PREMERA BLUE CROSS

Benefit Summary Report

Group Number: 1007261
Effective Date: 04/01/2024

Aegis Senior Communities, LLC

Product Name: CareCompass360 PBC WA - Large Group - 1/2024	Specification and Benefit Limits
Plan Name: CARECOMPASS - CORE*	
CORE PROGRAMS	
Personal Health Support	Included
Prior Authorization	Prior Auth without Penalty
Advanced Imaging	Prior Authorization without Penalty
Nurseline	Included
Newborn (NICU) Program	Included
Maternity Program	Included - Maternity Only
Outpatient Rehab Utilization Management	Excluded
Matchmaker for Behavioral Health	Excluded
PHARMACY PROGRAMS	
Rebate	100% rebate pass through
RationalMed	Included
Enhanced Controlled Substance Utilization Program	No Program
Point of Sale	Standard (POS + Biotech/Oral Chemo)
Rx Member Alerts	Excluded

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Plan Name: CARECOMPASS - BUY UP*	
CORE PROGRAMS	
Personal Health Support	Included
Prior Authorization	Prior Auth without Penalty
Advanced Imaging	Prior Authorization without Penalty
Nurseline	Included
Newborn (NICU) Program	Included
Maternity Program	Included - Maternity Only
Outpatient Rehab Utilization Management	Excluded
Matchmaker for Behavioral Health	Excluded
PHARMACY PROGRAMS	
Rebate	100% rebate pass through
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Plan Name: CARECOMPASS - CORE PRIME*	
CORE PROGRAMS	
Personal Health Support	Included
Prior Authorization	Prior Auth without Penalty
Advanced Imaging	Prior Authorization without Penalty
Nurseline	Included
Newborn (NICU) Program	Included
Maternity Program	Included - Maternity Only
Outpatient Rehab Utilization Management	Excluded
Matchmaker for Behavioral Health	Excluded
PHARMACY PROGRAMS	
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Plan Name: CARECOMPASS - BUY UP PRIME*	
CORE PROGRAMS	
Personal Health Support	Included
Prior Authorization	Prior Auth without Penalty
Advanced Imaging	Prior Authorization without Penalty
Nurseline	Included
Newborn (NICU) Program	Included
Maternity Program	Included - Maternity Only
Outpatient Rehab Utilization Management	Excluded
Matchmaker for Behavioral Health	Excluded
PHARMACY PROGRAMS	
Rebate	100% rebate pass through
RationalMed	Included
Enhanced Controlled Substance Utilization Program	No Program
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Plan Name: CARECOMPASS - PRIME*	
CORE PROGRAMS	
Personal Health Support	Included
Prior Authorization	Prior Auth without Penalty
Advanced Imaging	Prior Authorization without Penalty
Nurseline	Included
Newborn (NICU) Program	Included
Maternity Program	Included - Maternity Only
Outpatient Rehab Utilization Management	Excluded
Matchmaker for Behavioral Health	Excluded
PHARMACY PROGRAMS	
Rebate	100% rebate pass through
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Point of Sale	Standard (POS + Biotech/Oral Chemo)
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Benefit Summary Report

Group Number: 1007261

Aegis Senior Communities, LLC

Effective Date: 04/01/2024

Product Name: Essentials Medical Plan - Large Group - 1/2024	Specification and Benefit Limits	Heritage Prime In-Network	Out-of-Network
Plan Name: ESSENTIALS MEDICAL PLAN - HERITAGE PRIME - $8550 20%/NC $8550/NC OOP*			
MEDICAL COST SHARE OPTIONS			
Individual Deductible PCY	Family embedded deductible 2X Individual	$8,550	Not Covered
Fourth Quarter Deductible Carryover	Excluded		
Coinsurance (Member's percentage of costs after deductible based on allowable charges)		0%	Not Covered
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable	Family embedded OOP max 2X Individual	$8,550	Not Covered
Office Visit Cost Share		$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Kinwell Connect Cost Share Waiver	Included	All services rendered and billed by any Kinwell clinic are covered in full (waive deductible, 0%)	Not Applicable
Annual Plan Maximum		Unlimited	Unlimited
Health coverage meets the minimum value standard for benefits provided	Self Funded - No calculation		
FACILITY CARE			
Inpatient Facility		$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Inpatient Professional Services		$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered

Product Name: Essentials Medical Plan - Large Group - 1/2024	Specification and Benefit Limits	Heritage Prime In-Network	Out-of-Network
Plan Name: ESSENTIALS MEDICAL PLAN - HERITAGE PRIME - $8550 20%/NC $8550/NC OOP*			
Outpatient Surgery Facility		$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Outpatient Facility		$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Skilled Nursing Facility	60 days PCY; includes room and board, and facility billed professional and ancillary fees	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
HOSPICE & HOME HEALTH CARE			
Hospice Inpatient Facility	10 days Inpatient; within the 6 month lifetime maximum	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Hospice Care	Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Home Health Care	130 visits PCY	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
MATERNITY & REPRODUCTIVE CARE			
Inpatient Facility - Maternity	Coverage for subscriber, spouse, dependent	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Maternity Prenatal, Delivery and Postnatal Care	Coverage for subscriber, spouse, dependent	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Obstetrical Care for Dependent Daughters	Yes		
Contraceptive Management	Unlimited	Covered in Full	Not Covered
Sterilization - Female	Unlimited	Covered in Full	Not Covered
Sterilization - Male	Unlimited	Covered in Full	Not Covered
Infertility/Assisted Reproductive Services	Not Covered	Not Covered	Not Covered

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Plan Name: ESSENTIALS MEDICAL PLAN - HERITAGE PRIME - $8550 20%/NC $8550/NC OOP*			
Elective Termination of Pregnancy		$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Therapeutic Termination of Pregnancy		$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
PREMERA DESIGNATED CENTERS OF EXCELLENCE			
Centers of Excellence for Knee & Hip Total Joint Replacement (Including Partial & Revisions)	Included	Covered as any other service	Not covered
Centers of Excellence for Maternity	Included	Covered as any other service	Not covered
MEDICAL TRANSPORTATION BENEFITS			
Centers of Excellence Travel and Care Coordination	Not Covered	Not Covered	Not Covered
Cellular Immunotherapy and Gene Therapy Travel	Not Covered	Not Covered	Not Covered
Transplant Travel & Lodging	$7,500 per transplant	$8,550 Deductible, 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	$8,550 Deductible, 0% Coinsurance, applies to $8,550 Out of Pocket Maximum
Medical Transportation - State Restricted Care	Not Covered	Not Covered	Not Covered
EMERGENCY CARE AND TRANSPORTATION			
Emergency Care (Waive copay if admitted to inpatient facility)		$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum
Emergency Room Physician		$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum
Urgent Care Center		$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Ambulance Transportation	Unlimited	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum

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Air Ambulance	Unlimited	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum
DIAGNOSTIC SERVICES			
Preventive Professional Diagnostic Imaging and Laboratory Services - Including PAP/PSA		Covered in Full	Not Covered
Professional Diagnostic Major Imaging		$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Other Professional Diagnostic Imaging		$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Other Professional Diagnostic Laboratory/Pathology		$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Preventive Mammography		Covered in Full	Not Covered
Diagnostic Mammography		Covered in Full	Not Covered
Supplemental Breast Exam		Covered in Full	Not Covered
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
Seasonal Immunization provided at a mass immunizer location	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
Preventive Colon Health	Unlimited; subsequent colonoscopies within a 5 year limit apply to deductible and coinsurance	Covered in Full	Not Covered
Nutritional Therapy (Diabetes)	Unlimited	Covered in Full	Not Covered

