

Effective Date: 01/01/2019

Highlights of your Health Care Coverage

CLEANTECH ALLIANCE WASHINGTON

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 DURABLE 6000 IN-NETWORK OUT-OF-NETWORK MEDICAL COST SHARE OPTIONS Individual Deductible PCY (Family embedded deductible 2X Individual) \$6,000 \$12,000 Coinsurance (Member's percentage of costs after deductible based on allowable 20% 50% charges) Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay \$7,350 Unlimited and pharmacy if applicable (Family embedded OOP max 2X Individual) \$40 Copay, applies to the \$7,350 Out of \$12,000 Deductible, then 50% Coinsurance. Office Visit Cost Share Pocket Maximum applies to Unlimited Out of Pocket Maximum PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION Preventive Office Visit (Unlimited, subject to standard medical guidelines) Covered In Full Not Covered Immunizations (Unlimited, subject to standard medical guidelines) Covered In Full Not Covered Health Education (HE) (Unlimited) Covered In Full Not Covered Nicotine Dependency Programs (ND) (Unlimited) Covered In Full Not Covered Diabetes Health Education (DE) (Unlimited) Covered In Full Not Covered PROFESSIONAL CARE \$40 Copay, applies to the \$7,350 Out of \$12,000 Deductible, then 50% Coinsurance, Professional Office Visit Pocket Maximum applies to Unlimited Out of Pocket Maximum \$6,000 Deductible, then 20% Coinsurance, \$12,000 Deductible, then 50% Coinsurance, Inpatient Professional Services applies to \$7,350 Out of Pocket Maximum applies to Unlimited Out of Pocket Maximum \$12,000 Deductible, then 50% Coinsurance, Contraceptive Management Services (Unlimited) Covered In Full applies to Unlimited Out of Pocket Maximum

MEDICAL PLAN	DURABLE 6000	
	IN-NETWORK	OUT-OF-NETWORK
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	\$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Imaging	Waive Deductible, then 20% Coinsurance, applies to \$7,350 Out of Pocket Maximum	\$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Professional Diagnostic Major Imaging	Waive Deductible, then 20% Coinsurance, applies to \$7,350 Out of Pocket Maximum	\$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Laboratory/Pathology	Waive Deductible, then 20% Coinsurance, applies to \$7,350 Out of Pocket Maximum	\$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Diagnostic Mammography	Covered in Full	Out of Network Deductible, then 50%
FACILITY CARE OPTIONS		
Inpatient Facility	\$6,000 Deductible, then 20% Coinsurance, applies to \$7,350 Out of Pocket Maximum	\$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Surgery Facility	\$6,000 Deductible, then 20% Coinsurance, applies to \$7,350 Out of Pocket Maximum	\$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$6,000 Deductible, then 20% Coinsurance, applies to \$7,350 Out of Pocket Maximum	\$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	\$6,000 Deductible, then 20% Coinsurance, applies to \$7,350 Out of Pocket Maximum	\$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	\$250 Copay then \$6,000 Deductible and 20% Coinsurance; all cost shares apply to the \$7,350 Out of Pocket Maximum	\$250 Copay then \$6,000 Deductible and 20% Coinsurance; all cost shares apply to the \$7,350 Out of Pocket Maximum
Emergency Room Physician	\$6,000 Deductible, then 20% Coinsurance, applies to \$7,350 Out of Pocket Maximum	\$6,000 Deductible, then 20% Coinsurance, applies to \$7,350 Out of Pocket Maximum
Urgent Care Center	\$40 Copay, applies to the \$7,350 Out of Pocket Maximum	\$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Ambulance Transportation (Unlimited)	\$6,000 Deductible, then 20% Coinsurance, applies to \$7,350 Out of Pocket Maximum	\$6,000 Deductible, then 20% Coinsurance, applies to \$7,350 Out of Pocket Maximum
Air Ambulance (Unlimited)	\$6,000 Deductible, then 20% Coinsurance, applies to \$7,350 Out of Pocket Maximum	\$6,000 Deductible, then 20% Coinsurance, applies to \$7,350 Out of Pocket Maximum
OTHER SERVICES		
Allergy/Therapeutic Injections	\$6,000 Deductible, then 20% Coinsurance, applies to \$7,350 Out of Pocket Maximum	\$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	\$6,000 Deductible, then 20% Coinsurance, applies to \$7,350 Out of Pocket Maximum	\$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	\$40 Copay, applies to the \$7,350 Out of Pocket Maximum	\$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Inpatient Facility Care (Unlimited)	\$6,000 Deductible, then 20% Coinsurance, applies to \$7,350 Out of Pocket Maximum	\$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

