

# Highlights of your Health Care Coverage

MainVue Homes, LLC  
 Group Number: 4024205

Effective Date: 10/01/2024

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>PREFERRED CHOICE: PPO - \$1,000/20%/50%/\$4,500/\$25</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 2X Individual)	\$1,000	\$2,000	
<b>Coinsurance (Member's percentage of costs after deductible based on allowable charges)</b>	20%	50%	
<b>Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable</b> (Family embedded OOP max 2X Individual)	\$4,500	\$9,000	
<b>Office Visit Cost Share</b>	\$25 Copay, applies to the \$4,500 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>Kinwell Connect Cost Share Waiver</b> (Included)	All services rendered and billed by any Kinwell clinic are covered in full (waive deductible, 0%)	Not Applicable	
<b>PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION</b>			
<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	
<b>PROFESSIONAL CARE</b>			
<b>Professional Office Visit</b>	\$25 Copay, applies to the \$4,500 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>Telemedicine with Traditional Providers - General Medical</b>	\$10 Copay, applies to the \$4,500 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	

<b>MEDICAL PLAN</b>		<b>PREFERRED CHOICE: PPO - \$1,000/20%/50%/\$4,500/\$25</b>	
	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>VIRTUAL CARE SERVICES</b>			
<b>Telemedicine - General Medical (Virtual Care Only)</b>	\$10 Copay, applies to the \$4,500 Out of Pocket Maximum	Not Covered	
<b>Telemedicine - Mental Health (Virtual Care Only)</b>	Subject to Mental Health Outpatient Professional Care In-Network Cost Share	Not Covered	
<b>Telemedicine - Chemical Dependency (Virtual Care Only)</b>	Subject to Chemical Dependency Outpatient Office Visit	Not Covered	
<b>DIAGNOSTIC SERVICE OPTIONS</b>			
<b>Preventive Professional Imaging and Laboratory Services - Including Mammogram and PAP/PSA</b>	Covered in Full	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>Other Professional Diagnostic Imaging</b>	Waive Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>Professional Diagnostic Major Imaging</b>	Waive Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>Other Professional Diagnostic Laboratory/Pathology</b>	Waive Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>Diagnostic Mammography</b>	Covered in Full	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>Supplemental Breast Exam</b>	Covered in Full	Covered as any other service	
<b>FACILITY CARE OPTIONS</b>			
<b>Inpatient Facility</b>	\$1,000 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>Inpatient Professional Services</b>	\$1,000 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>Outpatient Surgery Facility</b>	\$1,000 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>Skilled Nursing Facility</b> (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$1,000 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>HOSPICE &amp; HOME HEALTH CARE</b>			
<b>Hospice Inpatient Facility</b> (10 days Inpatient; within the 6 month lifetime maximum)	\$1,000 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>Hospice Care</b> (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	\$1,000 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>MATERNITY &amp; REPRODUCTIVE CARE</b>			
<b>Contraceptive Management Services</b> (Unlimited)	Covered in Full	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	

<b>MEDICAL PLAN</b>		<b>PREFERRED CHOICE: PPO - \$1,000/20%/50%/\$4,500/\$25</b>	
	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>Sterilization - Female</b> (Unlimited)	Covered in Full	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>Sterilization - Male</b> (Unlimited)	Covered in Full	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>MEDICAL TRANSPORTATION BENEFITS</b>			
<b>Transplant Travel &amp; Lodging</b> (\$7,500 per transplant)	\$1,000 Deductible, 0% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$1,000 Deductible, 0% Coinsurance, applies to \$4,500 Out of Pocket Maximum	
<b>EMERGENCY CARE AND TRANSPORTATION OPTION</b>			
<b>Emergency Care (If applicable, waive copay if admitted to inpatient facility)</b>	\$150 Copay then \$1,000 Deductible and 20% Coinsurance; all cost shares apply to the \$4,500 Out of Pocket Maximum	\$150 Copay then \$1,000 Deductible and 20% Coinsurance; all cost shares apply to the \$4,500 Out of Pocket Maximum	
<b>Emergency Room Physician</b>	\$1,000 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$1,000 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	
<b>Urgent Care Center</b>	\$25 Copay, applies to the \$4,500 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>Ambulance Transportation</b> (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$1,000 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	
<b>ALTERNATIVE CARE</b>			
<b>Acupuncture</b> (12 visits PCY)	\$25 Copay, applies to the \$4,500 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>Manipulations (Spinal and other)</b> (12 visits PCY)	\$25 Copay, applies to the \$4,500 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>CHEMICAL DEPENDENCY &amp; MENTAL HEALTH</b>			
<b>Chemical Dependency Inpatient Facility Care</b> (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>Chemical Dependency Outpatient Professional Care</b> (Unlimited)	\$25 Copay, applies to the \$4,500 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>Mental Health Inpatient Facility Care</b> (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>Mental Health Outpatient Professional Care</b> (Unlimited)	\$25 Copay, applies to the \$4,500 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>REHABILITATION &amp; NEURO</b>			
<b>Rehab Inpatient Facility</b> (30 days PCY)	\$1,000 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain</b> (45 visits PCY)	\$25 Copay, applies to the \$4,500 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	

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	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer</b>	\$25 Copay, applies to the \$4,500 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>OTHER SERVICES</b>			
<b>Allergy/Therapeutic Injections</b>	Covered in Full	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>Medical Supplies, Equipment, Prosthetics (Unlimited)</b>	\$1,000 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>Transplants (Unlimited)</b>	Covered as any other service	Not Covered	
<b>SUPPLEMENTAL BENEFITS</b>			
<b>Routine Vision Exam (1 PCY)</b>	\$25 Copay	\$25 Copay	
<b>Vision Hardware (\$150 every 2 consecutive calendar years)</b>	Covered in Full	Covered in Full	
<b>Pediatric Vision Exam (1 PCY under age 19)</b>	\$25 Copay, applies to the \$4,500 Out of Pocket Maximum	\$25 Copay, applies to the \$4,500 Out of Pocket Maximum	
<b>Pediatric Vision Hardware (Under age 19: One pair of glasses PCY (frames &amp; lenses). 12 month supply of contacts PCY, in lieu of glasses (frames &amp; lenses).)</b>	Covered in Full	Covered in Full	
<b>Routine Hearing Exam (1 every 36 months)</b>	\$25 Copay	\$2,000 Deductible, then 50% Coinsurance, applies to \$9,000 Out of Pocket Maximum	
<b>Hearing Hardware (WA Mandate \$3,000 per ear with hearing loss every 36 months)</b>	Covered in Full	Covered in Full	
<b>ANNUAL PLAN MAXIMUM</b>			
<b>Annual Plan Maximum</b>	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.

*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

MainVue Homes, LLC

Group Number: 4024205

Effective Date: 10/01/2024

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)

PHARMACY PLAN		PREFERRED CHOICE: PHARMACY - \$10/\$25/\$45*
<b>PRESCRIPTION DRUGS</b>		
<b>Drug List</b>	Preferred B3 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands	
<b>Annual Benefit Maximum</b>	Unlimited	
<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>Retail Cost Shares</b>	\$10/\$25/\$45	
<b>Mail Cost Shares</b>	\$25/\$62/\$112	
<b>Day Supply</b>	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days	

\*This plan is self-funded by MainVue Homes, LLC, 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.

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