

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: PPO STANDARD - \$4,000/30%/50%/\$6,000/\$35 | |
|---|--|---|--|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK | |
| MEDICAL COST SHARES | | | |
| Individual Deductible PCY (Family embedded deductible 2X Individual) | \$4,000 | \$8,000 | |
| Coinsurance (Member's percentage of costs after deductible based on allowable charges) | 30% | 50% | |
| Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual) | \$6,000 | \$12,000 | |
| Office Visit Cost Share | \$35 Copay, applies to the \$6,000 Out of Pocket Maximum | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum | |
| Kinwell Connect Cost Share Waiver (Excluded) | All services rendered and billed by any Kinwell clinic are subject to standard cost shares | Not Applicable | |
| PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION | | | |
| 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 | |
| Health Education (HE) (Unlimited) | Covered in Full | Not Covered | |
| Nicotine Dependency Programs (ND) (Unlimited) | Covered in Full | Not Covered | |
| Diabetes Health Education (DE) (Unlimited) | Covered in Full | Not Covered | |
| CHRONIC CONDITION MANAGEMENT PROGRAMS | | | |
| Diabetes Management Plus | Included | Included | |
| Diabetes Prevention Plus | Excluded | Excluded | |
| Hypertension Plus | Excluded | Excluded | |
| Weight Management | Excluded | Excluded | |

| MEDICAL PLAN | | |
|---|--|---|
| PC: PPO STANDARD - \$4,000/30%/50%/\$6,000/\$35 | | |
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK |
| PROFESSIONAL CARE | | |
| Professional Office Visit | \$35 Copay, applies to the \$6,000 Out of Pocket Maximum | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| Telemedicine with Traditional Providers - General Medical | \$10 Copay, applies to the \$6,000 Out of Pocket Maximum | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| VIRTUAL CARE SERVICES | | |
| Telemedicine - General Medical (Virtual Care Only) | \$10 Copay, applies to the \$6,000 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 | Not Covered |
| DIAGNOSTIC SERVICES | | |
| Preventive Imaging and Lab | Covered in Full | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| Diagnostic Lab | Waive Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| Basic Diagnostic Imaging | Waive Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| Major Diagnostic Imaging | Waive Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| Preventive Mammography | Covered in Full | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| Diagnostic Mammography | Covered in Full | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| Supplemental Breast Exam | Covered in Full | Covered as any other service |
| FACILITY CARE | | |
| Inpatient Facility | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| Inpatient Professional Services | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| Outpatient Surgery Facility | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees) | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| HOSPICE & HOME HEALTH CARE | | |
| Hospice Inpatient Facility (Unlimited) | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| Hospice Care (Unlimited) | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |

| MEDICAL PLAN | | |
|---|---|---|
| PC: PPO STANDARD - \$4,000/30%/50%/\$6,000/\$35 | | |
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK |
| MATERNITY & REPRODUCTIVE CARE | | |
| Contraceptive Management Services (Unlimited) | Covered in Full | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| Sterilization - Female (Unlimited) | Covered in Full | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| Sterilization - Male (Unlimited) | Covered in Full | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| MEDICAL TRANSPORTATION BENEFITS | | |
| Transplant Travel & Lodging (\$7,500 per transplant) | \$4,000 Deductible, 0% Coinsurance, applies to \$6,000 Out of Pocket Maximum | \$4,000 Deductible, 0% Coinsurance, applies to \$6,000 Out of Pocket Maximum |
| EMERGENCY CARE AND TRANSPORTATION | | |
| Emergency Care (If applicable, waive copay if admitted to inpatient facility) | \$250 Copay then \$4,000 Deductible and 30% Coinsurance; all cost shares apply to the \$6,000 Out of Pocket Maximum | \$250 Copay then \$4,000 Deductible and 30% Coinsurance; all cost shares apply to the \$6,000 Out of Pocket Maximum |
| Emergency Room Physician | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum |
| Urgent Care Center | \$35 Copay, applies to the \$6,000 Out of Pocket Maximum | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| Ambulance Transportation (Unlimited) | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum |
| ALTERNATIVE CARE | | |
| Acupuncture (12 visits PCY) | \$35 Copay, applies to the \$6,000 Out of Pocket Maximum | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| Manipulations (Spinal and other) (12 visits PCY) | \$35 Copay, applies to the \$6,000 Out of Pocket Maximum | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| CHEMICAL DEPENDENCY & MENTAL HEALTH | | |
| Chemical Dependency Inpatient Facility Care (Unlimited) | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| Chemical Dependency Outpatient Professional Care (Unlimited) | \$35 Copay, applies to the \$6,000 Out of Pocket Maximum | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| Mental Health Inpatient Facility Care (Unlimited) | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| Mental Health Outpatient Professional Care (Unlimited) | \$35 Copay, applies to the \$6,000 Out of Pocket Maximum | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| REHABILITATION & NEURO | | |
| Rehab Inpatient Facility (60 days PCY combined limit for inpatient services) | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (60 visits PCY combined limit for outpatient services) | \$35 Copay, applies to the \$6,000 Out of Pocket Maximum | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |

| MEDICAL PLAN | | |
|--|--|---|
| PC: PPO STANDARD - \$4,000/30%/50%/\$6,000/\$35 | | |
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK |
| Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer | \$35 Copay, applies to the \$6,000 Out of Pocket Maximum | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| OTHER SERVICES | | |
| Allergy/Therapeutic Injections | Covered in Full | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| Medical Supplies, Equipment, Prosthetics (Unlimited) | \$4,000 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| Transplants (Unlimited) | Covered as any other service | Not Covered |
| SUPPLEMENTAL BENEFITS | | |
| Routine Vision Exam (1 PCY) | \$25 Copay | \$25 Copay |
| Vision Hardware (\$150 every 2 consecutive calendar years) | Covered in Full | Covered in Full |
| Pediatric Vision Exam (1 PCY under age 19) | \$25 Copay, applies to the \$6,000 Out of Pocket Maximum | \$25 Copay, applies to the \$6,000 Out of Pocket Maximum |
| Pediatric Vision Hardware (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 |
| Routine Hearing Exam (1 every 36 months) | \$25 Copay | \$8,000 Deductible, then 50% Coinsurance, applies to \$12,000 Out of Pocket Maximum |
| Hearing Hardware (WA Mandate \$3,000 per ear with hearing loss every 36 months) | Covered in Full | Covered in Full |
| ANNUAL PLAN MAXIMUM | | |
| Annual Plan Maximum | 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.