

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 - \$2,000/20%/50%/\$6,850/\$20/\$50	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
MEDICAL COST SHARES			
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$2,000	Shared with In-Network	
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	50%	
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	\$6,850	Unlimited	
Non Specialist Office Visit Cost Share	\$20 Copay, applies to the \$6,850 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Specialist Office Visit Cost Share	\$50 Copay, applies to the \$6,850 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Kinwell Connect Cost Share Waiver (Excluded)	All services rendered and billed by any Kinwell clinic are subject to standard cost shares	Not Applicable	
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION			
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Health Education (HE) (Unlimited)	Covered in Full	Not Covered	

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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 \$6,850 Out of Pocket Maximum; Specialist: \$50 Copay, applies to the \$6,850 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 \$6,850 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 \$6,850 Out of Pocket Maximum	Not Covered	
Telemedicine - Mental Health (Virtual Care Only)	\$10 Copay, applies to the \$6,850 Out of Pocket Maximum	Not Covered	
Telemedicine - Chemical Dependency (Virtual Care Only)	\$10 Copay, applies to the \$6,850 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 \$6,850 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 \$6,850 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 \$6,850 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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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	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Inpatient Professional Services	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Surgery Facility	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 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)	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 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)	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Hospice Care (Unlimited)	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 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)	\$2,000 Deductible, 0% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$2,000 Deductible, 0% Coinsurance, applies to \$6,850 Out of Pocket Maximum
EMERGENCY CARE AND TRANSPORTATION		

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Emergency Care (If applicable, waive copay if admitted to inpatient facility)	\$200 Copay then \$2,000 Deductible and 20% Coinsurance; all cost shares apply to the \$6,850 Out of Pocket Maximum	\$200 Copay then \$2,000 Deductible and 20% Coinsurance; all cost shares apply to the \$6,850 Out of Pocket Maximum	
Emergency Room Physician	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	
Urgent Care Center	\$50 Copay, applies to the \$6,850 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Ambulance Transportation (Unlimited)	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	
ALTERNATIVE CARE			
Acupuncture (24 visits PCY)	\$20 Copay, applies to the \$6,850 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Manipulations (Spinal and other) (24 visits PCY)	\$20 Copay, applies to the \$6,850 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
CHEMICAL DEPENDENCY & MENTAL HEALTH			
Chemical Dependency Inpatient Facility Care (Unlimited)	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Chemical Dependency Outpatient Professional Care (Unlimited)	\$10 Copay, applies to the \$6,850 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Mental Health Inpatient Facility Care (Unlimited)	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Mental Health Outpatient Professional Care (Unlimited)	\$10 Copay, applies to the \$6,850 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
REHABILITATION & NEURO			
Rehab Inpatient Facility (60 days PCY combined limit for inpatient services)	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (60 visits PCY combined limit for outpatient services)	\$50 Copay, applies to the \$6,850 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	\$50 Copay, applies to the \$6,850 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 \$6,850 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Medical Supplies, Equipment, Prosthetics (Unlimited)	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 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 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.