

# 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: PPO UNLIMITED NO VISION - \$1,000/20%/50%/\$5,500/\$20/\$40		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARES		
<b>Individual Deductible PCY</b> (Family embedded deductible 3X Individual)	\$1,000	Shared with In-Network
<b>Coinsurance (Member's percentage of costs after deductible based on allowable charges)</b>	20%	50%
<b>Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable</b> (Family embedded OOP max 2X Individual)	\$5,500	Unlimited
<b>Non Specialist Office Visit Cost Share</b>	\$20 Copay, applies to the \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Specialist Office Visit Cost Share</b>	\$40 Copay, applies to the \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Kinwell Connect Cost Share Waiver</b> (Excluded)	All services rendered and billed by any Kinwell clinic are subject to standard cost shares	Not Applicable
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
<b>Preventive Office Visit</b> (Unlimited, subject to standard medical guidelines)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Immunizations</b> (Unlimited, subject to standard medical guidelines)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Health Education (HE)</b> (Unlimited)	Covered in Full	Not Covered

MEDICAL PLAN		
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	HERITAGE IN-NETWORK	OUT-OF-NETWORK
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		
Professional Office Visit	Non Specialist: \$20 Copay, applies to the \$5,500 Out of Pocket Maximum; Specialist: \$40 Copay, applies to the \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Telemedicine with Traditional Providers - General Medical	\$10 Copay, applies to the \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	\$10 Copay, applies to the \$5,500 Out of Pocket Maximum	Not Covered
Telemedicine - Mental Health (Virtual Care Only)	\$10 Copay, applies to the \$5,500 Out of Pocket Maximum	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)	\$10 Copay, applies to the \$5,500 Out of Pocket Maximum	Not Covered
DIAGNOSTIC SERVICES		
Preventive Imaging and Lab	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Diagnostic Lab	Waive Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Basic Diagnostic Imaging	Waive Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Major Diagnostic Imaging	Waive Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Preventive Mammography	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

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	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Diagnostic Mammography	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Supplemental Breast Exam	Covered in Full	Covered as any other service
FACILITY CARE		
Inpatient Facility	\$1,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Inpatient Professional Services	\$1,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Surgery Facility	\$1,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Skilled Nursing Facility (120 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$1,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Hospice Care (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
MATERNITY & REPRODUCTIVE CARE		
Contraceptive Management Services (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Sterilization - Female (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Sterilization - Male (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
MEDICAL TRANSPORTATION BENEFITS		
Transplant Travel & Lodging (\$7,500 per transplant)	\$1,000 Deductible, 0% Coinsurance, applies to \$5,500 Out of Pocket Maximum	\$1,000 Deductible, 0% Coinsurance, applies to \$5,500 Out of Pocket Maximum
EMERGENCY CARE AND TRANSPORTATION		

<b>MEDICAL PLAN</b>		
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	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</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 \$5,500 Out of Pocket Maximum	\$150 Copay then \$1,000 Deductible and 20% Coinsurance; all cost shares apply to the \$5,500 Out of Pocket Maximum
<b>Emergency Room Physician</b>	\$1,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	\$1,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum
<b>Urgent Care Center</b>	\$50 Copay, applies to the \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Ambulance Transportation (Unlimited)</b>	\$1,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	\$1,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum
<b>ALTERNATIVE CARE</b>		
<b>Acupuncture (24 visits PCY)</b>	\$20 Copay, applies to the \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Manipulations (Spinal and other) (24 visits PCY)</b>	\$20 Copay, applies to the \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>CHEMICAL DEPENDENCY &amp; MENTAL HEALTH</b>		
<b>Chemical Dependency Inpatient Facility Care (Unlimited)</b>	\$1,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Chemical Dependency Outpatient Professional Care (Unlimited)</b>	\$10 Copay, applies to the \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Mental Health Inpatient Facility Care (Unlimited)</b>	\$1,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Mental Health Outpatient Professional Care (Unlimited)</b>	\$10 Copay, applies to the \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>REHABILITATION &amp; NEURO</b>		
<b>Rehab Inpatient Facility (60 days PCY combined limit for inpatient services)</b>	\$1,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (60 visits PCY combined limit for outpatient services)</b>	\$40 Copay, applies to the \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer</b>	\$40 Copay, applies to the \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

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OTHER SERVICES			
Allergy/Therapeutic Injections	Waive Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Medical Supplies, Equipment, Prosthetics (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$5,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Transplants (Unlimited)	Covered as any other service	Not Covered	
SUPPLEMENTAL BENEFITS			
Routine Hearing Exam (1 every 36 months)	\$25 Copay	\$25 Copay	
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 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 ដើម្បីជួយចំណាត់ថ្នាក់ដល់សមាជិក។

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 ሙሉሪዎቻችን 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.

ໃຫ້ເພື່ອນບໍລິການພິການຊ່ວຍເຫຼືອດ້ານພາສາ 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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