

**Premera Blue Cross Blue Shield Medical Plans**

	Classic 250		Classic 500		Frontier 750		Frontier 1000		Frontier 1500		Frontier 2000	
	PPO	Out-of-Network	PPO	Out-of-Network	PPO	Out-of-Network	PPO	Out-of-Network	PPO	Out-of-Network	PPO	Out-of-Network
Annual Maximum	\$2,000,000		\$2,000,000		\$2,000,000		\$2,000,000		\$2,000,000		\$2,000,000	
Deductible (Ind / Fam)	\$250 / \$750	\$500 / \$1,500	\$500 / \$1,500	\$1,000 / \$3,000	\$750 / \$2,250	\$1,500 / \$4,500	\$1,000 / \$3,000	\$2,000 / \$6,000	\$1,500 / \$4,500	\$3,000 / \$9,000	\$2,000 / \$6,000	\$4,000 / \$12,000
Max OOP (Ind / Fam)	\$1,750	No Limit	\$2,000	No Limit	\$3,750	No Limit	\$4,000	No Limit	\$5,000	No Limit	\$5,000	No Limit
Preventive	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
Office Visit Copay	20%		\$25*		\$30*		\$30*		\$30*		\$30*	
Diagnostic Lab & X-ray	20%*	40% UCR+	20%*	40% UCR+	20%*	40% UCR+	20%*	40% UCR+	20%*	40% UCR+	20%*	40% UCR+
Urgent Care Copay	20%	40% UCR+	\$25*	40% UCR+	\$30*	40% UCR+	\$30*	40% UCR+	\$30*	40% UCR+	\$30*	40% UCR+
Outpatient Surgery	20%	40% UCR+	20%	40% UCR+	20%	40% UCR+	20%	40% UCR+	20%	40% UCR+	20%	40% UCR+
Inpatient Hospital	20%	40% UCR+	20%	40% UCR+	20%	40% UCR+	20%	40% UCR+	20%	40% UCR+	20%	40% UCR+
**Emergency Room	\$50		\$50		\$150		\$150		\$150		\$150	
Ambulance	\$50 Copay / 20%		\$50 Copay / 20%		\$150 Copay / 20%		\$150 Copay / 20%		\$150 Copay / 20%		\$150 Copay / 20%	
Durable Medical Equipment	20%	40% UCR+	20%	40% UCR+	20%	40% UCR+	20%	40% UCR+	20%	40% UCR+	20%	40% UCR+
RX Included	\$15 / 25 / 40 (Mail Order 2x)		\$15 / 25 / 40 (Mail Order 2x)		\$15 / 35 / 50 (Mail Order 2.5x)		\$15 / 35 / 50 (Mail Order 2.5x)		\$15 / 35 / 50 (Mail Order 2.5x)		\$15 / 35 / 50 (Mail Order 2.5x)	

\*Deductible Waived

**Premera Blue Cross Blue Shield Medical Plans**

	Frontier 2500		Envoy 3000		Envoy 5000		Frontier HSA 2500		Frontier HSA 5000	
	PPO	Out-of-Network	PPO	Out-of-Network	PPO	Out-of-Network	PPO	Out-of-Network	PPO	Out-of-Network
Annual Maximum	\$2,000,000		\$2,000,000		\$2,000,000		\$2,000,000		\$2,000,000	
Deductible (Ind / Fam)	\$2,500 / \$7,500	\$5,000 / \$15,000	\$3,000 / \$9,000	\$6,000 / \$18,000	\$5,000 / \$15,000	\$10,000 / \$30,000	\$2,500 / \$5,000		\$5,000 / \$10,000	
Max OOP (Ind / Fam)	\$5,000	No Limit	\$6,000	No Limit	\$9,000	No Limit	\$5,000 / \$10,000		\$5,000 / \$10,000	
Preventive	Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
Office Visit Copay	\$30*	\$30*	\$40***	\$40***	\$45***	\$45***	20%		0%	
Diagnostic Lab & X-ray	20%*	40% UCR+	20%*	40% UCR+	30%*	40% UCR+	20%	50% UCR+	0%	50% UCR+
Urgent Care Copay	\$30*	40% UCR+	\$40*	40% UCR+	\$45*	40% UCR+	\$30*	50% UCR+	0%	50% UCR+
Outpatient Surgery	20%	40% UCR+	20%	40% UCR+	30%	40% UCR+	20%	50% UCR+	0%	50% UCR+
Inpatient Hospital	20%	40% UCR+	20%	40% UCR+	30%	40% UCR+	20%	50% UCR+	0%	50% UCR+
**Emergency Room	\$150		\$100		\$100		20%		0%	
Ambulance	\$150 Copay / 20%		\$100 Copay / 20%		\$100 Copay / 30%		20%		0%	
Durable Medical Equipment	20%	40% UCR+	20%	40% UCR+	30%	40% UCR+	20%	50% UCR+	0%	50% UCR+
RX Included	\$15 / 35 / 50 (Mail Order 2.5x)		\$15 / 35 / 50 (Mail Order 2.5x)		\$15 / 35 / 50 (Mail Order 2.5x)		20%	50% UCR+	0%	50% UCR+

\*Deductible Waived

\*\*Copay plus Deductible/Coinsurance except H.S.A. which is just Deductible/Coinsurance

\*\*\*Copay applies to first six visits only. Thereafter, coinsurance applies.

<b>Premera Dental Plans</b>			
	<b>\$1,000 Max</b>	<b>\$1,500 Max</b>	<b>\$2,000 Max</b>
<b>Deductible</b>	\$50	\$50	\$50
<b>Preventive Services</b>	80%*	100%*	100%*
<b>Basic Services</b>	80%	80%	80%
<b>Major Services</b>	50%	50%	50%
<b>Orthodontia Services</b>	N/A	N/A	N/A
<b>Calendar Year Maximum</b>	\$1,000	\$1,500	\$2,000

\*Deductible Waived

<b>VSP Vision Plans</b>				
	<b>\$10 / \$25</b>		<b>\$0 / \$10</b>	
	<b>PPO Network</b>	<b>Out-of-Network (Allowance)</b>	<b>PPO Network</b>	<b>Out-of-Network (Allowance)</b>
<b>Exam</b>	\$10 Copay	\$50 Max	\$0 Copay	\$50 Max
<b>Eyewear</b>	\$25 Copay		\$10 Copay	
<b>Single Vision Lenses</b>	Covered in Full	\$50	Covered in Full	\$50
<b>Lined Bi-Focal Lenses</b>	Covered in Full	\$75	Covered in Full	\$75
<b>Lined Tri-Focal Lenses</b>	Covered in Full	\$100	Covered in Full	\$100
<b>Frame Allowance</b>	\$120 Retail Allowance	\$70	\$120 Retail Allowance	\$70
<b>Contacts</b>	\$120 Allowance	\$120 Max	\$120 Allowance	\$105 Max