

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 3 \$10/\$20 RX PLAN HERITAGE	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
MEDICAL COST SHARES			
Individual Deductible PCY (Family embedded deductible 3X Individual)	\$100	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 3X Individual)	\$625	Unlimited	
Office Visit Cost Share	First 3 Office Visits Covered in Full; \$100 Deductible, 20% Coinsurance thereafter; applies to \$625 Out of Pocket Maximum; Excludes In Office Surgery	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	First 3 Office Visits Covered in Full; \$100 Deductible, 20% Coinsurance thereafter; applies to \$625 Out of Pocket Maximum; Excludes In Office Surgery	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum	

MEDICAL PLAN		PLAN 3 \$10/\$20 RX PLAN HERITAGE	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
Telemedicine with Traditional Providers - General Medical	\$100 Deductible, 20% Coinsurance thereafter; applies to \$625 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum	
VIRTUAL CARE SERVICES			
Telemedicine - General Medical (Virtual Care Only)	\$100 Deductible, then 20% Coinsurance, applies to \$625 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. \$100 Ded, then 20% Coins thereafter. Excludes TMJ, applies to \$625 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Basic Diagnostic Imaging	First \$100 Covered in Full. \$100 Ded, then 20% Coins thereafter. Excludes TMJ, applies to \$625 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Major Diagnostic Imaging	First \$100 Covered in Full. \$100 Ded, then 20% Coins thereafter. Excludes TMJ, applies to \$625 Out of Pocket Maximum	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	\$100 Deductible, then 20% Coinsurance, applies to \$625 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Inpatient Professional Services	\$100 Deductible, then 20% Coinsurance, applies to \$625 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Outpatient Surgery Facility	\$100 Deductible, then 20% Coinsurance, applies to \$625 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)	\$100 Deductible, then 20% Coinsurance, applies to \$625 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum	
HOSPICE & HOME HEALTH CARE			

MEDICAL PLAN		PLAN 3 \$10/\$20 RX PLAN HERITAGE	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
Hospice Inpatient Facility (Unlimited; within the 6 month lifetime maximum)	\$100 Deductible, then Covered in Full, applies to \$625 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	\$100 Deductible, then Covered in Full, applies to \$625 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)	\$100 Deductible, 0% Coinsurance, applies to \$625 Out of Pocket Maximum	\$100 Deductible, 0% Coinsurance, applies to \$625 Out of Pocket Maximum	
EMERGENCY CARE AND TRANSPORTATION			
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	\$100 Deductible, then 20% Coinsurance, applies to \$625 Out of Pocket Maximum	\$100 Deductible, then 20% Coinsurance, applies to \$625 Out of Pocket Maximum	
Emergency Room Physician	\$100 Deductible, then 20% Coinsurance, applies to \$625 Out of Pocket Maximum	\$100 Deductible, then 20% Coinsurance, applies to \$625 Out of Pocket Maximum	
Urgent Care Center	First 3 Office Visits Covered in Full; \$100 Deductible, 20% Coinsurance thereafter; applies to \$625 Out of Pocket Maximum; Excludes In Office Surgery	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Ambulance Transportation (Unlimited)	\$100 Deductible, then 20% Coinsurance, applies to \$625 Out of Pocket Maximum	\$100 Deductible, then 20% Coinsurance, applies to \$625 Out of Pocket Maximum	
ALTERNATIVE CARE			
Acupuncture (24 visits PCY)	\$100 Deductible, then 20% Coinsurance, applies to \$625 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)	\$100 Deductible, then 20% Coinsurance, applies to \$625 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)	\$100 Deductible, then 20% Coinsurance, applies to \$625 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum	

MEDICAL PLAN		PLAN 3 \$10/\$20 RX PLAN HERITAGE	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
Chemical Dependency Outpatient Professional Care (Unlimited)	First 3 Office Visits Covered in Full; \$100 Deductible, 20% Coinsurance thereafter; applies to \$625 Out of Pocket Maximum; Excludes TMJ	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Mental Health Inpatient Facility Care (Unlimited)	\$100 Deductible, then 20% Coinsurance, applies to \$625 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)	First 3 Office Visits Covered in Full; \$100 Deductible, 20% Coinsurance thereafter; applies to \$625 Out of Pocket Maximum; Excludes TMJ	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum	
REHABILITATION & NEURO			
Rehab Inpatient Facility (30 days PCY)	\$100 Deductible, then 20% Coinsurance, applies to \$625 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)	\$100 Deductible, then 20% Coinsurance, applies to \$625 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	\$100 Deductible, then 20% Coinsurance, applies to \$625 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum	
OTHER SERVICES			
Allergy/Therapeutic Injections	\$100 Deductible, then 20% Coinsurance, applies to \$625 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Medical Supplies, Equipment, Prosthetics (Unlimited)	\$100 Deductible, then 20% Coinsurance, applies to \$625 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)	Covered in Full	Shared with In-Network Deductible, then 40% 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.

PHARMACY PLAN		PLAN 3 RX RETAIL \$10/\$20 RX, NO MAIL ORDER*
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	\$10/\$20	
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/online/services/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: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃសម្រាប់អ្នកមានសំណើបំណើអ្នក។ ចូរទូរស័ព្ទ 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。
 ၎င်းတို့သည်: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም አርዳታ ድርጅቶች: በነጻ ሊያገለግሉት ተዘጋጅተዋል: ወደ ሚኒተላው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711).
XIYEEFFANNAA: 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).
பிரமாந் டிஊ: நீ துமீ ப்நாசுமி ஂலதே தே, த் த்நாசு டீசர் சதாபிதா சேத துதாசு ஂலதி ஡ுதத ஂபுலசசய தே। 800-722-1471 (TTY: 711) 'தே த்ல த்லதே।
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).
ໂປດອຸບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທສ 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.

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