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	**HSA MEDICAL - $2,000/$4,000/0%/0%***	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family aggregate deductible 2x Individual)	$2,000/$4,000	Shared with In Network Deductible
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	0%	0%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family aggregate OOP max 2x Individual)	$2,000/$4,000	Shared with In Network Out of Pocket Maximum
Office Visit Cost Share	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited)	Covered in Full	Not Covered
Immunizations (Unlimited)	Covered in Full	Not Covered
Health Education (HE) (Unlimited)	Covered in Full	Not Covered
Nicotine Dependency Programs (ND) (Unlimited)	Covered in Full	Not Covered
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Not Covered
PROFESSIONAL CARE		
Professional Office Visit	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
Telemedicine with Traditional Providers - General Medical	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 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

MEDICAL PLAN	HSA MEDICAL - $2,000/$4,000/0%/0%*	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in Full	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
Other Professional Diagnostic Imaging	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
Professional Diagnostic Major Imaging	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
Other Professional Diagnostic Laboratory/Pathology	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
Diagnostic Mammography	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
FACILITY CARE OPTIONS		
Inpatient Facility	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
Inpatient Professional Services	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
Outpatient Surgery Facility	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
HOSPICE & HOME HEALTH CARE		

MEDICAL PLAN	HSA MEDICAL - $2,000/$4,000/0%/0%*	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
MATERNITY & REPRODUCTIVE CARE		
Contraceptive Management Services (Unlimited)	Covered in Full	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
Sterilization - Female (Unlimited)	Covered in Full	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
Sterilization - Male (Unlimited)	Subject to the IRS Minimum Deductibles, then 0% Coinsurance, applies to $2,000 /$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum 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	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum
Emergency Room Physician	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum
Urgent Care Center	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
Ambulance Transportation (Unlimited)	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum
ALTERNATIVE CARE		

MEDICAL PLAN	HSA MEDICAL - $2,000/$4,000/0%/0%*	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Acupuncture (10 visits PCY)	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
Manipulations (Spinal and other) (20 visits PCY)	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
Chemical Dependency Outpatient Professional Care (Unlimited)	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (45 visits PCY; Massage: 15 visits PCY)	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
OTHER SERVICES		

MEDICAL PLAN	HSA MEDICAL - $2,000/$4,000/0%/0%*	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Allergy/Therapeutic Injections	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
Medical Supplies, Equipment, Prosthetics (Unlimited)	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to $2,000/$4,000 Out of Pocket Maximum	Shared with In Network Deductible Deductible, then 0% Coinsurance, applies to Shared with In Network Out of Pocket Maximum Out of Pocket Maximum
Transplants (Unlimited; $7,500 travel and lodging limits)	Covered as any other service	Not Covered
PHARMACY		
Prescription Drugs - Retail (Specific preventive drugs and legend Retail: 90 day supply/Mail: 90 day supply/Specialty: 30 day supply)	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to the $2,000/$4,000 Out of Pocket Maximum	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to the $2,000/$4,000 Out of Pocket Maximum
Prescription Drugs - Mail (Specific preventive drugs and legend Retail: 90 day supply/Mail: 90 day supply/Specialty: 30 day supply)	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to the $2,000/$4,000 Out of Pocket Maximum	Not Covered
Drug List	Open A1 No Tiers	Open A1 No Tiers
Specialty Pharmacy (Mandatory - Exclusive)	$2,000/$4,000 Deductible, then 0% Coinsurance, applies to the $2,000/$4,000 Out of Pocket Maximum	Not Covered
SUPPLEMENTAL BENEFITS		
Routine Hearing Exam (1 PCY)	Exam: Deductible, Waive Coinsurance Test: Deductible, waive coinsurance	Exam: OON Ded, waive Coins; Test: OON Ded, waive Coins
Hearing Hardware ($1000 every 3 calendar years)	Deductible, waive coinsurance	OON Deductible, waive coinsurance
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.