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Nutritional Therapy (Non-Diabetes)	Unlimited	Covered in Full	Not Covered
CHRONIC CONDITION MANAGEMENT PROGRAMS			
Diabetes Prevention Program	Excluded		
Diabetes Management	Excluded		
Hypertension Management	Excluded		
Weight Management	Excluded		
PROFESSIONAL CARE			
Professional Office Visit		$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Telemedicine with Traditional Providers - General Medical		Deductible/Coinsurance	Not Covered
Naturopathy Services		$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
VIRTUAL CARE SERVICES			
Telemedicine - General Medical (Virtual Care Only)		Covered in Full	Not Covered
Telemedicine - Mental Health (Virtual Care Only)		Covered in Full	Not Covered
Telemedicine - Mental Health for Children (Virtual Care Only)		Not Covered	Not Covered
Telemedicine - Chemical Dependency (Virtual Care Only)		Covered in Full	Not Covered
Telemedicine - Outpatient Rehab (Virtual Care Only)	Shared with Rehab Outpatient Care	Covered in Full	Not Covered
ALTERNATIVE CARE			
Acupuncture	12 visits PCY	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Manipulations (Spinal and Other)	12 visits PCY	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered

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Plan Name: ESSENTIALS MEDICAL PLAN - HERITAGE PRIME - $8550 20%/NC $8550/NC OOP*			
Therapeutic Massage Therapy	Not Covered	Not Covered	Not Covered
CHEMICAL DEPENDENCY & MENTAL HEALTH			
Chemical Dependency Inpatient Facility Care	Unlimited	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Chemical Dependency Outpatient Facility Care	Unlimited	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Chemical Dependency Outpatient Professional Care	Unlimited	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Mental Health Inpatient Facility Care	Unlimited	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Mental Health Outpatient Facility Care	Unlimited	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Mental Health Outpatient Professional Care	Unlimited	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Mental Health Residential Care		$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
REHABILITATION & NEURO			
Psychological & Neuropsychological Testing & Evaluation (Shared with Rehab, Neuro Dev & Mental Health)	Unlimited	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Rehab Inpatient Facility	30 days PCY	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain	45 visits PCY	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered

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Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer		$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
PHARMACY			
Drug List	E1 Essentials Formulary No Tiers	E1 Essentials Formulary	E1 Essentials Formulary
Formulary Exclusion List - Drugs with Over the Counter Alternative	Excluded		
Formulary Exclusion List - High-Cost Low Value Drugs	Excluded		
Generics Required When Available	Member pays the appropriate cost share (No DAW 1 and 2 provision)		
ACA Preventive Drug List		Covered in Full	Not Covered
Enhanced Preventive Drug List	No Buy Up	Subject to Standard Rx Cost share	Not Covered
Prescription Drugs - Retail	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Oral Chemotherapy Retail		Covered in Full	Covered in Full
Prescription Drugs - Mail	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Oral Chemotherapy Mail		Covered in Full	Covered in Full
Mandatory Home Delivery for Maintenance Drugs	Included - Exclusive Pharmacy		
Specialty Pharmacy	Mandatory - Exclusive		
SaveOn Specialty Pharmacy	Excluded		
Out of Pocket Protection Program	Excluded		
Specialty Split Fill	Included		
Right Price	Included		
Weight Loss Drugs	Not Covered	Not Covered	Not Covered
OTHER SERVICES			

Product Name: Essentials Medical Plan - Large Group - 1/2024	Specification and Benefit Limits	Heritage Prime In-Network	Out-of-Network
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Allergy/Therapeutic Injections		$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Medical Supplies (MS), Equipment (ME), Prosthetics (Pro)	Unlimited	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Foot Orthotics, Orthopedic Shoes and Accessories	$300 PCY; Includes orthotics and orthopedic shoes	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Transplants	Unlimited	Covered as any other service	Not Covered
Orthognathic/Maxillofacial Care	Not Covered	Not Covered	Not Covered
TMJ (Temporomandibular Joint Disorders)	Unlimited (Medical and Dental services - Medical and Dental cost shares based on type of service)	Covered as any other service	Not Covered
End Stage Renal Disease (ESRD) During Medicare's Waiting Period		$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
End Stage Renal Disease (ESRD) After Medicare's Waiting Period	Without Premium Reimbursement	$8,550 Deductible, then 0% Coinsurance, applies to $8,550 Out of Pocket Maximum	Not Covered
Bariatric Surgery	Not Covered	Not Covered	Not Covered
SUPPLEMENTAL BENEFITS			
Routine Vision Exam	Not Covered	Not Covered	Not Covered
Vision Hardware	Not Covered	Not Covered	Not Covered
Pediatric Vision Exam	Not Covered	Not Covered	Not Covered
Pediatric Vision Hardware	Not Covered	Not Covered	Not Covered
Routine Hearing Exam	Not Covered	Not Covered	Not Covered
Hearing Hardware	Not Covered	Not Covered	Not Covered
ADMINISTRATIVE OPTIONS			
BlueCard/National Coverage Program	EPO (Default) In-network Blue Card PPO network		
Extended Payment Integrity Services	Included		
Fiduciary Services	Excluded		

