

# Highlights of your Health Care Coverage

Effective Date: 01/01/2024

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		PREFERRED CHOICE: PREMERA PATHFINDER - \$1,000/20%/NOT APP/\$7,000/\$0/\$45	
	HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK	
<b>MEDICAL COST SHARE OPTIONS</b>			
<b>Individual Deductible PCY</b> (Family embedded deductible 2X Individual)	\$1,000	Not Covered	
<b>Coinsurance (Member's percentage of costs after deductible based on allowable charges)</b>	20%	Not Covered	
<b>Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable</b> (Family embedded OOP max 2X Individual)	\$7,000	Not Covered	
<b>Designated PCP Office Visit Cost Share</b>	\$0 Copay, applies to the \$7,000 Out of Pocket Maximum	Not Covered	
<b>Specialist and non designated PCP Office Visit Cost Share</b>	\$45 Copay, applies to the \$7,000 Out of Pocket Maximum	Not Covered	
<b>PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION</b>			
<b>Preventive Office Visit</b> (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered	
<b>Immunizations</b> (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered	
<b>Health Education (HE)</b> (Unlimited)	Covered in Full	Not Covered	
<b>Nicotine Dependency Programs (ND)</b> (Unlimited)	Covered in Full	Not Covered	
<b>Diabetes Health Education (DE)</b> (Unlimited)	Covered in Full	Not Covered	
<b>PROFESSIONAL CARE</b>			
<b>Professional Office Visit</b>	Designated PCP: \$0 Copay, applies to the \$7,000 Out of Pocket Maximum; Specialist and non designated PCP: \$45 Copay, applies to the \$7,000 Out of Pocket Maximum	Not Covered	

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	<b>HERITAGE PRIME IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>Telemedicine with Traditional Providers - General Medical</b>	Designated PCP: \$0 Copay, applies to the \$7,000 Out of Pocket Maximum; Specialist and non designated PCP: \$45 Copay, applies to the \$7,000 Out of Pocket Maximum	Not Covered	
<b>VIRTUAL CARE SERVICES</b>			
<b>Telemedicine - General Medical (Virtual Care Only)</b>	Designated PCP: \$0 Copay, applies to the \$7,000 Out of Pocket Maximum; Specialist and non designated PCP: \$45 Copay, applies to the \$7,000 Out of Pocket Maximum	Not Covered	
<b>Telemedicine - Mental Health (Virtual Care Only)</b>	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered	
<b>Telemedicine - Chemical Dependency (Virtual Care Only)</b>	Subject to Chemical Dependency Outpatient Office Visit	Not Covered	
<b>DIAGNOSTIC SERVICE OPTIONS</b>			
<b>Preventive Professional Imaging and Laboratory Services - Including Mammogram and PAP/PSA</b>	Covered in Full	Not Covered	
<b>Other Professional Diagnostic Imaging</b>	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	Not Covered	
<b>Professional Diagnostic Major Imaging</b>	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	Not Covered	
<b>Other Professional Diagnostic Laboratory/Pathology</b>	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	Not Covered	
<b>Diagnostic Mammography</b>	Covered in Full	Not Covered	
<b>Supplemental Breast Exam</b>	Covered in Full	Not Covered	
<b>FACILITY CARE OPTIONS</b>			
<b>Inpatient Facility</b>	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	Not Covered	
<b>Inpatient Professional Services</b>	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	Not Covered	
<b>Outpatient Surgery Facility</b>	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	Not Covered	
<b>Skilled Nursing Facility</b> (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	Not Covered	
<b>HOSPICE &amp; HOME HEALTH CARE</b>			
<b>Hospice Inpatient Facility</b> (10 days Inpatient; within the 6 month lifetime maximum)	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	Not Covered	
<b>Hospice Care</b> (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	Not Covered	

