PREMERA HMO

Highlights of your Health Care Coverage

Effective Date: 01/01/2027

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 1500 GOLD**	
	SHERWOOD HMO AND DENTAL CHOICE IN-NETWORK	**OUT-OF-NETWORK**
Deductible (In-network only - Family embedded deductible 2X Individual)	$1,500	Not Covered
Coinsurance (lower coinsurance may apply to certain locations)	20%	Not Covered
Out of Pocket Maximum (includes deductible, copays, coinsurance and pharmacy) (Family embedded OOP max 2X Individual)	$9,000	Not Covered
PCP Office Visit Cost Share	$20 Copay, applies to the $9,000 Out of Pocket Maximum	Not Covered
Specialist Office Visit Cost Share	$60 Copay, applies to the $9,000 Out of Pocket Maximum	Not Covered
Annual Maximum	Unlimited	Unlimited
1 Ambulatory Patient Services		
Professional Office Visit	PCP: $20 Copay, applies to the $9,000 Out of Pocket Maximum; Specialist: $60 Copay, applies to the $9,000 Out of Pocket Maximum	Not Covered
Telemedicine by Traditional Provider – General Medical	PCP: $20 Copay, applies to the $9,000 Out of Pocket Maximum; Specialist: $60 Copay, applies to the $9,000 Out of Pocket Maximum	Not Covered
Urgent Care Office Visits	$60 Copay, applies to the $9,000 Out of Pocket Maximum	$60 Copay, applies to the $9,000 Out of Pocket Maximum
Outpatient Professional Services (see Ambulatory Surgery Center for lower cost option)	$1,500 Deductible, then 20% Coinsurance, applies to the $9,000 Out of Pocket Maximum	Not Covered

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	SHERWOOD HMO AND DENTAL CHOICE IN-NETWORK	**OUT-OF-NETWORK**
Ambulatory Surgery Center	$1,500 Deductible, then 10% Coinsurance, applies to the $9,000 Out of Pocket Maximum	Not Covered
Contraceptive Management Services (Unlimited)	Covered in Full	Not Covered
2 Emergency and Transportation Services		
Emergency Room - Facility	$350 Copay then $1,500 Deductible and 20% Coinsurance; all cost shares apply to the $9,000 Out of Pocket Maximum	$350 Copay then $1,500 Deductible and 20% Coinsurance; all cost shares apply to the $9,000 Out of Pocket Maximum
Ambulance Service - Ground (Unlimited)	$1,500 Deductible, then 20% Coinsurance, applies to $9,000 Out of Pocket Maximum	$1,500 Deductible, then 20% Coinsurance, applies to $9,000 Out of Pocket Maximum
Ambulance Service - Air (Unlimited)	$1,500 Deductible, then 20% Coinsurance, applies to $9,000 Out of Pocket Maximum	$1,500 Deductible, then 20% Coinsurance, applies to $9,000 Out of Pocket Maximum
3 Hospitalization		
Inpatient Medical and Surgical Room and Board (Unlimited)	$1,500 Deductible, then 20% Coinsurance, applies to $9,000 Out of Pocket Maximum	Not Covered
Inpatient Professional Services	$1,500 Deductible, then 20% Coinsurance, applies to $9,000 Out of Pocket Maximum	Not Covered
Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	$1,500 Deductible, then 20% Coinsurance, applies to $9,000 Out of Pocket Maximum	Not Covered
Hospice Inpatient Facility (Unlimited)	$1,500 Deductible, then 20% Coinsurance, applies to $9,000 Out of Pocket Maximum	Not Covered
Organ Transplants (Unlimited)	Covered as any other service	Not Covered
4 Maternity & Newborn Care		
Maternity Delivery - Inpatient Facility (Coverage for subscriber, spouse, dependent)	$1,500 Deductible, then 20% Coinsurance, applies to $9,000 Out of Pocket Maximum	Not Covered
Maternity Prenatal, Delivery and Postnatal Care - Professional Services (Coverage for subscriber, spouse, dependent)	$1,500 Deductible, then 20% Coinsurance, applies to $9,000 Out of Pocket Maximum	Not Covered
Birth Center	$1,500 Deductible, then 10% Coinsurance, applies to $9,000 Out of Pocket Maximum	Not Covered
Fertility Treatment & Assisted Reproduction Procedures (Artificial insemination in vivo covered; other assisted reproduction treatments excluded)	Cover as any other service	Not Covered
5 Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment		
Chemical Dependency Office Visit (Unlimited)	$20 Copay, applies to the $9,000 Out of Pocket Maximum	Not Covered
Chemical Dependency Outpatient Facility (Unlimited)	$1,500 Deductible, then 20% Coinsurance, applies to $9,000 Out of Pocket Maximum	Not Covered
Chemical Dependency Inpatient Facility (Unlimited)	$1,500 Deductible, then 20% Coinsurance, applies to $9,000 Out of Pocket Maximum	Not Covered

