

Effective Date: 01/01/2019

# Highlights of your Health Care Coverage

LIFE SCIENCE 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	PLAN A	
	IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		-
Individual Deductible PCY (Family embedded deductible 3X Individual)	\$0	\$200
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	0%	50%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 3X Individual)	\$2,000	Unlimited
Office Visit Cost Share	\$20 Copay, applies to the \$2,000 Out of Pocket Maximum	\$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION	- <del>-</del>	-
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	\$20 Copay, applies to the \$2,000 Out of Pocket Maximum	\$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Inpatient Professional Services	\$0 Deductible, then 0% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Contraceptive Management Services (Unlimited)	Covered In Full	\$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

MEDICAL PLAN	PLAN A	
	IN-NETWORK	OUT-OF-NETWORK
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	\$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Imaging	\$0 Deductible, then 0% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Professional Diagnostic Major Imaging	\$0 Deductible, then 0% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Laboratory/Pathology	\$0 Deductible, then 0% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$200 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	\$0 Deductible, then 0% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Surgery Facility	\$0 Deductible, then 0% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Skilled Nursing Facility</b> (60 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$0 Deductible, then 0% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	\$0 Deductible, then 0% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$200 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 \$0 Deductible and 0% Coinsurance; all cost shares apply to the \$2,000 Out of Pocket Maximum	\$200 Copay then \$0 Deductible and 0% Coinsurance; all cost shares apply to the \$2,000 Out of Pocket Maximum
Emergency Room Physician	\$0 Deductible, then 0% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$0 Deductible, then 0% Coinsurance, applies to \$2,000 Out of Pocket Maximum
Urgent Care Center	\$20 Copay, applies to the \$2,000 Out of Pocket Maximum	\$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Ambulance Transportation (Unlimited)	\$0 Deductible, then 0% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$0 Deductible, then 0% Coinsurance, applies to \$2,000 Out of Pocket Maximum
Air Ambulance (Unlimited)	\$0 Deductible, then 0% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$0 Deductible, then 0% Coinsurance, applies to \$2,000 Out of Pocket Maximum
OTHER SERVICES		
Allergy/Therapeutic Injections	\$0 Deductible, then 0% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	\$0 Deductible, then 0% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	\$20 Copay, applies to the \$2,000 Out of Pocket Maximum	\$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Inpatient Facility Care (Unlimited)	\$0 Deductible, then 0% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

MEDICAL PLAN	PLAN A	
	IN-NETWORK	OUT-OF-NETWORK
Chemical Dependency Outpatient Professional Care (Unlimited)	\$20 Copay, applies to the \$2,000 Out of Pocket Maximum	\$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Inpatient Facility (30 days PCY)	\$0 Deductible, then 0% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$200 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)	\$20 Copay, applies to the \$2,000 Out of Pocket Maximum	\$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	\$20 Copay, applies to the \$2,000 Out of Pocket Maximum	\$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Medical Supplies, Equipment, Prosthetics (Unlimited)	\$0 Deductible, then 0% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>Foot Orthotics, Orthopedic Shoes and Accessories</b> (\$300 PCY; Includes orthotics and orthopedic shoes)	\$0 Deductible, then 0% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Home Health Visits (130 visits PCY)	\$0 Deductible, then 0% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$200 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)	\$0 Deductible, then 0% Coinsurance, applies to \$2,000 Out of Pocket Maximum	\$200 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)	\$20 Copay, applies to the \$2,000 Out of Pocket Maximum	\$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Acupuncture (12 visits PCY)	\$20 Copay, applies to the \$2,000 Out of Pocket Maximum	\$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
SUPPLEMENTAL BENEFITS		
Routine Hearing Exam (1 PCY)	\$20 Copay	\$200 Deductible, then 50% Coinsurance, applies to Unlimited 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.

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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	PLAN A - RX - 10/30/60/250	
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/\$30/\$60/\$250	
Mail Cost Shares	\$20/\$60/\$120/\$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	

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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:

- effectively with us, such as:

  Qualified sign Inaguage interpreters

  Withen Information in other formats (arge print, audio, accessible electronic formats, other formats).

