Group Name: Northwest Kidney Centers

Group ID: 4028580

Plan Effective Date: January 1, 2026

# Your Northwest Kidney Centers health plan

PREMERA BLUE CROSS

# Healthcare for all your ages and stages

Life is full of meaningful moments and milestones.

When those moments include a change to your **healthcare** needs, you'll be **prepared** for whatever life brings with an award-winning health plan in your corner. You can be **confident** knowing you have access to **quality** care and plenty of ways to find it.

When your needs do change, you can feel secure knowing you chose **the right health plan to serve you best at all stages of your life.**

## Awards and recognitions

- America's Greatest Workplaces for Diversity, Newsweek, 2024
- America's Best Midsize Employers, 4 Year Champion, Forbes, 2024
- Outstanding Corporation in Philanthropy, Association of Fundraising Professionals Alaska Chapter, 2022

To find out more, watch our **brand video**.

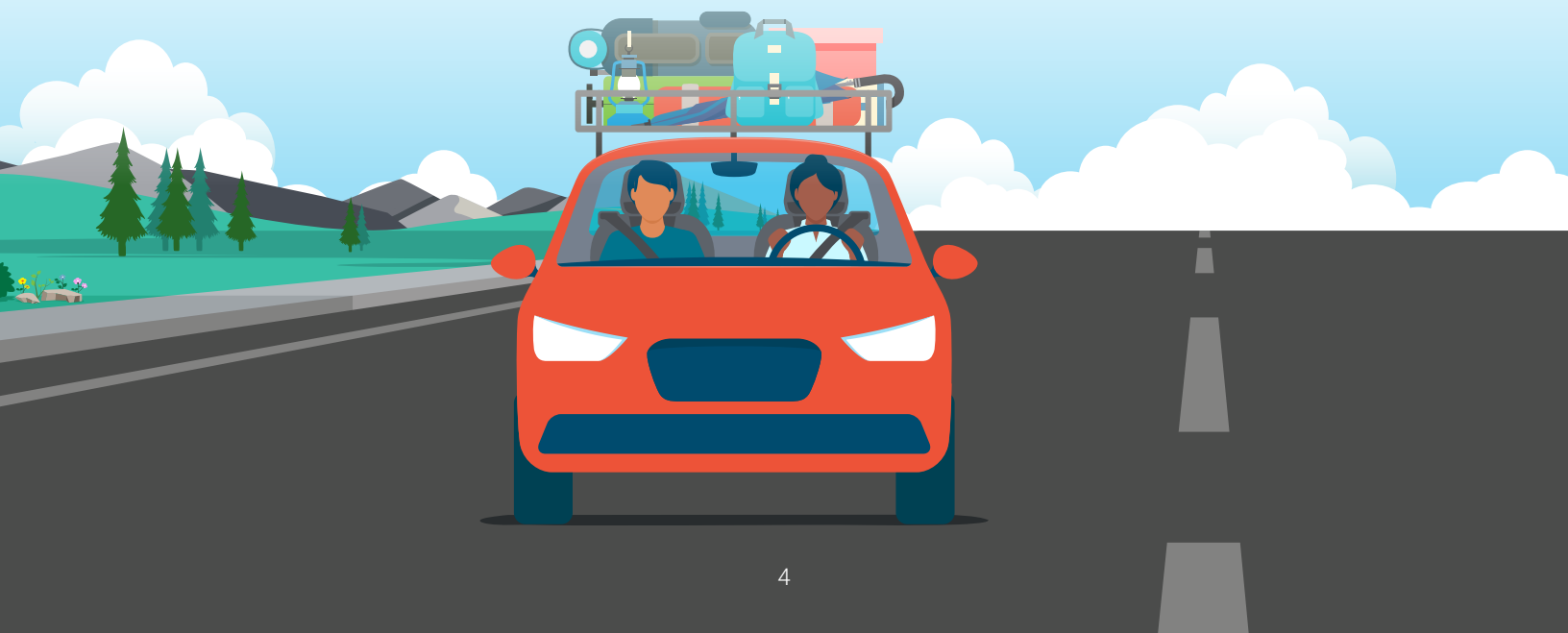
# Wherever you go

At home, across the country, and around the world—**the power of Blue is with you.**

**Locally,** our expansive network is built on strong relationships with providers, hospitals, and specialists.

**Across the United States,** you can see in-network providers anywhere in the country with the BlueCard® program.

**Around the world,** you can get care in nearly 200 countries and territories with the Blue Cross Blue Shield Global Core program.




We're in
your corner—
wherever that
may be.

# Care where and when you need it

Our purpose is to improve customers' lives by making healthcare work better. One of the main ways we do that is by giving you access to care when and where you need it.

| | |
|---|---|
| **Network** | Backed by the Blue Cross Blue Shield Association, Premera Blue Cross has the largest provider network in the country. More than 90% of doctors and hospitals nationwide are in our broadest network, so it's easy to get high-quality care at the best possible price. |
| **Primary care** | In a recent study, over one-third of Americans reported having trouble finding a doctor within the past three years.* To address the doctor shortage, Premera is investing in educational programs to increase the number of future primary care providers. |
| **Virtual care** | With so many care options, you can get treatment by phone, text, or video wherever you go and whenever you need it: |

| | | | |
|---|---|---|---|
| **Primary care** | **Urgent care** | **Mental health care** | **Specialty care** |

*Redford, Gabrielle, and Managing Editor. "What Makes a Good Doctor - and Other Findings from the 2019 AAMC Public Opinion Research." AAMC, 27 Apr. 2020, **https://www.aamc.org/news-insights/what-makes-good-doctor-and-other-findings-2019-aamc-public-opinion-research**

# Whatever kind of care you need

You have many ways to get quality care.

