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** | **BALANCE 2000 SILVER + FAMILY DENTAL** | |
|---|---|---|
| | **HERITAGE SIGNATURE AND DENTAL CHOICE IN-NETWORK** | **OUT-OF-NETWORK** |
| **Deductible** (In-network only - Family embedded deductible 2X Individual) | $2,000 | $4,000 |
| **Coinsurance** | 30% | 50% |
| **Out of Pocket Maximum (includes deductible, copays, coinsurance and pharmacy)** (Family embedded OOP max 2X Individual) | $8,150 | Unlimited |
| **Office Visit Cost Share** | $35 Copay designated PCP, applies to the $8,150 Out of Pocket Maximum; $70 Copay Specialist and non designated PCP, applies to the $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Annual Maximum** | Unlimited | Unlimited |
| **1 Ambulatory Patient Services** | | |
| **Professional Office Visit** | $35 Copay designated PCP, applies to the $8,150 Out of Pocket Maximum; $70 Copay Specialist and non designated PCP, applies to the $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Telemedicine by Traditional Provider – General Medical** | $35 Copay designated PCP, applies to the $8,150 Out of Pocket Maximum; $70 Copay Specialist and non designated PCP, applies to the $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Urgent Care Office Visits** | $70 Copay Specialist and non designated PCP, applies to the $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Outpatient Professional Services** | $2,000 Deductible, then 30% Coinsurance, applies to the $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to the Unlimited Out of Pocket Maximum |


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| | **HERITAGE SIGNATURE AND DENTAL CHOICE IN-NETWORK** | **OUT-OF-NETWORK** |
| **Contraceptive Management Services** (Unlimited) | Covered in Full | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **2 Emergency and Transportation Services** | | |
| **Emergency Room - facility** | $250 Copay then $2,000 Deductible and 30% Coinsurance; all cost shares apply to the $8,150 Out of Pocket Maximum | $250 Copay then $2,000 Deductible and 30% Coinsurance; all cost shares apply to the $8,150 Out of Pocket Maximum |
| **Ambulance Service - ground** (Unlimited) | $2,000 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum | $2,000 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum |
| **Ambulance Service - air** (Unlimited) | $2,000 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum | $2,000 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum |
| **3 Hospitalization** | | |
| **Inpatient Medical and Surgical Room and Board** (Unlimited) | $2,000 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum | $4,000 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) | $2,000 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Hospice Inpatient Facility** (Unlimited) | $2,000 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Inpatient Professional Services** | $2,000 Deductible, then 30% Coinsurance, applies to the $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to the Unlimited Out of Pocket Maximum |
| **Organ Transplants** (Unlimited; $5,000 travel and lodging limits) | Covered as any other service | Not Covered |
| **4 Maternity & Newborn Care** | | |
| **Prenatal, Delivery, Postnatal** (Coverage for subscriber, spouse, dependent) | $2,000 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **5 Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment** | | |
| **Chemical Dependency Office Visit** (Unlimited) | $70 Copay Specialist and non designated PCP, applies to the $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Chemical Dependency Outpatient Facility** (Unlimited) | $2,000 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Chemical Dependency Inpatient Facility** (Unlimited) | $2,000 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Mental Health Office Visit** (Unlimited) | $70 Copay Specialist and non designated PCP, applies to the $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Mental Health Outpatient Facility** (Unlimited) | $2,000 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |


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| **Mental Health Inpatient Facility** (Unlimited) | $2,000 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **6 Prescription Drug** | | |
| **Drug List** | M4<br>Tier 1 = preferred generic<br>Tier 2 = preferred brand<br>Tier 3 = non-preferred generic and brand<br>Tier 4 = specialty | Not Covered |
| **Retail (preferred generic/preferred brand/non-preferred)** (Retail and Specialty drugs 30 day supply/Mail Order 90 day and Specialty drugs 30 day supply) | Waive Deductible, then $35/ Waive Deductible, then $75/$2,000 Deductible, then 30% Coinsurance; all cost shares apply to the $8,150 Out of Pocket Maximum | Not Covered |
| **Mail Order (preferred generic/preferred brand/non-preferred)** (Retail and Specialty drugs 30 day supply/Mail Order 90 day and Specialty drugs 30 day supply) | Waive Deductible, then $105/ Waive Deductible, then $225/$2,000 Deductible, then 30% Coinsurance; all cost shares apply to the $8,150 Out of Pocket Maximum | Not Covered |
| **Specialty Rx** (Retail and Specialty drugs 30 day supply/Mail Order 90 day and Specialty drugs 30 day supply) | $2,000 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum | Not Covered |
| **7 Rehabilitative & Habilitative Services & Devices** | | |
| **Inpatient Rehabilitation** (30 days PCY combined limit for inpatient services) | $2,000 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Inpatient Habilitation** (30 days PCY combined limit for inpatient services) | $2,000 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Rehab Outpatient Professional - physical, speech, occupational therapy** (25 visits PCY combined limit for outpatient services) | $70 Copay Specialist and non designated PCP, applies to the $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Habilitation Outpatient Professional - physical, speech, occupational therapy** (25 visits PCY combined limit for outpatient services) | $70 Copay Specialist and non designated PCP, applies to the $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Massage Therapy** (Applies to rehab) | $70 Copay Specialist and non designated PCP, applies to the $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Durable Medical Equipment** (Unlimited) | $2,000 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **8 Laboratory/Imaging Services** | | |
| **Pathology** | $2,000 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Imaging - basic** | $2,000 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |


