PREMERA | BLUE CROSS

# Highlights of your Health Care Coverage

City of Spokane
Group Number: 1018813

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** | **PLAN 5 $10/$20/$40 RX PLAN HERITAGE** | |
|---|---|---|
| | **HERITAGE IN-NETWORK** | **OUT-OF-NETWORK** |
| **MEDICAL COST SHARES** | | |
| **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)** | 30% | 50% |
| **Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable** (Family embedded OOP max 3X Individual) | $1,000 | Unlimited |
| **Office Visit Cost Share** | $20 Copay, applies to the $1,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Kinwell Connect Cost Share Waiver** (Included) | All services rendered and billed by any Kinwell clinic are covered in full (waive deductible, 0%) | Not Applicable |
| **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** | $20 Copay, applies to the $1,000 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** | $20 Copay, applies to the $1,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |

| MEDICAL PLAN | PLAN 5 $10/$20/$40 RX PLAN HERITAGE | |
|---|---|---|
| | **HERITAGE IN-NETWORK** | **OUT-OF-NETWORK** |
| **VIRTUAL CARE SERVICES** | | |
| **Telemedicine - General Medical (Virtual Care Only)** | $20 Copay, applies to the $1,000 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** | First $100 Covered in Full. $200 Deductible, then 30% Coinsurance; applies to $1,000 Out of Pocket Maximum; Excludes TMJ | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Basic Diagnostic Imaging** | First $100 Covered in Full. $200 Deductible, then 30% Coinsurance; applies to $1,000 Out of Pocket Maximum; Excludes TMJ | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Major Diagnostic Imaging** | First $100 Covered in Full. $200 Deductible, then 30% Coinsurance; applies to $1,000 Out of Pocket Maximum; Excludes TMJ | 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 |
| **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** | $200 Deductible, then 30% Coinsurance, applies to $1,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Inpatient Professional Services** | $200 Deductible, then 30% Coinsurance, applies to $1,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Outpatient Surgery Facility** | $200 Deductible, then 30% Coinsurance, applies to $1,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Skilled Nursing Facility** (180 days PCY; includes room and board, and facility billed professional and ancillary fees) | $200 Deductible, then 30% Coinsurance, applies to $1,000 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; within the 6 month lifetime maximum) | $200 Deductible, then Covered in Full, applies to $1,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |

| MEDICAL PLAN | PLAN 5 $10/$20/$40 RX PLAN HERITAGE | |
|---|---|---|
| | **HERITAGE IN-NETWORK** | **OUT-OF-NETWORK** |
| **Hospice Care** (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum) | $200 Deductible, then Covered in Full, applies to $1,000 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) | $200 Deductible, 0% Coinsurance, applies to $1,000 Out of Pocket Maximum | $200 Deductible, 0% Coinsurance, applies to $1,000 Out of Pocket Maximum |
| **EMERGENCY CARE AND TRANSPORTATION** | | |
| **Emergency Care (If applicable, waive copay if admitted to inpatient facility)** | $100 Copay then $200 Deductible and 30% Coinsurance; all cost shares apply to the $1,000 Out of Pocket Maximum | $100 Copay then $200 Deductible and 30% Coinsurance; all cost shares apply to the $1,000 Out of Pocket Maximum |
| **Emergency Room Physician** | $200 Deductible, then 30% Coinsurance, applies to $1,000 Out of Pocket Maximum | $200 Deductible, then 30% Coinsurance, applies to $1,000 Out of Pocket Maximum |
| **Urgent Care Center** | $20 Copay, applies to the $1,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Ambulance Transportation** (Unlimited) | $200 Deductible, then 30% Coinsurance, applies to $1,000 Out of Pocket Maximum | $200 Deductible, then 30% Coinsurance, applies to $1,000 Out of Pocket Maximum |
| **ALTERNATIVE CARE** | | |
| **Acupuncture** (24 visits PCY) | $200 Deductible, then 30% Coinsurance, applies to $1,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Manipulations (Spinal and other)** (30 visits PCY) | $200 Deductible, then 30% Coinsurance, applies to $1,000 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) | $200 Deductible, then 30% Coinsurance, applies to $1,000 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) | $20 Copay, applies to the $1,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |

| MEDICAL PLAN | PLAN 5 $10/$20/$40 RX PLAN HERITAGE | |
|---|---|---|
| | **HERITAGE IN-NETWORK** | **OUT-OF-NETWORK** |
| **Mental Health Inpatient Facility Care** (Unlimited) | $200 Deductible, then 30% Coinsurance, applies to $1,000 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) | $20 Copay, applies to the $1,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **REHABILITATION & NEURO** | | |
| **Rehab Inpatient Facility** (30 days PCY) | $200 Deductible, then 30% Coinsurance, applies to $1,000 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** (45 visits PCY) | $20 Copay, applies to the $1,000 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** | $20 Copay, applies to the $1,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **OTHER SERVICES** | | |
| **Allergy/Therapeutic Injections** | $200 Deductible, then 30% Coinsurance, applies to $1,000 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Medical Supplies, Equipment, Prosthetics** (Unlimited) | $200 Deductible, then 30% Coinsurance, applies to $1,000 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 Vision Exam** (1 PCY) | Covered in Full | Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Vision Hardware** ($200 every 2 consecutive calendar years) | Covered in Full | Covered in Full |
| **Pediatric Vision Exam** (1 PCY Under age 19) | Covered in Full | Covered in Full |
| **Pediatric Vision Hardware** (Under age 19: One pair of glasses PCY (frames & lenses). 12 month supply of contacts PCY, in lieu of glasses (frames & lenses).) | 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.*

| PHARMACY PLAN | PLAN 5 RX RETAIL $10/$20/$40 NO MAIL ORDER* |
|---|---|
| **PRESCRIPTION DRUGS** | |
| **Formulary Drug List** | Preferred B3<br>Tier 1 = generic<br>Tier 2 = preferred brand<br>Tier 3 = non-preferred brands |
| **Annual Benefit Maximum** | Unlimited |
| **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 |
| **Retail Cost Shares** | Tier 1 = $10<br>Tier 2 = $20<br>Tier 3 = $40 |
| **Mail Cost Shares** | No Mail Order |
| **Day Supply** | 30 days or 100 units, whichever is greater |

*This plan is self-funded by City of Spokane, 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 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.*

## Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint Portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD). Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx.

## Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-722-1471（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-722-1471 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-722-1471 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.

037378 (07-01-2021)