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Benefit Summary Report

Group Number: 1007261

Aegis Senior Communities, LLC

Effective Date: 04/01/2024

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage In-Network	Out-of-Network
Plan Name: CORE PLAN - HERITAGE - $2750 30%/50% $5500 $20; ER $250*			
MEDICAL COST SHARE OPTIONS			
Individual Deductible PCY	Family embedded deductible 3X Individual	$2,750 PCY	Shared with In-Network
Fourth Quarter Deductible Carryover	Excluded		
Coinsurance (Member's percentage of costs after deductible based on allowable charges)		30%	50%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable	Family embedded OOP max 2X Individual	$5,500 PCY	Unlimited
Office Visit Cost Share		$20 Copay, applies to the $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Kinwell Connect Cost Share Waiver	Included	All services rendered and billed by any Kinwell clinic are covered in full (waive deductible, 0%)	Not Applicable
Annual Plan Maximum		Unlimited	Unlimited
Health coverage meets the minimum value standard for benefits provided	Self Funded - No calculation		
FACILITY CARE			
Inpatient Facility		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Inpatient Professional Services		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage In-Network	Out-of-Network
Plan Name: CORE PLAN - HERITAGE - $2750 30%/50% $5500 $20; ER $250*			
Outpatient Surgery Facility		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Facility		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network 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	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network 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	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network 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	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Home Health Care	130 visits PCY	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
MATERNITY & REPRODUCTIVE CARE			
Inpatient Facility - Maternity	Coverage for subscriber, spouse, dependent	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Maternity Prenatal, Delivery and Postnatal Care	Coverage for subscriber, spouse, dependent	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Obstetrical Care for Dependent Daughters	Yes		
Contraceptive Management	Unlimited	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Sterilization - Female	Unlimited	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage In-Network	Out-of-Network
Plan Name: CORE PLAN - HERITAGE - $2750 30%/50% $5500 $20; ER $250*			
Sterilization - Male	Unlimited	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Infertility/Assisted Reproductive Services	Not Covered	Not Covered	Not Covered
Elective Termination of Pregnancy		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Therapeutic Termination of Pregnancy		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
PREMERA DESIGNATED CENTERS OF EXCELLENCE			
Centers of Excellence for Knee & Hip Total Joint Replacement (Including Partial & Revisions)	Included	Covered as any other service	Covered as any other service
Centers of Excellence for Maternity	Included	Covered as any other service	Covered as any other service
MEDICAL TRANSPORTATION BENEFITS			
Centers of Excellence Travel and Care Coordination	Not Covered	Not Covered	Not Covered
Cellular Immunotherapy and Gene Therapy Travel	Not Covered	Not Covered	Not Covered
Transplant Travel & Lodging	$7,500 per transplant	$2,750 PCY Deductible, 0% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	$2,750 PCY Deductible, 0% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum
Medical Transportation - State Restricted Care	Not Covered	Not Covered	Not Covered
EMERGENCY CARE AND TRANSPORTATION			
Emergency Care (Waive copay if admitted to inpatient facility)		$250 Copay then $2,750 PCY Deductible and 30% Coinsurance; all cost shares apply to the $5,500 PCY Out of Pocket Maximum	$250 Copay then $2,750 PCY Deductible and 30% Coinsurance; all cost shares apply to the $5,500 PCY Out of Pocket Maximum
Emergency Room Physician		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage In-Network	Out-of-Network
Plan Name: CORE PLAN - HERITAGE - $2750 30%/50% $5500 $20; ER $250*			
Urgent Care Center		$35 Copay	Ded/Coins
Ambulance Transportation	Unlimited	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum
Air Ambulance	Unlimited	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum
DIAGNOSTIC SERVICES			
Preventive Professional Diagnostic Imaging and Laboratory Services - Including PAP/PSA		Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Professional Diagnostic Major Imaging		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Imaging		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Laboratory/Pathology		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Preventive Mammography		Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Diagnostic Mammography		Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Supplemental Breast Exam		Covered in Full	Covered as any other service
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION			
Preventive Office Visit	Unlimited	Covered in Full	Not Covered
Immunizations	Unlimited	Covered in Full	Not Covered
Seasonal Immunization provided at a mass immunizer location	Unlimited	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

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage In-Network	Out-of-Network
Plan Name: CORE PLAN - HERITAGE - $2750 30%/50% $5500 $20; ER $250*			
Diabetes Health Education (DE)	Unlimited	Covered in Full	Not Covered
Preventive Colon Health	Unlimited; no internal frequency limit	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Nutritional Therapy (Diabetes)	Unlimited	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Nutritional Therapy (Non-Diabetes)	Unlimited	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
CHRONIC CONDITION MANAGEMENT PROGRAMS			
Diabetes Prevention Program	Included		
Diabetes Management	Included		
Hypertension Management	Included		
Weight Management	Excluded		
PROFESSIONAL CARE			
Professional Office Visit		$20 Copay, applies to the $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Telemedicine with Traditional Providers - General Medical		$20 Copay, applies to the $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Naturopathy Services		$20 Copay, applies to the $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
VIRTUAL CARE SERVICES			
Telemedicine - General Medical (Virtual Care Only)		$20 Copay, applies to the $5,500 PCY 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 - Mental Health for Children (Virtual Care Only)		Not Covered	Not Covered

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage In-Network	Out-of-Network
Plan Name: CORE PLAN - HERITAGE - $2750 30%/50% $5500 $20; ER $250*			
Telemedicine - Chemical Dependency (Virtual Care Only)		Subject to Chemical Dependency Outpatient Office Visit	Not Covered
Telemedicine - Outpatient Rehab (Virtual Care Only)	Shared with Rehab Outpatient Care	Subject to Rehab Outpatient Care In-Network Cost Share	Not Covered
ALTERNATIVE CARE			
Acupuncture	12 visits PCY	$20 Copay, applies to the $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Manipulations (Spinal and Other)	12 visits PCY	$20 Copay, applies to the $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Therapeutic Massage Therapy	Not Covered	Not Covered	Not Covered
CHEMICAL DEPENDENCY & MENTAL HEALTH			
Chemical Dependency Inpatient Facility Care	Unlimited	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Outpatient Facility Care	Unlimited	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Outpatient Professional Care	Unlimited	$20 Copay, applies to the $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Inpatient Facility Care	Unlimited	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Facility Care	Unlimited	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Professional Care	Unlimited	$20 Copay, applies to the $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Residential Care		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
REHABILITATION & NEURO			

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage In-Network	Out-of-Network
Plan Name: CORE PLAN - HERITAGE - $2750 30%/50% $5500 $20; ER $250*			
Psychological & Neuropsychological Testing & Evaluation (Shared with Rehab, Neuro Dev & Mental Health)	Unlimited	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Inpatient Facility	30 days PCY	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network 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	$20 Copay, applies to the $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer		$20 Copay, applies to the $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
OTHER SERVICES			
Allergy/Therapeutic Injections		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Medical Supplies (MS), Equipment (ME), Prosthetics (Pro)	Unlimited	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Foot Orthotics, Orthopedic Shoes and Accessories	$300 PCY; Includes orthotics and orthopedic shoes	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Transplants	Unlimited	Covered as any other service	Not Covered
Orthognathic/Maxillofacial Care	Not Covered	Not Covered	Not Covered
TMJ (Temporomandibular Joint Disorders)	Unlimited (Medical and Dental services - Medical and Dental cost shares based on type of service)	Covered as any other service	Covered as any other service
End Stage Renal Disease (ESRD) During Medicare's Waiting Period		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
End Stage Renal Disease (ESRD) After Medicare's Waiting Period	Without Premium Reimbursement	Covered in Full	Covered in Full
Bariatric Surgery	Not Covered	Not Covered	Not Covered
SUPPLEMENTAL BENEFITS			

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage In-Network	Out-of-Network
Plan Name: CORE PLAN - HERITAGE - $2750 30%/50% $5500 $20; ER $250*			
Routine Vision Exam	Not Covered	Not Covered	Not Covered
Vision Hardware	Not Covered	Not Covered	Not Covered
Pediatric Vision Exam	Not Covered	Not Covered	Not Covered
Pediatric Vision Hardware	Not Covered	Not Covered	Not Covered
Routine Hearing Exam	1 PCY	$20 Copay	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Hearing Hardware	Not Covered	Not Covered	Not Covered
ADMINISTRATIVE OPTIONS			
BlueCard/National Coverage Program	(Default) In-network and Out of network PPO network		
Extended Payment Integrity Services	Included		
Fiduciary Services	Excluded		

*This plan is self-funded by Aegis Senior Communities, LLC, which means that this group is financially responsible for the payment of plan benefits. The group has contracted with Premera Blue Cross, an independent Licensee of the Blue Cross Blue Shield Association, to perform administrative duties, including the processing of claims, under the plan. Premera Blue Cross does not insure the benefits of this plan.

Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

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 summary 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.