MEDICAL PLAN	DURABLE 6000	
	IN-NETWORK	OUT-OF-NETWORK
Chemical Dependency Outpatient Professional Care (Unlimited)	\$40 Copay, applies to the \$7,350 Out of Pocket Maximum	\$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Inpatient Facility (30 days PCY)	\$6,000 Deductible, then 20% Coinsurance, applies to \$7,350 Out of Pocket Maximum	\$12,000 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)	\$40 Copay, applies to the \$7,350 Out of Pocket Maximum	\$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	\$40 Copay, applies to the \$7,350 Out of Pocket Maximum	\$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Medical Supplies, Equipment, Prosthetics (Unlimited)	\$6,000 Deductible, then 20% Coinsurance, applies to \$7,350 Out of Pocket Maximum	\$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Foot Orthotics, Orthopedic Shoes and Accessories (\$300 PCY; Includes orthotics and orthopedic shoes)	\$6,000 Deductible, then 20% Coinsurance, applies to \$7,350 Out of Pocket Maximum	\$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Home Health Visits (130 visits PCY)	\$6,000 Deductible, then 20% Coinsurance, applies to \$7,350 Out of Pocket Maximum	\$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	\$6,000 Deductible, then 20% Coinsurance, applies to \$7,350 Out of Pocket Maximum	\$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
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)	\$40 Copay, applies to the \$7,350 Out of Pocket Maximum	\$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Acupuncture (12 visits PCY)	\$40 Copay, applies to the \$7,350 Out of Pocket Maximum	\$12,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
SUPPLEMENTAL BENEFITS		
Routine Hearing Exam (1 PCY)	Exam \$40 Copay; Test: Covered In Full	\$12,000 Deductible, then 50% Coinsurance, applies to Out of Pocket Maximum
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited

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

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

This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms 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.

Highlights of your Health Care Coverage

CLEANTECH ALLIANCE WASHINGTON

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Below is a brief overview of your Pharmacy Benefits. For more information on your benefits, please refer to your benefit booklets. To find out what tiers apply to a specific medication, refer to our Preferred Drug List at www.premera.com

PHARMACY PLAN	DURABLE 6000 - RX - 10/50/100/50%	
PRESCRIPTION DRUGS	-	
Drug List	Preferred B4 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands Tier 4 = specialty	
Retail Cost Shares	\$10/\$50/\$100/50%	
Mail Cost Shares	\$20/\$100/\$200/50%	
Day Supply	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days	
Individual Deductible PCY	\$0	
Family Deductible PCY	No Family Deductible	
Out of Network (Non-participating retail pharmacies)	Cost Share, then 40% (to allowable)	
Out of Pocket Maximum	Applies to the medical out of pocket maximum	
Specialty Pharmacy Out of Pocket Maximum	Applies to the medical out of pocket maximum	
Annual Benefit Maximum	Unlimited	

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Discrimination is Against the Law

Premera Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

- Premera:
 Provides free aids and services to people with disabilities to communicate effectively with us, such as:

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, or sax, you can file a givenance with:
Chill Rights Coordinator - Complaints and Appeals
PO Bor \$110.2 Seatile, WA 8011
Tell rise 805-532-4535, Fax 405-918-5992, TTV 800-842-5357
Tell rise 805-532-4535, Fax 405-918-5992, TTV 800-842-5357

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 fee a civil rights compaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights, electronically through the Office for Civil Rights Compaint Protist, available at https://corportal.htms.pov/corportal.htms.p

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-722-1471 (TTY: 800-842-537).

