Highlights of your Health Care Coverage

City of Kent
Group Number: 1018212

Effective Date: 01/01/2022

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	**PPO - $15 COPAY PLAN - $0/$200/0%/30%$6350/OV $15 ER $50***	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 3X Individual)	$0	$200
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	0%	30%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$6,350	$6,200 PCY Individual/ No family Out of Network
Office Visit Cost Share	$15 Copay, applies to the $6,350 Out of Pocket Maximum	$200 Deductible, then 30% Coinsurance, applies to $6,200 PCY Individual/ No family Out of Network Out of Pocket Maximum
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited)	Covered in Full	Covered in Full
Immunizations (Unlimited)	Covered in Full	Covered in Full
Health Education (HE) (Unlimited)	Covered in Full	Covered in Full
Nicotine Dependency Programs (ND) (Unlimited)	Covered in Full	Covered in Full
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Covered in Full
PROFESSIONAL CARE		
Professional Office Visit	$15 Copay, applies to the $6,350 Out of Pocket Maximum	$200 Deductible, then 30% Coinsurance, applies to $6,200 PCY Individual/ No family Out of Network Out of Pocket Maximum
Telemedicine with Traditional Providers - General Medical	$15 Copay, applies to the $6,350 Out of Pocket Maximum	$200 Deductible, then 30% Coinsurance, applies to $6,200 PCY Individual/ No family Out of Network Out of Pocket Maximum
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	$15 Copay, applies to the $6,350 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
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in Full	Covered in Full

MEDICAL PLAN	PPO - $15 COPAY PLAN - $0/$200/0%/30%$6350/OV $15 ER $50*	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Other Professional Diagnostic Imaging	Covered in Full	$200 Deductible, then 30% Coinsurance, applies to $6,200 PCY Individual/ No family
Professional Diagnostic Major Imaging	Covered in Full	$200 Deductible, then 30% Coinsurance, applies to $6,200 PCY Individual/ No family
Other Professional Diagnostic Laboratory/Pathology	Covered in Full	$200 Deductible, then 30% Coinsurance, applies to $6,200 PCY Individual/ No family
Diagnostic Mammography	Covered In Full	$200 Deductible, then 30% Coinsurance, applies to $6,200 PCY Individual/ No family
FACILITY CARE OPTIONS		
Inpatient Facility	Covered in Full	$200 Deductible, then 30% Coinsurance, applies to $6,200 PCY Individual/ No family Out of Network Out of Pocket Maximum
Inpatient Professional Services	Covered in Full	$200 Deductible, then 30% Coinsurance, applies to $6,200 PCY Individual/ No family Out of Network Out of Pocket Maximum
Outpatient Surgery Facility	Covered in Full	$200 Deductible, then 30% Coinsurance, applies to $6,200 PCY Individual/ No family Out of Network Out of Pocket Maximum
Skilled Nursing Facility (Unlimited)	Covered in Full	$200 Deductible, then 30% Coinsurance, applies to $6,200 PCY Individual/ No family Out of Network Out of Pocket Maximum
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	Covered in Full	$200 Deductible, then 30% Coinsurance, applies to $6,200 PCY Individual/ No family Out of Network Out of Pocket Maximum
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	Covered in Full	$200 Deductible, then 30% Coinsurance, applies to $6,200 PCY Individual/ No family Out of Network Out of Pocket Maximum
MATERNITY & REPRODUCTIVE CARE		
Contraceptive Management Services (Unlimited)	Covered in Full	$200 Deductible, then 30% Coinsurance, applies to $6,200 PCY Individual/ No family Out of Network Out of Pocket Maximum
Sterilization - Female (Unlimited)	Covered in Full	$200 Deductible, then 30% Coinsurance, applies to $6,200 PCY Individual/ No family Out of Network Out of Pocket Maximum
Sterilization - Male (Unlimited)	Covered in Full	$200 Deductible, then 30% Coinsurance, applies to $6,200 PCY Individual/ No family Out of Network Out of Pocket Maximum
PREMERA DESIGNATED CENTERS OF EXCELLENCE		

