PREMERA BLUE CROSS

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: PREMERA PATHFINDER - $500/20%/NOT APP/$6,000/$0/$35**	
	HERITAGE PRIME IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	$500	Not Covered
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	Not Covered
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$6,000	Not Covered
Designated PCP Office Visit Cost Share	$0 Copay, applies to the $6,000 Out of Pocket Maximum	Not Covered
Specialist and non designated PCP Office Visit Cost Share	$35 Copay, applies to the $6,000 Out of Pocket Maximum	Not Covered
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
PROFESSIONAL CARE		

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	HERITAGE PRIME IN-NETWORK	**OUT-OF-NETWORK**
Professional Office Visit	Designated PCP: $0 Copay, applies to the $6,000 Out of Pocket Maximum; Specialist and non designated PCP: $35 Copay, applies to the $6,000 Out of Pocket Maximum	Not Covered
Telemedicine with Traditional Providers - General Medical	Designated PCP: $0 Copay, applies to the $6,000 Out of Pocket Maximum; Specialist and non designated PCP: $35 Copay, applies to the $6,000 Out of Pocket Maximum	Not Covered
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	Designated PCP: $0 Copay, applies to the $6,000 Out of Pocket Maximum; Specialist and non designated PCP: $35 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	Not Covered
Diagnostic Lab	$500 Deductible, then 20% Coinsurance, applies to $6,000 Out of Pocket Maximum	Not Covered
Basic Diagnostic Imaging	$500 Deductible, then 20% Coinsurance, applies to $6,000 Out of Pocket Maximum	Not Covered
Major Diagnostic Imaging	$500 Deductible, then 20% Coinsurance, applies to $6,000 Out of Pocket Maximum	Not Covered
Preventive Mammography	Covered in Full	Not Covered
Diagnostic Mammography	Covered in Full	Not Covered
Supplemental Breast Exam	Covered in Full	Not Covered
FACILITY CARE		
Inpatient Facility	$500 Deductible, then 20% Coinsurance, applies to $6,000 Out of Pocket Maximum	Not Covered
Inpatient Professional Services	$500 Deductible, then 20% Coinsurance, applies to $6,000 Out of Pocket Maximum	Not Covered
Outpatient Surgery Facility	$500 Deductible, then 20% Coinsurance, applies to $6,000 Out of Pocket Maximum	Not Covered
Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	$500 Deductible, then 20% Coinsurance, applies to $6,000 Out of Pocket Maximum	Not Covered
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (Unlimited)	$500 Deductible, then 20% Coinsurance, applies to $6,000 Out of Pocket Maximum	Not Covered

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Hospice Care (Unlimited)	$500 Deductible, then 20% Coinsurance, applies to $6,000 Out of Pocket Maximum	Not Covered
MATERNITY & REPRODUCTIVE CARE		
Contraceptive Management Services (Unlimited)	Covered in Full	Not Covered
Sterilization - Female (Unlimited)	Covered in Full	Not Covered
Sterilization - Male (Unlimited)	Covered in Full	Not Covered
MEDICAL TRANSPORTATION BENEFITS		
Transplant Travel & Lodging ($7,500 per transplant)	$500 Deductible, 0% Coinsurance, applies to $6,000 Out of Pocket Maximum	$500 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)	$150 Copay then $500 Deductible and 20% Coinsurance; all cost shares apply to the $6,000 Out of Pocket Maximum	$150 Copay then $500 Deductible and 20% Coinsurance; all cost shares apply to the $6,000 Out of Pocket Maximum
Emergency Room Physician	$500 Deductible, then 20% Coinsurance, applies to $6,000 Out of Pocket Maximum	$500 Deductible, then 20% Coinsurance, applies to $6,000 Out of Pocket Maximum
Urgent Care Center	$35 Copay, applies to the $6,000 Out of Pocket Maximum	$35 Copay, applies to the $6,000 Out of Pocket Maximum
Ambulance Transportation (Unlimited)	$500 Deductible, then 20% Coinsurance, applies to $6,000 Out of Pocket Maximum	$500 Deductible, then 20% Coinsurance, applies to $6,000 Out of Pocket Maximum
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	$0 Copay, applies to the $6,000 Out of Pocket Maximum	Not Covered
Manipulations (Spinal and other) (12 visits PCY)	$0 Copay, applies to the $6,000 Out of Pocket Maximum	Not Covered
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	$500 Deductible, then 20% Coinsurance, applies to $6,000 Out of Pocket Maximum	Not Covered
Chemical Dependency Outpatient Professional Care (Unlimited)	$35 Copay, applies to the $6,000 Out of Pocket Maximum	Not Covered
Mental Health Inpatient Facility Care (Unlimited)	$500 Deductible, then 20% Coinsurance, applies to $6,000 Out of Pocket Maximum	Not Covered
Mental Health Outpatient Professional Care (Unlimited)	$35 Copay, applies to the $6,000 Out of Pocket Maximum	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (60 days PCY combined limit for inpatient services)	$500 Deductible, then 20% Coinsurance, applies to $6,000 Out of Pocket Maximum	Not Covered
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	Not Covered

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	HERITAGE PRIME 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	Not Covered
OTHER SERVICES		
Allergy/Therapeutic Injections	$500 Deductible, then 20% Coinsurance, applies to $6,000 Out of Pocket Maximum	Not Covered
Medical Supplies, Equipment, Prosthetics (Unlimited)	$500 Deductible, then 20% Coinsurance, applies to $6,000 Out of Pocket Maximum	Not Covered
Transplants (Unlimited)	Covered as any other service	Not Covered
SUPPLEMENTAL BENEFITS		
Routine Vision Exam (1 PCY)	$25 Copay	Not Covered
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	Not Covered
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	Not Covered
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.