(Arabic): الحربية يعربي هذا الإنجلس طعرات هامة في ليموني منا الإنسران معترفات مهمة بخصوص مثلث أو مناسبة التركية راحضون شهاد من Premara Blue Cross لذك تورز مناسبة التركيب مناسبة الإنساسية المساسلة في هنا الإنجلس وقال تعالى المناسبة أو المساسلة من التناسبة أو المساسلة من التناسبة الإنساسية المساسلة من التناسبة الإنساسية المساسلة المناسبة المناسبة المناسبة المناسبة المناسبة التناسبة المناسبة المناس

中文 (Chinese): - 本藝林有景學/加拿。 本黃知可尚有關於思清 Premira Blue Cross 提交的 申請或保險的重要訊息。 本黃知可可能有重求日期。 密可能需要在截止日期 之前採取付款。 以保留室的抽度依据或看用相談。 20 年舉代表以配約四 請得所承訊見配款。 與簡單區 800-722-4471 (TTV-00-042-5357)

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Lakkoofsa biibliaa 800-722-1471 (TTY: 800-842-5357) tii biibliaa.

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Qualified sign inapuage interpreters

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Kreyôl ayisyen (Creole):
Avi sila a gen Enfomasyon Enpôtan Iadann. Avi sila a kapab genyen erfomasyon enpôtan konsidena aplikasyon w lan oswa konsidena kouvěti asirans lan attava Premera Blue Cross. Kapab genyen dat ki enpôtan nan sila a. O. uka gen pou pra nek kid skyon avan setden dat limit pou ka kenbe kouvěti asirans sarte w la oswa pou ya ka dde w avikt depans yo. Se dwa w pou resewa erfomasyon a a ak asidaran ana lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 600-722-1471
(Trr. 500-442-542)

Detasche (Germann):
Detasche (Germann):
Diese Benachrichtigung enthält wichtige Informationen. Diese
Benachrichtigung enthält wirder Umständen wichtige Informationen
bedüglich hires Arträgs auf Krankenversichenungsschrätz durch Phremeta
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müssen, um Ihren Krankenversicherungsschutzt oder Hille mit den Kosten
zu behalten. Bie haben das Recht, kostenloss Hille und informationen in
ihrer Signache zu erhalten. Rufen Sie an unter 800-722-1471
(TTV: 800-442-5857).

Himobo (Himogo):
Tash nitawy tshuji xo no muaji cov ntshiab lus tseem ceeb. Tej zaum
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(TTY: 800-842-5357).

Boke (Bocano):
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Natiano (Italian):

Gesta sviso confese informazioni importasti. Questo avviso può contenere informazioni importanti sulla bua domanda o copertura attraverso Premer Blue Cross. Potrebbhero esserei ciatte chiave in questo avviso. Petrebbhe essere necessario un truo intervento entro una scadenza determinata per consentiti di martenere la trua copertura o sovvenzione. Hai il diritto di oftenere queste informazioni e assistienza nella tua ingua gratultamente. Chiama 800-722-1471 (TTY: 800-842-5357).

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Teplogo (Tagaligo):
Angi Pinawan na fin ay nagililaman ng mahalagang impormasyor panawan na fin ay nagililaman ng mahalagang impormasyor panawan na fin ay mangang nagililaman ng mahalagang rememban tangki ali aying asililangin nagalinin sa pamempalan ng Pinaman nagililangsa ta na mangangan ng Alakang i na lamin galining tangkin panahan ngung mapanakai nay teng papashan sa kalawang asililangin nagalining naganan nagalilangsa tan sa mangangsa ng Alakang i na lamin galining malawan sa mangalilangsa tan sa mangangsa ng Alakang i na lamin galining malawan sa mangalilangsa tan sa mangangsa ng kalawang sa kalawang sa sa mangalilangsa ng kalawang sa kalawang sa

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