| | |
|---|---|
| **24-Hour NurseLine ($0)** | Call the free 24-Hour NurseLine when you want advice about a health concern. You can discuss your symptoms with a registered nurse and find out the best way to receive care. The number is available on the back of your member ID card and in the Premera mobile app. |
| **Virtual care ($0–$)** | Avoid the hassle, wait, and cost of visiting a provider in person by receiving care from in-network providers, therapists, and other specialists—on the go or from the comfort of home. Sign in to the Premera mobile app to view virtual care services available under your plan on the Find Care landing page. |
| **Office visit ($)** | Visit a provider's office to get examinations, x-rays, lab work, and other in-person medical services. |
| **Urgent care ($$)** | Get care for conditions or illnesses like ear infections, the flu, sprains, or other minor injuries. |
| **ER ($$$)** | Go to the closest emergency room for immediate care for serious or life-threatening conditions like severe abdominal pain, shortness of breath, sudden numbness, loss of consciousness, or broken bones. |

Current member? Get plan info on your phone.

PREMERA

**Download the Premera app for easy, convenient, on-the-go access to health plan info.**
Available on iOS and Android.

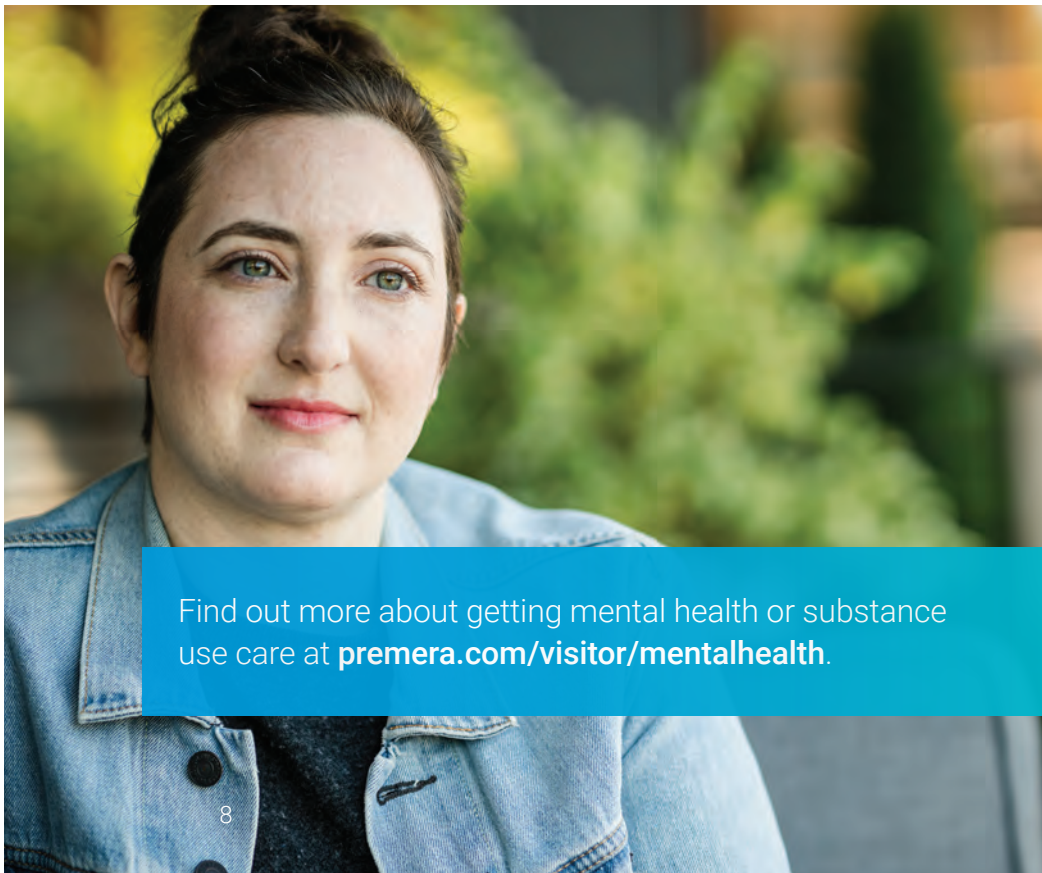
# Access to all levels of mental health care

## Sometimes it's not a physical ailment that disrupts our lives.

We may find ourselves unable to shake feelings of sadness, exhaustion, or anger. We may rely too much on substances, such as alcohol, to get us through the day. In fact, the National Alliance on Mental Illness (NAMI) reports that 1 in 5 U.S. adults and 1 in 6 U.S. youths ages 6–17 experience mental illness each year. And, tragically, suicide is the second or third leading cause of death among people aged 10–34.*

Every Premera plan covers mental health visits the same as a standard office visit with your primary care provider. There are no visit limits. And you have many choices for getting care, so you can find the type of care that fits your life and your needs, whether that's a virtual visit, an in-person appointment, or an in-patient stay.

> "It's important that we all have people in our lives who we feel we can be open and honest with. Having that support system plays a vital role in working through our thoughts and feelings. But to do that, there needs to be a change in how we think about this topic. We can end the stigma around mental health issues and forge a new path forward for all of us, but only when we recognize that we're all in this together."
>
> **Dr. Josephine Young, Premera medical director**



Find out more about getting mental health or substance use care at **premera.com/visitor/mentalhealth**.

*"Suicide." National Institute of Mental Health, U.S. Department of Health and Human Services, **www.nimh.nih.gov/health/statistics/suicide**. Accessed 9 July 2025.

# You'll get no-cost preventive care

When you get routine preventive care from an in-network provider, you don't pay for it—your health plan does.

