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 7 $15/$30 RX PLAN HERITAGE**	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 3X Individual)	$150	Shared with In-Network
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	40%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$2,000	Unlimited
Office Visit Cost Share	$20 Copay, applies to the $2,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% 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 $2,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Telemedicine with Traditional Providers - General Medical	$20 Copay, applies to the $2,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum

MEDICAL PLAN	PLAN 7 $15/$30 RX PLAN HERITAGE	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	$20 Copay, applies to the $2,000 Out of Pocket Maximum	Not Covered
DIAGNOSTIC SERVICES		
Preventive Imaging and Lab	Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Diagnostic Lab	First $100 Covered in Full. $150 Deductible, then 20% Coinsurance. applies to $2,000 Out of Pocket Maximum; Excludes TMJ	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Basic Diagnostic Imaging	First $100 Covered in Full. $150 Deductible, then 20% Coinsurance. applies to $2,000 Out of Pocket Maximum; Excludes TMJ	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Major Diagnostic Imaging	First $100 Covered in Full. $150 Deductible, then 20% Coinsurance. applies to $2,000 Out of Pocket Maximum; Excludes TMJ	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Preventive Mammography	Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Diagnostic Mammography	Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Supplemental Breast Exam	Covered in Full	Covered as any other service
FACILITY CARE		
Inpatient Facility	$150 Deductible, then 20% Coinsurance, applies to $2,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Inpatient Professional Services	$150 Deductible, then 20% Coinsurance, applies to $2,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Surgery Facility	$150 Deductible, then 20% Coinsurance, applies to $2,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% 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)	$150 Deductible, then 20% Coinsurance, applies to $2,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (Unlimited; within the 6 month lifetime maximum)	$150 Deductible, then Covered in Full, applies to $2,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	$150 Deductible, then Covered in Full, applies to $2,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
MATERNITY & REPRODUCTIVE CARE		
Contraceptive Management Services (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Sterilization - Female (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Sterilization - Male (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
MEDICAL TRANSPORTATION BENEFITS		
Transplant Travel & Lodging ($7,500 per transplant)	$150 Deductible, 0% Coinsurance, applies to $2,000 Out of Pocket Maximum	$150 Deductible, 0% Coinsurance, applies to $2,000 Out of Pocket Maximum
EMERGENCY CARE AND TRANSPORTATION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$100 Copay then $150 Deductible and 20% Coinsurance; all cost shares apply to the $2,000 Out of Pocket Maximum	$100 Copay then $150 Deductible and 20% Coinsurance; all cost shares apply to the $2,000 Out of Pocket Maximum
Emergency Room Physician	$150 Deductible, then 20% Coinsurance, applies to $2,000 Out of Pocket Maximum	$150 Deductible, then 20% Coinsurance, applies to $2,000 Out of Pocket Maximum
Urgent Care Center	$20 Copay, applies to the $2,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Ambulance Transportation (Unlimited)	$150 Deductible, then 20% Coinsurance, applies to $2,000 Out of Pocket Maximum	$150 Deductible, then 20% Coinsurance, applies to $2,000 Out of Pocket Maximum
ALTERNATIVE CARE		
Acupuncture (24 visits PCY)	$150 Deductible, then 20% Coinsurance, applies to $2,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Manipulations (Spinal and other) (30 visits PCY)	$150 Deductible, then 20% Coinsurance, applies to $2,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	$150 Deductible, then 20% Coinsurance, applies to $2,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Outpatient Professional Care (Unlimited)	$20 Copay, applies to the $2,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum

MEDICAL PLAN	PLAN 7 $15/$30 RX PLAN HERITAGE	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Mental Health Inpatient Facility Care (Unlimited)	$150 Deductible, then 20% Coinsurance, applies to $2,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	$20 Copay, applies to the $2,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
REHABILITATION & NEURO		
Rehab Inpatient Facility (30 days PCY)	$150 Deductible, then 20% Coinsurance, applies to $2,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (45 visits PCY)	$150 Deductible, then 20% Coinsurance, applies to $2,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	$150 Deductible, then 20% Coinsurance, applies to $2,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
OTHER SERVICES		
Allergy/Therapeutic Injections	$150 Deductible, then 20% Coinsurance, applies to $2,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Medical Supplies, Equipment, Prosthetics (Unlimited)	$150 Deductible, then 20% Coinsurance, applies to $2,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Transplants (Unlimited)	Covered as any other service	Not Covered
SUPPLEMENTAL BENEFITS		
Routine Vision Exam (1 PCY)	$20 Copay	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Vision Hardware ($300 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 7 RX RETAIL $15/$30 RX, MAIL $20/$60*
PRESCRIPTION DRUGS	
Formulary Drug List	Preferred A2 Tier 1 = generic Tier 2 = 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	$15/$30
Mail Cost Shares	Tier 1 = $20 Tier 2 = $60
Day Supply	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days

*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.

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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)