

Highlights of your Health Care Coverage

2016 PPO 70% PLAN 3000

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 70% PLAN 3000 | |
|--|--|--|
| | HERITAGE IN-NETWORK | HERITAGE OUT-OF-NETWORK |
| MEDICAL COST SHARE OPTIONS | | |
| Individual Deductible PCY (Family embedded deductible 2X Individual) | \$3,000 PCY | Shared with In-Network |
| 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) | \$6,000 PCY | Shared with In-Network |
| Office Visit Cost Share | \$40 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 | \$40 Copay, applies to the Out Of Pocket Maximum | 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 | 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 30% | Out of Network Deductible, then 50% |
| Outpatient Surgery Facility | In Network Deductible, then 30% | Out of Network Deductible, then 50% |
| Hospice Inpatient Facility (30 days Inpatient; within the 6 month lifetime maximum) | In Network Deductible, then 30% | 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, 30% | \$200 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 30% |
| Emergency Room Physician | In Network Deductible, then 30% | In Network Deductible, then 30% |
| 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% |

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| MEDICAL PLAN | 2016 PPO 70% PLAN 3000 | |
|--|--|-------------------------------------|
| | HERITAGE IN-NETWORK | HERITAGE OUT-OF-NETWORK |
| 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) | \$40 Copay, applies to the Out Of Pocket Maximum | 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) | \$40 Copay, applies to the Out Of Pocket Maximum | 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 (25 Visits PCY) | \$40 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 | \$40 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 30% | Out of Network Deductible, then 50% |
| Foot Orthotics, Orthopedic Shoes and Accessories (Unlimited) | 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 |
| 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 30% | Out of Network Deductible, then 50% |
| Acupuncture (12 visits PCY) | In Network Deductible, then 30% | 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 highlight 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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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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| PHARMACY PLAN | 2016 PPO 70% PLAN 3000 - RX |
|---|--|
| | Cost Share Category Tier1/Tier2/Tier3 |
| PRESCRIPTION DRUGS | |
| Retail Cost Shares | \$10/\$50/\$80 |
| Mail Cost Shares | \$30/\$150/\$240 |
| 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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