

# Highlights of your Health Care Coverage

Effective Date: 01/01/2027

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 - \$6000/30%/NOT APP/\$7,000/\$10/\$65                                                                                                          |                                                                                            |                |
|                                                                                                                                                         | SHERWOOD HMO IN-NETWORK                                                                    | OUT-OF-NETWORK |
| MEDICAL COST SHARES                                                                                                                                     |                                                                                            |                |
| <b>Individual Deductible PCY</b> (Family embedded deductible 2X Individual)                                                                             | \$6,000                                                                                    | Not Covered    |
| <b>Coinsurance (Member's percentage of costs after deductible based on allowable charges)</b>                                                           | 30%                                                                                        | Not Covered    |
| <b>Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable</b> (Family embedded OOP max 2X Individual) | \$7,000                                                                                    | Not Covered    |
| <b>PCP Office Visit Cost Share</b>                                                                                                                      | \$10 Copay, applies to the \$7,000 Out of Pocket Maximum                                   | Not Covered    |
| <b>Specialist Office Visit Cost Share</b>                                                                                                               | \$65 Copay, applies to the \$7,000 Out of Pocket Maximum                                   | Not Covered    |
| <b>Kinwell Connect Cost Share Waiver</b> (Excluded)                                                                                                     | All services rendered and billed by any Kinwell clinic are subject to standard cost shares | Not Applicable |
| PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION                                                                                                            |                                                                                            |                |
| <b>Preventive Office Visit</b> (Unlimited, subject to standard medical guidelines)                                                                      | Covered in Full                                                                            | Not Covered    |
| <b>Immunizations</b> (Unlimited, subject to standard medical guidelines)                                                                                | Covered in Full                                                                            | Not Covered    |
| <b>Health Education (HE)</b> (Unlimited)                                                                                                                | Covered in Full                                                                            | Not Covered    |
| <b>Nicotine Dependency Programs (ND)</b> (Unlimited)                                                                                                    | Covered in Full                                                                            | Not Covered    |
| <b>Diabetes Health Education (DE)</b> (Unlimited)                                                                                                       | Covered in Full                                                                            | Not Covered    |
| PROFESSIONAL CARE                                                                                                                                       |                                                                                            |                |

| MEDICAL PLAN                                                                                                         |                                                                                                                                     | PC: HMO - \$6000/30%/NOT APP/\$7,000/\$10/\$65 |
|----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|
|                                                                                                                      | SHERWOOD HMO IN-NETWORK                                                                                                             | OUT-OF-NETWORK                                 |
| Professional Office Visit                                                                                            | PCP: \$10 Copay, applies to the \$7,000 Out of Pocket Maximum; Specialist: \$65 Copay, applies to the \$7,000 Out of Pocket Maximum | Not Covered                                    |
| Telemedicine with Traditional Providers - General Medical                                                            | \$10 Copay, applies to the \$7,000 Out of Pocket Maximum                                                                            | Not Covered                                    |
| Telemedicine with Traditional Providers - Specialist                                                                 | \$65 Copay, applies to the \$7,000 Out of Pocket Maximum                                                                            | Not Covered                                    |
| VIRTUAL CARE SERVICES                                                                                                |                                                                                                                                     |                                                |
| Telemedicine - General Medical (Virtual Care Only)                                                                   | \$10 Copay, applies to the \$7,000 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 Cost Share                                                                   | Not Covered                                    |
| DIAGNOSTIC SERVICES                                                                                                  |                                                                                                                                     |                                                |
| Preventive Imaging and Laboratory                                                                                    | Covered in Full                                                                                                                     | Not Covered                                    |
| Diagnostic Laboratory                                                                                                | \$6,000 Deductible, then 30% Coinsurance, applies to \$7,000 Out of Pocket Maximum                                                  | Not Covered                                    |
| Basic Diagnostic Imaging                                                                                             | \$6,000 Deductible, then 30% Coinsurance, applies to \$7,000 Out of Pocket Maximum                                                  | Not Covered                                    |
| Major Diagnostic Imaging                                                                                             | \$6,000 Deductible, then 30% Coinsurance, applies to \$7,000 Out of Pocket Maximum                                                  | Not Covered                                    |
| Breast Cancer Screening (including mammography)                                                                      | Covered in Full                                                                                                                     | Not Covered                                    |
| FACILITY CARE                                                                                                        |                                                                                                                                     |                                                |
| Inpatient Facility                                                                                                   | \$6,000 Deductible, then 30% Coinsurance, applies to \$7,000 Out of Pocket Maximum                                                  | Not Covered                                    |
| Inpatient Professional Services                                                                                      | \$6,000 Deductible, then 30% Coinsurance, applies to \$7,000 Out of Pocket Maximum                                                  | Not Covered                                    |
| Hospital Outpatient Surgery Facility                                                                                 | \$6,000 Deductible, then 30% Coinsurance, applies to \$7,000 Out of Pocket Maximum                                                  | Not Covered                                    |
| Ambulatory Surgery Center                                                                                            | \$6,000 Deductible, then 20% Coinsurance, applies to the \$7,000 Out of Pocket Maximum                                              | Not Covered                                    |
| Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees) | \$6,000 Deductible, then 30% Coinsurance, applies to \$7,000 Out of Pocket Maximum                                                  | Not Covered                                    |
| HOSPICE & HOME HEALTH CARE                                                                                           |                                                                                                                                     |                                                |
| Hospice Inpatient Facility (Unlimited)                                                                               | \$6,000 Deductible, then 30% Coinsurance, applies to \$7,000 Out of Pocket Maximum                                                  | Not Covered                                    |

