

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 - 80%/20% PLAN - \$200/20%/30%/\$1,200/OV \$20/ER \$75*	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
MEDICAL COST SHARE OPTIONS			
Individual Deductible PCY (Family embedded deductible 3X Individual)	\$200	Shared with In-Network	
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	30%	
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 3X Individual)	\$1,200	\$3,200	
Office Visit Cost Share	First 6 Visits: \$20 Copay. Subsequent visits are subject to \$200 Deductible, then 20% Coinsurance	Shared with In-Network Deductible, then 30% Coinsurance, applies to \$3,200 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	First 6 Visits: \$20 Copay. Subsequent visits are subject to \$200 Deductible, then 20% Coinsurance	Shared with In-Network Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum	
Telemedicine with Traditional Providers - General Medical	First 6 Visits: \$20 Copay. Subsequent visits are subject to \$200 Deductible, then 20% Coinsurance	Shared with In-Network Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum	
VIRTUAL CARE SERVICES			
Telemedicine - General Medical (Virtual Care Only)	First 6 Visits: \$20 Copay. Subsequent visits are subject to \$200 Deductible, then 20% Coinsurance	Not Covered	
Telemedicine - Mental Health (Virtual Care Only)	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered	
DIAGNOSTIC SERVICE OPTIONS			

MEDICAL PLAN		PPO - 80%/20% PLAN - \$200/20%/30%/\$1,200/OV \$20/ER \$75*	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in Full	Covered in Full	
Other Professional Diagnostic Imaging	Waive Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	\$200 Deductible, then 30% Coinsurance, applies to the \$3,200 Out of Pocket Maximum	
Professional Diagnostic Major Imaging	Waive Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	\$200 Deductible, then 30% Coinsurance, applies to the \$3,200 Out of Pocket Maximum	
Other Professional Diagnostic Laboratory/Pathology	Waive Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	\$200 Deductible, then 30% Coinsurance, applies to the \$3,200 Out of Pocket Maximum	
Diagnostic Mammography	Covered in Full	\$200 Deductible, then 30% Coinsurance, applies to the \$3,200 Out of Pocket Maximum	
FACILITY CARE OPTIONS			
Inpatient Facility	\$200 Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	Shared with In-Network Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum	
Inpatient Professional Services	\$200 Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	Shared with In-Network Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum	
Outpatient Surgery Facility	\$200 Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	Shared with In-Network Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum	
Skilled Nursing Facility (Unlimited)	\$200 Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	Shared with In-Network Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum	
HOSPICE & HOME HEALTH CARE			
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	Waive Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	Waive Deductible, then constant 30% Coinsurance	
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	Waive Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	Waive Deductible, then constant 30% Coinsurance	
MATERNITY & REPRODUCTIVE CARE			
Contraceptive Management Services (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum	
Sterilization - Female (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum	

MEDICAL PLAN			PPO - 80%/20% PLAN - \$200/20%/30%/\$1,200/OV \$20/ER \$75*		
		HERITAGE IN-NETWORK	OUT-OF-NETWORK		
Sterilization - Male (Unlimited)		Covered in Full	Shared with In-Network Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum		
PREMERA DESIGNATED CENTERS OF EXCELLENCE					
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)		\$75 Copay then \$200 Deductible and 20% Coinsurance; all cost shares apply to the \$1,200 Out of Pocket Maximum	\$75 Copay then \$200 Deductible and 20% Coinsurance; all cost shares apply to the \$1,200 Out of Pocket Maximum		
Emergency Room Physician		\$200 Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	\$200 Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum		
Urgent Care Center		First 6 Visits: \$20 Copay. Subsequent visits are subject to \$200 Deductible, then 20% Coinsurance	Shared with In-Network Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum		
Ambulance Transportation (Unlimited)		Waive Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	Waive Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum		
ALTERNATIVE CARE					
Acupuncture (10 visits PCY)		Waive Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	Waive Deductible, then constant 30% Coinsurance		
Manipulations (Spinal and other) (20 visits PCY)		Waive Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	Waive Deductible, then constant 30% Coinsurance		
CHEMICAL DEPENDENCY & MENTAL HEALTH					
Chemical Dependency Inpatient Facility Care (Unlimited)		\$200 Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	Shared with In-Network Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum		
Chemical Dependency Outpatient Professional Care (Unlimited)		First 6 Visits: \$20 Copay. Subsequent visits are subject to \$200 Deductible, then 20% Coinsurance	Shared with In-Network Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum		
Mental Health Inpatient Facility Care (Unlimited)		\$200 Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	Shared with In-Network Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum		
Mental Health Outpatient Professional Care (Unlimited)		First 6 Visits: \$20 Copay. Subsequent visits are subject to \$200 Deductible, then 20% Coinsurance	Shared with In-Network Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum		
REHABILITATION & NEURO					
Rehab Inpatient Facility (30 Days PCY)		\$200 Deductible, then 20% Coinsurance, applies to the \$1,200 Out of Pocket Maximum	\$200 Deductible, then 30% Coinsurance, applies to the \$3,200 Out of Pocket Maximum		

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	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (45 visits PCY; Massage: 15 visits PCY)	\$200 Deductible, then 20% Coinsurance, applies to the \$1,200 Out of Pocket Maximum	\$200 Deductible, then 30% Coinsurance, applies to the \$3,200 Out of Pocket Maximum	
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	\$200 Deductible, then 20% Coinsurance, applies to the \$1,200 Out of Pocket Maximum	\$200 Deductible, then 30% Coinsurance, applies to the \$3,200 Out of Pocket Maximum	
OTHER SERVICES			
Allergy/Therapeutic Injections	\$200 Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	Shared with In-Network Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum	
Medical Supplies, Equipment, Prosthetics (Unlimited)	Waive Deductible, then 20% Coinsurance, applies to \$1,200 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	Shared with In-Network Deductible, then 30% Coinsurance, applies to \$3,200 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 - 80%/20% PLAN - RX \$5/\$20/\$40 MO \$10/\$40/\$80*
PRESCRIPTION DRUGS		
Drug List	Preferred B3 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands	
Retail Cost Shares	\$5/\$20/\$40	
Mail Cost Shares	\$10/\$40/\$80	
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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