Under the Affordable Care Act, all health plans cover certain preventive services with no out-of-pocket cost to you. These include the following:

- Routine wellness exams
- Screenings and tests
- Vaccinations
- Medications and supplements
- Reproductive and women's health

**Note:** This is not a complete list of covered preventive services. Services within the above categories may have age, risk, and other requirements to be considered preventive. Go to **premera.com/visitor/care-essentials** for more information about preventive care. Current members can sign in at **premera.com** for specific benefits covered by their plan.

**Check with your primary care provider** to find out what services are right for you.

*"Background: The Affordable Care Act's New Rules on Preventive Care." CMS.Gov, **cms.gov/cciio/resources/fact-sheets-and-faqs/preventive-care-background#:~:text=Improved%20health%3A%20One%20study%20found,avert%20100%2C000%20deaths%20each%20year**. Accessed 30 May 2024.

### Choose a Primary Care Provider

### Book a Preventive Care Visit


### Understand Preventive Care Visits

**According to the Centers for Disease Control and Prevention, preventive care services could save over 100,000 lives in the United States every year.***

# Simplify your life with virtual care

**Whether you are seeking primary care or mental health care, our virtual care services prioritize your needs and provide first-rate care.**

Illness can occur at any time. So why wait for office hours to have your medical concerns addressed? Providers are just a few taps away, ready to offer you the care you need. Avoid the wait and cost of in-person care with a virtual care visit instead.

To find out more about the virtual care options available to you, sign in to your account at **premera.com** or reach out to your HR representative.


**Current member?** Sign in to the Premera mobile app to view virtual care services available under your plan on the Find Care landing page.

Download on the App Store | GET IT ON Google Play

# Plus, there are lots of easy ways to manage your care

Here are some tasks to complete after your plan starts.
They'll make it easier to manage your care down the road.

## Create an account

When you create an account on **premera.com**, you can do the following:

- **Track your care costs** (such as deductible and out-of-pocket maximum)
- **Refill or manage your prescriptions** and get dose reminders
- **Find care providers, hospitals, and pharmacies** that are in your network
- **Compare prices on medical procedures**, services, and prescription drugs
- **Read more** about the details of your benefits

## Download the app

Our mobile app offers the quickest access to plan information and care.

**The Premera mobile app** ensures you always have access to your health plan information and find care—wherever you are.

- Search for doctors and other providers
- Monitor your claims
- Show proof of your coverage with your virtual ID card
- See which virtual care services are available to you
- Connect with virtual care providers
- Have virtual care visits with your provider

Download the Premera mobile app on **Android** or **iOS**.

Download on the App Store | GET IT ON Google Play

## Recieve discounts

**Blue365** is a health and wellness discount program available to Premera Blue Cross members.

Blue365 offers year-round discounts on gym memberships, fitness gear, hearing aids, prescription glasses, healthy eating options, and more. Go to **blue365deals.com/premera** to create a free account and explore all the available discounts.

## Give us a call

If you prefer to talk by phone, call our customer service team at 800-722-1471.

We're available to assist you from 5 a.m. to 8 p.m. Pacific Time, Monday through Friday.

To the new arrivals, the young at heart, and everyone in between— we're in your corner.

# Getting started with your pharmacy benefit

With Premera Blue Cross pharmacy benefits, our goal is to ensure your plan is simple to understand and your medications are easy to manage.

Here's some information to get you started.

### Find a medication

Each formulary drug list covers thousands of medications. To check if a medication is covered by your plan and find out if there are any restrictions:

- Visit **premera.com/visitor/covered-drugs**
- Sign in to your account at **premera.com**

### Find a pharmacy

Pharmacies in your plan network can be found through the **Find a Doctor** tool on **premera.com**.

### Explore more

The online **Pharmacy Benefit Guide** at **premera.com/pharmacy-benefit-guide** has additional need-to-know information, including how prescription pricing works.

## Terms to know

**Formulary**

A list of drugs covered by a prescription drug plan. Also called a formulary drug list.

**Tier**

Within a formulary drug list, medications fall into categories or levels, each with a different copay or coinsurance.

**Copay**

A set fee you pay when you get prescriptions filled. The copay may vary depending on which tier the drugs are in.

**Coinsurance**

Your share of the cost of medication. For example, if your plan pays 90%, your coinsurance (the part you pay) is the remaining 10%.

**Current member?**

Your pharmacy plan is on your ID card or in the **Premera mobile app**.

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# Save on prescriptions

Keep more money in your wallet by using these easy tips.

**Current member?**

Sign in to your account on premera.com to manage your prescriptions:

- Check which prescriptions are covered
- Compare costs
- Find in-network pharmacies
- Order and refill prescriptions

The high cost of medications is a major factor in increasing healthcare costs. We work to keep your out-of-pocket costs as low as possible by providing access to a broad retail pharmacy network with competitive rates.

How you can lower your costs on prescriptions:

**Choose generic drugs.** Generic drugs are the same as brand drugs, but they cost less. Be sure to ask your provider if a generic drug is available the next time you need a new prescription.

**Choose biosimilars.** A biosimilar is a biologic medication. It is highly similar to a biologic medication that has already been approved by the U.S. Food and Drug Administration. Be sure to ask your provider if a biosimilar is available the next time you need a new prescription.

**Get prescriptions delivered.** Mail order is ideal for prescriptions you take regularly. You can save on prescriptions when you choose home delivery. This service is part of your pharmacy benefit. Visit the Pharmacy page on premera.com for information and order forms.

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# Your prescription drug coverage

### Manage your medications easily

Sign in to **premera.com** to:

- Check which medications are covered
- Compare costs
- Find in-network pharmacies
- Order and refill prescriptions

### Specialty drugs

If you have a complex condition such as multiple sclerosis, rheumatoid arthritis, or cancer, you may need medications that require special handling and monitoring. They are usually self-injected and may need refrigeration.

The Premera Specialty Pharmacy Program:

- Shows you how to use these drugs
- Offers free delivery and refill reminders
- Gives you 24-hour access to pharmacists and nurses

For more information, sign in to **premera.com** and select **Prescriptions**.