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Mental Health Office Visit (Unlimited)	$20 Copay, applies to the $9,000 Out of Pocket Maximum	Not Covered
Mental Health Outpatient Facility (Unlimited)	$1,500 Deductible, then 20% Coinsurance, applies to $9,000 Out of Pocket Maximum	Not Covered
Mental Health Inpatient Facility (Unlimited)	$1,500 Deductible, then 20% Coinsurance, applies to $9,000 Out of Pocket Maximum	Not Covered
6 Prescription Drug		
Formulary Drug List	Summit S6 Tier 1 = Value Generic Tier 2 = Preferred Generic Tier 3 = Preferred Brand Tier 4 = Non Preferred Generic/Brand Tier 5 = Preferred Specialty Tier 6 = Non Preferred Specialty	Not Covered
Prescription Drugs - Retail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	Tier 1 = $10 Tier 2 = $40 Tier 3 = $75 Tier 4 = $150 Tier 5 = Subject to Deductible, then 40% Tier 6 = Subject to Deductible, then 50% (cost shares apply to the OOP Max)	Not Covered
Prescription Drugs - Mail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	Tier 1 = $30 Tier 2 = $120 Tier 3 = $225 Tier 4 = $450 Tier 5 = Subject to Deductible, then 40% Tier 6 = Subject to Deductible, then 50% (cost shares apply to the OOP Max)	Not Covered
7 Rehabilitative & Habilitative Services & Devices		
Inpatient Rehabilitation (30 days PCY)	$1,500 Deductible, then 20% Coinsurance, applies to $9,000 Out of Pocket Maximum	Not Covered
Outpatient Rehabilitation - Physical, Occupational Therapy (25 visits PCY)	$60 Copay, applies to the $9,000 Out of Pocket Maximum	Not Covered
Outpatient Habilitation - Physical, Occupational Therapy (25 visits PCY)	$60 Copay, applies to the $9,000 Out of Pocket Maximum	Not Covered
Outpatient Massage Therapy (Applies to the outpatient rehab limit)	$60 Copay, applies to the $9,000 Out of Pocket Maximum	Not Covered
Outpatient Speech Therapy (Applies to the outpatient rehab limit)	$60 Copay, applies to the $9,000 Out of Pocket Maximum	Not Covered
Inpatient Habilitation (30 days PCY)	$1,500 Deductible, then 20% Coinsurance, applies to $9,000 Out of Pocket Maximum	Not Covered

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Durable Medical Equipment (Unlimited)	$1,500 Deductible, then 20% Coinsurance, applies to $9,000 Out of Pocket Maximum	Not Covered
8 Laboratory/Imaging Services		
Diagnostic Laboratory & Pathology	$1,500 Deductible, then 20% Coinsurance, applies to $9,000 Out of Pocket Maximum	Not Covered
Diagnostic Imaging - Basic	$1,500 Deductible, then 20% Coinsurance, applies to $9,000 Out of Pocket Maximum	Not Covered
Diagnostic Imaging - Major (MRI, CT, PET)	$1,500 Deductible, then 20% Coinsurance, applies to $9,000 Out of Pocket Maximum	Not Covered
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
Breast Cancer Screening (Including Mammography)	Covered in Full	Not Covered
10 Pediatric Services, including Oral & Vision Care		
Pediatric Vision Exam (1 PCY Under age 19)	$30 Copay, applies to the $9,000 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 $9,000 Out of Pocket Maximum	Not Covered
Pediatric Dental - Major	Medical $1,500 Deductible, then 50% Coinsurance, applies to $9,000 Out of Pocket Maximum	Not Covered
Virtual Care Services		
Telemedicine – General Medical (Virtual Care Only)	$20 Copay, applies to the $9,000 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 Cost Share	Not Covered
Routine Hearing		
Routine Hearing Exam (1 PCY)	$60 Copay, applies to the $9,000 Out of Pocket Maximum	Not Covered
Routine Hearing Aids and Hardware (1 device per ear every 3 years)	Covered in Full	Covered in Full

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Alternative Care		
Chiropractic (10 visits PCY)	$30 Copay, applies to the $9,000 Out of Pocket Maximum	Not Covered
Acupuncture (Unlimited)	$30 Copay, applies to the $9,000 Out of Pocket Maximum	Not Covered
Naturopath	PCP: $20 Copay, applies to the $9,000 Out of Pocket Maximum; Specialist: $60 Copay, applies to the $9,000 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.

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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.
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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。
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Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
મુફત ભાષા સહાયતા સેવાઓ અને ઉચિત સહાયક ચીજો અને સેવાઓ વાસતે કાલ કરો।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໂທຫາເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ຕະ ການບໍລິການ ຕະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.
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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.

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