PREMERA HMO

Highlights of your Health Care Coverage

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	**PC: HMO - $5000/30%/NOT APP/$6,500/$10/$65**	
	SHERWOOD HMO IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARES		
Individual Deductible PCY (Family embedded deductible 2X Individual)	$5,000	Not Covered
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	30%	Not Covered
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$6,500	Not Covered
PCP Office Visit Cost Share	$10 Copay, applies to the $6,500 Out of Pocket Maximum	Not Covered
Specialist Office Visit Cost Share	$65 Copay, applies to the $6,500 Out of Pocket Maximum	Not Covered
Kinwell Connect Cost Share Waiver (Excluded)	All services rendered and billed by any Kinwell clinic are subject to standard cost shares	Not Applicable
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered
Immunizations (Unlimited, subject to standard medical guidelines)	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
CHRONIC CONDITION MANAGEMENT PROGRAMS		
Diabetes Management Plus	Included	Included
Diabetes Prevention Plus	Excluded	Excluded
Hypertension Plus	Excluded	Excluded

MEDICAL PLAN	PC: HMO - $5000/30%/NOT APP/$6,500/$10/$65	
	SHERWOOD HMO IN-NETWORK	**OUT-OF-NETWORK**
Weight Management	Excluded	Excluded
PROFESSIONAL CARE		
Professional Office Visit	PCP: $10 Copay, applies to the $6,500 Out of Pocket Maximum; Specialist: $65 Copay, applies to the $6,500 Out of Pocket Maximum	Not Covered
Telemedicine with Traditional Providers - General Medical	$10 Copay, applies to the $6,500 Out of Pocket Maximum	Not Covered
Telemedicine with Traditional Providers - Specialist	$65 Copay, applies to the $6,500 Out of Pocket Maximum	Not Covered
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	$10 Copay, applies to the $6,500 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
Telemedicine - Chemical Dependency (Virtual Care Only)	Subject to Chemical Dependency Outpatient Office Visit	Not Covered
DIAGNOSTIC SERVICES		
Preventive Imaging and Lab	Covered in Full	Not Covered
Diagnostic Lab	$5,000 Deductible, then 30% Coinsurance, applies to $6,500 Out of Pocket Maximum	Not Covered
Basic Diagnostic Imaging	$5,000 Deductible, then 30% Coinsurance, applies to $6,500 Out of Pocket Maximum	Not Covered
Major Diagnostic Imaging	$5,000 Deductible, then 30% Coinsurance, applies to $6,500 Out of Pocket Maximum	Not Covered
Preventive Mammography	Covered in Full	Not Covered
Diagnostic Mammography	Covered in Full	Not Covered
Supplemental Breast Exam	Covered in Full	Not Covered
FACILITY CARE		
Inpatient Facility	$5,000 Deductible, then 30% Coinsurance, applies to $6,500 Out of Pocket Maximum	Not Covered
Inpatient Professional Services	$5,000 Deductible, then 30% Coinsurance, applies to $6,500 Out of Pocket Maximum	Not Covered
Outpatient Surgery Facility	$5,000 Deductible, then 30% Coinsurance, applies to $6,500 Out of Pocket Maximum	Not Covered
Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	$5,000 Deductible, then 30% Coinsurance, applies to $6,500 Out of Pocket Maximum	Not Covered
HOSPICE & HOME HEALTH CARE		

