

# 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.

<b>MEDICAL PLAN</b>		
	<b>PC: HPN - \$2,000/20%/NOT APP/\$5,000/\$30</b>	
	<b>HERITAGE PRIME HPN IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>MEDICAL COST SHARES</b>		
<b>Individual Deductible PCY</b> (Family embedded deductible 2X Individual)	\$2,000	Not Covered
<b>Coinsurance (Member's percentage of costs after deductible based on allowable charges)</b>	20%	Not Covered
<b>Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable</b> (Family embedded OOP max 2X Individual)	\$5,000	Not Covered
<b>Office Visit Cost Share</b>	\$30 Copay, applies to the \$5,000 Out of Pocket Maximum	Not Covered
<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
<b>Weight Management</b>	Excluded	Excluded

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<b>PROFESSIONAL CARE</b>		
<b>Professional Office Visit</b>	\$30 Copay, applies to the \$5,000 Out of Pocket Maximum	Not Covered
<b>Telemedicine with Traditional Providers - General Medical</b>	\$10 Copay, applies to the \$5,000 Out of Pocket Maximum	Not Covered
<b>VIRTUAL CARE SERVICES</b>		
<b>Telemedicine - General Medical (Virtual Care Only)</b>	\$10 Copay, applies to the \$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	Not Covered
<b>Diagnostic Lab</b>	\$2,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Not Covered
<b>Basic Diagnostic Imaging</b>	\$2,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Not Covered
<b>Major Diagnostic Imaging</b>	\$2,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Not Covered
<b>Preventive Mammography</b>	Covered in Full	Not Covered
<b>Diagnostic Mammography</b>	Covered in Full	Not Covered
<b>Supplemental Breast Exam</b>	Covered in Full	Not Covered
<b>FACILITY CARE</b>		
<b>Inpatient Facility</b>	\$2,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Not Covered
<b>Inpatient Professional Services</b>	\$2,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Not Covered
<b>Outpatient Surgery Facility</b>	\$2,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Not Covered
<b>Skilled Nursing Facility</b> (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$2,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Not Covered
<b>HOSPICE &amp; HOME HEALTH CARE</b>		
<b>Hospice Inpatient Facility</b> (Unlimited)	\$2,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Not Covered
<b>Hospice Care</b> (Unlimited)	\$2,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Not Covered
<b>MATERNITY &amp; REPRODUCTIVE CARE</b>		
<b>Contraceptive Management Services</b> (Unlimited)	Covered in Full	Not Covered

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<b>Sterilization - Female</b> (Unlimited)	Covered in Full	Not Covered
<b>Sterilization - Male</b> (Unlimited)	Covered in Full	Not Covered
<b>MEDICAL TRANSPORTATION BENEFITS</b>		
<b>Transplant Travel &amp; Lodging</b> (\$7,500 per transplant)	\$2,000 Deductible, 0% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$2,000 Deductible, 0% Coinsurance, applies to \$5,000 Out of Pocket Maximum
<b>EMERGENCY CARE AND TRANSPORTATION</b>		
<b>Emergency Care (If applicable, waive copay if admitted to inpatient facility)</b>	\$200 Copay then \$2,000 Deductible and 20% Coinsurance; all cost shares apply to the \$5,000 Out of Pocket Maximum	\$200 Copay then \$2,000 Deductible and 20% Coinsurance; all cost shares apply to the \$5,000 Out of Pocket Maximum
<b>Emergency Room Physician</b>	\$2,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$2,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum
<b>Urgent Care Center</b>	\$30 Copay, applies to the \$5,000 Out of Pocket Maximum	HPN Product Area: Not covered; Non-HPN Product Area: Same as in-network cost share
<b>Ambulance Transportation</b> (Unlimited)	\$2,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$2,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum
<b>ALTERNATIVE CARE</b>		
<b>Acupuncture</b> (12 visits PCY)	\$30 Copay, applies to the \$5,000 Out of Pocket Maximum	Not Covered
<b>Manipulations (Spinal and other)</b> (12 visits PCY)	\$30 Copay, applies to the \$5,000 Out of Pocket Maximum	Not Covered
<b>CHEMICAL DEPENDENCY &amp; MENTAL HEALTH</b>		
<b>Chemical Dependency Inpatient Facility Care</b> (Unlimited)	\$2,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Not Covered
<b>Chemical Dependency Outpatient Professional Care</b> (Unlimited)	\$30 Copay, applies to the \$5,000 Out of Pocket Maximum	Not Covered
<b>Mental Health Inpatient Facility Care</b> (Unlimited)	\$2,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Not Covered
<b>Mental Health Outpatient Professional Care</b> (Unlimited)	\$30 Copay, applies to the \$5,000 Out of Pocket Maximum	Not Covered
<b>REHABILITATION &amp; NEURO</b>		
<b>Rehab Inpatient Facility</b> (60 days PCY combined limit for inpatient services)	\$2,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Not Covered
<b>Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain</b> (60 visits PCY combined limit for outpatient services)	\$30 Copay, applies to the \$5,000 Out of Pocket Maximum	Not Covered
<b>Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer</b>	\$30 Copay, applies to the \$5,000 Out of Pocket Maximum	Not Covered
<b>OTHER SERVICES</b>		
<b>Allergy/Therapeutic Injections</b>	\$2,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Not Covered

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<b>Medical Supplies, Equipment, Prosthetics</b> (Unlimited)	\$2,000 Deductible, then 20% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Not Covered
<b>Transplants</b> (Unlimited)	Covered as any other service	Not Covered
<b>SUPPLEMENTAL BENEFITS</b>		
<b>Routine Vision Exam</b> (1 PCY)	\$25 Copay	Not Covered
<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	Not Covered
<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)	\$25 Copay	Not Covered
<b>Hearing Hardware</b> (WA Mandate \$3,000 per ear with hearing loss every 36 months)	Covered in Full	Covered in Full
<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.*