Benefit Summary Report

Group Number: 1007261

Aegis Senior Communities, LLC

Effective Date: 04/01/2024

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage In-Network	Out-of-Network
Plan Name: BUY UP PLAN - HERITAGE - $1250 20%/40% $4500 $20; ER $250*			
MEDICAL COST SHARE OPTIONS			
Individual Deductible PCY	Family embedded deductible 3X Individual	$1,250	Shared with In-Network
Fourth Quarter Deductible Carryover	Excluded		
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	$4,500	Unlimited
Office Visit Cost Share		$20 Copay, applies to the $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Kinwell Connect Cost Share Waiver	Included	All services rendered and billed by any Kinwell clinic are covered in full (waive deductible, 0%)	Not Applicable
Annual Plan Maximum		Unlimited	Unlimited
Health coverage meets the minimum value standard for benefits provided	Self Funded - No calculation		
FACILITY CARE			
Inpatient Facility		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Inpatient Professional Services		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage In-Network	Out-of-Network
Plan Name: BUY UP PLAN - HERITAGE - $1250 20%/40% $4500 $20; ER $250*			
Outpatient Surgery Facility		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Facility		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network 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	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network 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	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network 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	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Home Health Care	130 visits PCY	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
MATERNITY & REPRODUCTIVE CARE			
Inpatient Facility - Maternity	Coverage for subscriber, spouse, dependent	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Maternity Prenatal, Delivery and Postnatal Care	Coverage for subscriber, spouse, dependent	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Obstetrical Care for Dependent Daughters	Yes		
Contraceptive Management	Unlimited	Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Sterilization - Female	Unlimited	Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage In-Network	Out-of-Network
Plan Name: BUY UP PLAN - HERITAGE - $1250 20%/40% $4500 $20; ER $250*			
Sterilization - Male	Unlimited	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Infertility/Assisted Reproductive Services	Not Covered	Not Covered	Not Covered
Elective Termination of Pregnancy		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Therapeutic Termination of Pregnancy		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
PREMERA DESIGNATED CENTERS OF EXCELLENCE			
Centers of Excellence for Knee & Hip Total Joint Replacement (Including Partial & Revisions)	Included	Covered as any other service	Covered as any other service
Centers of Excellence for Maternity	Included	Covered as any other service	Covered as any other service
MEDICAL TRANSPORTATION BENEFITS			
Centers of Excellence Travel and Care Coordination	Not Covered	Not Covered	Not Covered
Cellular Immunotherapy and Gene Therapy Travel	Not Covered	Not Covered	Not Covered
Transplant Travel & Lodging	$7,500 per transplant	$1,250 Deductible, 0% Coinsurance, applies to $4,500 Out of Pocket Maximum	$1,250 Deductible, 0% Coinsurance, applies to $4,500 Out of Pocket Maximum
Medical Transportation - State Restricted Care	Not Covered	Not Covered	Not Covered
EMERGENCY CARE AND TRANSPORTATION			
Emergency Care (Waive copay if admitted to inpatient facility)		$250 Copay then $1,250 Deductible and 20% Coinsurance; all cost shares apply to the $4,500 Out of Pocket Maximum	$250 Copay then $1,250 Deductible and 20% Coinsurance; all cost shares apply to the $4,500 Out of Pocket Maximum
Emergency Room Physician		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage In-Network	Out-of-Network
Plan Name: BUY UP PLAN - HERITAGE - $1250 20%/40% $4500 $20; ER $250*			
Urgent Care Center		$30 copay	Ded/Coins
Ambulance Transportation	Unlimited	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum
Air Ambulance	Unlimited	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum
DIAGNOSTIC SERVICES			
Preventive Professional Diagnostic Imaging and Laboratory Services - Including PAP/PSA		Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Professional Diagnostic Major Imaging		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Imaging		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Laboratory/Pathology		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Preventive Mammography		Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Diagnostic Mammography		Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Supplemental Breast Exam		Covered in Full	Covered as any other service
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION			
Preventive Office Visit	Unlimited	Covered in Full	Not Covered
Immunizations	Unlimited	Covered in Full	Not Covered
Seasonal Immunization provided at a mass immunizer location	Unlimited	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

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage In-Network	Out-of-Network
Plan Name: BUY UP PLAN - HERITAGE - $1250 20%/40% $4500 $20; ER $250*			
Diabetes Health Education (DE)	Unlimited	Covered in Full	Not Covered
Preventive Colon Health	Unlimited; no internal frequency limit	Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Nutritional Therapy (Diabetes)	Unlimited	Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Nutritional Therapy (Non-Diabetes)	Unlimited	Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
CHRONIC CONDITION MANAGEMENT PROGRAMS			
Diabetes Prevention Program	Included		
Diabetes Management	Included		
Hypertension Management	Included		
Weight Management	Excluded		
PROFESSIONAL CARE			
Professional Office Visit		$20 Copay, applies to the $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Telemedicine with Traditional Providers - General Medical		$20 Copay, applies to the $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Naturopathy Services		$20 Copay, applies to the $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
VIRTUAL CARE SERVICES			
Telemedicine - General Medical (Virtual Care Only)		$20 Copay, applies to the $4,500 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
Telemedicine - Mental Health for Children (Virtual Care Only)		Not Covered	Not Covered

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage In-Network	Out-of-Network
Plan Name: BUY UP PLAN - HERITAGE - $1250 20%/40% $4500 $20; ER $250*			
Telemedicine - Chemical Dependency (Virtual Care Only)		Subject to Chemical Dependency Outpatient Office Visit	Not Covered
Telemedicine - Outpatient Rehab (Virtual Care Only)	Shared with Rehab Outpatient Care	Subject to Rehab Outpatient Care In-Network Cost Share	Not Covered
ALTERNATIVE CARE			
Acupuncture	12 visits PCY	$20 Copay, applies to the $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Manipulations (Spinal and Other)	12 visits PCY	$20 Copay, applies to the $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Therapeutic Massage Therapy	Not Covered	Not Covered	Not Covered
CHEMICAL DEPENDENCY & MENTAL HEALTH			
Chemical Dependency Inpatient Facility Care	Unlimited	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Outpatient Facility Care	Unlimited	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Outpatient Professional Care	Unlimited	$20 Copay, applies to the $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Inpatient Facility Care	Unlimited	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Facility Care	Unlimited	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Professional Care	Unlimited	$20 Copay, applies to the $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Residential Care		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
REHABILITATION & NEURO			

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage In-Network	Out-of-Network
Plan Name: BUY UP PLAN - HERITAGE - $1250 20%/40% $4500 $20; ER $250*			
Psychological & Neuropsychological Testing & Evaluation (Shared with Rehab, Neuro Dev & Mental Health)	Unlimited	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Inpatient Facility	30 days PCY	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain	45 visits PCY	$20 Copay, applies to the $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer		$20 Copay, applies to the $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
OTHER SERVICES			
Allergy/Therapeutic Injections		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Medical Supplies (MS), Equipment (ME), Prosthetics (Pro)	Unlimited	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Foot Orthotics, Orthopedic Shoes and Accessories	$300 PCY; Includes orthotics and orthopedic shoes	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Transplants	Unlimited	Covered as any other service	Not Covered
Orthognathic/Maxillofacial Care	Not Covered	Not Covered	Not Covered
TMJ (Temporomandibular Joint Disorders)	Unlimited (Medical and Dental services - Medical and Dental cost shares based on type of service)	Covered as any other service	Covered as any other service
End Stage Renal Disease (ESRD) During Medicare's Waiting Period		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
End Stage Renal Disease (ESRD) After Medicare's Waiting Period	Without Premium Reimbursement	Covered in Full	Covered in Full
Bariatric Surgery	Not Covered	Not Covered	Not Covered
SUPPLEMENTAL BENEFITS			