MEDICAL PLAN	PC: HMO - $5000/30%/NOT APP/$6,500/$10/$65	
	SHERWOOD HMO IN-NETWORK	**OUT-OF-NETWORK**
Hospice Inpatient Facility (Unlimited)	$5,000 Deductible, then 30% Coinsurance, applies to $6,500 Out of Pocket Maximum	Not Covered
Hospice Care (Unlimited)	$5,000 Deductible, then 30% Coinsurance, applies to $6,500 Out of Pocket Maximum	Not Covered
MATERNITY & REPRODUCTIVE CARE		
Contraceptive Management Services (Unlimited)	Covered in Full	Not Covered
Sterilization - Female (Unlimited)	Covered in Full	Not Covered
Sterilization - Male (Unlimited)	Covered in Full	Not Covered
MEDICAL TRANSPORTATION BENEFITS		
Transplant Travel & Lodging ($7,500 per transplant)	$5,000 Deductible, 0% Coinsurance, applies to $6,500 Out of Pocket Maximum	$5,000 Deductible, 0% Coinsurance, applies to $6,500 Out of Pocket Maximum
EMERGENCY CARE AND TRANSPORTATION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$350 Copay then $5,000 Deductible and 30% Coinsurance; all cost shares apply to the $6,500 Out of Pocket Maximum	$350 Copay then $5,000 Deductible and 30% Coinsurance; all cost shares apply to the $6,500 Out of Pocket Maximum
Emergency Room Physician	$5,000 Deductible, then 30% Coinsurance, applies to $6,500 Out of Pocket Maximum	$5,000 Deductible, then 30% Coinsurance, applies to $6,500 Out of Pocket Maximum
Urgent Care Center	$25 Copay, applies to the $6,500 Out of Pocket Maximum	$25 Copay, applies to the $6,500 Out of Pocket Maximum
Ambulance Transportation (Unlimited)	$5,000 Deductible, then 30% Coinsurance, applies to $6,500 Out of Pocket Maximum	$5,000 Deductible, then 30% Coinsurance, applies to $6,500 Out of Pocket Maximum
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	$10 Copay, applies to the $6,500 Out of Pocket Maximum	Not Covered
Manipulations (Spinal and other) (12 visits PCY)	$10 Copay, applies to the $6,500 Out of Pocket Maximum	Not Covered
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	$5,000 Deductible, then 30% Coinsurance, applies to $6,500 Out of Pocket Maximum	Not Covered
Chemical Dependency Outpatient Professional Care (Unlimited)	$10 Copay, applies to the $6,500 Out of Pocket Maximum	Not Covered
Mental Health Inpatient Facility Care (Unlimited)	$5,000 Deductible, then 30% Coinsurance, applies to $6,500 Out of Pocket Maximum	Not Covered
Mental Health Outpatient Professional Care (Unlimited)	$10 Copay, applies to the $6,500 Out of Pocket Maximum	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (60 days PCY combined limit for inpatient services)	$5,000 Deductible, then 30% Coinsurance, applies to $6,500 Out of Pocket Maximum	Not Covered

MEDICAL PLAN	PC: HMO - $5000/30%/NOT APP/$6,500/$10/$65	
	SHERWOOD HMO IN-NETWORK	**OUT-OF-NETWORK**
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (60 visits PCY combined limit for outpatient services)	$65 Copay, applies to the $6,500 Out of Pocket Maximum	Not Covered
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	$65 Copay, applies to the $6,500 Out of Pocket Maximum	Not Covered
OTHER SERVICES		
Allergy/Therapeutic Injections	$5,000 Deductible, then 30% Coinsurance, applies to $6,500 Out of Pocket Maximum	Not Covered
Medical Supplies, Equipment, Prosthetics (Unlimited)	$5,000 Deductible, then 30% Coinsurance, applies to $6,500 Out of Pocket Maximum	Not Covered
Transplants (Unlimited)	Covered as any other service	Not Covered
SUPPLEMENTAL BENEFITS		
Routine Vision Exam (1 PCY)	$25 Copay	Not Covered
Vision Hardware ($150 every 2 consecutive calendar years)	Covered in Full	Covered in Full
Pediatric Vision Exam (1 PCY under age 19)	$25 Copay, applies to the $6,500 Out of Pocket Maximum	Not Covered
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
Routine Hearing Exam (1 every 36 months)	$25 Copay	Not Covered
Hearing Hardware (WA Mandate $3,000 per ear with hearing loss every 36 months)	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 HMO. 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.

PREMERA HMO

Discrimination is Against the Law

Premera Blue Cross HMO (Premera HMO) 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 HMO does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera HMO 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 HMO 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 HMO 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 844-722-4661 (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 844-722-4661（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 844-722-4661 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 844-722-4661 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 844-722-4661 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 844-722-4661 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 844-722-4661 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 844-722-4661 (TTY: 711)។

844-722-4661 TTY:711

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 844-722-4661 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 844-722-4661 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 844-722-4661 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 844-722-4661 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 844-722-4661 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 844-722-4661 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 844-722-4661 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 844-722-4661 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 844-722-4661 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 844-722-4661 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 844-722-4661 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 844-722-4661 (TTY: 711) تماس بگیرید.