

Highlights of your Health Care Coverage

Effective Date: 01/01/2021

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: ESSENTIALS - \$8550		
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$8,550	Not Covered
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	0%	Not Covered
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	\$8,550	Not Covered
Office Visit Cost Share	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 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
PROFESSIONAL CARE		
Professional Office Visit (Includes TeleMedicine)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	Covered In Full	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	Covered in Full	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	Covered in Full	Not Covered
DIAGNOSTIC SERVICE OPTIONS		

MEDICAL PLAN		
PREMERA PREFERRED CHOICE: ESSENTIALS - \$8550		
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	Not Covered
Other Professional Diagnostic Imaging	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Professional Diagnostic Major Imaging	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Other Professional Diagnostic Laboratory/Pathology	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Diagnostic Mammography	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
FACILITY CARE OPTIONS		
Inpatient Facility	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Inpatient Professional Services	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Outpatient Surgery Facility	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 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
PREMERA DESIGNATED CENTERS OF EXCELLENCE		
Centers of Excellence Packaged Services (Heritage Prime Network - No Eligible Services)	Covered as any other service	Covered as any other service
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Room Physician	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum

MEDICAL PLAN		
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	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK
Urgent Care Center	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Ambulance Transportation (Unlimited)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Manipulations (Spinal and other) (12 visits PCY)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Chemical Dependency Outpatient Professional Care (Unlimited)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Mental Health Inpatient Facility Care (Unlimited)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Mental Health Outpatient Professional Care (Unlimited)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (45 visits PCY)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
OTHER SERVICES		
Allergy/Therapeutic Injections	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Medical Supplies, Equipment, Prosthetics (Unlimited)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Transplants (Unlimited; \$7,500 travel and lodging limits)	Covered as any other service	Not Covered
PHARMACY		

MEDICAL PLAN		
PREMERA PREFERRED CHOICE: ESSENTIALS - \$8550		
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK
Prescription Drugs - Retail (Retail & Specialty drugs 30 day Supply/Mail Order 90 day and Specialty 30 day supply)	\$8,550 Deductible, then 0% Coinsurance, applies to the \$8,550 Out of Pocket Maximum	Not Covered
Prescription Drugs - Mail (Retail & Specialty drugs 30 day Supply/Mail Order 90 day and Specialty 30 day supply)	\$8,550 Deductible, then 0% Coinsurance, applies to the \$8,550 Out of Pocket Maximum	Not Covered
Drug List	E1 Essentials Formulary No Tiers	E1 Essentials Formulary No Tiers
Specialty Pharmacy (Mandatory - Exclusive)	\$8,550 Deductible, then 0% Coinsurance, applies to the \$8,550 Out of Pocket Maximum	Not Covered
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.

Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. 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, or sex, 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>.

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: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល

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 አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711)።

XIYYEEFFANNA: 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).

ໂປດອຸບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ແມ່ນມີສ່ວນໃຫ້ທ່ານ. ໂທ 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 بہ زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.