### Why generics?

It's always a good idea to ask about generics when your healthcare provider prescribes medications. Generics are:

- Often lower cost than brand drugs
- Comprised of the same active ingredients in the same dosage form as brand drugs
- Approved by the U.S. Food and Drug Administration (FDA)

### How it works

When you fill a prescription at the pharmacy, you pay a designated copay or coinsurance. How much you pay depends on the tier, or level, the drug is assigned to.

| | | |
|---|---|---|
| **$** | **TIER 1** | Generics |
| **$$** | **TIER 2** | Preferred brand drugs |
| **$$$** | **TIER 3** | Non-preferred brand drugs |

If you are considering your plan options, visit **premera.com** and select **Covered Drugs** to see how your medications are covered on a Premera plan. If you are a current member, your member ID card lists what your copay or coinsurance is.

### Why biosimilars?

It's also a good idea to ask about biosimilars when your healthcare provider prescribes medications. Biosimilars are:

- Often lower cost than the original biologic medication
- Similar in safety and effectiveness
- Approved by the U.S. Food and Drug Administration

**Save with mail order**
Mail-order prescriptions may cost less.
Sign in to your Premera account to find out more.

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# Virtual care — anytime, anywhere

## Primary, urgent, and mental health care

**Illness can occur at any time. So why wait for office hours to have your medical concerns addressed?**

Whether it's primary, urgent, or mental health care, the Premera virtual care network prioritizes our member's needs. Providers are just a few clicks away, and ready to offer you the care you need.*

98point6

On-demand video and text-based primary care where general medicine and primary care providers are available to answer your questions. They can diagnose and treat you if you're sick or have a chronic condition. Sign in to the **Premera mobile app** to access 98point6 from the Find Care section.

Spring Health

Receive mental health therapy by phone or video chat for ages 6 and older. Psychiatric and medication management are also available for ages 18 and older. Sign in to the **Premera mobile app** to access Spring Health from the Find Care section.

Talkspace

Receive virtual access to a licensed therapist through text or video for non-urgent mental health care. Sign in to the **Premera mobile app** to access Talkspace from the Find Care section.

*If you already have the 98point6, Spring Health, or Talkspace apps downloaded, you can continue using them as is. You are not required to access them through the Premera mobile app.

98point6, Spring Health, and Talkspace are independent companies that provide virtual care services on behalf of Premera Blue Cross.



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# Kinwell primary care

## Primary care services just for Premera Blue Cross members

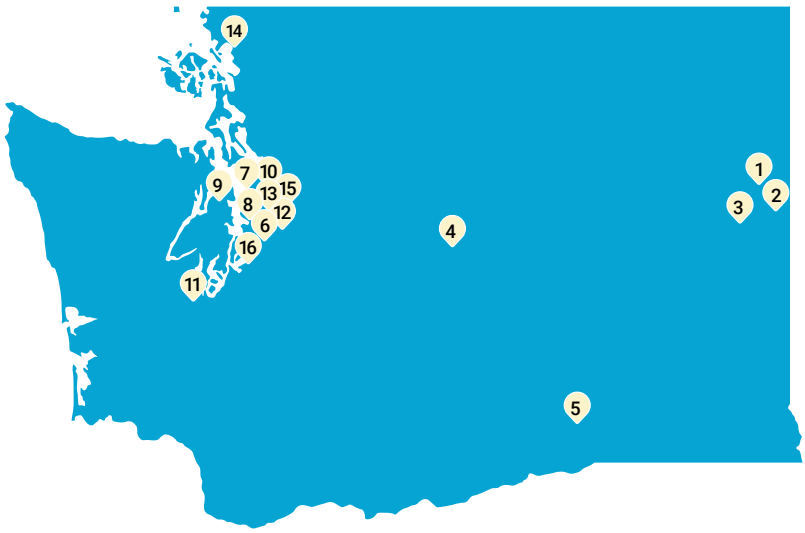
As a Premera member, you and your family have access to advanced primary care at Kinwell clinics—where your nutrition, fitness, sleep, and mental health are all part of the healthcare conversation.

**Kinwell's advanced primary care experience includes:**

- Integrated preventive services and behavioral health care
- Longer appointment times to establish a better one-to-one patient-provider relationship
- Dedicated clinician and health coaching support for lifestyle medical programs
- Convenient access to in-person and virtual care just for Premera members
- Timelier appointment availability

**CURRENT MEMBER?**

Schedule a virtual or in-person appointment today at **kinwellhealth.com**.




### Open now

1. Spokane (North Country Homes)
2. Spokane Valley
3. Spokane (6th & Washington)
4. East Wenatchee
5. Pasco
6. Renton
7. Lynnwood
8. Denny Way
9. Poulsbo
10. Mill Creek
11. Olympia
12. Westlake
13. Ballard
14. Bellingham
15. Redmond
16. Federal Way

> *"It was amazing. [My provider] took the time to listen and answer all my questions. I did not feel rushed. It was one of the best doctors appointments I have ever had. I'm so grateful that I made the switch. Definitely will recommend."* — **Kinwell patient**

PREMERA BLUE CROSS

An Independent Licensee of the Blue Cross Blue Shield Association

Kinwell Medical Group is an independent organization that operates primary care clinics providing services for Premera members on behalf of Premera Blue Cross.



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—

“The person I talked to was very helpful and kind to me. I appreciated her taking the time to get things settled while I was on the phone.”

**- PremeraLISTENS feedback**

88.5% of members rate Premera customer service as excellent.

Tell us what you think at **premeralistens.com**. We read every comment and your responses help us serve you better.

“I wish that I was able to submit the paperwork requested from the claims application. It either requires me to fax, or download and send by postal.”

