALIFIED PLANS Heritage and Dental Choice Network		
	Balance HSA-qualified 1600 Gold	**Balance HSA-qualified 3200 Silver**	**Balance HSA-qualified 7000 Bronze**	**Choice HSA-qualified 1600 Gold**	**Choice HSA-qualified 3200 Silver**	**Choice HSA-qualified 7000 Bronze**
Deductible Family = 2x individual	$1,600 (Aggregate)	$3,200 (Embedded)	$7,000 (Embedded)	$1,600 (Aggregate)	$3,200 (Embedded)	$7,000 (Embedded)
Coinsurance	20%	30%	40%	20%	30%	40%
Out-of-pocket maximum Family = 2x individual	$4,025 (Aggregate)	$7,500 (Embedded)	$8,050 (Embedded)	$4,025 (Aggregate)	$7,500 (Embedded)	$8,050 (Embedded)
Emergency room	Deductible/Coinsurance					
Office visit	Deductible/Coinsurance					
Basic imaging and lab services	Deductible/Coinsurance					
Retail Rx 30-day supply cost (mail order 3x retail)	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
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)
Hardware (in and out of network)	Covered in full ($1,000 every 3 calendar years)	Deductible/Coinsurance ($1,000 every 3 calendar years)

Exclusive provider organization (EPO) plans

PCP = Primary care provider
PCY = Per calendar year
D = Deductible

	BALANCE EPO PLAN Heritage Signature and Dental Choice Network
	Balance EPO 8550 Bronze
Deductible Family = 2x Individual	$8,550
Coinsurance	0%
Out-of-pocket maximum Family = 2x Individual	$8,550
Emergency room	Deductible/Coinsurance
Office visit	Deductible/Coinsurance
Basic imaging and lab services	Deductible/Coinsurance
Retail Rx 30-day supply cost (mail order 3x retail)	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

Introducing Rx Savings Solutions

Members receive personalized alerts regarding savings opportunities including generic drugs, combination fills, pharmacy changes and more. The Rx Savings Solutions concierge team can manage the change on behalf of the member, by request, enabling a seamless transition to the new prescription.

Rx Savings Solutions is an independent company that does not provide Blue Cross Blue Shield products or services.

Medical plans with family dental

Eight of our medical plans have Family Dental benefits built in. By bundling pediatric and adult dental benefits with medical coverage, employees get well-rounded health coverage for their whole family.

Medical + Family Dental plans

PCP = Primary care provider
CIF = Covered in full
PCY = Per calendar year
D = Deductible

	BALANCE MEDICAL + FAMILY DENTAL PLANS Heritage Signature and Dental Choice Network				CHOICE MEDICAL + FAMILY DENTAL PLANS Heritage and Dental Choice Network			
	Balance 500 Gold + Family Dental	**Balance 1000 Gold + Family Dental**	**Balance 2000 Silver + Family Dental**	**Balance HSA-Qualified 3200 Silver + Family Dental**	**Choice 750 Gold + Family Dental**	**Choice 1000 Gold + Family Dental**	**Choice 2500 Silver + Family Dental**	**Choice HSA-Qualified 3200 Silver + Family Dental**
Deductible Family = 2x individual	$500	$1,000	$2,000	$3,200 (Embedded)	$750	$1,000	$2,500	$3,200 (Embedded)
Coinsurance	20%		30%		20%		30%	
Out-of-pocket maximum Family = 2x individual	$8,000		$8,550	$7,500 (Embedded)	$8,000		$8,550	$7,500 (Embedded)
Emergency room	$200 copay, deductible/coinsurance		$300 copay, deductible/ coinsurance	Deductible/ coinsurance	$200 copay, deductible/coinsurance		$300 copay, deductible/ coinsurance	Deductible/ coinsurance
Office visit	PCP designated $25; Specialist/non-designated PCP $55		PCP designated $35; Specialist/ non-designated PCP $70	Deductible/ coinsurance	PCP designated $25; Specialist/non-designated PCP $55		PCP designated $35; Specialist/ non-designated PCP $70	Deductible/ coinsurance
Basic imaging and lab services	Deductible/ coinsurance	Waive deductible, then coinsurance	Deductible/coinsurance		Deductible/ coinsurance	Waive deductible, then coinsurance	Deductible/coinsurance	
Retail Rx 30-day supply cost (mail order copay = 3x retail)	$20 / $50 / $80 / D25%	$20 / $50 / $80 / D25%	$35 / $75 / D30% / D30%	Deductible/ coinsurance	$20 / $50/ $80 / D25%	$20 / $50 / $80 / D25%	$30 / $75 / D30% / D30%	Deductible/ coinsurance

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

Adult dental benefits as part of medical plans with family dental

Covered services	IN NETWORK	OUT OF NETWORK
Individual dental deductible PCY	$50	
DIAGNOSTIC AND PREVENTIVE		
Routine oral exams 2 PCY	Covered in full	Dental deductible waived, then 30%
Complete series X-rays once every 60 months		
Bitewing X-rays 2 sets (up to 4) PCY		
Cleanings 2 PCY		
BASIC		
Problem-focused exams including emergency 1 PCY	Dental deductible, then 20%	Dental deductible, then 40%
Panoramic X-rays once every 60 months		
Fillings once per tooth surface every 24 months		
Endodontic (root canal) therapy once per tooth per lifetime		
Periodontal maintenance 4 PCY		
Periodontal scaling and root planning once per quadrant every 24 months		
Simple and surgical extractions		
Intravenous or general anesthesia for covered dental procedures at a dental-care provider's office when dentally necessary		
MAJOR		
Porcelain, ceramic, and metal crowns once every 7 CY	Dental deductible, then 50%	
Build-ups for covered crowns once every 7 CY		
Dental plan maximum	$1,000 PCY	

Note: Coinsurance amounts based on allowable charges. Balance billing may apply if a provider is not contracting with Premera Blue Cross. Metallic medical plans that include Family Dental cannot be paired with Adult Dental Optima or Adult Dental Optima Voluntary plans.

Get the details

2024 benefit highlights for small group plans can be viewed on **premera.com**.

Additional benefits of Family Dental

- Employees get core dental benefits at a lower cost.
- When your employees have a medical plan and a dental plan from Premera, they get one easy experience: one ID card, one customer service number, one website, and one secure account for managing their healthcare.