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: HPN - $1,000/20%/NOT APP/$4,500/$25**	
	HERITAGE PRIME HPN IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	$1,000	Not Covered
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	Not Covered
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$4,500	Not Covered
Office Visit Cost Share	$25 Copay, applies to the $4,500 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
CHRONIC CONDITION MANAGEMENT PROGRAMS		
Diabetes Management Plus	Included	Included
Diabetes Prevention Plus	Excluded	Excluded
Hypertension Plus	Excluded	Excluded
Weight Management	Excluded	Excluded
PROFESSIONAL CARE		

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	HERITAGE PRIME HPN IN-NETWORK	**OUT-OF-NETWORK**
Professional Office Visit	$25 Copay, applies to the $4,500 Out of Pocket Maximum	Not Covered
Telemedicine with Traditional Providers - General Medical	$10 Copay, applies to the $4,500 Out of Pocket Maximum	Not Covered
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	$10 Copay, applies to the $4,500 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
DIAGNOSTIC SERVICES		
Preventive Imaging and Lab	Covered in Full	Not Covered
Diagnostic Lab	$1,000 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Not Covered
Basic Diagnostic Imaging	$1,000 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Not Covered
Major Diagnostic Imaging	$1,000 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Not Covered
Preventive Mammography	Covered in Full	Not Covered
Diagnostic Mammography	Covered in Full	Not Covered
Supplemental Breast Exam	Covered in Full	Not Covered
FACILITY CARE		
Inpatient Facility	$1,000 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Not Covered
Inpatient Professional Services	$1,000 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Not Covered
Outpatient Surgery Facility	$1,000 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Not Covered
Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	$1,000 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Not Covered
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (Unlimited)	$1,000 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Not Covered
Hospice Care (Unlimited)	$1,000 Deductible, then 20% Coinsurance, applies to $4,500 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

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Sterilization - Male (Unlimited)	Covered in Full	Not Covered
MEDICAL TRANSPORTATION BENEFITS		
Transplant Travel & Lodging ($7,500 per transplant)	$1,000 Deductible, 0% Coinsurance, applies to $4,500 Out of Pocket Maximum	$1,000 Deductible, 0% Coinsurance, applies to $4,500 Out of Pocket Maximum
EMERGENCY CARE AND TRANSPORTATION		
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 $4,500 Out of Pocket Maximum	$150 Copay then $1,000 Deductible and 20% Coinsurance; all cost shares apply to the $4,500 Out of Pocket Maximum
Emergency Room Physician	$1,000 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	$1,000 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum
Urgent Care Center	$25 Copay, applies to the $4,500 Out of Pocket Maximum	HPN Product Area: Not covered; Non-HPN Product Area: Same as in-network cost share
Ambulance Transportation (Unlimited)	$1,000 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	$1,000 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	$25 Copay, applies to the $4,500 Out of Pocket Maximum	Not Covered
Manipulations (Spinal and other) (12 visits PCY)	$25 Copay, applies to the $4,500 Out of Pocket Maximum	Not Covered
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	$1,000 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Not Covered
Chemical Dependency Outpatient Professional Care (Unlimited)	$25 Copay, applies to the $4,500 Out of Pocket Maximum	Not Covered
Mental Health Inpatient Facility Care (Unlimited)	$1,000 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Not Covered
Mental Health Outpatient Professional Care (Unlimited)	$25 Copay, applies to the $4,500 Out of Pocket Maximum	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (60 days PCY combined limit for inpatient services)	$1,000 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Not Covered
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (60 visits PCY combined limit for outpatient services)	$25 Copay, applies to the $4,500 Out of Pocket Maximum	Not Covered
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	$25 Copay, applies to the $4,500 Out of Pocket Maximum	Not Covered
OTHER SERVICES		
Allergy/Therapeutic Injections	$1,000 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Not Covered

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Medical Supplies, Equipment, Prosthetics (Unlimited)	$1,000 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Not Covered
Transplants (Unlimited)	Covered as any other service	Not Covered
SUPPLEMENTAL BENEFITS		
Routine Vision Exam (1 PCY)	$25 Copay	Not Covered
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 $4,500 Out of Pocket Maximum	Not Covered
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
Routine Hearing Exam (1 every 36 months)	$25 Copay	Not Covered
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.

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.
Звертайтесь 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 መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር
Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.
મુફત ભાષા સહાયિતા સેવાવાં અને ઉચિત સહાયિક ચીજાં અને સેવાવાં વાસતે કાલ કરો।
Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.
ໃຫ້ເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ 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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