**- PremeraLISTENS feedback**

**We heard you! We’re improving the digital submission process and status experience for member claims.**

Tell us what you think at **premeralistens.com**. We read every comment and your responses help us serve you better.

# YOUR PLAN HIGHLIGHTS

PREMERA BLUE CROSS

# Highlights of your Health Care Coverage

Northwest Kidney Centers

Group Number: 4028580

Effective Date: 01/01/2026

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 | YOUR FUTURE AGG HSA $2,000 20% $3,500 | |
|---|---|---|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK |
| **MEDICAL COST SHARES** | | |
| **Individual Deductible PCY** (Family aggregate deductible 2x Individual) | $2,000/$4,000 | $4,000/$8,000 |
| **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 aggregate OOP max 2x Individual) | $3,500 | Unlimited |
| **Office Visit Cost Share** | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Kinwell Connect Cost Share Waiver** (Excluded) | All services rendered and billed by any Kinwell clinic are subject to standard cost shares | Not Applicable |
| **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 |
| **PREMERA HEALTH HUB** | | |
| **Diabetes Management** (Excluded) | Excluded | Excluded |
| **Digestive Health** (Excluded) | Excluded | Excluded |
| **Hypertension** (Excluded) | Excluded | Excluded |
| **Mental Health** (Excluded) | Excluded | Excluded |

| MEDICAL PLAN | YOUR FUTURE AGG HSA $2,000 20% $3,500 | |
|---|---|---|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK |
| **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** | Excluded | Excluded |
| **PROFESSIONAL CARE** | | |
| **Professional Office Visit** | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Telemedicine with Traditional Providers - General Medical** | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **VIRTUAL CARE SERVICES** | | |
| **Telemedicine - General Medical (Virtual Care Only)** | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 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 |
| **DIAGNOSTIC SERVICES** | | |
| **Preventive Imaging and Laboratory** | Covered in Full | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Diagnostic Laboratory** | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Basic Diagnostic Imaging** | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Major Diagnostic Imaging** | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |

| MEDICAL PLAN | YOUR FUTURE AGG HSA $2,000 20% $3,500 | |
|---|---|---|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK |
| **Preventive Mammography** | Covered in Full | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Diagnostic Mammography** | Covered in Full | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Supplemental Breast Exam** | Covered in Full | Covered as any other service |
| **FACILITY CARE** | | |
| **Inpatient Facility** | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Inpatient Professional Services** | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Hospital Outpatient Surgery Facility** | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Ambulatory Surgery Center** | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 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) | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 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) | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 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) | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **MATERNITY & REPRODUCTIVE CARE** | | |
| **Birth Center** | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Contraceptive Management Services** (Unlimited) | Covered in Full | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Sterilization - Female** (Unlimited) | Covered in Full | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |

| MEDICAL PLAN | YOUR FUTURE AGG HSA $2,000 20% $3,500 | |
|---|---|---|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK |
| **Sterilization - Male** (Unlimited) | Subject to the IRS Minimum Deductible, then 0% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **MEDICAL TRANSPORTATION BENEFITS** | | |
| **Transplant Travel & Lodging** ($7,500 per transplant) | $2,000/$4,000 Deductible, 0% Coinsurance, applies to $3,500 Out of Pocket Maximum | $2,000/$4,000 Deductible, 0% Coinsurance, applies to $3,500 Out of Pocket Maximum |
| **EMERGENCY CARE AND TRANSPORTATION** | | |
| **Emergency Care** | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum |
| **Emergency Room Physician** | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum |
| **Urgent Care Center** | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Ambulance Transportation** (Unlimited) | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum |
| **ALTERNATIVE CARE** | | |
| **Acupuncture** (15 visits PCY) | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Manipulations (Spinal and other)** (15 visits PCY) | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **CHEMICAL DEPENDENCY & MENTAL HEALTH** | | |
| **Chemical Dependency Inpatient Facility Care** (Unlimited) | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Chemical Dependency Outpatient Professional Care** (Unlimited) | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Mental Health Inpatient Facility Care** (Unlimited) | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Mental Health Outpatient Professional Care** (Unlimited) | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |

| MEDICAL PLAN | YOUR FUTURE AGG HSA $2,000 20% $3,500 | |
|---|---|---|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK |
| **PHARMACY** | | |
| **Formulary Drug List** | Open A1<br>No Tiers | Open A1<br>No Tiers |
| **Prescription Drugs - Retail** (Retail: 90 Days, if applicable one copay every 30 day supply; Mail: 90 Days; Specialty: 30 Days) | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 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) | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | Not Covered |
| **REHABILITATION & NEURODEVELOPMENTAL THERAPY** | | |
| **Inpatient Rehab** (60 days PCY) | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Outpatient Rehab, Including Physical and Occupational Therapy** (60 visits PCY) | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Outpatient Rehab for Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer** (Unlimited) | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Outpatient Massage Therapy** (Applies to the outpatient rehab limit) | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Outpatient Speech Therapy** (Applies to the outpatient rehab limit) | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Inpatient Neurodevelopmental Therapy** | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Outpatient Neurodevelopmental Therapy** (60 visits PCY) | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **OTHER SERVICES** | | |
| **Allergy/Therapeutic Injections** | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Medical Supplies, Equipment, Prosthetics** (Unlimited) | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Transplants** (Unlimited) | Covered as any other service | Not Covered |

| MEDICAL PLAN | YOUR FUTURE AGG HSA $2,000 20% $3,500 | |
|---|---|---|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK |
| **SUPPLEMENTAL BENEFITS** | | |
| **Routine Hearing Exam** (1 PCY) | $2,000/$4,000 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,000/$8,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Hearing Hardware** (1 device per ear every 36 months) | Deductible, then Coinsurance | Deductible, then Coinsurance |
| **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.
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.*

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# Highlights of your Health Care Coverage