| MEDICAL PLAN                                                                  |                                                                                                                     | PC: HMO - \$6000/30%/NOT APP/\$7,000/\$10/\$65                                                                      |
|-------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|
|                                                                               | SHERWOOD HMO IN-NETWORK                                                                                             | OUT-OF-NETWORK                                                                                                      |
| Hospice Care (Unlimited)                                                      | \$6,000 Deductible, then 30% Coinsurance, applies to \$7,000 Out of Pocket Maximum                                  | Not Covered                                                                                                         |
| MATERNITY & REPRODUCTIVE CARE                                                 |                                                                                                                     |                                                                                                                     |
| Birth Center                                                                  | \$6,000 Deductible, then 20% Coinsurance, applies to \$7,000 Out of Pocket Maximum                                  | Not Covered                                                                                                         |
| 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)                          | \$6,000 Deductible, 0% Coinsurance, applies to \$7,000 Out of Pocket Maximum                                        | \$6,000 Deductible, 0% Coinsurance, applies to \$7,000 Out of Pocket Maximum                                        |
| EMERGENCY CARE AND TRANSPORTATION                                             |                                                                                                                     |                                                                                                                     |
| Emergency Care (If applicable, waive copay if admitted to inpatient facility) | \$350 Copay then \$6,000 Deductible and 30% Coinsurance; all cost shares apply to the \$7,000 Out of Pocket Maximum | \$350 Copay then \$6,000 Deductible and 30% Coinsurance; all cost shares apply to the \$7,000 Out of Pocket Maximum |
| Emergency Room Physician                                                      | \$6,000 Deductible, then 30% Coinsurance, applies to \$7,000 Out of Pocket Maximum                                  | \$6,000 Deductible, then 30% Coinsurance, applies to \$7,000 Out of Pocket Maximum                                  |
| Urgent Care Center                                                            | \$25 Copay, applies to the \$7,000 Out of Pocket Maximum                                                            | \$25 Copay, applies to the \$7,000 Out of Pocket Maximum                                                            |
| Ambulance Transportation (Unlimited)                                          | \$6,000 Deductible, then 30% Coinsurance, applies to \$7,000 Out of Pocket Maximum                                  | \$6,000 Deductible, then 30% Coinsurance, applies to \$7,000 Out of Pocket Maximum                                  |
| ALTERNATIVE CARE                                                              |                                                                                                                     |                                                                                                                     |
| Acupuncture (12 visits PCY)                                                   | \$10 Copay, applies to the \$7,000 Out of Pocket Maximum                                                            | Not Covered                                                                                                         |
| Manipulations (Spinal and other) (12 visits PCY)                              | \$10 Copay, applies to the \$7,000 Out of Pocket Maximum                                                            | Not Covered                                                                                                         |
| CHEMICAL DEPENDENCY & MENTAL HEALTH                                           |                                                                                                                     |                                                                                                                     |
| Chemical Dependency Inpatient Facility Care (Unlimited)                       | \$6,000 Deductible, then 30% Coinsurance, applies to \$7,000 Out of Pocket Maximum                                  | Not Covered                                                                                                         |
| Chemical Dependency Outpatient Professional Care (Unlimited)                  | \$10 Copay, applies to the \$7,000 Out of Pocket Maximum                                                            | Not Covered                                                                                                         |
| Mental Health Inpatient Facility Care (Unlimited)                             | \$6,000 Deductible, then 30% Coinsurance, applies to \$7,000 Out of Pocket Maximum                                  | Not Covered                                                                                                         |
| Mental Health Outpatient Professional Care (Unlimited)                        | \$10 Copay, applies to the \$7,000 Out of Pocket Maximum                                                            | Not Covered                                                                                                         |
| REHABILITATION & NEURODEVELOPMENTAL THERAPY                                   |                                                                                                                     |                                                                                                                     |
| Inpatient Rehab (60 days PCY)                                                 | \$6,000 Deductible, then 30% Coinsurance, applies to \$7,000 Out of Pocket Maximum                                  | Not Covered                                                                                                         |

