

# Highlights of your Health Care Coverage

City of Kent

Group Number: 1018212

Effective Date: 01/01/2019

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.

<b>MEDICAL PLAN</b>		
	<b>80%/20% PLAN</b>	
	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>MEDICAL COST SHARE OPTIONS</b>		
<b>Individual Deductible PCY</b> (Family embedded deductible 3X Individual)	\$200 Individual \$600 Family	Shared with In-Network
<b>Coinsurance (Member's percentage of costs after deductible based on allowable charges)</b>	20%	30%
<b>Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable</b> (Family embedded OOP max 3X Individual)	\$1,200 Individual \$3,600 Family	\$3,200 Individual \$9,600 Family
<b>Office Visit Cost Share</b>	First 6 Visits: \$20 Copay. Subsequent visits: \$200 Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	\$200 Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum
<b>PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION</b>		
<b>Preventive Office Visit</b> (Unlimited)	Covered in Full	Covered in Full
<b>Immunizations</b> (Unlimited)	Covered in Full	Covered in Full
<b>Health Education (HE)</b> (Unlimited)	Covered in Full	Covered in Full
<b>Nicotine Dependency Programs (ND)</b> (Unlimited)	Covered in Full	Covered in Full
<b>Diabetes Health Education (DE)</b> (Unlimited)	Covered in Full	Covered in Full
<b>PROFESSIONAL CARE</b>		
<b>Professional Office Visit</b>	First 6 Visits: \$20 Copay. Subsequent visits: \$200 Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	\$200 Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum
<b>Inpatient Professional Services</b>	\$200 Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	\$200 Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum

<b>MEDICAL PLAN</b>		<b>80%/20% PLAN</b>	
	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>Contraceptive Management Services (Unlimited)</b>	Covered In Full	\$200 Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum	
<b>DIAGNOSTIC SERVICE OPTIONS</b>			
<b>Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA</b>	Covered in Full	Covered in Full	
<b>Other Professional Diagnostic Imaging</b>	Waive Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	\$200 Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum	
<b>Professional Diagnostic Major Imaging</b>	Waive Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	\$200 Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum	
<b>Other Professional Diagnostic Laboratory/Pathology</b>	Waive Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	\$200 Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum	
<b>Diagnostic Mammography</b>	Covered in Full	\$200 Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum	
<b>FACILITY CARE OPTIONS</b>			
<b>Inpatient Facility</b>	\$200 Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	\$200 Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum	
<b>Outpatient Surgery Facility</b>	\$200 Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	\$200 Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum	
<b>Skilled Nursing Facility (Unlimited)</b>	\$200 Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	\$200 Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum	
<b>Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)</b>	Waive Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	Waive Deductible, then constant 30% Coinsurance	
<b>EMERGENCY CARE AND TRANSPORTATION OPTION</b>			
<b>Emergency Care (If applicable, waive copay if admitted to inpatient facility)</b>	\$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	
<b>Emergency Room Physician</b>	\$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	
<b>Urgent Care Center</b>	First 6 Visits: \$20 Copay. Subsequent visits: \$200 Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	\$200 Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum	
<b>Ambulance Transportation (Unlimited)</b>	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	
<b>Air Ambulance (Unlimited)</b>	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	
<b>OTHER SERVICES</b>			
<b>Allergy/Therapeutic Injections</b>	\$200 Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	\$200 Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum	
<b>Mental Health Inpatient Facility Care (Unlimited)</b>	\$200 Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	\$200 Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum	

<b>MEDICAL PLAN</b>		
	<b>80%/20% PLAN</b>	
	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Mental Health Outpatient Professional Care</b> (Unlimited)	First 6 Visits: \$20 Copay. Subsequent visits: \$200 Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	\$200 Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum
<b>Chemical Dependency Inpatient Facility Care</b> (Unlimited)	\$200 Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	\$200 Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum
<b>Chemical Dependency Outpatient Professional Care</b> (Unlimited)	First 6 Visits: \$20 Copay. Subsequent visits: \$200 Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	\$200 Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum
<b>Rehab Inpatient Facility</b> (30 Days PCY)	\$200 Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	\$200 Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum
<b>Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain</b> (45 visits PCY; Massage: 15 visits PCY)	\$200 Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	\$200 Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum
<b>Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer</b>	\$200 Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	\$200 Deductible, then 30% Coinsurance, applies to \$3,200 Out of Pocket Maximum
<b>Medical Supplies, Equipment, Prosthetics</b> (Unlimited)	Waive Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	Waive Deductible, then constant 30% Coinsurance
<b>Foot Orthotics, Orthopedic Shoes and Accessories</b> (Unlimited Diabetes Related; Non-diabetes related: Not Covered)	Waive Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	Waive Deductible, then constant 30% Coinsurance
<b>Home Health Visits</b> (130 visits PCY)	Waive Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	Waive Deductible, then constant 30% Coinsurance
<b>Hospice Care</b> (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
<b>TMJ (Temporomandibular Joint Disorders)</b> (Unlimited (Medical and Dental services - Medical and Dental cost shares based on type of service))	Covered as any other service	Covered as any other service
<b>Transplants</b> (Unlimited; \$7,500 travel and lodging limits)	Covered as any other service	Not Covered
<b>ALTERNATIVE CARE</b>		
<b>Manipulations (Spinal and other)</b> (20 Visits PCY)	Waive Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	Waive Deductible, then constant 30% Coinsurance
<b>Acupuncture</b> (10 Visits PCY)	Waive Deductible, then 20% Coinsurance, applies to \$1,200 Out of Pocket Maximum	Waive Deductible, then constant 30% Coinsurance
<b>ANNUAL PLAN MAXIMUM</b>		
<b>Annual Plan Maximum</b>	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: 01/01/2019

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](http://www.premera.com)

<b>PHARMACY PLAN</b>	
<b>80%/20% PLAN</b>	
<b>PRESCRIPTION DRUGS</b>	
<b>Drug List</b>	Preferred B3 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands
<b>Retail Cost Shares</b>	\$5/\$20/\$40
<b>Mail Cost Shares</b>	\$10/\$40/\$80
<b>Day Supply</b>	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days
<b>Individual Deductible PCY</b>	\$0
<b>Family Deductible PCY</b>	No Family Deductible
<b>Out of Network (Non-participating retail pharmacies)</b>	Cost Share, then 40% (to allowable)
<b>Out of Pocket Maximum</b>	Applies to the medical out of pocket maximum
<b>Annual Benefit Maximum</b>	Unlimited

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