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| | **HERITAGE SIGNATURE AND DENTAL CHOICE IN-NETWORK** | **OUT-OF-NETWORK** |
| **Imaging - major (MRI, CT, PET)** | $2,000 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Diagnostic Mammography** | $2,000 Deductible, then 30% Coinsurance, applies to $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **9 Preventive/Wellness Services & Chronic Disease Management** | | |
| **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 |
| **Preventive Laboratory Screens** | Covered in Full | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Preventive Imaging** | Covered in Full | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Preventive Routine Mammography** | Covered in Full | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **10 Pediatric Services, including Oral & Vision Care** | | |
| **Pediatric Vision Exam** (1 PCY Under age 19) | $70 Copay Specialist and non designated PCP, applies to the $8,150 Out of Pocket Maximum | $70 Copay Specialist and non designated PCP, applies to the $8,150 Out of Pocket Maximum |
| **Pediatric Eyewear** (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 |
| **Pediatric Dental (preventive)** | Covered in Full | Medical $4,000 Deductible, then 30% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Pediatric Dental (basic)** | Waive Medical Deductible, then 20% Coinsurance, applies to $8,150 Out of Pocket Maximum | Medical $4,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Pediatric Dental (major)** | Medical $2,000 Deductible, then 50% Coinsurance, applies to $8,150 Out of Pocket Maximum | Medical $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Virtual Care Services** | | |
| **Telemedicine – General Medical (Virtual Care Only)** | $5 Copay, applies to the $8,150 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 |
| **Routine Hearing** | | |
| **Routine Hearing Exam** (1 every 2 calendar years) | $70 Copay | $70 Copay |
| **Routine Hearing Aids and Hardware** ($1000 every 3 calendar years) | Covered in Full | Covered in Full |


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| | HERITAGE SIGNATURE AND DENTAL CHOICE IN-NETWORK | OUT-OF-NETWORK |
| **Alternative Care** | | |
| **Chiropractic** (10 visits PCY) | $35 Copay, applies to the $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Acupuncture** (12 visits PCY) | $35 Copay, applies to the $8,150 Out of Pocket Maximum | $4,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Naturopath** (Unlimited) | $35 Copay designated PCP, applies to the $8,150 Out of Pocket Maximum; $70 Copay Specialist and non designated PCP, applies to the $8,150 Out of Pocket Maximum | $4,000 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)) | Designated Provider: Covered in Full; Non-Designated Provider: Not Covered | Not Covered |
| **Travel and Care Coordination** (Limited to IRS Guidelines) | Covered in Full | Not Covered |
| **Centers of Excellence for Radiology** (Member Outreach Included) | Covered as any other service | Covered as any other service |
| **Adult Dental Services** | | |
| **Individual Deductible** | $50 | $50 |
| **Preventive Cost Share** | Covered In Full | Deductible Waived, then 30% |
| **Basic Cost Share** | Deductible, then 20% | Deductible, then 40% |
| **Major Cost Share** | Deductible, then 50% | Deductible, then 50% |
| **Dental Annual Maximum** | $1,000 PCY | Shared with In Network |
| **Diagnostic / Preventive** | | |
| **Routine Oral Exams** (2 PCY) | Preventive Cost Share | Preventive Cost Share |
| **Routine X-Rays** (1 complete series every 60 months) | Preventive Cost Share | Preventive Cost Share |
| **Cleanings** (2 PCY) | Preventive Cost Share | Preventive Cost Share |
| **Basic** | | |
| **Non-Routine / Problem-Focused Exams** (1 PCY) | Basic Cost Share | Basic Cost Share |
| **Fillings** (Once every 24 months) | Basic Cost Share | Basic Cost Share |
| **Pulp Cap** (Pulp Cap: Direct only; Pulp Therapy: Not Covered) | Basic Cost Share | Basic Cost Share |
| **Endodontics** (Once per tooth per Lifetime) | Basic Cost Share | Basic Cost Share |
| **Full Mouth Debridement** (Once per lifetime) | Basic Cost Share | Basic Cost Share |
| **Periodontal Maintenance** (4 PCY) | Basic Cost Share | Basic Cost Share |
| **Periodontal Scaling and Root Planing** (Scaling and Root Planing 1 every 24 months) | Basic Cost Share | Basic Cost Share |
| **Simple Extractions** | Basic Cost Share | Basic Cost Share |
| **Surgical Extractions** | Basic Cost Share | Basic Cost Share |
| **General Anesthesia** | Basic Cost Share | Basic Cost Share |
| **Emergency Palliative Treatment** | Basic Cost Share | Basic Cost Share |
| **Limited Occlusal Adjustment** (1 per 24 months) | Basic Cost Share | Basic Cost Share |


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| | HERITAGE SIGNATURE AND DENTAL CHOICE IN-NETWORK | OUT-OF-NETWORK |
| **Major** | | |
| **Installation of Crowns** (Porcelain, ceramic and metal crowns only 1 every 7 years) | Major Cost Share | Major Cost Share |
| **Build-Ups** (Once every 7 years) | Major Cost Share | Major Cost Share |
| **Re-Cementing/Repair of Crowns** (Crowns only 1 every 24 months, 6 months after placement) | Major Cost Share | Major Cost Share |

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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## Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator ─ Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: 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). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

## Language Assistance

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, ໂດຍບໍ່ເສັ້ຽຄ່າ, 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.