| MEDICAL PLAN                                                                                                                                                |                                                                                    | PC: HMO - \$6000/30%/NOT APP/\$7,000/\$10/\$65 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|------------------------------------------------|--|
|                                                                                                                                                             | SHERWOOD HMO IN-NETWORK                                                            | OUT-OF-NETWORK                                 |  |
| Outpatient Rehab, Including Physical and Occupational Therapy (60 visits PCY)                                                                               | \$65 Copay, applies to the \$7,000 Out of Pocket Maximum                           | Not Covered                                    |  |
| Outpatient Rehab for Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer (Unlimited)                                                         | \$65 Copay, applies to the \$7,000 Out of Pocket Maximum                           | Not Covered                                    |  |
| Outpatient Massage Therapy (Applies to the outpatient rehab limit)                                                                                          | \$65 Copay, applies to the \$7,000 Out of Pocket Maximum                           | Not Covered                                    |  |
| Outpatient Speech Therapy (Applies to the outpatient rehab limit)                                                                                           | \$65 Copay, applies to the \$7,000 Out of Pocket Maximum                           | Not Covered                                    |  |
| Inpatient Neurodevelopmental Therapy                                                                                                                        | \$6,000 Deductible, then 30% Coinsurance, applies to \$7,000 Out of Pocket Maximum | Not Covered                                    |  |
| Outpatient Neurodevelopmental Therapy (60 visits PCY)                                                                                                       | \$65 Copay, applies to the \$7,000 Out of Pocket Maximum                           | Not Covered                                    |  |
| OTHER SERVICES                                                                                                                                              |                                                                                    |                                                |  |
| Allergy/Therapeutic Injections                                                                                                                              | \$6,000 Deductible, then 30% Coinsurance, applies to \$7,000 Out of Pocket Maximum | Not Covered                                    |  |
| Medical Supplies, Equipment, Prosthetics (Unlimited)                                                                                                        | \$6,000 Deductible, then 30% Coinsurance, applies to \$7,000 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 \$7,000 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 PCY)                                                                                                                                | \$25 Copay, applies to the \$7,000 Out of Pocket Maximum                           | Not Covered                                    |  |
| Hearing Hardware (1 device per ear every 3 years)                                                                                                           | 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 Premiera 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.*

## Notice of availability and nondiscrimination 844-722-4661 | TTY: 711

Call for free language assistance services and appropriate auxiliary aids and services.

Llame para obtener servicios gratuitos de asistencia lingüística, y ayudas y servicios auxiliares apropiados.

呼吁提供免费的语言援助服务和适当的辅助设备及服务。

呼籲提供免費的語言援助服務和適當的輔助設備及服務。

Gọi cho các dịch vụ hỗ trợ ngôn ngữ miễn phí và các hỗ trợ và dịch vụ phụ trợ thích hợp.

무료 언어 지원 서비스와 적절한 보조 도구 및 서비스를 신청하십시오.

Звоните для получения бесплатных услуг по переводу и других вспомогательных средств и услуг.

Tumawag para sa mga libreng serbisyo ng tulong sa wika at angkop na mga karagdagang tulong at serbisyo.

Звертайтеся за безкоштовною мовною підтримкою та відповідними додатковими послугами.

សូមហៅទូរសព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាផ្សេងៗ ដើម្បីជួយចំណាត់ថ្នាក់ដល់សមាសភាពផ្សេងៗ។

無料言語支援サービスと適切な補助器具及びサービスをお求めください。

ለነፃ የቋንቋ እርዳታ አገልግሎቶች እና ተገቢ ድጋፍ ሰጪ አጋኾ መሳሪያዎችን እና አገልግሎቶችን ለማግኘት በስልክ ቁጥር

Tajaajiloota deeggarsa afaan bilisaa fi gargaarsaa fi tajaajiloota barbaachisaa ta'an argachuuf bilbilaa.

ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਅਤੇ ਉਚਿਤ ਸਹਾਇਕ ਚੀਜ਼ਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਵਾਸਤੇ ਕਾਲ ਕਰੋ।

Fordern Sie kostenlose Sprachunterstützungsdienste und geeignete Hilfsmittel und Dienstleistungen an.

ໃຫ້ເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ການບໍລິການ ແລະ ການຊ່ວຍເຫຼືອພິເສດທີ່ເໝາະສົມແບບບໍ່ເສຍຄ່າ.

Rele pou w jwenn sèvis asistans lengwistik gratis ak èd epi sèvis oksilyè ki apwopriye.

Appelez pour obtenir des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriés.

Zadzwonń, aby uzyskać bezpłatną pomoc językową oraz odpowiednie wsparcie i usługi pomocnicze.

Ligue para serviços gratuitos de assistência linguística e auxiliares e serviços auxiliares adequados.

Chiama per i servizi di assistenza linguistica gratuiti e per gli ausili e i servizi ausiliari appropriati.

اتصل للحصول على خدمات المساعدة اللغوية المجانية والمساعدات والخدمات المناسبة.

برای خدمات کمک زبانی رایگان و کمک‌ها و خدمات امدادی مقتضی، تماس بگیرید.

**Discrimination is against the law.** Premera Blue Cross 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, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera Blue Cross HMO does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera Blue Cross HMO provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 Blue Cross HMO provides free language assistance services to people whose primary language is not English, which may include qualified interpreters and information written in other languages. If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator. If you believe that Premera Blue Cross HMO has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, TTY: 711, Fax: 425-918-5592, Email [AppealsDepartmentInquiries@Premera.com](mailto:AppealsDepartmentInquiries@Premera.com). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our 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>.