Northwest Kidney Centers

Group Number: 4028580

Effective Date: 01/01/2026

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 | HIGH OPTION PPO $1,000 20% $2,500 $30 | |
|---|---|---|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK |
| **MEDICAL COST SHARES** | | |
| **Individual Deductible PCY** (Family embedded deductible 3X Individual) | $1,000 | $2,000 |
| **Coinsurance (Member's percentage of costs after deductible based on allowable charges)** | 20% | 40% |
| **Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable** (Family embedded OOP max 3X Individual) | $2,500 | Unlimited |
| **Office Visit Cost Share** | $30 Copay, applies to the $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Kinwell Connect Cost Share Waiver** (Excluded) | All services rendered and billed by any Kinwell clinic are subject to standard cost shares | Not Applicable |
| **PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION** | | |
| **Preventive Office Visit** (Unlimited, subject to standard medical guidelines) | Covered in Full | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Immunizations** (Unlimited, subject to standard medical guidelines) | Covered in Full | Covered in Full |
| **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 |
| **PREMERA HEALTH HUB** | | |
| **Diabetes Management** (Excluded) | Excluded | Excluded |
| **Digestive Health** (Excluded) | Excluded | Excluded |
| **Hypertension** (Excluded) | Excluded | Excluded |
| **Mental Health** (Excluded) | Excluded | Excluded |
| **Musculoskeletal Health** (Excluded) | Excluded | Excluded |
| **Tobacco Cessation** (Excluded) | Excluded | Excluded |

| MEDICAL PLAN | HIGH OPTION PPO $1,000 20% $2,500 $30 | |
|---|---|---|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK |
| **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** | Excluded | Excluded |
| **PROFESSIONAL CARE** | | |
| **Professional Office Visit** | $30 Copay, applies to the $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Telemedicine with Traditional Providers - General Medical** | Covered in Full | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **VIRTUAL CARE SERVICES** | | |
| **Telemedicine - General Medical (Virtual Care Only)** | $10 Copay, applies to the $2,500 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 |
| **DIAGNOSTIC SERVICES** | | |
| **Preventive Imaging and Laboratory** | Covered in Full | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Diagnostic Laboratory** | $1,000 Deductible, then 20% Coinsurance, applies to $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Basic Diagnostic Imaging** | $1,000 Deductible, then 20% Coinsurance, applies to $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Major Diagnostic Imaging** | $1,000 Deductible, then 20% Coinsurance, applies to $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Preventive Mammography** | Covered in Full | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Diagnostic Mammography** | Covered in Full | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Supplemental Breast Exam** | Covered in Full | Covered as any other service |
| **FACILITY CARE** | | |
| **Inpatient Facility** | $1,000 Deductible, then 20% Coinsurance, applies to $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Inpatient Professional Services** | $1,000 Deductible, then 20% Coinsurance, applies to $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |

| MEDICAL PLAN | HIGH OPTION PPO $1,000 20% $2,500 $30 | |
|---|---|---|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK |
| **Hospital Outpatient Surgery Facility** | $1,000 Deductible, then 20% Coinsurance, applies to $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Ambulatory Surgery Center** | $1,000 Deductible, then 20% Coinsurance, applies to $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% 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) | $1,000 Deductible, then 20% Coinsurance, applies to $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **HOSPICE & HOME HEALTH CARE** | | |
| **Hospice Inpatient Facility** (10 days Inpatient; within the 6 month lifetime maximum) | $1,000 Deductible, then 20% Coinsurance, applies to $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Hospice Care** (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum) | $1,000 Deductible, then 20% Coinsurance, applies to $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **MATERNITY & REPRODUCTIVE CARE** | | |
| **Birth Center** | $1,000 Deductible, then 20% Coinsurance, applies to $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Contraceptive Management Services** (Unlimited) | Covered in Full | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Sterilization - Female** (Unlimited) | Covered in Full | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Sterilization - Male** (Unlimited) | Covered in Full | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **MEDICAL TRANSPORTATION BENEFITS** | | |
| **Transplant Travel & Lodging** ($7,500 per transplant) | $1,000 Deductible, 0% Coinsurance, applies to $2,500 Out of Pocket Maximum | $1,000 Deductible, 0% Coinsurance, applies to $2,500 Out of Pocket Maximum |
| **EMERGENCY CARE AND TRANSPORTATION** | | |
| **Emergency Care (If applicable, waive copay if admitted to inpatient facility)** | $150 Copay then $1,000 Deductible and 20% Coinsurance; all cost shares apply to the $2,500 Out of Pocket Maximum | $150 Copay then $1,000 Deductible and 20% Coinsurance; all cost shares apply to the $2,500 Out of Pocket Maximum |
| **Emergency Room Physician** | $1,000 Deductible, then 20% Coinsurance, applies to $2,500 Out of Pocket Maximum | $1,000 Deductible, then 20% Coinsurance, applies to $2,500 Out of Pocket Maximum |
| **Urgent Care Center** | $30 Copay, applies to the $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Ambulance Transportation** (Unlimited) | $1,000 Deductible, then 20% Coinsurance, applies to $2,500 Out of Pocket Maximum | $1,000 Deductible, then 20% Coinsurance, applies to $2,500 Out of Pocket Maximum |
| **ALTERNATIVE CARE** | | |
| **Acupuncture** (12 visits PCY) | $30 Copay, applies to the $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |