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage In-Network	Out-of-Network
Plan Name: BUY UP PLAN - HERITAGE - $1250 20%/40% $4500 $20; ER $250*			
Routine Vision Exam	Not Covered	Not Covered	Not Covered
Vision Hardware	Not Covered	Not Covered	Not Covered
Pediatric Vision Exam	Not Covered	Not Covered	Not Covered
Pediatric Vision Hardware	Not Covered	Not Covered	Not Covered
Routine Hearing Exam	1 PCY	$20 Copay	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Hearing Hardware	Not Covered	Not Covered	Not Covered
ADMINISTRATIVE OPTIONS			
BlueCard/National Coverage Program	(Default) In-network and Out of network PPO network		
Extended Payment Integrity Services	Included		
Fiduciary Services	Excluded		

*This plan is self-funded by Aegis Senior Communities, LLC, which means that this group is financially responsible for the payment of plan benefits. The group has contracted with Premera Blue Cross, an independent Licensee of the Blue Cross Blue Shield Association, to perform administrative duties, including the processing of claims, under the plan. Premera Blue Cross does not insure the benefits of this plan.

Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

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 summary 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.

Benefit Summary Report

Group Number: 1007261

Aegis Senior Communities, LLC

Effective Date: 04/01/2024

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage Prime In-Network	Out-of-Network
Plan Name: CORE PLAN - HERITAGE PRIME $2750 30%/50% $5500 $20; ER $250*			
MEDICAL COST SHARE OPTIONS			
Individual Deductible PCY	Family embedded deductible 3X Individual	$2,750 PCY	Shared with In-Network
Fourth Quarter Deductible Carryover	Excluded		
Coinsurance (Member's percentage of costs after deductible based on allowable charges)		30%	50%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable	Family embedded OOP max 2X Individual	$5,500 PCY	Unlimited
Office Visit Cost Share		$20 Copay, applies to the $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Kinwell Connect Cost Share Waiver	Included	All services rendered and billed by any Kinwell clinic are covered in full (waive deductible, 0%)	Not Applicable
Annual Plan Maximum		Unlimited	Unlimited
Health coverage meets the minimum value standard for benefits provided	Self Funded - No calculation		
FACILITY CARE			
Inpatient Facility		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Inpatient Professional Services		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage Prime In-Network	Out-of-Network
Plan Name: CORE PLAN - HERITAGE PRIME $2750 30%/50% $5500 $20; ER $250*			
Outpatient Surgery Facility		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Facility		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network 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	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network 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	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network 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	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Home Health Care	130 visits PCY	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
MATERNITY & REPRODUCTIVE CARE			
Inpatient Facility - Maternity	Coverage for subscriber, spouse, dependent	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Maternity Prenatal, Delivery and Postnatal Care	Coverage for subscriber, spouse, dependent	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Obstetrical Care for Dependent Daughters	Yes		
Contraceptive Management	Unlimited	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Sterilization - Female	Unlimited	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage Prime In-Network	Out-of-Network
Plan Name: CORE PLAN - HERITAGE PRIME $2750 30%/50% $5500 $20; ER $250*			
Sterilization - Male	Unlimited	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Infertility/Assisted Reproductive Services	Not Covered	Not Covered	Not Covered
Elective Termination of Pregnancy		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Therapeutic Termination of Pregnancy		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
PREMERA DESIGNATED CENTERS OF EXCELLENCE			
Centers of Excellence for Knee & Hip Total Joint Replacement (Including Partial & Revisions)	Included	Covered as any other service	Covered as any other service
Centers of Excellence for Maternity	Included	Covered as any other service	Covered as any other service
MEDICAL TRANSPORTATION BENEFITS			
Centers of Excellence Travel and Care Coordination	Not Covered	Not Covered	Not Covered
Cellular Immunotherapy and Gene Therapy Travel	Not Covered	Not Covered	Not Covered
Transplant Travel & Lodging	$7,500 per transplant	$2,750 PCY Deductible, 0% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	$2,750 PCY Deductible, 0% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum
Medical Transportation - State Restricted Care	Not Covered	Not Covered	Not Covered
EMERGENCY CARE AND TRANSPORTATION			
Emergency Care (Waive copay if admitted to inpatient facility)		$250 Copay then $2,750 PCY Deductible and 30% Coinsurance; all cost shares apply to the $5,500 PCY Out of Pocket Maximum	$250 Copay then $2,750 PCY Deductible and 30% Coinsurance; all cost shares apply to the $5,500 PCY Out of Pocket Maximum
Emergency Room Physician		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage Prime In-Network	Out-of-Network
Plan Name: CORE PLAN - HERITAGE PRIME $2750 30%/50% $5500 $20; ER $250*			
Urgent Care Center		$35 Copay	Ded/Coins
Ambulance Transportation	Unlimited	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum
Air Ambulance	Unlimited	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum
DIAGNOSTIC SERVICES			
Preventive Professional Diagnostic Imaging and Laboratory Services - Including PAP/PSA		Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Professional Diagnostic Major Imaging		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Imaging		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Laboratory/Pathology		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Preventive Mammography		Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Diagnostic Mammography		Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Supplemental Breast Exam		Covered in Full	Covered as any other service
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION			
Preventive Office Visit	Unlimited	Covered in Full	Not Covered
Immunizations	Unlimited	Covered in Full	Not Covered
Seasonal Immunization provided at a mass immunizer location	Unlimited	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

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage Prime In-Network	Out-of-Network
Plan Name: CORE PLAN - HERITAGE PRIME $2750 30%/50% $5500 $20; ER $250*			
Diabetes Health Education (DE)	Unlimited	Covered in Full	Not Covered
Preventive Colon Health	Unlimited; no internal frequency limit	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Nutritional Therapy (Diabetes)	Unlimited	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Nutritional Therapy (Non-Diabetes)	Unlimited	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
CHRONIC CONDITION MANAGEMENT PROGRAMS			
Diabetes Prevention Program	Included		
Diabetes Management	Included		
Hypertension Management	Included		
Weight Management	Excluded		
PROFESSIONAL CARE			
Professional Office Visit		$20 Copay, applies to the $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Telemedicine with Traditional Providers - General Medical		$20 Copay, applies to the $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Naturopathy Services		$20 Copay, applies to the $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
VIRTUAL CARE SERVICES			
Telemedicine - General Medical (Virtual Care Only)		$20 Copay, applies to the $5,500 PCY 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 - Mental Health for Children (Virtual Care Only)		Not Covered	Not Covered

