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	SUSTAINABLE 2000	
	IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		-
Individual Deductible PCY (Family embedded deductible 3x Individual)	\$2,000	\$2,000
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)	\$6,850	Unlimited
Office Visit Cost Share	\$40 Copay, applies to the \$6,850 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, 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	-	
Professional Office Visit	\$40 Copay, applies to the \$6,850 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Inpatient Professional Services	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Contraceptive Management Services (Unlimited)	Covered In Full	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

Effective Date: 01/01/2019



MEDICAL PLAN	SUSTAINABLE 2000	
	IN-NETWORK	OUT-OF-NETWORK
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Imaging	Waive Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Professional Diagnostic Major Imaging	Waive Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Laboratory/Pathology	Waive Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$2,000 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	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Surgery Facility	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$2,000 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)	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$2,000 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)	\$200 Copay then \$2,000 Deductible and 20% Coinsurance; all cost shares apply to the \$6,850 Out of Pocket Maximum	\$200 Copay then \$2,000 Deductible and 20% Coinsurance; all cost shares apply to the \$6,850 Out of Pocket Maximum
Emergency Room Physician	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum
Urgent Care Center	\$40 Copay, applies to the \$6,850 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Ambulance Transportation (Unlimited)	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum
Air Ambulance (Unlimited)	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum
OTHER SERVICES		
Allergy/Therapeutic Injections	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	\$40 Copay, applies to the \$6,850 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Inpatient Facility Care (Unlimited)	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

MEDICAL PLAN	SUSTAINABLE 2000	
	IN-NETWORK	OUT-OF-NETWORK
Chemical Dependency Outpatient Professional Care (Unlimited)	\$40 Copay, applies to the \$6,850 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Inpatient Facility (30 days PCY)	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$2,000 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 \$6,850 Out of Pocket Maximum	\$2,000 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 \$6,850 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Medical Supplies, Equipment, Prosthetics (Unlimited)	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Foot Orthotics, Orthopedic Shoes and Accessories (\$300 PCY; Includes orthotics and orthopedic shoes)	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Home Health Visits (130 visits PCY)	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$2,000 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)	\$2,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$2,000 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 \$6,850 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Acupuncture (12 visits PCY)	\$40 Copay, applies to the \$6,850 Out of Pocket Maximum	\$2,000 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	\$2,000 PCY 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

Effective Date: 01/01/2019

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		
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/\$250	
Mail Cost Shares	\$20/\$100/\$200/\$250	
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	

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.

Discrimination is Against the Law

Premera Blue Cross compiles 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:
- effectively with us, such as:
 Cualified sign language interpreters
 Witten information in other formats (arge print, audio, accessible
 electronic formats, other formats)
 Provides free language services to papple whose primary language is not
 English, such interpreters
 Caalified integrates

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 sex, you can file a given new with: Chrill Rights Coordinator - Complaints and Appeals PO flox of 1102, States, WAR Bit 11 To The States, WAR Bit 11 To The States, WAR Bit 11 To The States, States, WAR Bit 11 To The States, States,

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.

and a generative, in evidence of the second structure of energy of Year can also file a civil rights complaint Postiwill the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Postiwa, available at https://comportal.htms.gov/comportal.ibbby jif, of the mail or phone at U.S. Department of Health and Human Services 200 Independence Avenue SW, Room 506F, HiH Building Washington, D.C. 2001, 14:00-368, U.S. 108, GOV (TDD) Camplant forms are available at http://www.htms.gov/complicationed.html.

Getting Help in Other Languages

This Notice has Important Information. This notice may have important information about your application or coverage through Premers Blue Cross. There may be key date in thin notice. You may meed 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: 800-642-5357).

