

# 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: PPO SHARED NO VISION - \$250/10%/50%/\$3,000/\$20/\$40</b>	
	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>MEDICAL COST SHARES</b>			
<b>Individual Deductible PCY</b> (Family embedded deductible 3X Individual)	\$250	Shared with In-Network	
<b>Coinsurance (Member's percentage of costs after deductible based on allowable charges)</b>	10%	50%	
<b>Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable</b> (Family embedded OOP max 3X Individual)	\$3,000	Shared with In-Network	
<b>Non Specialist Office Visit Cost Share</b>	\$20 Copay, applies to the \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Specialist Office Visit Cost Share</b>	\$40 Copay, applies to the \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network 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	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Immunizations</b> (Unlimited, subject to standard medical guidelines)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Health Education (HE)</b> (Unlimited)	Covered in Full	Not Covered	

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	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<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
<b>PROFESSIONAL CARE</b>		
<b>Professional Office Visit</b>	Non Specialist: \$20 Copay, applies to the \$3,000 Out of Pocket Maximum; Specialist: \$40 Copay, applies to the \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Telemedicine with Traditional Providers - General Medical</b>	\$10 Copay, applies to the \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>VIRTUAL CARE SERVICES</b>		
<b>Telemedicine - General Medical (Virtual Care Only)</b>	\$10 Copay, applies to the \$3,000 Out of Pocket Maximum	Not Covered
<b>Telemedicine - Mental Health (Virtual Care Only)</b>	\$10 Copay, applies to the \$3,000 Out of Pocket Maximum	Not Covered
<b>Telemedicine - Chemical Dependency (Virtual Care Only)</b>	\$10 Copay, applies to the \$3,000 Out of Pocket Maximum	Not Covered
<b>DIAGNOSTIC SERVICES</b>		
<b>Preventive Imaging and Lab</b>	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Diagnostic Lab</b>	Waive Deductible, then 10% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Basic Diagnostic Imaging</b>	Waive Deductible, then 10% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Major Diagnostic Imaging</b>	Waive Deductible, then 10% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Preventive Mammography</b>	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum

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	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>Diagnostic Mammography</b>	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Supplemental Breast Exam</b>	Covered in Full	Covered as any other service	
<b>FACILITY CARE</b>			
<b>Inpatient Facility</b>	\$250 Deductible, then 10% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Inpatient Professional Services</b>	\$250 Deductible, then 10% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Outpatient Surgery Facility</b>	\$250 Deductible, then 10% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Skilled Nursing Facility</b> (120 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$250 Deductible, then 10% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>HOSPICE &amp; HOME HEALTH CARE</b>			
<b>Hospice Inpatient Facility</b> (Unlimited)	\$250 Deductible, then 10% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Hospice Care</b> (Unlimited)	\$250 Deductible, then 10% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>MATERNITY &amp; REPRODUCTIVE CARE</b>			
<b>Contraceptive Management Services</b> (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Sterilization - Female</b> (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Sterilization - Male</b> (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>MEDICAL TRANSPORTATION BENEFITS</b>			
<b>Transplant Travel &amp; Lodging</b> (\$7,500 per transplant)	\$250 Deductible, 0% Coinsurance, applies to \$3,000 Out of Pocket Maximum	\$250 Deductible, 0% Coinsurance, applies to \$3,000 Out of Pocket Maximum	
<b>EMERGENCY CARE AND TRANSPORTATION</b>			

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	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Emergency Care (If applicable, waive copay if admitted to inpatient facility)</b>	\$150 Copay then \$250 Deductible and 10% Coinsurance; all cost shares apply to the \$3,000 Out of Pocket Maximum	\$150 Copay then \$250 Deductible and 10% Coinsurance; all cost shares apply to the \$3,000 Out of Pocket Maximum
<b>Emergency Room Physician</b>	\$250 Deductible, then 10% Coinsurance, applies to \$3,000 Out of Pocket Maximum	\$250 Deductible, then 10% Coinsurance, applies to \$3,000 Out of Pocket Maximum
<b>Urgent Care Center</b>	\$50 Copay, applies to the \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Ambulance Transportation (Unlimited)</b>	\$250 Deductible, then 10% Coinsurance, applies to \$3,000 Out of Pocket Maximum	\$250 Deductible, then 10% Coinsurance, applies to \$3,000 Out of Pocket Maximum
<b>ALTERNATIVE CARE</b>		
<b>Acupuncture (24 visits PCY)</b>	\$20 Copay, applies to the \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Manipulations (Spinal and other) (24 visits PCY)</b>	\$20 Copay, applies to the \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>CHEMICAL DEPENDENCY &amp; MENTAL HEALTH</b>		
<b>Chemical Dependency Inpatient Facility Care (Unlimited)</b>	\$250 Deductible, then 10% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Chemical Dependency Outpatient Professional Care (Unlimited)</b>	\$10 Copay, applies to the \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Mental Health Inpatient Facility Care (Unlimited)</b>	\$250 Deductible, then 10% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Mental Health Outpatient Professional Care (Unlimited)</b>	\$10 Copay, applies to the \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>REHABILITATION &amp; NEURO</b>		
<b>Rehab Inpatient Facility (60 days PCY combined limit for inpatient services)</b>	\$250 Deductible, then 10% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (60 visits PCY combined limit for outpatient services)</b>	\$40 Copay, applies to the \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer</b>	\$40 Copay, applies to the \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum

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<b>OTHER SERVICES</b>			
<b>Allergy/Therapeutic Injections</b>	Waive Deductible, then 10% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Medical Supplies, Equipment, Prosthetics</b> (Unlimited)	\$250 Deductible, then 10% Coinsurance, applies to \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Transplants</b> (Unlimited)	Covered as any other service	Not Covered	
<b>SUPPLEMENTAL BENEFITS</b>			
<b>Routine Hearing Exam</b> (1 every 36 months)	\$25 Copay	\$25 Copay	
<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.*