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage Prime In-Network	Out-of-Network
Plan Name: CORE PLAN - HERITAGE PRIME $2750 30%/50% $5500 $20; ER $250*			
Telemedicine - Chemical Dependency (Virtual Care Only)		Subject to Chemical Dependency Outpatient Office Visit	Not Covered
Telemedicine - Outpatient Rehab (Virtual Care Only)	Shared with Rehab Outpatient Care	Subject to Rehab Outpatient Care In-Network Cost Share	Not Covered
ALTERNATIVE CARE			
Acupuncture	12 visits PCY	$20 Copay, applies to the $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Manipulations (Spinal and Other)	12 visits PCY	$20 Copay, applies to the $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Therapeutic Massage Therapy	Not Covered	Not Covered	Not Covered
CHEMICAL DEPENDENCY & MENTAL HEALTH			
Chemical Dependency Inpatient Facility Care	Unlimited	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Outpatient Facility Care	Unlimited	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Outpatient Professional Care	Unlimited	$20 Copay, applies to the $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Inpatient Facility Care	Unlimited	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Facility Care	Unlimited	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Professional Care	Unlimited	$20 Copay, applies to the $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Residential Care		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
REHABILITATION & NEURO			

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage Prime In-Network	Out-of-Network
Plan Name: CORE PLAN - HERITAGE PRIME $2750 30%/50% $5500 $20; ER $250*			
Psychological & Neuropsychological Testing & Evaluation (Shared with Rehab, Neuro Dev & Mental Health)	Unlimited	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Inpatient Facility	30 days PCY	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network 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	$20 Copay, applies to the $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer		$20 Copay, applies to the $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
OTHER SERVICES			
Allergy/Therapeutic Injections		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Medical Supplies (MS), Equipment (ME), Prosthetics (Pro)	Unlimited	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Foot Orthotics, Orthopedic Shoes and Accessories	$300 PCY; Includes orthotics and orthopedic shoes	$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Transplants	Unlimited	Covered as any other service	Not Covered
Orthognathic/Maxillofacial Care	Not Covered	Not Covered	Not Covered
TMJ (Temporomandibular Joint Disorders)	Unlimited (Medical and Dental services - Medical and Dental cost shares based on type of service)	Covered as any other service	Covered as any other service
End Stage Renal Disease (ESRD) During Medicare's Waiting Period		$2,750 PCY Deductible, then 30% Coinsurance, applies to $5,500 PCY Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
End Stage Renal Disease (ESRD) After Medicare's Waiting Period	Without Premium Reimbursement	Covered in Full	Covered in Full
Bariatric Surgery	Not Covered	Not Covered	Not Covered
SUPPLEMENTAL BENEFITS			

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage Prime In-Network	Out-of-Network
Plan Name: CORE PLAN - HERITAGE PRIME $2750 30%/50% $5500 $20; ER $250*			
Routine Vision Exam	Not Covered	Not Covered	Not Covered
Vision Hardware	Not Covered	Not Covered	Not Covered
Pediatric Vision Exam	Not Covered	Not Covered	Not Covered
Pediatric Vision Hardware	Not Covered	Not Covered	Not Covered
Routine Hearing Exam	1 PCY	$20 Copay	Shared with In-Network Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Hearing Hardware	Not Covered	Not Covered	Not Covered
ADMINISTRATIVE OPTIONS			
BlueCard/National Coverage Program	(Default) In-network and Out of network PPO network		
Extended Payment Integrity Services	Included		
Fiduciary Services	Excluded		

*This plan is self-funded by Aegis Senior Communities, LLC, which means that this group is financially responsible for the payment of plan benefits. The group has contracted with Premera Blue Cross, an independent Licensee of the Blue Cross Blue Shield Association, to perform administrative duties, including the processing of claims, under the plan. Premera Blue Cross does not insure the benefits of this plan.

Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

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 summary 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.

Benefit Summary Report

Group Number: 1007261

Aegis Senior Communities, LLC

Effective Date: 04/01/2024

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage Prime In-Network	Out-of-Network
Plan Name: BUY UP PLAN - HERITAGE PRIME - $1250 20%/40% $4500 $20; ER $250*			
MEDICAL COST SHARE OPTIONS			
Individual Deductible PCY	Family embedded deductible 3X Individual	$1,250	Shared with In-Network
Fourth Quarter Deductible Carryover	Excluded		
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	$4,500	Unlimited
Office Visit Cost Share		$20 Copay, applies to the $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Kinwell Connect Cost Share Waiver	Included	All services rendered and billed by any Kinwell clinic are covered in full (waive deductible, 0%)	Not Applicable
Annual Plan Maximum		Unlimited	Unlimited
Health coverage meets the minimum value standard for benefits provided	Self Funded - No calculation		
FACILITY CARE			
Inpatient Facility		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Inpatient Professional Services		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage Prime In-Network	Out-of-Network
Plan Name: BUY UP PLAN - HERITAGE PRIME - $1250 20%/40% $4500 $20; ER $250*			
Outpatient Surgery Facility		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Facility		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network 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	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network 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	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network 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	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Home Health Care	130 visits PCY	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
MATERNITY & REPRODUCTIVE CARE			
Inpatient Facility - Maternity	Coverage for subscriber, spouse, dependent	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Maternity Prenatal, Delivery and Postnatal Care	Coverage for subscriber, spouse, dependent	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Obstetrical Care for Dependent Daughters	Yes		
Contraceptive Management	Unlimited	Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Sterilization - Female	Unlimited	Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage Prime In-Network	Out-of-Network
Plan Name: BUY UP PLAN - HERITAGE PRIME - $1250 20%/40% $4500 $20; ER $250*			
Sterilization - Male	Unlimited	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Infertility/Assisted Reproductive Services	Not Covered	Not Covered	Not Covered
Elective Termination of Pregnancy		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Therapeutic Termination of Pregnancy		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
PREMERA DESIGNATED CENTERS OF EXCELLENCE			
Centers of Excellence for Knee & Hip Total Joint Replacement (Including Partial & Revisions)	Included	Covered as any other service	Covered as any other service
Centers of Excellence for Maternity	Included	Covered as any other service	Covered as any other service
MEDICAL TRANSPORTATION BENEFITS			
Centers of Excellence Travel and Care Coordination	Not Covered	Not Covered	Not Covered
Cellular Immunotherapy and Gene Therapy Travel	Not Covered	Not Covered	Not Covered
Transplant Travel & Lodging	$7,500 per transplant	$1,250 Deductible, 0% Coinsurance, applies to $4,500 Out of Pocket Maximum	$1,250 Deductible, 0% Coinsurance, applies to $4,500 Out of Pocket Maximum
Medical Transportation - State Restricted Care	Not Covered	Not Covered	Not Covered
EMERGENCY CARE AND TRANSPORTATION			
Emergency Care (Waive copay if admitted to inpatient facility)		$250 Copay then $1,250 Deductible and 20% Coinsurance; all cost shares apply to the $4,500 Out of Pocket Maximum	$250 Copay then $1,250 Deductible and 20% Coinsurance; all cost shares apply to the $4,500 Out of Pocket Maximum
Emergency Room Physician		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage Prime In-Network	Out-of-Network
Plan Name: BUY UP PLAN - HERITAGE PRIME - $1250 20%/40% $4500 $20; ER $250*			
Urgent Care Center		$30 Copay	Ded/Coins
Ambulance Transportation	Unlimited	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum
Air Ambulance	Unlimited	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum
DIAGNOSTIC SERVICES			
Preventive Professional Diagnostic Imaging and Laboratory Services - Including PAP/PSA		Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Professional Diagnostic Major Imaging		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Imaging		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Laboratory/Pathology		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Preventive Mammography		Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Diagnostic Mammography		Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Supplemental Breast Exam		Covered in Full	Covered as any other service
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION			
Preventive Office Visit	Unlimited	Covered in Full	Not Covered
Immunizations	Unlimited	Covered in Full	Not Covered
Seasonal Immunization provided at a mass immunizer location	Unlimited	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

