PREMERA BLUE CROSS

Highlights of your Health Care Coverage

LIFE SCIENCE 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.

MEDICAL PLAN	**PLAN B**	
	IN-NETWORK	**OUT-OF-NETWORK**
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 3X Individual)	$200	$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)	$3,200	Unlimited
Office Visit Cost Share	$25 Copay, applies to the $3,200 Out of Pocket Maximum	$200 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	$25 Copay, applies to the $3,200 Out of Pocket Maximum	$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Inpatient Professional Services	$200 Deductible, then 0% Coinsurance, applies to $3,200 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 B	
	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	Waive Deductible, then 0% Coinsurance, applies to $3,200 Out of Pocket Maximum	$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Professional Diagnostic Major Imaging	Waive Deductible, then 0% Coinsurance, applies to $3,200 Out of Pocket Maximum	$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Laboratory/Pathology	Waive Deductible, then 0% Coinsurance, applies to $3,200 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	$200 Deductible, then 0% Coinsurance, applies to $3,200 Out of Pocket Maximum	$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Surgery Facility	$200 Deductible, then 0% Coinsurance, applies to $3,200 Out of Pocket Maximum	$200 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)	$200 Deductible, then 0% Coinsurance, applies to $3,200 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)	$200 Deductible, then 0% Coinsurance, applies to $3,200 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 $200 Deductible and 0% Coinsurance; all cost shares apply to the $3,200 Out of Pocket Maximum	$200 Copay then $200 Deductible and 0% Coinsurance; all cost shares apply to the $3,200 Out of Pocket Maximum
Emergency Room Physician	$200 Deductible, then 0% Coinsurance, applies to $3,200 Out of Pocket Maximum	$200 Deductible, then 0% Coinsurance, applies to $3,200 Out of Pocket Maximum
Urgent Care Center	$25 Copay, applies to the $3,200 Out of Pocket Maximum	$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Ambulance Transportation (Unlimited)	$200 Deductible, then 0% Coinsurance, applies to $3,200 Out of Pocket Maximum	$200 Deductible, then 0% Coinsurance, applies to $3,200 Out of Pocket Maximum
Air Ambulance (Unlimited)	$200 Deductible, then 0% Coinsurance, applies to $3,200 Out of Pocket Maximum	$200 Deductible, then 0% Coinsurance, applies to $3,200 Out of Pocket Maximum
OTHER SERVICES		
Allergy/Therapeutic Injections	$200 Deductible, then 0% Coinsurance, applies to $3,200 Out of Pocket Maximum	$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	$200 Deductible, then 0% Coinsurance, applies to $3,200 Out of Pocket Maximum	$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	$25 Copay, applies to the $3,200 Out of Pocket Maximum	$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Inpatient Facility Care (Unlimited)	$200 Deductible, then 0% Coinsurance, applies to $3,200 Out of Pocket Maximum	$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

MEDICAL PLAN	PLAN B	
	IN-NETWORK	**OUT-OF-NETWORK**
Chemical Dependency Outpatient Professional Care (Unlimited)	$25 Copay, applies to the $3,200 Out of Pocket Maximum	$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Inpatient Facility (30 days PCY)	$200 Deductible, then 0% Coinsurance, applies to $3,200 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)	$25 Copay, applies to the $3,200 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	$25 Copay, applies to the $3,200 Out of Pocket Maximum	$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Medical Supplies, Equipment, Prosthetics (Unlimited)	$200 Deductible, then 0% Coinsurance, applies to $3,200 Out of Pocket Maximum	$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Foot Orthotics, Orthopedic Shoes and Accessories ($300 PCY; Includes orthotics and orthopedic shoes)	$200 Deductible, then 0% Coinsurance, applies to $3,200 Out of Pocket Maximum	$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Home Health Visits (130 visits PCY)	$200 Deductible, then 0% Coinsurance, applies to $3,200 Out of Pocket Maximum	$200 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)	$200 Deductible, then 0% Coinsurance, applies to $3,200 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)	$25 Copay, applies to the $3,200 Out of Pocket Maximum	$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Acupuncture (12 visits PCY)	$25 Copay, applies to the $3,200 Out of Pocket Maximum	$200 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
SUPPLEMENTAL BENEFITS		
Routine Hearing Exam (1 PCY)	$25 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.

Highlights of your Health Care Coverage

LIFE SCIENCE 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	**PLAN B - 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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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 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:
  - Qualified sign language interpreters
  - Written information in other formats (large 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 sex, you can file a grievance with:
Civil Rights Coordinator - Complaints and Appeals
PO Box 91102, Seattle, WA 98111
Toll free 855-332-4535, Fax 425-918-5592, TTY 800-842-5357
Email AppealsDepartmentInquiries@Premera.com

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 file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building
Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

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: 800-842-5357).

