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: PPO UNLIMITED NO VISION - $1,000/20%/50%/$5,500/$20/$40**	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 3X Individual)	$1,000	Shared with In-Network
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	50%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$5,500	Unlimited
Non Specialist Office Visit Cost Share	$20 Copay, applies to the $5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Specialist Office Visit Cost Share	$40 Copay, applies to the $5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited 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	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Health Education (HE) (Unlimited)	Covered in Full	Not Covered

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
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		
Professional Office Visit	Non Specialist: $20 Copay, applies to the $5,500 Out of Pocket Maximum; Specialist: $40 Copay, applies to the $5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Telemedicine with Traditional Providers - General Medical	$10 Copay, applies to the $5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	$10 Copay, applies to the $5,500 Out of Pocket Maximum	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	$10 Copay, applies to the $5,500 Out of Pocket Maximum	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	$10 Copay, applies to the $5,500 Out of Pocket Maximum	Not Covered
DIAGNOSTIC SERVICES		
Preventive Imaging and Lab	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Diagnostic Lab	Waive Deductible, then 20% Coinsurance, applies to $5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Basic Diagnostic Imaging	Waive Deductible, then 20% Coinsurance, applies to $5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Major Diagnostic Imaging	Waive Deductible, then 20% Coinsurance, applies to $5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Preventive Mammography	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

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Diagnostic Mammography	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Supplemental Breast Exam	Covered in Full	Covered as any other service
FACILITY CARE		
Inpatient Facility	$1,000 Deductible, then 20% Coinsurance, applies to $5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Inpatient Professional Services	$1,000 Deductible, then 20% Coinsurance, applies to $5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Surgery Facility	$1,000 Deductible, then 20% Coinsurance, applies to $5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Skilled Nursing Facility (120 days PCY; includes room and board, and facility billed professional and ancillary fees)	$1,000 Deductible, then 20% Coinsurance, applies to $5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (Unlimited)	$1,000 Deductible, then 20% Coinsurance, applies to $5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Hospice Care (Unlimited)	$1,000 Deductible, then 20% Coinsurance, applies to $5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
MATERNITY & REPRODUCTIVE CARE		
Contraceptive Management Services (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Sterilization - Female (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Sterilization - Male (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
MEDICAL TRANSPORTATION BENEFITS		
Transplant Travel & Lodging ($7,500 per transplant)	$1,000 Deductible, 0% Coinsurance, applies to $5,500 Out of Pocket Maximum	$1,000 Deductible, 0% Coinsurance, applies to $5,500 Out of Pocket Maximum
EMERGENCY CARE AND TRANSPORTATION		

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Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$150 Copay then $1,000 Deductible and 20% Coinsurance; all cost shares apply to the $5,500 Out of Pocket Maximum	$150 Copay then $1,000 Deductible and 20% Coinsurance; all cost shares apply to the $5,500 Out of Pocket Maximum
Emergency Room Physician	$1,000 Deductible, then 20% Coinsurance, applies to $5,500 Out of Pocket Maximum	$1,000 Deductible, then 20% Coinsurance, applies to $5,500 Out of Pocket Maximum
Urgent Care Center	$50 Copay, applies to the $5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Ambulance Transportation (Unlimited)	$1,000 Deductible, then 20% Coinsurance, applies to $5,500 Out of Pocket Maximum	$1,000 Deductible, then 20% Coinsurance, applies to $5,500 Out of Pocket Maximum
ALTERNATIVE CARE		
Acupuncture (24 visits PCY)	$20 Copay, applies to the $5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Manipulations (Spinal and other) (24 visits PCY)	$20 Copay, applies to the $5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	$1,000 Deductible, then 20% Coinsurance, applies to $5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Outpatient Professional Care (Unlimited)	$10 Copay, applies to the $5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	$1,000 Deductible, then 20% Coinsurance, applies to $5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	$10 Copay, applies to the $5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
REHABILITATION & NEURO		
Rehab Inpatient Facility (60 days PCY combined limit for inpatient services)	$1,000 Deductible, then 20% Coinsurance, applies to $5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited 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)	$40 Copay, applies to the $5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	$40 Copay, applies to the $5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

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OTHER SERVICES		
Allergy/Therapeutic Injections	Waive Deductible, then 20% Coinsurance, applies to $5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Medical Supplies, Equipment, Prosthetics (Unlimited)	$1,000 Deductible, then 20% Coinsurance, applies to $5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Transplants (Unlimited)	Covered as any other service	Not Covered
SUPPLEMENTAL BENEFITS		
Routine Hearing Exam (1 every 36 months)	$25 Copay	$25 Copay
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.