Highlights of your Healthcare Coverage: Basic

Effective Date: 11/01/2017

PREMERA EDUCATION PROGRAM

Plan enhancements:

- Temporomandibular joint (TMJ) disorders are covered in medical benefits like any other service.

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.
Medical Benefits apply after the calendar-year deductible is met unless otherwise noted, or if the cost share is a copay.

MEDICAL PLAN	BASIC: $2,100/30%/$6,600/$35 - HERITAGE	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible Per Calendar Year (PCY) (Family embedded deductible 2X Individual)	$2,100 PCY	$2,500 PCY
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	30%	50%
Individual Out-of-Pocket Maximum (OOP) PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$6,600 PCY	Not applicable
Office Visit Cost Share	Non-Specialist: $35 copay, applies to OOP max; Specialist: $50 copay, applies to OOP max	Out-of-network deductible, then 50%
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited)	Covered in full	Not covered
Vaccinations (Unlimited)	Covered in full	Not covered
Health Education (HE) (Unlimited)	Covered in full	Not covered
Nicotine Dependency Programs (ND) (Unlimited)	Covered in full	Out-of-network deductible, then 50%
Diabetes Health Education (DE) (Unlimited)	Covered in full	Out-of-network deductible, then 50%
PROFESSIONAL CARE		
Professional Office Visit	Non-Specialist: $35 copay, applies to OOP max; Specialist: $50 copay, applies to OOP max	Out-of-network deductible, then 50%
Maternity; Prenatal Care	Covered in full	Out-of-network deductible, then 50%
Inpatient Professional Services	In-network deductible, then 30%	Out-of-network deductible, then 50%
Contraceptive Management Services (Unlimited)	Covered in full	Out-of-network deductible, then 50%
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in full	Out-of-network deductible, then 50%
Other Professional Diagnostic Imaging	In-network deductible, then 30%	Out-of-network deductible, then 50%
Other Professional Diagnostic Laboratory/Pathology	In-network deductible, then 30%	Out-of-network deductible, then 50%
Diagnostic Mammography	In-network deductible, then 30%	Out-of-network deductible, then 50%
FACILITY CARE OPTIONS		
Inpatient Facility	In-network deductible, then 30%	Out-of-network deductible, then 50%
Outpatient Surgery Facility	In-network deductible, then 30%	Out-of-network deductible, then 50%
Hospice Inpatient Facility (10 days inpatient; within the 6 month lifetime maximum)	In-network deductible, then 30%	Out-of-network deductible, then 50%
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$200 copay applies to the OOP max, then in-network deductible, 30%	$200 copay applies to the OOP max, then in-network deductible, 30%
Emergency Room Physician	In-network deductible, then 30%	In-network deductible, then 30%
Urgent Care Center	Non-Specialist: $35 copay, applies to OOP max; Specialist: $50 copay, applies to OOP max	Out-of-network deductible, then 50%

	BASIC: $2,100/30%/$6,600/$35 - HERITAGE	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Ambulance Transportation (Unlimited)	In-network deductible, then 30%	In-network deductible then 30%
Air Ambulance (Unlimited)	In-network deductible, then 30%	In-network deductible then 30%
OTHER SERVICES		
Allergy/Therapeutic Injections	In-network deductible, then 30%	Out-of-network deductible, then 50%
Mental Health Inpatient Facility Care (Unlimited)	In-network deductible, then 30%	Out-of-network deductible, then 50%
Mental Health Outpatient Professional Care (Unlimited)	Non-Specialist: $35 copay, applies to OOP max	Out-of-network deductible, then 50%
Chemical Dependency Inpatient Facility Care (Unlimited)	In-network deductible, then 30%	Out-of-network deductible, then 50%
Chemical Dependency Outpatient Professional Care (Unlimited)	Non-Specialist: $35 copay, applies to OOP max	Out-of-network deductible, then 50%
Rehab Inpatient Facility (30 days PCY)	In-network deductible, then 30%	Out-of-network deductible, then 50%
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy (30 visits PCY)	Specialist: $50 copay, applies to OOP max	Out-of-network deductible, then 50%
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, Chronic Pain, and Cancer	Specialist: $50 copay, applies to OOP max	Out-of-network deductible, then 50%
Medical Supplies, Equipment, Prosthetics (Unlimited)	In-network deductible, then 30%	Out-of-network deductible, then 50%
Foot Orthotics, Orthopedic Shoes and Accessories (One pair max PCY (no $ limit) (Unlimited Diabetes Related))	In-network deductible, then 30%	Out-of-network deductible, then 50%
Home Health Visits (130 visits PCY)	In-network deductible, then 30%	Out-of-network deductible, then 50%
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	In-network deductible, then 30%	Out-of-network deductible, then 50%
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
ALTERNATIVE CARE		
Manipulations (Spinal and other) (12 visits PCY)	$35 copay (applies to OOP max)	Out-of-network deductible, then 50%
Acupuncture (12 visits PCY)	$35 copay (applies to OOP max)	Out-of-network deductible, then 50%
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited
PRESCRIPTION DRUGS		
Drug List	B4	Not covered
Retail Cost Shares	$15/$30/$50/30%	Not covered
Mail Cost Shares	$30/$60/$100/30%	Not covered
Day Supply	Retail: 30 Days; Mail Order: 90 Days; Specialty: 30 Days	Not covered
Individual Deductible PCY	$750 PCY	Not covered
Family Deductible PCY	Family Deductible 2X Individual	Not covered
Out of Pocket Maximum	Applies to the medical out of pocket maximum	Not covered
Specialty Pharmacy Out of Pocket Maximum	Applies to the medical out of pocket maximum	Not covered
SYMETRA LIFE AND AD&D INSURANCE	$25,000 Term Life and AD&D for employee only	

Copays are not subject to the deductible unless otherwise noted.
Pre-approval is required for many services to be covered. For more information please refer to your benefit booklet.
PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross. Members are responsible for amounts in excess of the allowable charge.
This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms under which the program may be continued in force. This benefit highlights is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.