Highlights of your Health Care Coverage

City of Spokane

Group Number: 1018813

Effective Date: 01/01/2024

*Premera Blue Cross believes this plan is a “grandfathered health plan” under the Affordable Care Act. For more information, please refer to your Benefit Booklet.
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 *GRANDFATHERED	**CITY PLAN 1 - RETIREE WITHOUT MEDICARE***
	ALL PROVIDERS
MEDICAL COST SHARE OPTIONS	
Individual Deductible PCY (Family embedded deductible 2X Individual)	$500
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	30%
Individual Out of Pocket Maximum PCY, excludes copay and deductible (No Family OOP max)	$3,000 Out of Pocket Maximum Exclude Deductible
Office Visit Cost Share	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION	
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full
Health Education (HE) (Unlimited)	Covered In Full
Nicotine Dependency Programs (ND) (Unlimited)	Covered in Full
Diabetes Health Education (DE) (Unlimited)	Covered in Full
PROFESSIONAL CARE	
Professional Office Visit	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum
Telemedicine with Traditional Providers - General Medical	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum
VIRTUAL CARE SERVICES	
Telemedicine - General Medical (Virtual Care Only)	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum
DIAGNOSTIC SERVICE OPTIONS	
Preventive Professional Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in Full
Other Professional Diagnostic Imaging	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum
Professional Diagnostic Major Imaging	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum
Other Professional Diagnostic Laboratory/Pathology	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum
Diagnostic Mammography	Covered in Full
FACILITY CARE OPTIONS	
Inpatient Facility	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum

MEDICAL PLAN *GRANDFATHERED	CITY PLAN 1 - RETIREE WITHOUT MEDICARE*
	ALL PROVIDERS
Inpatient Professional Services	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum
Outpatient Surgery Facility	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum
Skilled Nursing Facility (180 days PCY; includes room and board, and facility billed professional and ancillary fees)	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum
HOSPICE & HOME HEALTH CARE	
Hospice Inpatient Facility (Unlimited; within the 6 month lifetime maximum)	$500 Deductible, then Covered in Full
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	$500 Deductible, then Covered in Full
MATERNITY & REPRODUCTIVE CARE	
Sterilization - Female (Unlimited)	Covered in Full
Sterilization - Male (Unlimited)	Covered in Full
MEDICAL TRANSPORTATION BENEFITS	
Transplant Travel & Lodging ($7,500 per transplant)	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum
EMERGENCY CARE AND TRANSPORTATION OPTION	
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum
Emergency Room Physician	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum
Urgent Care Center	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum
Ambulance Transportation (Unlimited)	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum
ALTERNATIVE CARE	
Acupuncture (12 visits PCY)	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum
Manipulations (Spinal and other) (30 visits PCY)	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum
CHEMICAL DEPENDENCY & MENTAL HEALTH	
Chemical Dependency Inpatient Facility Care (Unlimited)	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum
Chemical Dependency Outpatient Professional Care (Unlimited)	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum
REHABILITATION & NEURO	
Rehab Inpatient Facility (30 days PCY)	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab.; and Chronic Pain (45 visits PCY)	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum
OTHER SERVICES	
Allergy/Therapeutic Injections	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum
Medical Supplies, Equipment, Prosthetics (Unlimited)	$500 Deductible, then 30% Coinsurance, applies to $3,000 Out of Pocket Maximum
Transplants (Unlimited)	Covered as any other service
ANNUAL PLAN MAXIMUM	
Annual Plan Maximum	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.

Highlights of your Health Care Coverage

City of Spokane
Group Number: 1018813

Effective Date: 01/01/2024

Below is a brief overview of your pharmacy benefit. For more information, please refer to your benefit booklet or sign into www.premera.com to find drug costs and coverages specific to your plan.

PHARMACY PLAN	**CITY PLAN 1 - RX RETAIL 30% RX MAJOR MED***
PRESCRIPTION DRUGS	
Drug List	Open A2 Tier 1 = generic Tier 2 = brands
Annual Benefit Maximum	Unlimited
Individual Deductible PCY	$500
Family Deductible PCY	$1,000
Out of Network (Non-participating retail pharmacies)	30% Coinsurance
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Retail Cost Shares	30% Coinsurance
Mail Cost Shares	30% Coinsurance
Day Supply	Supply is 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.

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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 አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ 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)