Heritage Preferred Plus 20

PREMERA | BLUE CROSS

Deductible, coinsurance and copay represent what you pay. Benefits apply after calendar year deductible is met, unless otherwise noted.

MEDICAL BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible per individual PCY	$1,000	Shared with in-network deductible
Coinsurance	20%	50%
Annual Coinsurance Maximum[1] PCY	$2,000	Unlimited
Lifetime Benefit Maximum	$2 Million	
COVERED SERVICES		
PREVENTIVE CARE		
Preventive Care Exam	Covered in full[2] ($300 PCY)	Not covered
Immunizations		
PROFESSIONAL CARE		
Office Visit including Urgent Care	20%	50%
Other Outpatient Professional Services	20%	50%
Inpatient Professional Services	20%	50%
PHARMACY		
Prescription Drugs $5,000 PCY (If applicable) (separate annual deductible applies; prescriptions limited to 30-day supply)	After $200 prescription drug deductible, member pays: Tier 1 = 20% (generic drugs); Tier 2 = 30% (preferred brand-name drugs); Tier 3 = 50% (non-preferred brand-name drugs)	
VISION		
Routine Vision Exam	Covered in full[2] (one exam per 2 calendar years)	
Vision Hardware (frames, lenses and contacts)	Covered in full[2] ($200 per 2 calendar years)	
DIAGNOSTIC SERVICES		
Diagnostic X-ray and Laboratory Services	20%	50%
Mammography	20%	50%
Cancer Screening and Cholesterol Screening (including pap smears, PSA testing, home colon cancer screening and cholesterol screening)	Deductible waived; 20%	50%
FACILITY CARE		
Inpatient Facility	20%	50%
Outpatient Surgery Facility		
Skilled Nursing Facility	20% (45 days PCY)	50% (limit shared with in-network)
EMERGENCY CARE		
Emergency Care (copay waived if direct admit to an inpatient facility)	$100 Copay plus 20%	
Ambulance Transportation	20% ($5,000 PCY)	
OTHER SERVICES		
Maternity Care including Prenatal Care	20%	50%
Spinal and Other Manipulations	20% (12 visits PCY)	50% (limit shared with in-network)
Acupuncture	20% (12 visits PCY)	50% (limit shared with in-network)
Supplies, Equipment and Prosthetics	20% ($5,000 PCY)	50% (limit shared with in-network)
Home Health Care	20% (130 Home Health visits PCY)	50% (limit shared with in-network)
Hospice Care (6-month maximum)	20% (Inpatient: 10 days max; Respite: 240 hrs. max)	50% (limit shared with in-network)
Rehabilitation (including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab; and Chronic Pain)	20% (Outpatient: 20 visits PCY; Inpatient: 8 days PCY)	50% (limit shared with in-network)
Transplants (Organ & Bone Marrow) 12-month waiting period; $250,000 lifetime benefit maximum	20%	Not covered

PCY = Per Calendar Year

[1] After the coinsurance maximum is met, in-network providers are covered in full.

[2] Benefits provided at 100% of allowable charges; not subject to deductible or coinsurance.

Note: All coinsurance amounts are based on allowable charges. Balance billing may apply if a provider is not contracted with Premera Blue Cross.

Please note this is only a summary of benefits for the Premera Blue Cross plans. The complete terms of coverage are determined by the contract.