

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 - \$5,000/30%/NOT APP/\$9,200/\$0/\$65	
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK	
MEDICAL COST SHARES			
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$5,000	Not Covered	
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	30%	Not Covered	
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	\$9,200	Not Covered	
Designated PCP Office Visit Cost Share	\$0 Copay, applies to the \$9,200 Out of Pocket Maximum	Not Covered	
Specialist and non designated PCP Office Visit Cost Share	\$65 Copay, applies to the \$9,200 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			

MEDICAL PLAN		
PC: PREMIERA PATHFINDER - \$5,000/30%/NOT APP/\$9,200/\$0/\$65		
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK
Professional Office Visit	Designated PCP: \$0 Copay, applies to the \$9,200 Out of Pocket Maximum; Specialist and non designated PCP: \$65 Copay, applies to the \$9,200 Out of Pocket Maximum	Not Covered
Telemedicine with Traditional Providers - General Medical	Designated PCP: \$0 Copay, applies to the \$9,200 Out of Pocket Maximum; Specialist and non designated PCP: \$65 Copay, applies to the \$9,200 Out of Pocket Maximum	Not Covered
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	Designated PCP: \$0 Copay, applies to the \$9,200 Out of Pocket Maximum; Specialist and non designated PCP: \$65 Copay, applies to the \$9,200 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	\$5,000 Deductible, then 30% Coinsurance, applies to \$9,200 Out of Pocket Maximum	Not Covered
Basic Diagnostic Imaging	\$5,000 Deductible, then 30% Coinsurance, applies to \$9,200 Out of Pocket Maximum	Not Covered
Major Diagnostic Imaging	\$5,000 Deductible, then 30% Coinsurance, applies to \$9,200 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	\$5,000 Deductible, then 30% Coinsurance, applies to \$9,200 Out of Pocket Maximum	Not Covered
Inpatient Professional Services	\$5,000 Deductible, then 30% Coinsurance, applies to \$9,200 Out of Pocket Maximum	Not Covered
Outpatient Surgery Facility	\$5,000 Deductible, then 30% Coinsurance, applies to \$9,200 Out of Pocket Maximum	Not Covered
Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$5,000 Deductible, then 30% Coinsurance, applies to \$9,200 Out of Pocket Maximum	Not Covered
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (Unlimited)	\$5,000 Deductible, then 30% Coinsurance, applies to \$9,200 Out of Pocket Maximum	Not Covered

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Hospice Care (Unlimited)	\$5,000 Deductible, then 30% Coinsurance, applies to \$9,200 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)	\$5,000 Deductible, 0% Coinsurance, applies to \$9,200 Out of Pocket Maximum	\$5,000 Deductible, 0% Coinsurance, applies to \$9,200 Out of Pocket Maximum	
EMERGENCY CARE AND TRANSPORTATION			
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	\$150 Copay then \$5,000 Deductible and 30% Coinsurance; all cost shares apply to the \$9,200 Out of Pocket Maximum	\$150 Copay then \$5,000 Deductible and 30% Coinsurance; all cost shares apply to the \$9,200 Out of Pocket Maximum	
Emergency Room Physician	\$5,000 Deductible, then 30% Coinsurance, applies to \$9,200 Out of Pocket Maximum	\$5,000 Deductible, then 30% Coinsurance, applies to \$9,200 Out of Pocket Maximum	
Urgent Care Center	\$65 Copay, applies to the \$9,200 Out of Pocket Maximum	\$65 Copay, applies to the \$9,200 Out of Pocket Maximum	
Ambulance Transportation (Unlimited)	\$5,000 Deductible, then 30% Coinsurance, applies to \$9,200 Out of Pocket Maximum	\$5,000 Deductible, then 30% Coinsurance, applies to \$9,200 Out of Pocket Maximum	
ALTERNATIVE CARE			
Acupuncture (12 visits PCY)	\$0 Copay, applies to the \$9,200 Out of Pocket Maximum	Not Covered	
Manipulations (Spinal and other) (12 visits PCY)	\$0 Copay, applies to the \$9,200 Out of Pocket Maximum	Not Covered	
CHEMICAL DEPENDENCY & MENTAL HEALTH			
Chemical Dependency Inpatient Facility Care (Unlimited)	\$5,000 Deductible, then 30% Coinsurance, applies to \$9,200 Out of Pocket Maximum	Not Covered	
Chemical Dependency Outpatient Professional Care (Unlimited)	\$65 Copay, applies to the \$9,200 Out of Pocket Maximum	Not Covered	
Mental Health Inpatient Facility Care (Unlimited)	\$5,000 Deductible, then 30% Coinsurance, applies to \$9,200 Out of Pocket Maximum	Not Covered	
Mental Health Outpatient Professional Care (Unlimited)	\$65 Copay, applies to the \$9,200 Out of Pocket Maximum	Not Covered	
REHABILITATION & NEURO			
Rehab Inpatient Facility (60 days PCY combined limit for inpatient services)	\$5,000 Deductible, then 30% Coinsurance, applies to \$9,200 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)	\$65 Copay, applies to the \$9,200 Out of Pocket Maximum	Not Covered	

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Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	\$65 Copay, applies to the \$9,200 Out of Pocket Maximum	Not Covered	
OTHER SERVICES			
Allergy/Therapeutic Injections	\$5,000 Deductible, then 30% Coinsurance, applies to \$9,200 Out of Pocket Maximum	Not Covered	
Medical Supplies, Equipment, Prosthetics (Unlimited)	\$5,000 Deductible, then 30% Coinsurance, applies to \$9,200 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 \$9,200 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.