

# 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	PC: HSA QUALIFIED AGG STANDARD - \$2,500/20%/50%/\$5,000/DED.COINS	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
<b>MEDICAL COST SHARES</b>		
<b>Individual Deductible PCY</b> (Family aggregate deductible 2x Individual)	\$2,500/\$5,000	\$5,000/\$10,000
<b>Coinsurance (Member's percentage of costs after deductible based on allowable charges)</b>	20%	50%
<b>Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable</b> (Family embedded OOP max 2X Individual)	\$5,000	\$10,000
<b>Office Visit Cost Share</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum
<b>Kinwell Connect Cost Share Waiver</b> (Excluded)	All services rendered and billed by any Kinwell clinic are subject to standard cost shares	Not Applicable
<b>PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION</b>		
<b>Preventive Office Visit</b> (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered
<b>Immunizations</b> (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered
<b>Health Education (HE)</b> (Unlimited)	Covered in Full	Not Covered
<b>Nicotine Dependency Programs (ND)</b> (Unlimited)	Covered in Full	Not Covered
<b>Diabetes Health Education (DE)</b> (Unlimited)	Covered in Full	Not Covered
<b>CHRONIC CONDITION MANAGEMENT PROGRAMS</b>		
<b>Diabetes Management Plus</b>	Included	Included
<b>Diabetes Prevention Plus</b>	Excluded	Excluded
<b>Hypertension Plus</b>	Excluded	Excluded

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	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>Weight Management</b>	Excluded	Excluded	
<b>PROFESSIONAL CARE</b>			
<b>Professional Office Visit</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>Telemedicine with Traditional Providers - General Medical</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>VIRTUAL CARE SERVICES</b>			
<b>Telemedicine - General Medical (Virtual Care Only)</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Not Covered	
<b>Telemedicine - Mental Health (Virtual Care Only)</b>	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered	
<b>Telemedicine - Chemical Dependency (Virtual Care Only)</b>	Subject to Chemical Dependency Outpatient Office Visit	Not Covered	
<b>DIAGNOSTIC SERVICES</b>			
<b>Preventive Imaging and Lab</b>	Covered in Full	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>Diagnostic Lab</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>Basic Diagnostic Imaging</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>Major Diagnostic Imaging</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>Preventive Mammography</b>	Covered in Full	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>Diagnostic Mammography</b>	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>Supplemental Breast Exam</b>	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Covered as any other service	
<b>FACILITY CARE</b>			

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	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>Inpatient Facility</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>Inpatient Professional Services</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>Outpatient Surgery Facility</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>Skilled Nursing Facility</b> (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>HOSPICE &amp; HOME HEALTH CARE</b>			
<b>Hospice Inpatient Facility</b> (Unlimited)	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>Hospice Care</b> (Unlimited)	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>MATERNITY &amp; REPRODUCTIVE CARE</b>			
<b>Contraceptive Management Services</b> (Unlimited)	Covered in Full	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>Sterilization - Female</b> (Unlimited)	Covered in Full	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>Sterilization - Male</b> (Unlimited)	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>MEDICAL TRANSPORTATION BENEFITS</b>			
<b>Transplant Travel &amp; Lodging</b> (\$7,500 per transplant)	\$2,500/\$5,000 Deductible, 0% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$2,500/\$5,000 Deductible, 0% Coinsurance, applies to \$5,000 Out of Pocket Maximum	
<b>EMERGENCY CARE AND TRANSPORTATION</b>			
<b>Emergency Care</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	
<b>Emergency Room Physician</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	

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	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>Urgent Care Center</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>Ambulance Transportation (Unlimited)</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	
<b>ALTERNATIVE CARE</b>			
<b>Acupuncture (12 visits PCY)</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>Manipulations (Spinal and other) (12 visits PCY)</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>CHEMICAL DEPENDENCY &amp; MENTAL HEALTH</b>			
<b>Chemical Dependency Inpatient Facility Care (Unlimited)</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>Chemical Dependency Outpatient Professional Care (Unlimited)</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>Mental Health Inpatient Facility Care (Unlimited)</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>Mental Health Outpatient Professional Care (Unlimited)</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>PHARMACY</b>			
<b>Formulary Drug List</b>	Open A1 No Tiers	Open A1 No Tiers	
<b>Prescription Drugs - Retail (Retail: 90 Days; Mail: 90 Days; Specialty: 30 Days)</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share	
<b>Prescription Drugs - Mail (Retail: 90 Days; Mail: 90 Days; Specialty: 30 Days)</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Not Covered	
<b>REHABILITATION &amp; NEURO</b>			
<b>Rehab Inpatient Facility (60 days PCY combined limit for inpatient services)</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	

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	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain</b> (60 visits PCY combined limit for outpatient services)	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>OTHER SERVICES</b>			
<b>Allergy/Therapeutic Injections</b>	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>Medical Supplies, Equipment, Prosthetics</b> (Unlimited)	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>Transplants</b> (Unlimited)	Covered as any other service	Not Covered	
<b>SUPPLEMENTAL BENEFITS</b>			
<b>Routine Vision Exam</b> (1 PCY)	\$25 Copay	\$25 Copay	
<b>Vision Hardware</b> (\$150 every 2 consecutive calendar years)	Covered in Full	Covered in Full	
<b>Pediatric Vision Exam</b> (1 PCY under age 19)	\$25 Copay, applies to the \$5,000 Out of Pocket Maximum	\$25 Copay, applies to the \$5,000 Out of Pocket Maximum	
<b>Pediatric Vision Hardware</b> (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	
<b>Routine Hearing Exam</b> (1 every 36 months)	\$2,500/\$5,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to \$10,000 Out of Pocket Maximum	
<b>Hearing Hardware</b> (WA Mandate \$3,000 per ear with hearing loss every 36 months)	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$5,000 Out of Pocket Maximum	
<b>ANNUAL PLAN MAXIMUM</b>			
<b>Annual Plan Maximum</b>	Unlimited	Unlimited	

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. 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.*