PREMERA BLUE CROSS

Highlights of your Health Care Coverage

F5, Inc.

Group Number: 1038715

Effective Date: 10/01/2025

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	**HSA - $1700 / 10/50% / $3000 - PV CORE PLUS / ESSENTIALS / PHYSERA WITH $25K INFERTILITY**	
	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARES		
Individual Deductible PPY (Family aggregate deductible 2x Individual)	$1,700/$3,400	Shared with In-Network
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	10%	50%
Individual Out of Pocket Maximum PPY, includes deductible, coinsurance, copay and pharmacy if applicable (Family aggregate OOP max 2x Individual)	$3,000/$6,000	$6,000/$12,000 PPY
Office Visit Cost Share	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
Kinwell Connect Cost Share Waiver (Included)	All services rendered and billed by any Kinwell clinic are subject to deductible, then 0%	Not Applicable
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
Immunizations (Unlimited)	Covered in Full	Out of Network Deductible, then 50%
Health Education (HE) (Unlimited)	Covered In Full	Out of Network Deductible, then 50%
Nicotine Dependency Programs (ND) (Unlimited)	Covered In Full	Out of Network Deductible, then 50%
Diabetes Health Education (DE) (Unlimited)	Covered In Full	Out of Network Deductible, then 50%
CHRONIC CONDITION MANAGEMENT PROGRAMS		
Diabetes Management Plus	Excluded	Excluded

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Diabetes Prevention Plus	Excluded	Excluded
Hypertension Plus	Excluded	Excluded
Weight Management	Included - Advanced	Included - Advanced
PROFESSIONAL CARE		
Professional Office Visit	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
Telemedicine with Traditional Providers - General Medical	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
VIRTUAL CARE SERVICES		
Telemedicine - General Medical (Virtual Care Only)	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 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
Telemedicine - Outpatient Rehab (Virtual Care Only) (Shared with Rehab Outpatient Care)	Subject to Rehab Outpatient Care In-Network Cost Share	Not Covered
DIAGNOSTIC SERVICES		
Preventive Imaging and Laboratory	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
Diagnostic Laboratory	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
Basic Diagnostic Imaging	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
Major Diagnostic Imaging	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
Preventive Mammography	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Diagnostic Mammography	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
Supplemental Breast Exam	Covered in Full	Covered as any other service
FACILITY CARE		
Inpatient Facility	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
Inpatient Professional Services	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
Outpatient Surgery Facility	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
Skilled Nursing Facility (120 days PPY; includes room and board, and facility billed professional and ancillary fees)	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
HOSPICE & HOME HEALTH CARE		
Hospice Inpatient Facility (Unlimited)	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
Hospice Care (Unlimited)	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
MATERNITY & REPRODUCTIVE CARE		
Contraceptive Management Services (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
Sterilization - Female (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
Sterilization - Male (Unlimited)	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to $3,000 /$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
PREMERA DESIGNATED CENTERS OF EXCELLENCE		
Centers of Excellence for Bariatric Surgery (Included)	Ded/Coins	Ded/Coins
MEDICAL TRANSPORTATION BENEFITS		

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
Centers of Excellence Travel and Care Coordination (Not subject to IRS guidelines)	Ded/Coins	Ded/Coins
Transplant Travel & Lodging (Unlimited)	$1,700/$3,400 Deductible, 0% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	$1,700/$3,400 Deductible, 0% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum
EMERGENCY CARE AND TRANSPORTATION		
Emergency Care	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum
Emergency Room Physician	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum
Urgent Care Center	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
Ambulance Transportation (Unlimited)	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum
ALTERNATIVE CARE		
Acupuncture (Unlimited)	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
Manipulations (Spinal and other) (30 visits PPY)	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
CHEMICAL DEPENDENCY & MENTAL HEALTH		
Chemical Dependency Inpatient Facility Care (Unlimited)	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
Chemical Dependency Outpatient Professional Care (Unlimited)	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	$1,700 PPY/$3,400 PPY Ded, then 10% Coins, applies to $3,000 PPY Out of Pocket Maximum	Shared with INN Ded, then 50% Coins, applies to $6,000 PPY Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	$1,700 PPY/$3,400 PPY Ded, then 10% Coins, applies to $3,000 PPY Out of Pocket Maximum	$1,700 PPY/$3,400 PPY Ded, then 10% Coins, applies to $3,000 PPY Out of Pocket Maximum

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	HERITAGE IN-NETWORK	**OUT-OF-NETWORK**
PHARMACY		
Formulary Drug List	E1 Essentials Formulary; No Tiers	E1 Essentials Formulary; No Tiers
Prescription Drugs - Retail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	Specialty Drugs: Not Covered; All other Drugs: Same as In-network cost share
Prescription Drugs - Mail (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days)	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	Not Covered
REHABILITATION & NEURO		
Rehab Inpatient Facility (Unlimited)	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (Massage Therapy limited to 30 visits PPY. Other therapies unlimited)	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
OTHER SERVICES		
Allergy/Therapeutic Injections	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
Medical Supplies, Equipment, Prosthetics (Unlimited)	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
Transplants (Unlimited)	Covered as any other service	Not Covered
SUPPLEMENTAL BENEFITS		
Routine Hearing Exam (1 every 2 plan years)	$1,700/$3,400 Deductible, then 10% Coinsurance, applies to $3,000/$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to $6,000 PPY Out of Pocket Maximum
Hearing Hardware ($3,000 per ear every 3 plan years)	Deductible, not subject to coinsurance, $3,000 every 3 plan years	Deductible, not subject to coinsurance, $3,000 every 3 plan years
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.
PPY = Per Plan 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.

Notice of availability and nondiscrimination 800-722-1471 | 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.
Звертайтесь за безкоштовною мовною підтримкою та відповідними додатковими послугами.
សូមហៅទូរស័ព្ទទៅសេវាជំនួយភាសាដោយឥតគិតថ្លៃ ព្រមទាំងសេវាកម្ម និងជំនួយចាំបាច់ដែលសមរម្យផ្សេងៗ។
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 አጋዥ 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.
ໂທເພື່ອຮັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ 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.
Zadzwoń, 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 (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, or sex, including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes. Premera does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. Premera 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 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 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. 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/onlineservices/cc/pub/complaintinformation.aspx.

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