

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		
BALANCE EPO 8550 BRONZE		
	HERITAGE SIGNATURE AND DENTAL CHOICE IN-NETWORK	OUT-OF-NETWORK
Deductible (In-network only - Family embedded deductible 2X Individual)	\$8,550	Not Covered
Coinsurance	0%	Not Covered
Out of Pocket Maximum (includes deductible, copays, coinsurance and pharmacy) (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
Annual Maximum	Unlimited	Unlimited
1 Ambulatory Patient Services		
Professional Office Visit	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Telemedicine by Traditional Provider – General Medical	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Urgent Care Office Visits	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Outpatient Professional Services	\$8,550 Deductible, then 0% Coinsurance, applies to the \$8,550 Out of Pocket Maximum	Not Covered
Ambulatory Surgery Center	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Contraceptive Management Services (Unlimited)	Covered in Full	Not Covered
2 Emergency and Transportation Services		

MEDICAL PLAN		
	BALANCE EPO 8550 BRONZE	
	HERITAGE SIGNATURE AND DENTAL CHOICE IN-NETWORK	OUT-OF-NETWORK
Emergency Room - Facility	\$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
Ambulance Service - Ground (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
Ambulance Service - Air (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
3 Hospitalization		
Inpatient Medical and Surgical Room and Board (Unlimited)	\$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 Inpatient Facility (Unlimited)	\$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 the \$8,550 Out of Pocket Maximum	Not Covered
Organ Transplants (Unlimited)	Covered as any other service	Not Covered
4 Maternity & Newborn Care		
Prenatal, Delivery, Postnatal (Coverage for subscriber, spouse, dependent)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
5 Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment		
Chemical Dependency Office Visit (Unlimited)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Chemical Dependency Outpatient Facility (Unlimited)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Chemical Dependency Inpatient Facility (Unlimited)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Mental Health Office Visit (Unlimited)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Mental Health Inpatient Facility (Unlimited)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
6 Prescription Drug		
Formulary Drug List	M1 No Tiers	Not Covered
Prescription Drugs - Retail (Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Prescription Drugs - Mail (Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered

MEDICAL PLAN		BALANCE EPO 8550 BRONZE	
	HERITAGE SIGNATURE AND DENTAL CHOICE IN-NETWORK	OUT-OF-NETWORK	
7 Rehabilitative & Habilitative Services & Devices			
Inpatient Rehabilitation (30 days PCY combined limit for inpatient services)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered	
Inpatient Habilitation (30 days PCY combined limit for inpatient services)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered	
Rehab Outpatient Professional - Physical, Speech, Occupational Therapy (25 visits PCY combined limit for outpatient services)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered	
Habilitation Outpatient Professional - Physical, Speech, Occupational Therapy (25 visits PCY combined limit for outpatient services)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered	
Massage Therapy (25 visits PCY combined limit for outpatient services)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered	
Durable Medical Equipment (Unlimited)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered	
8 Laboratory/Imaging Services			
Diagnostic Lab & Pathology	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered	
Diagnostic Imaging - Basic	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered	
Diagnostic Imaging - Major (MRI, CT, PET)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered	
Diagnostic Mammography	Covered in Full	Not Covered	
Supplemental Breast Exam	Covered in Full	Not Covered	
9 Preventive/Wellness Services			
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	Not Covered	
Preventive Imaging	Covered in Full	Not Covered	
Preventive Mammography	Covered in Full	Not Covered	
10 Pediatric Services, including Oral & Vision Care			
Pediatric Vision Exam (1 PCY Under age 19)	\$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	
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	Covered in Full	
Pediatric Dental - Basic	Waive Medical Deductible, then 30% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Medical \$8,550 Deductible, then 30% Coinsurance, applies to \$8,550 Out of Pocket Maximum	

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Pediatric Dental - Major	Medical \$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Medical \$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum
Chronic Condition Management Programs		
Diabetes Management Plus	Included	Included
Virtual Care Services		
Telemedicine – General Medical (Virtual Care Only)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 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)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Routine Hearing Aids and Hardware (\$1000 every 3 calendar years)	Covered in Full	Covered in Full
Alternative Care		
Chiropractic (10 visits PCY)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Acupuncture (12 visits PCY)	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered
Naturopath	\$8,550 Deductible, then 0% Coinsurance, applies to \$8,550 Out of Pocket Maximum	Not Covered

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.

Notice of availability and nondiscrimination 800-722-1471 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.

Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.

呼吁提供免费的语言援助服务和适当的辅助设备及服务。

呼籲提供免費的語言援助服務和適當的輔助設備及服務。

Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.

무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.

Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.

Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.

Звертайте за безкоштовною мовною підтримкою та відповідними додатковими послугами.

សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។

無料言語支援サービスと適切な補助器具及びサービスをお求めください。

ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋዥ ማሳሰቢያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር

Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.

ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।

Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.

ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.

Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.

Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.

Zadzwoń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.

Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.

Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.

اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.

برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

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