MEDICAL PLAN	PPO - $15 COPAY PLAN - $0/$200/0%/30%$6350/OV $15 ER $50*	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Centers of Excellence Packaged Services (Opting Out: No Eligible Services)	Covered as any other service	Covered as any other service
Centers of Excellence for Radiology (Member Outreach Excluded)	Covered as any other service	Covered as any other service
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$50 Copay then $0 Deductible and 0% Coinsurance; all cost shares apply to the $6,350 Out of Pocket Maximum	$50 Copay then $0 Deductible and 0% Coinsurance; all cost shares apply to the $6,350 Out of Pocket Maximum
Emergency Room Physician	Covered in Full	Covered in Full
Urgent Care Center	$15 Copay, applies to the $6,350 Out of Pocket Maximum	$200 Deductible, then 30% Coinsurance, applies to $6,200 PCY Individual/ No family Out of Network Out of Pocket Maximum
Ambulance Transportation (Unlimited)	Waive Deductible, then 20% Coinsurance, applies to the Out of Pocket Maximum	Waive Deductible, then constant 30% Coinsurance
ALTERNATIVE CARE		
Acupuncture (10 visits PCY)	Waive Deductible, then 20% Coinsurance, applies to $6,350 Out of Pocket Maximum	Waive Deductible, then constant 30% Coinsurance
Manipulations (Spinal and other) (20 visits PCY)	Waive Deductible, then 20% Coinsurance, applies to $6,350 Out of Pocket Maximum	Waive Deductible, then constant 30% Coinsurance
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	Covered in Full	$200 Deductible, then 30% Coinsurance, applies to $6,200 PCY Individual/ No family Out of Network Out of Pocket Maximum
Chemical Dependency Outpatient Professional Care (Unlimited)	$15 Copay, applies to the $6,350 Out of Pocket Maximum	$200 Deductible, then 30% Coinsurance, applies to $6,200 PCY Individual/ No family Out of Network Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	Covered in Full	$200 Deductible, then 30% Coinsurance, applies to $6,200 PCY Individual/ No family Out of Network Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	$15 Copay, applies to the $6,350 Out of Pocket Maximum	$200 Deductible, then 30% Coinsurance, applies to $6,200 PCY Individual/ No family Out of Network Out of Pocket Maximum
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	Waive Deductible, then 20% Coinsurance, applies to $6,350 Out of Pocket Maximum	Waive Deductible, then Subject to Constant 30% Coinsurance
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (45 visits PCY; Massage: seperate 15 visits PCY)	Waive Deductible, then 20% Coinsurance, applies to $6,350 Out of Pocket Maximum	Waive Deductible, then Subject to constant 30% Coinsurance
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	Waive Deductible, then 20% Coinsurance, applies to $6,350 Out of Pocket Maximum	Waive Deductible, then Subject to constant 30% Coinsurance
OTHER SERVICES		

MEDICAL PLAN	PPO - $15 COPAY PLAN - $0/$200/0%/30%$6350/OV $15 ER $50*	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Allergy/Therapeutic Injections	Covered in Full	$200 Deductible, then 30% Coinsurance, applies to $6,200 PCY Individual/ No family Out of Network Out of Pocket Maximum
Medical Supplies, Equipment, Prosthetics (Unlimited)	Waive Deductible, then 20% Coinsurance, applies to $6,350 Out of Pocket Maximum	Waive Deductible, then constant 30% Coinsurance
Transplants (Unlimited; $7,500 travel and lodging limits)	Covered as any other service	Not Covered
SUPPLEMENTAL BENEFITS		
Routine Hearing Exam (1 PCY)	Covered in Full	$200 Deductible, then 30% Coinsurance, applies to $6,200 PCY Individual/ No family Out of Network Out of Pocket Maximum
Hearing Hardware ($1000 every 3 calendar years)	Covered in Full	Covered in Full
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited

*This plan is self-funded by City of Kent, which means that this group is financially responsible for the payment of plan benefits. The group has contracted with Premera Blue Cross, an independent Licensee of the Blue Cross Blue Shield Association, to perform administrative duties, including the processing of claims, under the plan. Premera Blue Cross does not insure the benefits of this plan.

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 under which the program may be continued in force. This benefit highlight is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.

Highlights of your Health Care Coverage

City of Kent

Group Number: 1018212 Effective Date: 01/01/2022

Below is a brief overview of your Pharmacy Benefits. For more information on your benefits, please refer to your benefit booklets. To find out what tiers apply to a specific medication, refer to our Preferred Drug List in your Pharmacy Packet or at www.premera.com

PHARMACY PLAN	**RX - $15 COPAY PLAN - RX/MO $5/10/20***
PRESCRIPTION DRUGS	
Drug List	Preferred B3 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands
Retail Cost Shares	$5/$10$/20
Mail Cost Shares	$5/$10/$20
Day Supply	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days
Individual Deductible PCY	$0
Family Deductible PCY	No Family Deductible
Out of Network (Non-participating retail pharmacies)	Cost Share, then 40% (to allowable)
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Annual Benefit Maximum	Unlimited

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