| MEDICAL PLAN | HIGH OPTION PPO $1,000 20% $2,500 $30 | |
|---|---|---|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK |
| **Manipulations (Spinal and other)** (12 visits PCY) | $30 Copay, applies to the $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **CHEMICAL DEPENDENCY & MENTAL HEALTH** | | |
| **Chemical Dependency Inpatient Facility Care** (Unlimited) | $1,000 Deductible, then 20% Coinsurance, applies to $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Chemical Dependency Outpatient Professional Care** (Unlimited) | $30 Copay, applies to the $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Mental Health Inpatient Facility Care** (Unlimited) | $1,000 Deductible, then 20% Coinsurance, applies to $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Mental Health Outpatient Professional Care** (Unlimited) | $30 Copay, applies to the $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **REHABILITATION & NEURODEVELOPMENTAL THERAPY** | | |
| **Inpatient Rehab** (30 days PCY) | $1,000 Deductible, then 20% Coinsurance, applies to $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Outpatient Rehab, Including Physical and Occupational Therapy** (45 visits PCY) | $30 Copay, applies to the $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Outpatient Rehab for Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer** (Unlimited) | $30 Copay, applies to the $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Outpatient Massage Therapy** (Applies to the outpatient rehab limit) | $30 Copay, applies to the $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Outpatient Speech Therapy** (Applies to the outpatient rehab limit) | $30 Copay, applies to the $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Inpatient Neurodevelopmental Therapy** | $1,000 Deductible, then 20% Coinsurance, applies to $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Outpatient Neurodevelopmental Therapy** (45 visits PCY) | $30 Copay, applies to the $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **OTHER SERVICES** | | |
| **Allergy/Therapeutic Injections** | $1,000 Deductible, then 20% Coinsurance, applies to $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Medical Supplies, Equipment, Prosthetics** (Unlimited) | $1,000 Deductible, then 20% Coinsurance, applies to $2,500 Out of Pocket Maximum | $2,000 Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum |
| **Transplants** (Unlimited) | Covered as any other service | Not Covered |
| **SUPPLEMENTAL BENEFITS** | | |
| **Routine Hearing Exam** (1 PCY) | $30 Copay, applies to the $2,500 Out of Pocket Maximum | $30 Copay, applies to the $2,500 Out of Pocket Maximum |
| **Hearing Hardware** (1 device per ear every 36 months) | Covered in Full | Covered in Full |
| **ANNUAL PLAN MAXIMUM** | | |

| MEDICAL PLAN | HIGH OPTION PPO $1,000 20% $2,500 $30 | |
|---|---|---|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK |
| **Annual Plan Maximum** | 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.*

| PHARMACY PLAN | HIGH OPTION PHARMACY RETAIL $20/$45/$65 MAIL 2X* |
|---|---|
| **PRESCRIPTION DRUGS** | |
| **Formulary Drug List** | Preferred B3<br>Tier 1 = generic<br>Tier 2 = preferred brand<br>Tier 3 = non-preferred brands |
| **Annual Benefit Maximum** | Unlimited |
| **Individual Deductible PCY** | $0 |
| **Family Deductible PCY** | No Family Deductible |
| **Out of Network (Non-participating retail pharmacies)** | Cost Share, then 40% (to allowable) |
| **Out of Pocket Maximum** | Applies to the medical out of pocket maximum |
| **Retail Cost Shares** | Tier 1 = $20 Tier 2 = $45 Tier 3 = $65 |
| **Mail Cost Shares** | Tier 1 = $40 Tier 2 = $90 Tier 3 = $130 |
| **Day Supply** | Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days |

*This plan is self-funded by Northwest Kidney Centers, 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 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.*

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# Highlights of your Health Care Coverage

Northwest Kidney Centers

Group Number: 4028580

Effective Date: 01/01/2026

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** | **LOW OPTION PPO $1,500 20% $3,500 $30--$45** | |
|---|---|---|
| | **HERITAGE IN-NETWORK** | **OUT-OF-NETWORK** |
| **MEDICAL COST SHARES** | | |
| **Individual Deductible PCY** (Family embedded deductible 3X Individual) | $1,500 | $4,500 |
| **Coinsurance (Member's percentage of costs after deductible based on allowable charges)** | 20% | 40% |
| **Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable** (Family embedded OOP max 2X Individual) | $3,500 | $7,000 |
| **Non Specialist Office Visit Cost Share** | $30 Copay, applies to the $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Specialist Office Visit Cost Share** | $45 Copay, applies to the $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Kinwell Connect Cost Share Waiver** (Excluded) | All services rendered and billed by any Kinwell clinic are subject to standard cost shares | Not Applicable |
| **PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION** | | |
| **Preventive Office Visit** (Unlimited, subject to standard medical guidelines) | Covered in Full | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Immunizations** (Unlimited, subject to standard medical guidelines) | Covered in Full | Covered in Full |
| **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 |
| **PREMERA HEALTH HUB** | | |
| **Diabetes Management** (Excluded) | Excluded | Excluded |
| **Digestive Health** (Excluded) | Excluded | Excluded |
| **Hypertension** (Excluded) | Excluded | Excluded |
| **Mental Health** (Excluded) | Excluded | Excluded |

| MEDICAL PLAN | LOW OPTION PPO $1,500 20% $3,500 $30--$45 | |
|---|---|---|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK |
| **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** | Excluded | Excluded |
| **PROFESSIONAL CARE** | | |
| **Professional Office Visit** | Non Specialist: $30 Copay, applies to the $3,500 Out of Pocket Maximum; Specialist: $45 Copay, applies to the $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Telemedicine with Traditional Providers - General Medical** | Covered in Full | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **VIRTUAL CARE SERVICES** | | |
| **Telemedicine - General Medical (Virtual Care Only)** | $10 Copay, applies to the $3,500 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 |
| **DIAGNOSTIC SERVICES** | | |
| **Preventive Imaging and Laboratory** | Covered in Full | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Diagnostic Laboratory** | $1,500 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Basic Diagnostic Imaging** | $1,500 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Major Diagnostic Imaging** | $1,500 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Preventive Mammography** | Covered in Full | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Diagnostic Mammography** | Covered in Full | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Supplemental Breast Exam** | Covered in Full | Covered as any other service |
| **FACILITY CARE** | | |

