

Highlights of your Health Care Coverage

Effective Date: 01/01/2026

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: PREMERA PATHFINDER EPO - \$1,000/20%/NOT APP/\$7,500/\$5/\$45		
	HERITAGE 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)	\$7,500	Not Covered
Designated PCP Office Visit Cost Share	\$5 Copay, applies to the \$7,500 Out of Pocket Maximum	Not Covered
Specialist and non designated PCP Office Visit Cost Share	\$45 Copay, applies to the \$7,500 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		

MEDICAL PLAN		PC: PREMIERA PATHFINDER EPO - \$1,000/20%/NOT APP/\$7,500/\$5/\$45	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
Professional Office Visit	Designated PCP: \$5 Copay, applies to the \$7,500 Out of Pocket Maximum; Specialist and non designated PCP: \$45 Copay, applies to the \$7,500 Out of Pocket Maximum	Not Covered	
Telemedicine with Traditional Providers - General Medical	Designated PCP: \$5 Copay, applies to the \$7,500 Out of Pocket Maximum; Specialist and non designated PCP: \$45 Copay, applies to the \$7,500 Out of Pocket Maximum	Not Covered	
VIRTUAL CARE SERVICES			
Telemedicine - General Medical (Virtual Care Only)	Designated PCP: \$5 Copay, applies to the \$7,500 Out of Pocket Maximum; Specialist and non designated PCP: \$45 Copay, applies to the \$7,500 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 Cost Share	Not Covered	
DIAGNOSTIC SERVICES			
Preventive Imaging and Laboratory	Covered in Full	Not Covered	
Diagnostic Laboratory	Waive Deductible, 0% (Covered in Full) up to \$400; then deductible and coinsurance (\$400 limit shared with major imaging & lab)	Not Covered	
Basic Diagnostic Imaging	Waive Deductible, 0% (Covered in Full) up to \$400; then deductible and coinsurance (\$400 limit shared with major imaging & lab)	Not Covered	
Major Diagnostic Imaging	Waive Deductible, 0% (Covered in Full) up to \$400; then deductible and coinsurance (\$400 limit shared with basic imaging & lab)	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 \$7,500 Out of Pocket Maximum	Not Covered	
Inpatient Professional Services	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,500 Out of Pocket Maximum	Not Covered	
Hospital Outpatient Surgery Facility	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,500 Out of Pocket Maximum	Not Covered	
Ambulatory Surgery Center	\$1,000 Deductible, then 10% Coinsurance, applies to the \$7,500 Out of Pocket Maximum	Not Covered	

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	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
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 \$7,500 Out of Pocket Maximum	Not Covered	
HOSPICE & HOME HEALTH CARE			
Hospice Inpatient Facility (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,500 Out of Pocket Maximum	Not Covered	
Hospice Care (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,500 Out of Pocket Maximum	Not Covered	
MATERNITY & REPRODUCTIVE CARE			
Birth Center	\$1,000 Deductible, then 10% Coinsurance, applies to \$7,500 Out of Pocket Maximum	Not Covered	
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	
MEDICAL TRANSPORTATION BENEFITS			
Transplant Travel & Lodging (\$7,500 per transplant)	\$1,000 Deductible, 0% Coinsurance, applies to \$7,500 Out of Pocket Maximum	\$1,000 Deductible, 0% Coinsurance, applies to \$7,500 Out of Pocket Maximum	
EMERGENCY CARE AND TRANSPORTATION			
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	\$250 Copay then \$1,000 Deductible and 20% Coinsurance; all cost shares apply to the \$7,500 Out of Pocket Maximum	\$250 Copay then \$1,000 Deductible and 20% Coinsurance; all cost shares apply to the \$7,500 Out of Pocket Maximum	
Emergency Room Physician	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,500 Out of Pocket Maximum	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,500 Out of Pocket Maximum	
Urgent Care Center	\$45 Copay, applies to the \$7,500 Out of Pocket Maximum	\$45 Copay, applies to the \$7,500 Out of Pocket Maximum	
Ambulance Transportation (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,500 Out of Pocket Maximum	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,500 Out of Pocket Maximum	
ALTERNATIVE CARE			
Acupuncture (12 visits PCY)	\$5 Copay, applies to the \$7,500 Out of Pocket Maximum	Not Covered	
Manipulations (Spinal and other) (12 visits PCY)	\$5 Copay, applies to the \$7,500 Out of Pocket Maximum	Not Covered	
CHEMICAL DEPENDENCY & MENTAL HEALTH			
Chemical Dependency Inpatient Facility Care (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,500 Out of Pocket Maximum	Not Covered	
Chemical Dependency Outpatient Professional Care (Unlimited)	\$45 Copay, applies to the \$7,500 Out of Pocket Maximum	Not Covered	
Mental Health Inpatient Facility Care (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,500 Out of Pocket Maximum	Not Covered	

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	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
Mental Health Outpatient Professional Care (Unlimited)	\$45 Copay, applies to the \$7,500 Out of Pocket Maximum	Not Covered	
REHABILITATION & NEURODEVELOPMENTAL THERAPY			
Inpatient Rehab (60 days PCY)	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,500 Out of Pocket Maximum	Not Covered	
Outpatient Rehab, Including Physical and Occupational Therapy (60 visits PCY)	\$45 Copay, applies to the \$7,500 Out of Pocket Maximum	Not Covered	
Outpatient Rehab for Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer (Unlimited)	\$45 Copay, applies to the \$7,500 Out of Pocket Maximum	Not Covered	
Outpatient Massage Therapy (Applies to the outpatient rehab limit)	\$45 Copay, applies to the \$7,500 Out of Pocket Maximum	Not Covered	
Outpatient Speech Therapy (Applies to the outpatient rehab limit)	\$45 Copay, applies to the \$7,500 Out of Pocket Maximum	Not Covered	
Inpatient Neurodevelopmental Therapy	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,500 Out of Pocket Maximum	Not Covered	
Outpatient Neurodevelopmental Therapy (60 visits PCY)	\$45 Copay, applies to the \$7,500 Out of Pocket Maximum	Not Covered	
OTHER SERVICES			
Allergy/Therapeutic Injections	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,500 Out of Pocket Maximum	Not Covered	
Medical Supplies, Equipment, Prosthetics (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$7,500 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 \$7,500 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, applies to the \$7,500 Out of Pocket Maximum	Not Covered	
Hearing Hardware (1 device per ear 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 Premiera 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.

Звертайтеся за безкоштовною мовною підтримкою та відповідними додатковими послугами.

សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាផ្សេងៗ ដើម្បីជួយចំណាត់ថ្នាក់ដល់សមាស្បៀងផ្សេងៗ។

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。

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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.

Zadzwonń, 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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