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		HERITAGE PRIME IN-NETWORK	OUT-OF-NETWORK
<b>MATERNITY &amp; REPRODUCTIVE CARE</b>			
<b>Contraceptive Management Services</b> (Unlimited)		Covered in Full	Not Covered
<b>Sterilization - Female</b> (Unlimited)		Covered in Full	Not Covered
<b>Sterilization - Male</b> (Unlimited)		Covered in Full	Not Covered
<b>MEDICAL TRANSPORTATION BENEFITS</b>			
<b>Transplant Travel &amp; Lodging</b> (\$7,500 per transplant)		\$1,000 Deductible, 0% Coinsurance, applies to \$7,000 Out of Pocket Maximum	\$1,000 Deductible, 0% Coinsurance, applies to \$7,000 Out of Pocket Maximum
<b>EMERGENCY CARE AND TRANSPORTATION OPTION</b>			
<b>Emergency Care (If applicable, waive copay if admitted to inpatient facility)</b>		\$150 Copay then \$1,000 Deductible and 20% Coinsurance; all cost shares apply to the \$7,000 Out of Pocket Maximum	\$150 Copay then \$1,000 Deductible and 20% Coinsurance; all cost shares apply to the \$7,000 Out of Pocket Maximum
<b>Emergency Room Physician</b>		\$1,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum
<b>Urgent Care Center</b>		\$45 Copay, applies to the \$7,000 Out of Pocket Maximum	\$45 Copay, applies to the \$7,000 Out of Pocket Maximum
<b>Ambulance Transportation</b> (Unlimited)		\$1,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum
<b>ALTERNATIVE CARE</b>			
<b>Acupuncture</b> (12 visits PCY)		\$0 Copay, applies to the \$7,000 Out of Pocket Maximum	Not Covered
<b>Manipulations (Spinal and other)</b> (12 visits PCY)		\$0 Copay, applies to the \$7,000 Out of Pocket Maximum	Not Covered
<b>CHEMICAL DEPENDENCY &amp; MENTAL HEALTH</b>			
<b>Chemical Dependency Inpatient Facility Care</b> (Unlimited)		\$1,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	Not Covered
<b>Chemical Dependency Outpatient Professional Care</b> (Unlimited)		\$45 Copay, applies to the \$7,000 Out of Pocket Maximum	Not Covered
<b>Mental Health Inpatient Facility Care</b> (Unlimited)		\$1,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	Not Covered
<b>Mental Health Outpatient Professional Care</b> (Unlimited)		\$45 Copay, applies to the \$7,000 Out of Pocket Maximum	Not Covered
<b>REHABILITATION &amp; NEURO</b>			
<b>Rehab Inpatient Facility</b> (30 days PCY)		\$1,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	Not Covered
<b>Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain</b> (45 visits PCY)		\$45 Copay, applies to the \$7,000 Out of Pocket Maximum	Not Covered

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<b>Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer</b>	\$45 Copay, applies to the \$7,000 Out of Pocket Maximum	Not Covered
<b>OTHER SERVICES</b>		
<b>Allergy/Therapeutic Injections</b>	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	Not Covered
<b>Medical Supplies, Equipment, Prosthetics</b> (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum	Not Covered
<b>Transplants</b> (Unlimited)	Covered as any other service	Not Covered
<b>SUPPLEMENTAL BENEFITS</b>		
<b>Routine Vision Exam</b> (1 PCY)	\$25 Copay	Not Covered
<b>Vision Hardware</b> (\$150 every 2 consecutive calendar years)	Covered in Full	Covered in Full
<b>Pediatric Vision Exam</b> (1 PCY under age 19)	\$25 Copay, applies to the \$7,000 Out of Pocket Maximum	Not Covered
<b>Pediatric Vision Hardware</b> (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
<b>Routine Hearing Exam</b> (1 every 36 months)	\$25 Copay	Not Covered
<b>Hearing Hardware</b> (WA Mandate \$3,000 per ear with hearing loss every 36 months)	Covered in Full	Covered in Full
<b>ANNUAL PLAN MAXIMUM</b>		
<b>Annual Plan Maximum</b>	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.*

**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](mailto: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 ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ 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。

800-722-1471 ( : 711).

**XIYYEEFFANNAA:** Afaan dubbattu Oroomiffa, tajaajjila 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).

**ໄປດອຸບ:** ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ຄ່າ, ຄ່າມາດມີພ້ອມໃຫ້ທ່ານ. 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 به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.