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Arabic)، الابية يعري ها (Yanbic): يعري ها (Yanbic)، طبوعة لذي يعري ها الإلمار مترمات مهم بغصوم طلك أو طبقاً الارتبار، ولدعتج الالالزواء في واريل ميمة العظا طي تطلك المسامة ال الساحة الم الالتاريبي والاسلامي طي المصر أط مدا المقارب والساحة بقات بون كله الية كامة المسلم والمواقعة (Herrise 2004) والمعار ط مدا المقارب والساحة بقات بون كله الم تكام المسلم 1980-1992 (Herrise 2004) والمعار المعارب المقارب والساحة المقارب والمالية المقارب والمعارب المعالي المعارب المعارب المعارب المعارب والمعارب والمع والم والمعارب والمع و

中文(Chinese): 未通知有重要保護員,未通知均可能有重日利。但可能需要石載上日期 之前国政行動。其保留的份值保健能在費用相基。也有重将免責工能力的 之前国政行動。其保留的份值保健能在費用相基。也有僅将免責工的的。 指导和末見包括某款。」對整置這個00-722-1471 (TTY: 600-842-5357)。

日本夏(Apparented) この意気には重要な快速が含まれています。この違気には、Proventa Blue Comes の登録方には現実期に関する重要な可能ができたているも思いです。 なり、信息を取ります。このも思いたもも美聞の日本に加えていた時 あらいたださなない最近なりで、「などの知道までは「などの知道」をございたき あらいたださなない最近なりで、「などの知道」をございたき あらいたださなない最近なりです。 あらいたださなない最近なりです。 などのないたないます。600-723-407 (TY: 000-640-505)までは思想 ください、

(1993) (Contest) 2014년 - 1912) 월양 월양 입습니다. 속이 포지사는 구점의 신뢰에 2014년 - 1912) 고마mane Rain Orasia 문화는 가성지 위한 전 일종 표준하고 314 - 1912년 그 분류 지사에 위한 1912 년 환경은 전율 수 전 입니다. 기원는 구점의 근원 가방지지를 계속 위지하기 의 원동을 관람하기 위해 인정한 전보 이 프로마지 그 프로마지 역사 명양 모두 일종 인정을 수 인데다. 기원는 구점의 그 전통 특히는 인정 빈동을 부탁했다. 지하는 인터나, 지하는 인정한 전보도 이동을 목하는 인정 빈동을 부탁했다. 역사 인정 2017 1일입니다. 전승규가 410 (TTY Node-4055) 전 등 취하여 시장.

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Portuguia (Portuguesa): Este arise costelin teleconogoles importantes. Este arise postori conten-te en este costelin teleconogoles importantes arbora de la contenza por tesso de limentes Bala Crisso. Revelos ester esta importantes esteres arias. Tarvar sega nacessitiva que vivol tuna providibilitas detalo de determinidas paras para manter sua colocitara de saloda de costen. Von tarva divela de tar vara informação a quata em sea dama e am costen. Que para Bolo-2214/01, TUT: 80.044.2025.

Oromoo (Cushite): Beeksimi kun odeeffannoo barbaachisaa qaba, Beeksisti kun sagartaa yoolan karaa Pomera Bluo Cross tiin tajaajila keessan laalchisee odeeffannoo barbaachisaa qabaachuu danda'a. Guyyaawwan muteessaa tara beeksia kana keessatti alaada. Tari karthitohaa deeggaramwan jiraachuu danda'a. Kaftatii irraa bilisa halali to'een ataan keessaa miaachuu deeffannoo argachuu deeggara aaguchuu mirga na qabaathu. Lakkoofsa bibliaa 800-722-1471 (TTY: 800-842-5357) ta bibliaa.

Prançais (French): Cet avis a d'improvincient informations. Cet avis peut avoir d'impotantes per la source de la courte peut d'internet par l'internet dissi s de Premora Bille cross. Le présent avis pout content rés détas cles. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverire de santé ou d'aliae dans vote la argue à aucun coit. Apprise la 600-721.4/11 (117: 00042-2057).