| MEDICAL PLAN | LOW OPTION PPO $1,500 20% $3,500 $30--$45 | |
|---|---|---|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK |
| **Inpatient Facility** | $1,500 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Inpatient Professional Services** | $1,500 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Hospital Outpatient Surgery Facility** | $1,500 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Ambulatory Surgery Center** | $1,500 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Skilled Nursing Facility** (60 days PCY; includes room and board, and facility billed professional and ancillary fees) | $1,500 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **HOSPICE & HOME HEALTH CARE** | | |
| **Hospice Inpatient Facility** (10 days Inpatient; within the 6 month lifetime maximum) | $1,500 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Hospice Care** (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum) | $1,500 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **MATERNITY & REPRODUCTIVE CARE** | | |
| **Birth Center** | $1,500 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Contraceptive Management Services** (Unlimited) | Covered in Full | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Sterilization - Female** (Unlimited) | Covered in Full | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Sterilization - Male** (Unlimited) | Covered in Full | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **MEDICAL TRANSPORTATION BENEFITS** | | |
| **Transplant Travel & Lodging** ($7,500 per transplant) | $1,500 Deductible, 0% Coinsurance, applies to $3,500 Out of Pocket Maximum | $1,500 Deductible, 0% Coinsurance, applies to $3,500 Out of Pocket Maximum |
| **EMERGENCY CARE AND TRANSPORTATION** | | |
| **Emergency Care (If applicable, waive copay if admitted to inpatient facility)** | $150 Copay then $1,500 Deductible and 20% Coinsurance; all cost shares apply to the $3,500 Out of Pocket Maximum | $150 Copay then $1,500 Deductible and 20% Coinsurance; all cost shares apply to the $3,500 Out of Pocket Maximum |
| **Emergency Room Physician** | $1,500 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $1,500 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum |
| **Urgent Care Center** | $45 Copay, applies to the $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Ambulance Transportation** (Unlimited) | $1,500 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $1,500 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum |

| MEDICAL PLAN | LOW OPTION PPO $1,500 20% $3,500 $30--$45 | |
|---|---|---|
| | HERITAGE IN-NETWORK | OUT-OF-NETWORK |
| **ALTERNATIVE CARE** | | |
| **Acupuncture** (12 visits PCY) | $30 Copay, applies to the $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Manipulations (Spinal and other)** (12 visits PCY) | $30 Copay, applies to the $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **CHEMICAL DEPENDENCY & MENTAL HEALTH** | | |
| **Chemical Dependency Inpatient Facility Care** (Unlimited) | $1,500 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Chemical Dependency Outpatient Professional Care** (Unlimited) | $30 Copay, applies to the $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Mental Health Inpatient Facility Care** (Unlimited) | $1,500 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Mental Health Outpatient Professional Care** (Unlimited) | $30 Copay, applies to the $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **REHABILITATION & NEURODEVELOPMENTAL THERAPY** | | |
| **Inpatient Rehab** (30 days PCY) | $1,500 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Outpatient Rehab, Including Physical and Occupational Therapy** (45 visits PCY) | $45 Copay, applies to the $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Outpatient Rehab for Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer** (Unlimited) | $45 Copay, applies to the $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Outpatient Massage Therapy** (Applies to the outpatient rehab limit) | $45 Copay, applies to the $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Outpatient Speech Therapy** (Applies to the outpatient rehab limit) | $45 Copay, applies to the $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Inpatient Neurodevelopmental Therapy** | $1,500 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Outpatient Neurodevelopmental Therapy** (45 visits PCY) | $45 Copay, applies to the $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **OTHER SERVICES** | | |
| **Allergy/Therapeutic Injections** | $1,500 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Medical Supplies, Equipment, Prosthetics** (Unlimited) | $1,500 Deductible, then 20% Coinsurance, applies to $3,500 Out of Pocket Maximum | $4,500 Deductible, then 40% Coinsurance, applies to $7,000 Out of Pocket Maximum |
| **Transplants** (Unlimited) | Covered as any other service | Not Covered |
| **SUPPLEMENTAL BENEFITS** | | |

| MEDICAL PLAN | LOW OPTION PPO $1,500 20% $3,500 $30--$45 | |
|---|---|---|
| | **HERITAGE IN-NETWORK** | **OUT-OF-NETWORK** |
| **Routine Hearing Exam** (1 PCY) | $30 Copay, applies to the $3,500 Out of Pocket Maximum | $30 Copay, applies to the $3,500 Out of Pocket Maximum |
| **Hearing Hardware** (1 device per ear every 36 months) | Covered in Full | Covered in Full |
| **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.
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

Northwest Kidney Centers

Group Number: 4028580

Effective Date: 01/01/2026

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

| **PHARMACY PLAN** | **LOW OPTION PHARMACY RETAIL $25/$50/$75 MAIL 2X*** |
|---|---|
| **PRESCRIPTION DRUGS** | |
| **Formulary Drug List** | Preferred B3<br>Tier 1 = generic<br>Tier 2 = preferred brand<br>Tier 3 = non-preferred brands |
| **Annual Benefit Maximum** | Unlimited |
| **Individual Deductible PCY** | $0 |
| **Family Deductible PCY** | No Family Deductible |
| **Out of Network (Non-participating retail pharmacies)** | Cost Share, then 40% (to allowable) |
| **Out of Pocket Maximum** | Applies to the medical out of pocket maximum |
| **Retail Cost Shares** | Tier 1 = $25 Tier 2 = $50 Tier 3 = $75 |
| **Mail Cost Shares** | Tier 1 = $50 Tier 2 = $100 Tier 3 = $150 |
| **Day Supply** | Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days |

*This plan is self-funded by Northwest Kidney Centers, 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 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.*

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