

Highlights of your Health Care Coverage

F5, Inc.

Group Number: 1038715

Effective Date: 10/01/2026

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 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 /\$12,000 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 /\$12,000 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%	
PREMERA HEALTH HUB			
Diabetes Management (Excluded)	Excluded	Excluded	

MEDICAL PLAN		HSA - \$1700 / 10/50% / \$3000 - PV CORE PLUS / ESSENTIALS WITH \$25K INFERTILITY	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
Digestive Health (Excluded)	Excluded	Excluded	
Hypertension (Excluded)	Excluded	Excluded	
Mental Health (Excluded)	Excluded	Excluded	
Musculoskeletal Health (Excluded)	Excluded	Excluded	
Tobacco Cessation (Excluded)	Excluded	Excluded	
Weight Management (Excluded)	Excluded	Excluded	
Women's Health (Excluded)	Excluded	Excluded	
CHRONIC CONDITION MANAGEMENT PROGRAMS			
Diabetes Management Plus	Excluded	Excluded	
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 /\$12,000 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 /\$12,000 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	
DIAGNOSTIC SERVICES			
Preventive Imaging and Laboratory	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to \$6,000 /\$12,000 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 /\$12,000 PPY Out of Pocket Maximum	

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	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
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 /\$12,000 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 /\$12,000 PPY Out of Pocket Maximum	
Preventive Mammography	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to \$6,000 /\$12,000 PPY Out of Pocket Maximum	
Diagnostic Mammography	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to \$6,000 /\$12,000 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 /\$12,000 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 /\$12,000 PPY Out of Pocket Maximum	
Hospital 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 /\$12,000 PPY Out of Pocket Maximum	
Ambulatory Surgery 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 /\$12,000 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 /\$12,000 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 /\$12,000 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 /\$12,000 PPY Out of Pocket Maximum	
MATERNITY & REPRODUCTIVE CARE			

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	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
Birth 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 /\$12,000 PPY Out of Pocket Maximum	
Contraceptive Management Services (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to \$6,000 /\$12,000 PPY Out of Pocket Maximum	
Sterilization - Female (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to \$6,000 /\$12,000 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 /\$12,000 PPY Out of Pocket Maximum	
PREMERA DESIGNATED CENTERS OF EXCELLENCE			
Centers of Excellence for Bariatric Surgery (Included)	Ded/Coins	Ded/Coins	
MEDICAL TRANSPORTATION BENEFITS			
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 /\$12,000 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 /\$12,000 PPY Out of Pocket Maximum	

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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 /\$12,000 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 /\$12,000 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 /\$12,000 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	
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 & NEURODEVELOPMENTAL THERAPY			
Inpatient Rehab (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 /\$12,000 PPY Out of Pocket Maximum	
Outpatient Rehab, Including Physical and Occupational Therapy (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 /\$12,000 PPY Out of Pocket Maximum	
Outpatient Rehab for Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer (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 /\$12,000 PPY Out of Pocket Maximum	
Outpatient Massage Therapy (Applies to the outpatient rehab limit)	\$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 /\$12,000 PPY Out of Pocket Maximum	

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Outpatient Speech Therapy (Applies to the outpatient rehab limit)	\$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 /\$12,000 PPY Out of Pocket Maximum	
Inpatient Neurodevelopmental Therapy	\$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 /\$12,000 PPY Out of Pocket Maximum	
Outpatient Neurodevelopmental Therapy (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 /\$12,000 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 /\$12,000 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 /\$12,000 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 /\$12,000 PPY Out of Pocket Maximum	
Hearing Hardware (1 device per ear every 3 plan years)	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$3,000 /\$6,000 Out of Pocket Maximum	Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to \$3,000 /\$6,000 Out of Pocket Maximum	
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 Premier 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.