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage Prime In-Network	Out-of-Network
Plan Name: BUY UP PLAN - HERITAGE PRIME - $1250 20%/40% $4500 $20; ER $250*			
Diabetes Health Education (DE)	Unlimited	Covered in Full	Not Covered
Preventive Colon Health	Unlimited; no internal frequency limit	Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Nutritional Therapy (Diabetes)	Unlimited	Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Nutritional Therapy (Non-Diabetes)	Unlimited	Covered in Full	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
CHRONIC CONDITION MANAGEMENT PROGRAMS			
Diabetes Prevention Program	Included		
Diabetes Management	Included		
Hypertension Management	Included		
Weight Management	Excluded		
PROFESSIONAL CARE			
Professional Office Visit		$20 Copay, applies to the $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Telemedicine with Traditional Providers - General Medical		$20 Copay, applies to the $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Naturopathy Services		$20 Copay, applies to the $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
VIRTUAL CARE SERVICES			
Telemedicine - General Medical (Virtual Care Only)		$20 Copay, applies to the $4,500 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
Telemedicine - Mental Health for Children (Virtual Care Only)		Not Covered	Not Covered

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage Prime In-Network	Out-of-Network
Plan Name: BUY UP PLAN - HERITAGE PRIME - $1250 20%/40% $4500 $20; ER $250*			
Telemedicine - Chemical Dependency (Virtual Care Only)		Subject to Chemical Dependency Outpatient Office Visit	Not Covered
Telemedicine - Outpatient Rehab (Virtual Care Only)	Shared with Rehab Outpatient Care	Subject to Rehab Outpatient Care In-Network Cost Share	Not Covered
ALTERNATIVE CARE			
Acupuncture	12 visits PCY	$20 Copay, applies to the $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Manipulations (Spinal and Other)	12 visits PCY	$20 Copay, applies to the $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Therapeutic Massage Therapy	Not Covered	Not Covered	Not Covered
CHEMICAL DEPENDENCY & MENTAL HEALTH			
Chemical Dependency Inpatient Facility Care	Unlimited	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Outpatient Facility Care	Unlimited	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Outpatient Professional Care	Unlimited	$20 Copay, applies to the $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Inpatient Facility Care	Unlimited	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Facility Care	Unlimited	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Professional Care	Unlimited	$20 Copay, applies to the $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Residential Care		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
REHABILITATION & NEURO			

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage Prime In-Network	Out-of-Network
Plan Name: BUY UP PLAN - HERITAGE PRIME - $1250 20%/40% $4500 $20; ER $250*			
Psychological & Neuropsychological Testing & Evaluation (Shared with Rehab, Neuro Dev & Mental Health)	Unlimited	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Inpatient Facility	30 days PCY	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain	45 visits PCY	$20 Copay, applies to the $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer		$20 Copay, applies to the $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
OTHER SERVICES			
Allergy/Therapeutic Injections		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Medical Supplies (MS), Equipment (ME), Prosthetics (Pro)	Unlimited	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Foot Orthotics, Orthopedic Shoes and Accessories	$300 PCY; Includes orthotics and orthopedic shoes	$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Transplants	Unlimited	Covered as any other service	Not Covered
Orthognathic/Maxillofacial Care	Not Covered	Not Covered	Not Covered
TMJ (Temporomandibular Joint Disorders)	Unlimited (Medical and Dental services - Medical and Dental cost shares based on type of service)	Covered as any other service	Covered as any other service
End Stage Renal Disease (ESRD) During Medicare's Waiting Period		$1,250 Deductible, then 20% Coinsurance, applies to $4,500 Out of Pocket Maximum	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
End Stage Renal Disease (ESRD) After Medicare's Waiting Period	Without Premium Reimbursement	Covered in Full	Covered in Full
Bariatric Surgery	Not Covered	Not Covered	Not Covered
SUPPLEMENTAL BENEFITS			

Product Name: Your Choice NGF - Large Group - 1/2024	Specification and Benefit Limits	Heritage Prime In-Network	Out-of-Network
Plan Name: BUY UP PLAN - HERITAGE PRIME - $1250 20%/40% $4500 $20; ER $250*			
Routine Vision Exam	Not Covered	Not Covered	Not Covered
Vision Hardware	Not Covered	Not Covered	Not Covered
Pediatric Vision Exam	Not Covered	Not Covered	Not Covered
Pediatric Vision Hardware	Not Covered	Not Covered	Not Covered
Routine Hearing Exam	1 PCY	$20 Copay	Shared with In-Network Deductible, then 40% Coinsurance, applies to Unlimited Out of Pocket Maximum
Hearing Hardware	Not Covered	Not Covered	Not Covered
ADMINISTRATIVE OPTIONS			
BlueCard/National Coverage Program	(Default) In-network and Out of network PPO network		
Extended Payment Integrity Services	Included		
Fiduciary Services	Excluded		

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Benefit Summary Report

Group Number: 1007261

Aegis Senior Communities, LLC

Effective Date: 04/01/2024

Product Name: Essentials Pharmacy WA NGF - Large Group - 1/2024	Specification and Benefit Limits	In-Network	Out-Of-Network
Plan Name: RX ESSENTIALS - CORE - RETAIL $15/$30/$50/30% MAIL $37.50/$75/$50/30%*			
Prescription Drug General Information			
Drug List	E4 Essentials Formulary Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = preferred specialty Tier 4 = non-preferred all drugs	E4 Essentials Formulary	E4 Essentials Formulary
Formulary Exclusion List - Drugs with Over the Counter Alternative	Excluded		
Formulary Exclusion List - High-Cost Low Value Drugs	Excluded		
Generics required when available	Member pays the difference when they request a brand name drug (regardless of medical necessity)		
Annual Benefit Maximum	Unlimited		
Pharmacy Deductibles and Out of Pocket Maximums			
Individual Deductible PCY	$0		
Family Deductible PCY	No Family Deductible		
Out of Pocket Max	Applies to the medical out of pocket maximum	Applies to the medical out of pocket maximum	Not Applicable
Preventive Pharmacy			
ACA Preventive Drug List		Covered in Full	Cost Share, then 40% (to allowable)
Enhanced Preventive Drug List	PV Lite (Buy-Up)	Covered in Full	Cost Share, then 40% (to allowable)
Retail Cost Share			
Retail Cost Shares	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days	$15/$30/$50/30%	Cost Share, then 40% (to allowable)
Oral Chemotherapy Retail		Covered in Full	Covered in Full
Mail Order Cost Share			

Product Name: Essentials Pharmacy WA NGF - Large Group - 1/2024	Specification and Benefit Limits	In-Network	Out-Of-Network
Plan Name: RX ESSENTIALS - CORE - RETAIL $15/$30/$50/30% MAIL $37.50/$75/$50/30%*			
Mail Cost Shares	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days	$37.50/$75/$50/30%	Not Covered
Oral Chemotherapy Mail		Covered in Full	Covered in Full
Mandatory Home Delivery for Maintenance Drugs	Excluded		
Pharmacy Other			
Specialty Pharmacy	Mandatory - Exclusive		
SaveOn Specialty Pharmacy	Included		
Out of Pocket Protection Program	Excluded		
Specialty Split Fill	Included		
Right Price	Included		
Infertility Drugs	Not Covered	Not Covered	Not Covered
Weight Loss Drugs	Not Covered	Not Covered	Not Covered

