

# Highlights of your Health Care Coverage

CLEANTECH ALLIANCE WASHINGTON

Effective Date: 01/01/2019

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.

<b>MEDICAL PLAN</b>		<b>HSA 5000</b>	
	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>MEDICAL COST SHARE OPTIONS</b>			
Individual Deductible PCY (Family aggregate deductible 2x Individual)	\$5,000 / \$6,550	\$5,000/\$10,000	
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)	\$6,550 / \$13,100	Unlimited	
Office Visit Cost Share	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION</b>			
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	
<b>PROFESSIONAL CARE</b>			
Professional Office Visit	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	

<b>MEDICAL PLAN</b>		<b>HSA 5000</b>	
	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
Inpatient Professional Services	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Contraceptive Management Services (Unlimited)	Covered In Full	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>DIAGNOSTIC SERVICE OPTIONS</b>			
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Other Professional Diagnostic Imaging	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Professional Diagnostic Major Imaging	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Other Professional Diagnostic Laboratory/Pathology	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Diagnostic Mammography	Deductible then covered in full	Deductible/then 50%	
<b>FACILITY CARE OPTIONS</b>			
Inpatient Facility	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Outpatient Surgery Facility	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000/\$10,000 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)	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>EMERGENCY CARE AND TRANSPORTATION OPTION</b>			
Emergency Care	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	
Emergency Room Physician	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	

<b>MEDICAL PLAN</b>		<b>HSA 5000</b>	
	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>Urgent Care Center</b>	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Ambulance Transportation (Unlimited)</b>	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	
<b>Air Ambulance (Unlimited)</b>	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	
<b>OTHER SERVICES</b>			
<b>Allergy/Therapeutic Injections</b>	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Mental Health Inpatient Facility Care (Unlimited)</b>	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Mental Health Outpatient Professional Care (Unlimited)</b>	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Chemical Dependency Inpatient Facility Care (Unlimited)</b>	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Chemical Dependency Outpatient Professional Care (Unlimited)</b>	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Rehab Inpatient Facility (30 Days PCY combined limit for inpatient services)</b>	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (15 Visits PCY combined limit for outpatient services)</b>	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer</b>	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Medical Supplies, Equipment, Prosthetics (Unlimited)</b>	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Foot Orthotics, Orthopedic Shoes and Accessories (\$300 PCY; Includes orthotics and orthopedic shoes)</b>	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	

<b>MEDICAL PLAN</b>		<b>HSA 5000</b>	
	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>Home Health Visits</b> (130 visits PCY)	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Hospice Care</b> (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>TMJ (Temporomandibular Joint Disorders)</b> (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	
<b>Transplants</b> (Unlimited; \$7,500 travel and lodging limits)	Covered as any other service	Not Covered	
<b>Drug List</b>	Open A1 No Tiers	Open A1 No Tiers	
<b>Prescription Drugs - Retail</b> (Specific preventive drugs and legend Retail: 90 day supply/Mail: 90 day supply/Specialty: 30 day supply)	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to the \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to the \$6,550 / \$13,100 Out of Pocket Maximum	
<b>Prescription Drugs - Mail</b> (Specific preventive drugs and legend Retail: 90 day supply/Mail: 90 day supply/Specialty: 30 day supply)	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to the \$6,550 / \$13,100 Out of Pocket Maximum	Not Covered	
<b>Specialty Pharmacy</b> (Mandatory - Exclusive)	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to the \$6,550 / \$13,100 Out of Pocket Maximum	Not covered	
<b>ALTERNATIVE CARE</b>			
<b>Manipulations (Spinal and other)</b> (12 visits PCY)	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>Acupuncture</b> (12 visits PCY)	\$5,000 / \$6,550 Deductible, then 20% Coinsurance, applies to \$6,550 / \$13,100 Out of Pocket Maximum	\$5,000/\$10,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>ANNUAL PLAN MAXIMUM</b>			
<b>Annual Plan Maximum</b>	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.*

