

Highlights of your Health Care Coverage

Verus Advisory

Group Number: 4012885

Effective Date: 01/01/2021

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		PREMERA PREFERRED CHOICE: PPO - \$500/20%/50%/\$4,000/\$25 - HERITAGE*	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
MEDICAL COST SHARE OPTIONS			
Individual Deductible PCY (Family embedded deductible 2X Individual)	\$500	\$1,000	
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	50%	
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	\$4,000	Unlimited	
Office Visit Cost Share	\$25 Copay, applies to the \$4,000 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION			
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered	
Immunizations (Unlimited, subject to standard medical guidelines)	Covered in Full	Not Covered	
Health Education (HE) (Unlimited)	Covered in Full	Not Covered	
Nicotine Dependency Programs (ND) (Unlimited)	Covered in Full	Not Covered	
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Not Covered	
PROFESSIONAL CARE			
Professional Office Visit (Includes Telemedicine)	\$25 Copay, applies to the \$4,000 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
VIRTUAL CARE SERVICES			
Telemedicine - General Medical (Virtual Care Only)	\$5 Copay, applies to the \$4,000 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	Not Covered	
DIAGNOSTIC SERVICE OPTIONS			
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in Full	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Other Professional Diagnostic Imaging	Waive Deductible, then 20% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	

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Professional Diagnostic Major Imaging	Waive Deductible, then 20% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Other Professional Diagnostic Laboratory/Pathology	Waive Deductible, then 20% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Diagnostic Mammography	Waive Deductible, then 20% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
FACILITY CARE OPTIONS			
Inpatient Facility	\$500 Deductible, then 20% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Inpatient Professional Services	\$500 Deductible, then 20% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Outpatient Surgery Facility	\$500 Deductible, then 20% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$500 Deductible, then 20% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
HOSPICE & HOME HEALTH CARE			
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	\$500 Deductible, then 20% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	\$500 Deductible, then 20% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
MATERNITY & REPRODUCTIVE CARE			
Contraceptive Management Services (Unlimited)	Covered in Full	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Sterilization - Female (Unlimited)	Covered in Full	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Sterilization - Male (Unlimited)	Covered in Full	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
PREMERA DESIGNATED CENTERS OF EXCELLENCE			
Centers of Excellence Packaged Services (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement))	Covered in Full	Covered as any other service	
Travel and Care Coordination (Limited to IRS Guidelines)	Covered in Full	Not Covered	
EMERGENCY CARE AND TRANSPORTATION OPTION			
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	\$150 Copay then \$500 Deductible and 20% Coinsurance; all cost shares apply to the \$4,000 Out of Pocket Maximum	\$150 Copay then \$500 Deductible and 20% Coinsurance; all cost shares apply to the \$4,000 Out of Pocket Maximum	
Emergency Room Physician	\$500 Deductible, then 20% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$500 Deductible, then 20% Coinsurance, applies to \$4,000 Out of Pocket Maximum	

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Urgent Care Center	\$25 Copay, applies to the \$4,000 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum			
Ambulance Transportation (Unlimited)	\$500 Deductible, then 20% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$500 Deductible, then 20% Coinsurance, applies to \$4,000 Out of Pocket Maximum			
ALTERNATIVE CARE					
Acupuncture (12 visits PCY)	\$25 Copay, applies to the \$4,000 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum			
Manipulations (Spinal and other) (12 visits PCY)	\$25 Copay, applies to the \$4,000 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum			
CHEMICAL DEPENDENCY & MENTAL HEALTH					
Chemical Dependency Inpatient Facility Care (Unlimited)	\$500 Deductible, then 20% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum			
Chemical Dependency Outpatient Professional Care (Unlimited)	\$25 Copay, applies to the \$4,000 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum			
Mental Health Inpatient Facility Care (Unlimited)	\$500 Deductible, then 20% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum			
Mental Health Outpatient Professional Care (Unlimited)	\$25 Copay, applies to the \$4,000 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum			
REHABILITATION & NEURO					
Rehab Inpatient Facility (30 days PCY)	\$500 Deductible, then 20% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum			
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (45 visits PCY)	\$25 Copay, applies to the \$4,000 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum			
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	\$25 Copay, applies to the \$4,000 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum			
OTHER SERVICES					
Allergy/Therapeutic Injections	Covered in Full	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum			
Medical Supplies, Equipment, Prosthetics (Unlimited)	\$500 Deductible, then 20% Coinsurance, applies to \$4,000 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum			
Transplants (Unlimited; \$7,500 travel and lodging limits)	Covered as any other service	Not Covered			
SUPPLEMENTAL BENEFITS					
Routine Vision Exam (1 PCY)	\$25 Copay	\$25 Copay			
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 \$4,000 Out of Pocket Maximum	\$25 Copay, applies to the \$4,000 Out of Pocket Maximum			

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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
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited

*This plan is self-funded by Verus Advisory, 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.

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms under which the program may be continued in force. This benefit highlight is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.