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Group Number: 1007261

Aegis Senior Communities, LLC

Effective Date: 04/01/2024

Product Name: Essentials Pharmacy WA NGF - Large Group - 1/2024	Specification and Benefit Limits	In-Network	Out-Of-Network
Plan Name: RX ESSENTIALS - BUY UP - RETAIL $15/$30/$50/30% MAIL $37.50/$75/$50/30%*			
Prescription Drug General Information			
Drug List	E4 Essentials Formulary Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = preferred specialty Tier 4 = non-preferred all drugs	E4 Essentials Formulary	E4 Essentials Formulary
Formulary Exclusion List - Drugs with Over the Counter Alternative	Excluded		
Formulary Exclusion List - High-Cost Low Value Drugs	Excluded		
Generics required when available	Member pays the difference when they request a brand name drug (regardless of medical necessity)		
Annual Benefit Maximum	Unlimited		
Pharmacy Deductibles and Out of Pocket Maximums			
Individual Deductible PCY	$0		
Family Deductible PCY	No Family Deductible		
Out of Pocket Max	Applies to the medical out of pocket maximum	Applies to the medical out of pocket maximum	Not Applicable
Preventive Pharmacy			
ACA Preventive Drug List		Covered in Full	Cost Share, then 40% (to allowable)
Enhanced Preventive Drug List	PV Lite (Buy-Up)	Covered in Full	Cost Share, then 40% (to allowable)
Retail Cost Share			
Retail Cost Shares	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days	$15/$30/$50/30%	Cost Share, then 40% (to allowable)
Oral Chemotherapy Retail		Covered in Full	Covered in Full
Mail Order Cost Share			

Product Name: Essentials Pharmacy WA NGF - Large Group - 1/2024	Specification and Benefit Limits	In-Network	Out-Of-Network
Plan Name: RX ESSENTIALS - BUY UP - RETAIL $15/$30/$50/30% MAIL $37.50/$75/$50/30%*			
Mail Cost Shares	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days	$37.50/$75/$50/30%	Not Covered
Oral Chemotherapy Mail		Covered in Full	Covered in Full
Mandatory Home Delivery for Maintenance Drugs	Excluded		
Pharmacy Other			
Specialty Pharmacy	Mandatory - Exclusive		
SaveOn Specialty Pharmacy	Included		
Out of Pocket Protection Program	Excluded		
Specialty Split Fill	Included		
Right Price	Included		
Infertility Drugs	Not Covered	Not Covered	Not Covered
Weight Loss Drugs	Not Covered	Not Covered	Not Covered

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Plan Name: RX ESSENTIALS - CORE PRIME RETAIL $15/$30/$50/30% MAIL $37.50/$75/$50/30%*			
Prescription Drug General Information			
Drug List	E4 Essentials Formulary Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = preferred specialty Tier 4 = non-preferred all drugs	E4 Essentials Formulary	E4 Essentials Formulary
Formulary Exclusion List - Drugs with Over the Counter Alternative	Excluded		
Formulary Exclusion List - High-Cost Low Value Drugs	Excluded		
Generics required when available	Member pays the difference when they request a brand name drug (regardless of medical necessity)		
Annual Benefit Maximum	Unlimited		
Pharmacy Deductibles and Out of Pocket Maximums			
Individual Deductible PCY	$0		
Family Deductible PCY	No Family Deductible		
Out of Pocket Max	Applies to the medical out of pocket maximum	Applies to the medical out of pocket maximum	Not Applicable
Preventive Pharmacy			
ACA Preventive Drug List		Covered in Full	Cost Share, then 40% (to allowable)
Enhanced Preventive Drug List	PV Lite (Buy-Up)	Covered in Full	Cost Share, then 40% (to allowable)
Retail Cost Share			
Retail Cost Shares	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days	$15/$30/$50/30%	Cost Share, then 40% (to allowable)
Oral Chemotherapy Retail		Covered in Full	Covered in Full
Mail Order Cost Share			

Product Name: Essentials Pharmacy WA NGF - Large Group - 1/2024	Specification and Benefit Limits	In-Network	Out-Of-Network
Plan Name: RX ESSENTIALS - CORE PRIME RETAIL $15/$30/$50/30% MAIL $37.50/$75/$50/30%*			
Mail Cost Shares	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days	$37.50/$75/$50/30%	Not Covered
Oral Chemotherapy Mail		Covered in Full	Covered in Full
Mandatory Home Delivery for Maintenance Drugs	Excluded		
Pharmacy Other			
Specialty Pharmacy	Mandatory - Exclusive		
SaveOn Specialty Pharmacy	Included		
Out of Pocket Protection Program	Excluded		
Specialty Split Fill	Included		
Right Price	Included		
Infertility Drugs	Not Covered	Not Covered	Not Covered
Weight Loss Drugs	Not Covered	Not Covered	Not Covered

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Aegis Senior Communities, LLC

Effective Date: 04/01/2024

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Formulary Exclusion List - Drugs with Over the Counter Alternative	Excluded		
Formulary Exclusion List - High-Cost Low Value Drugs	Excluded		
Generics required when available	Member pays the difference when they request a brand name drug (regardless of medical necessity)		
Annual Benefit Maximum	Unlimited		
Pharmacy Deductibles and Out of Pocket Maximums			
Individual Deductible PCY	$0		
Family Deductible PCY	No Family Deductible		
Out of Pocket Max	Applies to the medical out of pocket maximum	Applies to the medical out of pocket maximum	Not Applicable
Preventive Pharmacy			
ACA Preventive Drug List		Covered in Full	Cost Share, then 40% (to allowable)
Enhanced Preventive Drug List	PV Lite (Buy-Up)	Covered in Full	Cost Share, then 40% (to allowable)
Retail Cost Share			
Retail Cost Shares	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days	$15/$30/$50/30%	Cost Share, then 40% (to allowable)
Oral Chemotherapy Retail		Covered in Full	Covered in Full
Mail Order Cost Share			

Product Name: Essentials Pharmacy WA NGF - Large Group - 1/2024	Specification and Benefit Limits	In-Network	Out-Of-Network
Plan Name: RX ESSENTIALS - BUY UP PRIME RETAIL $15/$30/$50/30% MAIL $37.50/$75/$50/30%*			
Mail Cost Shares	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days	$37.50/$75/$50/30%	Not Covered
Oral Chemotherapy Mail		Covered in Full	Covered in Full
Mandatory Home Delivery for Maintenance Drugs	Excluded		
Pharmacy Other			
Specialty Pharmacy	Mandatory - Exclusive		
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Infertility Drugs	Not Covered	Not Covered	Not Covered
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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, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities 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 services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the 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, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the 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.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-722-1471（TTY：711）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.
Телефонуйте за номером 800-722-1471 (телетайп: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800-722-1471 (TTY: 711)។

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471（TTY:711）まで、お電話にてご連絡ください。

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፡ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-722-1471 (መስማት ለተሳናቸው: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-722-1471 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-722-1471 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS : 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-722-1471 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.

037378 (07-01-2021)