Kreyől ayisyen (Creole): Avi sila a gen Enfőmasyon Enpótan ladann. Avi sila a kapab genyen efformasyon enpótan konskana najlikasyon w lan oswa konskana kouvéla asirans lan attavá Premera Blue Cross. Kapab genyen dat ki enpótan nan avi sila a. O uka gen pou pran kik kiksyon avan sited nat limit pou ka kenbé kouvél asirans sarte v la oswa pou ya ka dék w avik dégena yo. Sé dva w pou renevave efformasyon a a a ki asidana nali ndi gou pale a, san ou pa gen pou payk ka bina a a ki asidana nali ndi gou pale a, san ou pa gen pou paye pou sa. Rele nan BOD-722-1471 (TTV: 500-422-557).

(111: Sources-Casor).
Detasche (German):
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Detasche (German):
Benachrichigung enhält unter Umständen wichtige Informationen betzglich here Artings auf Kannewersicherogischutz durch Armenia Benachrichigung, Sie könten bis zu bestimmten Stöcklagen handeln müssen, um Ihren Krankerwersicherungsschutz, oder Hille mit den Kosten zu behalten. Sie aben das Reckt Ascelhisse Hille mit den Kosten zu behalten. Sie söten). Kuten Sie an unter 806-722-1471
(TY: 506-942-557).

(11) Sourcescoor), Traba Indove trabaj co no muaj cov ntshiab lus tseem ceeb. Tej zaum taba Indove thaj co no muaj cov ntshiab lus tseem ceeb tog koj daim ntavu thov kev pab los yog koj dnov kev pab caam los ntavm Premere Blue Cross. Tej zaum nuj cov hnub bearo ceeb uas sata vra havu daim ntavu no. Tej zaum koj kuj yuav tau ua geo yam uas pek kom koj ua tsis pub dhau cov caj nyog aus teve traga pra havu daim ntavu o man koj tabi pravi tau tasis kev pab caam ho mob los yog kev pab them tej ng kho mob u koj hom kas du daho za ukoj. Hu rau 600-722-1471 (TTV: 800-842-5357).

(In licke (liceano): Daytoy a Pakdaar ket nagtaon til Napateg nga Impormasion. Daytoy a pakdaar mubain nga adda ket nagtion til napateg nga impormasion majanggep til apkisayonyo wenno coverage babeen til Premera Bue Cicess. Dayto ket mubain dagti importante a petsta til daytoy a pakdaar. Mabain nga adda rumberg nga aramidenyo nga addang sakbay dagti partikular a natikuling nga addar til biculodya a pagabaso nga awo til salun-siyo wenno tulong kadagti gastos. Adda kurbenganyo a mangala til daytoy nga impormasio ken tulong ti biculodya a pagabaso nga awo ti bayadanyo. Tumawag ili numero nga 800-722-1471 (TTY: 900-842-6357).

Ratiano (Haliano): Geeta avviso conferei latiomazioni importanti. Oucesto avviso può contenere informazioni importanti sulta tua domanda o copertura attraverso Premere Bue Cross. Pottebbero esserci date chiave in questo avviso. Pottebbe essere necessario un tuo intervente netto rua scadenate deteminata per consentiti di mantenere la tua copertura o sovienzione. Hai il diritto di offenere queste informazioni a assidieraza nella tua lingua gratutamente. Chiama 800-722-1471 (TTY: 800-842-5357).

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Haghen Lamar # 1800-722 kH² (TTT 800-94-83-807). Tagsleg (Tagsleg): Ang Pharman na the sy nagliatenan ng muhalagang Impormasyon Ang Pharman na the sy nagliatenan ng muhalagang Impormasyon tangki la long asitanyon a pagiatena sa amemagikan ng Pharman magalitanga ta ka nagaapan ng balawang ta long mg Taribata panahon yang mapawati nag yang pagakato sa kikangasa t- kikang anahon yang mapawati nag yang pagakato sa kikangasa t- kikang anahon yang mapawati nag yang pagakato sa kikangasa t- kikang anahon yang mapawati nag yang pagakato sa kikangasa t- kikang atabang gasitan. Buya kanga kang bagakato sa kikang at bang ga kang ukang kang kang bagakato sa tabo 722-1471 (TTT. 90044-6238).

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