  Provides free language services to people whose primary language is not English, such as

  Qualified interpreters

  Information written in other languages

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 المناس

中文 (Chinese):
- 本國和有意學的原象,本書知可能有關於思想達 Premera Blue Cross 提交的中族政策論的重要訊息,本書知可能有實之日末。 巴罗德爾森在森上郭東
- 古新龍女师弟。 《政策会》的唯意教练或者實用結局。 多种单纯美型处验的 语符列本讯息和策勒。 與豫電話 800-722-1471 (TTY: 800-842-5357)。

## 한국의 (Moraelli 보통 한자교육의 업업이다. 속이 본지하는 가장의 신경에 보통 전시에는 현대를 보면 경기를 받아 없었다. 속이 본지하는 가장의 신경에 되는 것이 되는 것이 되는 것이 되는 본 한 가장이 되는 한 경기를 되는 것이 되는 가장의 구강 가장이기를 가장이 되는 보통을 받아 되는 것이 되는 가장의 구강 가장이기를 가장 가장이나 의료를 받아가 기계를 위한 가장의 구강 가장이기를 가장이 가장이나 의료를 받아가 기계를 위한 가장이 구강 가장이기를 받아 되는 것이 될 속 되는 가장이 다양한 경기를 가장이 있다면 보통 부모로 이렇게 되었다. 그런 기계 되었다. 이것이라면 한 당시 기계를 수 있다.

Oromoo (Cushite):
Beeksini kun oderffannoo barbaachisaa qaba, Beeksisti kun sagartaa
yoolaa karaa Pfenera Bliuc Cross tiin tajaajila keessan ilaalchisee
oderffannoo barbaachisaa qabaachuu danda'a. Guyyaawwan murdeessa
tan beeksisa karaa keessatii alaalaa. Tarii kaffaitiohaan deeggarmudi
yaachuu danda o, kaffali irraa biitaa saabat teen dahan keessaniidaan
oderffannoo argabuut diregapaan aganbuut miigan a qabaattu.
Lakkoofsa biibliaa 800-722-1471 (TTY: 800-842-5357) tii biibliaa.

Français (French):
Cet avis a d'importantes informations. Cet avis pout avoir d'importantes.
Cet avis a d'importantes informations. Cet avis pout avoir d'importantes.
Premiers Blue Criscos. Le présent avis pout content no destes clès. Vous
devixe peut-être prendre des mesures par certains délais pour maintenir
votre couverture de santée ou d'alle avre les coûts. Vous avez le doit
d'ôctenir cetts information et de l'aide dans votre langue à aucun coût.
Applice les 607-21-411 (TIT: 806-42-5057).

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 avik depans yo. Se dwa w pou resewa erfomasyon a a ak asidans nan lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 600-722-1471

Detasche (Germann):
Detasche (Germann):
Diese Benachrichtigung enthält wichtige Informationen. Diese
Benachrichtigung enthält wirder Umständen wichtige Informationen
bedüglich hires Arträgs auf Krankenversichenungsschrätz durch Phremeta
Benachrichtigung, sie beitrente his zu bestämmten Söckhägen handelin
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
tash ntawy tshuji xo no muaji cov ntshiab lus tseem ceeb toog koj daim ntawy
thow kev pab loo yeg koj dhovi kev pab cuam loo ntawm Premerse Blue
Cross. Tej zaum maji cov hnub tseem ceeb usas sura nahar vidam ntawy
no. Tej zaum soj kuji yuur bau ua qee yam uas peb kom koji ua tisis pub
dhau cov caji yogo gus teet verti gara lauva dam ntawa no mas koj tilais
yuav tsu tash kev pab cuam kho mob los yogi kev pab them tej ngi kho mob
dhau cov caji yogo gus teet verti gara over mahab la ne ua sati su maab sau
us koj hom lus pad dawir au koji, thai rau 600-722-1471
(TTY: 800-842-5357).

Boke (Bocano):
Daytoy a Pakdaar ket naglaon iti Napateg nga Impormasion. Daytoy a Pakdaar mbalin nga adda ket naglaon iti napateg nga Impormasion napadaar mbalin nga adda ket naglaon iti napateg nga Impormasion majanagap iti apiksayonyo weren coverage babaen iti Premera Bibe (Cross. Daytoy ket mbalin dagit importanta a petas tai daytoy a pakdaar. Mabalin nga adda rumbeng nga aramidenyo nga addang sakbay dagit partikular a natividing nga addew samo mapagalianedyo i coverage it salun-alyo wenno tutong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong iti bixoloy o apagabaan onga awan ti baysdaanyo. Tumawag iti numero nga 800-722-1471 (TTY: 800-842-3557).

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).

reginos. Lamin el 1907-721-49 (1171: 000-04-0-050).
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

## les (Thai): (constituy