አማርኛ (Amharic):
ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Premera Blue Cross ሽፋን አስፈላጊ መረጃ ሊኖረው ይችላል። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖች ሊኖሩ ይችላሉ። የጤና ሽፋንዎን ለመጠበቅና በአከፋፈል እርዳታ ለማግኘት በተወሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲሁም እና ያለምንም ክፍያ በቋንቋዎ እርዳታ የማግኘት መብት አለዎት።በስልክ ቁጥር 800-722-1471 (TTY: 800-842-5357) ይደውሉ።

العربية (Arabic):
يحوي هذا الإشعار معلومات هامة. قد يحوي هذا الإشعار معلومات مهمة بخصوص طلبك أو التغطية التي تريد الحصول عليها من خلال Premera Blue Cross. قد تكون هناك تواريخ مهمة في هذا الإشعار. وقد تحتاج لاتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون تكبد أية تكلفة. اتصل بـ800-722-1471 (TTY: 800-842-5357)

中文 (Chinese):
本通知有重要的訊息。本通知可能有關於您透過 Premera Blue Cross 提交的申請或保險的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-722-1471 (TTY: 800-842-5357)。

Oromoo (Cushite):
Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa Premera Blue Cross tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qabaachuu danda'a. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 800-722-1471 (TTY: 800-842-5357) tii bilbilaa.

Français (French):
Cet avis a d'importantes informations. Cet avis peut avoir d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Premera Blue Cross. Le présent avis peut contenir des dates clés. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez le 800-722-1471 (TTY: 800-842-5357).

Kreyòl ayisyen (Creole):
Avi sila a gen Enfòmasyon Enpòtan ladann. Avi sila a kapab genyen enfòmasyon enpòtan konsènan aplikasyon w lan oswa konsènan kouvèti asirans lan atravè Premera Blue Cross. Kapab genyen dat ki enpòtan nan avi sila a. Ou ka gen pou pran kèk aksyon avan sèten dat limit pou ka kenbe kouvèti asirans sante w la oswa pou yo ka ede w avèk depans yo. Se dwa w pou resevwa enfòmasyon sa a ak asistans nan lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 800-722-1471 (TTY: 800-842-5357).

Deutsche (German):
Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält unter Umständen wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Premera Blue Cross. Suchen Sie nach eventuellen wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 800-722-1471 (TTY: 800-842-5357).

Hmoob (Hmong):
Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tej zaum tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm Premera Blue Cross. Tej zaum muaj cov hnub tseem ceeb uas sau rau hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam uas peb kom koj ua tsis pub dhau cov caij nyoog uas teev tseg rau hauv daim ntawv no mas koj thiaj yuav tau txais kev pab cuam kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawv muab cov ntshiab lus no uas tau muab sau ua koj hom lus pub dawb rau koj. Hu rau 800-722-1471 (TTY: 800-842-5357).

Iloko (Ilocano):
Daytoy a Pakdaar ket naglaon iti Napateg nga Impormasion. Daytoy a pakdaar mabalin nga adda ket naglaon iti napateg nga impormasion maipanggep iti apliksayonyo wenno coverage babaen iti Premera Blue Cross. Daytoy ket mabalin dagiti importante a petsa iti daytoy a pakdaar. Mabalin nga adda rumbeng nga aramidenyo nga addang sakbay dagiti partikular a naituding nga aldaw tapno mapagtalinaedyo ti coverage ti salun-atyo wenno tulong kadagiti gastos. Adda karbenganyo a mangala iti daytoy nga impormasion ken tulong iti bukodyo a pagsasao nga awan ti bayadanyo. Tumawag iti numero nga 800-722-1471 (TTY: 800-842-5357).

Italiano (Italian):
Questo avviso contiene informazioni importanti. Questo avviso può contenere informazioni importanti sulla tua domanda o copertura attraverso Premera Blue Cross. Potrebbero esserci date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama 800-722-1471 (TTY: 800-842-5357).

日本語 (Japanese):
[illegible] 800-722-1471 (TTY: 800-842-5357) [illegible]

한국어 (Korean):
[illegible] Premera Blue Cross [illegible] 800-722-1471 (TTY: 800-842-5357) [illegible]

ພາສາລາວ (Lao):
[illegible] Premera Blue Cross [illegible] 800-722-1471 (TTY: 800-842-5357).

ភាសាខ្មែរ (Khmer):
[illegible] Premera Blue Cross [illegible] 800-722-1471 (TTY: 800-842-5357)។

ਪੰਜਾਬੀ (Punjabi):
[illegible] Premera Blue Cross [illegible] 800-722-1471 (TTY: 800-842-5357).

فارسی (Farsi):
[illegible] Premera Blue Cross [illegible] 800-722-1471 (TTY: 800-842-5357) [illegible]

Polskie (Polish):
[illegible]

Português (Portuguese):
[illegible]

Română (Romanian):
[illegible] Sunați la 800-722-1471 (TTY: 800-842-5357).

Русский (Russian):
[illegible] 800-722-1471 (TTY: 800-842-5357).

Fa'asamoa (Samoan):
[illegible] 800-722-1471 (TTY: 800-842-5357).

Español (Spanish):
[illegible] Llame al 800-722-1471 (TTY: 800-842-5357).

Tagalog (Tagalog):
[illegible] 800-722-1471 (TTY: 800-842-5357).

ไทย (Thai):
[illegible] Premera Blue Cross [illegible] 800-722-1471 (TTY: 800-842-5357)

Українська (Ukrainian):
[illegible] 800-722-1471 (TTY: 800-842-5357).

Tiếng Việt (Vietnamese):
[illegible] 800-722-1471 (TTY: 800-842-5357).