PREMERA | BLUE CROSS

# Highlights of your Health Care Coverage

## 2016 PPO 80% PLAN 1500

**HERITAGE PRIME NETWORK**

**Effective Date: 10/01/2016**

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 | 2016 PPO 80% PLAN 1500 | |
|---|---|---|
| | HERITAGE IN-NETWORK | HERITAGE OUT-OF-NETWORK |
| **MEDICAL COST SHARE OPTIONS** | | |
| **Individual Deductible PCY** (Family embedded deductible 2X Individual) | $1,500 PCY | Shared with In-Network |
| **Coinsurance (Member's percentage of costs after deductible based on allowable charges)** | 20% | 50% |
| **Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable** (Family embedded OOP max 2X Individual) | $5,000 PCY | Shared with In-Network |
| **Office Visit Cost Share** | $30 Copay, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% |
| **PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION** | | |
| **Preventive Office Visit** (Unlimited) | Covered In Full | Out of Network Deductible, then 50% |
| **Immunizations** (Unlimited) | Covered In Full | Dep Child to Age 18 Covered in Full; Members Over 18 Out of Network Deductible, then 50% |
| **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 Including Urgent Care** | $30 Copay, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% |
| **Inpatient Professional Services** | In Network Deductible, then 20% | 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 | First $500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance |
| **Other Professional Diagnostic Imaging** | First $500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance | First $500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance |
| **Other Professional Diagnostic Laboratory/Pathology** | First $500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance | First $500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance |
| **Diagnostic Mammography** | First $500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance | First $500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance |
| **FACILITY CARE OPTIONS** | | |
| **Inpatient Facility** | In Network Deductible, then 20% | Out of Network Deductible, then 50% |
| **Outpatient Surgery Facility** | In Network Deductible, then 20% | Out of Network Deductible, then 50% |
| **Hospice Inpatient Facility** (30 days Inpatient; within the 6 month lifetime maximum) | In Network Deductible, then 20% | Out of Network Deductible, then 50% |
| **EMERGENCY CARE AND TRANSPORTATION OPTIONS** | | |
| **Emergency Care (If applicable, waive copay if admitted to inpatient facility)** | $200 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% | $200 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20% |
| **Emergency Room Physician** | In Network Deductible, then 20% | In Network Deductible, then 20% |
| **Ambulance Transportation** (Unlimited) | In Network Deductible, then 20% | In Network Deductible, then 20% |
| **Air Ambulance** (Unlimited) | In Network Deductible, then 20% | In Network Deductible, then 20% |

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| MEDICAL PLAN | 2016 PPO 80% PLAN 1500 | |
|---|---|---|
| | HERITAGE IN-NETWORK | HERITAGE OUT-OF-NETWORK |
| **OTHER SERVICES** | | |
| **Allergy/Therapeutic Injections** | In Network Deductible, then 20% | Out of Network Deductible, then 50% |
| **Mental Health Inpatient Facility Care** (Unlimited) | In Network Deductible, then 20% | Out of Network Deductible, then 50% |
| **Mental Health Outpatient Professional Care** (Unlimited) | $30 Copay, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% |
| **Chemical Dependency Inpatient Facility Care** (Unlimited) | In Network Deductible, then 20% | Out of Network Deductible, then 50% |
| **Chemical Dependency Outpatient Professional Care** (Unlimited) | $30 Copay, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% |
| **Rehab Inpatient Facility** (30 Days PCY) | In Network Deductible, then 20% | Out of Network Deductible, then 50% |
| **Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy** (25 Visits PCY) | $30 Copay, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% |
| **Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, Chronic Pain and Cancer** | $30 Copay, applies to the Out of Pocket Maximum | Out of Network Deductible, then 50% |
| **Medical Supplies, Equipment, Prosthetics** (MS: Unlimited; ME: Unlimited; Pro:Unlimited) | In Network Deductible, then 20% | Out of Network Deductible, then 50% |
| **Foot Orthotics, Orthopedic Shoes and Accessories** (Unlimited) | In Network Deductible, then 20% | Out of Network Deductible, then 50% |
| **Home Health Visits** (130 visits PCY) | In Network Deductible, then 20% | 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 20% | 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 |
| **Transplants** (Unlimited; $7,500 travel and lodging limits) | Covered as any other service | Not Covered |
| **ALTERNATIVE CARE** | | |
| **Manipulations (Spinal and other)** (12 visits PCY) | In Network Deductible, then 20% | Out of Network Deductible, then 50% |
| **Acupuncture** (12 visits PCY) | In Network Deductible, then 20% | Out of Network Deductible, then 50% |
| **ANNUAL PLAN MAXIMUM** | | |
| **Annual Plan Maximum** | Unlimited | Unlimited |

Copays are not subject to the deductible unless otherwise noted.
Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross. Members are responsible for amounts in excess of the allowable charge.

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

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**HERITAGE PRIME NETWORK**

## Pharmacy Benefits

Tier 1 = Generic
Tier 2 = Preferred Brand Name
Tier 3 = Non Preferred Brand Name

Below is a brief overview of what you can expect to pay for a prescription drug, depending on which "tier" category it falls under in the Preferred Drug List for your plan when using an In-Network Pharmacy. For more information on your pharmacy benefits, including Out-of-Network benefits, see your benefit booklet. To find out what tier applies to a specific medication, see our Preferred Drug List at www.premera.com.

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**Effective Date: 10/01/2016**

| **PHARMACY PLAN** | **2016 PPO 80% PLAN 1500 - RX** |
|---|---|
| | **Cost Share Category**<br>Tier1/Tier2/Tier3 |
| **PRESCRIPTION DRUGS** | |
| **Retail Cost Shares** | $10/$40/$70 |
| **Mail Cost Shares** | $30/$120/$210 |
| **Day Supply** | Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days |
| **Individual Deductible PCY** | $0 |
| **Out of Network (Non-participating retail pharmacies)** | Retail Pharmacy & Preventive Generic Drug List Same as INN; OON Mail Order Not Covered |
| **Out of Pocket Maximum** | Applies to the medical out of pocket maximum |
| **Annual Benefit Maximum** | Unlimited |
| **Drug List** | Preferred B3 |

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