PREMERA BLUE CROSS

Highlights of your Health Care Coverage

Effective Date: 01/01/2022

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	PREMERA PREFERRED CHOICE: PPO - $2,500/30%/50%/$6,850/$35 - HERITAGE	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 2X Individual)	$2,500	$5,000
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	30%	50%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$6,850	Unlimited
Office Visit Cost Share	$35 Copay, applies to the $6,850 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
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
PROFESSIONAL CARE		
Professional Office Visit	$35 Copay, applies to the $6,850 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Telemedicine with Traditional Providers - General Medical	$10 Copay, applies to the $6,850 Out of Pocket Maximum	$5,000 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 $6,850 Out of Pocket Maximum	Not Covered

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
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 SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in Full	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Imaging	Waive Deductible, then 30% Coinsurance, applies to $6,850 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Professional Diagnostic Major Imaging	Waive Deductible, then 30% Coinsurance, applies to $6,850 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Laboratory/Pathology	Waive Deductible, then 30% Coinsurance, applies to $6,850 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Diagnostic Mammography	Waive Deductible, then 30% Coinsurance, applies to $6,850 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
FACILITY CARE OPTIONS		
Inpatient Facility	$2,500 Deductible, then 30% Coinsurance, applies to $6,850 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Inpatient Professional Services	$2,500 Deductible, then 30% Coinsurance, applies to $6,850 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Surgery Facility	$2,500 Deductible, then 30% Coinsurance, applies to $6,850 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	$2,500 Deductible, then 30% Coinsurance, applies to $6,850 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	$2,500 Deductible, then 30% Coinsurance, applies to $6,850 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	$2,500 Deductible, then 30% Coinsurance, applies to $6,850 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
MATERNITY & REPRODUCTIVE CARE		
Contraceptive Management Services (Unlimited)	Covered in Full	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Sterilization - Female (Unlimited)	Covered in Full	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Sterilization - Male (Unlimited)	Covered in Full	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
PREMERA DESIGNATED CENTERS OF EXCELLENCE		
Centers of Excellence Packaged Services (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement))	Covered in Full	Covered as any other service

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Centers of Excellence for Radiology (Member Outreach Included)	Covered as any other service	Covered as any other service
MEDICAL TRANSPORTATION BENEFITS		
Centers of Excellence Travel and Care Coordination (Limited to IRS Guidelines)	Covered in Full	Covered in Full
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$300 Copay then $2,500 Deductible and 30% Coinsurance; all cost shares apply to the $6,850 Out of Pocket Maximum	$300 Copay then $2,500 Deductible and 30% Coinsurance; all cost shares apply to the $6,850 Out of Pocket Maximum
Emergency Room Physician	$2,500 Deductible, then 30% Coinsurance, applies to $6,850 Out of Pocket Maximum	$2,500 Deductible, then 30% Coinsurance, applies to $6,850 Out of Pocket Maximum
Urgent Care Center	$35 Copay, applies to the $6,850 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Ambulance Transportation (Unlimited)	$2,500 Deductible, then 30% Coinsurance, applies to $6,850 Out of Pocket Maximum	$2,500 Deductible, then 30% Coinsurance, applies to $6,850 Out of Pocket Maximum
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	$35 Copay, applies to the $6,850 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Manipulations (Spinal and other) (12 visits PCY)	$35 Copay, applies to the $6,850 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	$2,500 Deductible, then 30% Coinsurance, applies to $6,850 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Outpatient Professional Care (Unlimited)	$35 Copay, applies to the $6,850 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	$2,500 Deductible, then 30% Coinsurance, applies to $6,850 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	$35 Copay, applies to the $6,850 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	$2,500 Deductible, then 30% Coinsurance, applies to $6,850 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (45 visits PCY)	$35 Copay, applies to the $6,850 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	$35 Copay, applies to the $6,850 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
OTHER SERVICES		
Allergy/Therapeutic Injections	Covered in Full	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

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Medical Supplies, Equipment, Prosthetics (Unlimited)	$2,500 Deductible, then 30% Coinsurance, applies to $6,850 Out of Pocket Maximum	$5,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Transplants (Unlimited; $7,500 travel and lodging limits)	Covered as any other service	Not Covered
SUPPLEMENTAL BENEFITS		
Routine Vision Exam (1 PCY)	$25 Copay	$25 Copay
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 $6,850 Out of Pocket Maximum	$25 Copay, applies to the $6,850 Out of Pocket Maximum
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
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 under which the program may be continued in force. This benefit highlight is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.

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La discriminación es prohibida

Premera Blue Cross (Premera) cumple con las leyes de derechos civiles federales y del estado Washington aplicables, y no discrimina según la raza, el color, la nacionalidad, la edad, la discapacidad, el sexo, la identidad de género o la orientación sexual. Premera no excluye a las personas ni las trata de manera diferente debido a su raza, color, nacionalidad, edad, discapacidad, sexo, identidad de género u orientación sexual.

Premera:

- Proporciona ayuda y servicios gratuitos a personas con discapacidades para comunicarse con nosotros de manera eficiente, por ejemplo:
  - Intérpretes de lenguaje de señas calificados.
  - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos).
- Proporciona servicios lingüísticos gratuitos para las personas cuyo idioma principal no sea el inglés, tales como:
  - Intérpretes calificados.
  - Información escrita en otros idiomas.

Si necesita estos servicios, comuníquese con el coordinador de derechos civiles.

Si considera que Premera no le ha proporcionado estos servicios o se sintió discriminado de algún modo por su raza, color, nacionalidad, edad, discapacidad, sexo, identidad de género u orientación sexual, puede presentar una queja formal a la siguiente dirección: Civil Rights Coordinator ─ Complaints and Appeals, PO Box 91102, Seattle, WA 98111, número gratuito: 855-332-4535, fax: 425-918-5592, TTY: 711, correo electrónico AppealsDepartmentInquiries@Premera.com. Puede presentar una queja formal en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para presentar una queja formal, el coordinador de derechos civiles está disponible para ayudarle.

También puede presentar un reclamo de derechos civiles ante:

- La Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU., de manera electrónica a través del portal de reclamos de la Oficina de Derechos Civiles disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o bien, por correo postal o teléfono a la dirección y al número de teléfono indicados a continuación: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Los formularios de reclamos están disponibles en http://www.hhs.gov/ocr/office/file/index.html.

- La Oficina del Comisionado de Seguros del Estado de Washington, de manera electrónica a través del portal de reclamos de la Oficina del Comisionado de Seguros, disponible en https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, o por teléfono al 800-562-6900, 360-586-0241 (TDD). Los formularios de reclamos están disponibles en https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

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Asistencia con el idioma

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 800-722-1471 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-722-1471（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-722-1471 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-722-1471 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 711) 800-722-1471 تماس بگیرید.