High LIFF SCIF

MEDICAL PLAN

Office Visit Cost Share

Health Education (HE) (Unlimited)

PROFESSIONAL CARE

Professional Office Visit

Inpatient Professional Services

Nicotine Dependency Programs (ND) (Unlimited)

Contraceptive Management Services (Unlimited)

Diabetes Health Education (DE) (Unlimited)

charges)

MEDICAL COST SHARE OPTIONS

Individual Deductible PCY (Family embedded deductible 3X Individual)

and pharmacy if applicable (Family embedded OOP max 3X Individual)

Preventive Office Visit (Unlimited, subject to standard medical guidelines)

PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION

Immunizations (Unlimited, subject to standard medical guidelines)

Coinsurance (Member's percentage of costs after deductible based on allowable

Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay

PLAN B

\$3,200 Unlimited \$200 Deductible, then 50% Coinsurance. \$25 Copay, applies to the \$3,200 Out of Pocket Maximum applies to Unlimited Out of Pocket Maximum

IN-NETWORK

\$200

0%

Covered In Full

\$25 Copay, applies to the \$3,200 Out of

Pocket Maximum

\$200 Deductible, then 0% Coinsurance,

applies to \$3,200 Out of Pocket Maximum

nlights of your Health Care Coverage	

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.



Effective Date: 01/01/2019

OUT-OF-NETWORK

\$200

50%

Not Covered

Not Covered

Not Covered

Not Covered

Not Covered

\$200 Deductible, then 50% Coinsurance,

applies to Unlimited Out of Pocket Maximum

\$200 Deductible, then 50% Coinsurance,

applies to Unlimited Out of Pocket Maximum

MEDICAL PLAN PLAN B		AN 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	

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.

may a generative, in the activit rights conditions to strange to the pro-tory can all solit activity fails congular boots with the U.S. Desartment of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Congular Pools, available at https://corpotal.htms.gov/conjcent/allobby jif, of by 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. 1018, good 57:7607 (TDD) Camplant forms are available at http://www.hts.gov/confide-officeIndex.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 (Chrisses): 未通知有重要和同意,未通知可信有關於包酒道 Premera Blue Cross 建交的 中族在段龄的重要现象。未通知内气能有重日和、包可能需要在截止目期 之前能取行物。此保留的的增度检测成者具用相称。这时增长的复数形式 品件并不识色和策制、调合笔品 800-722-1471 (TTY: 800-842-6357)。

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、「全要なの意味」を見ての見てまていた時 あらいたださなない最近なりで、「全要なの意味」とない、現在を利用すていた。 あらいたださなない最近なりで、「全要なの意味」とない、 あらいたださなないまたが、800-723-407 (TY: 000-840-5057)までは思想 ください、

(1993) (Contest) 2014년 - 1912) 월양 월양 입습니다. 속은 로디서는 구점의 신뢰에 2014년 - 1912) 고려하여 3월 4월 가서라지역 전 김 인종 2014년 - 1912 - 가려하여 3월 4월 가서라지역 전 일종 2014년 - 기천은 구점의 근정 가려지가를 가서 유지하기 의 분류를 필급하기 기회님 일종은 인명이 가지는 가지는 지하지 않는 부산인이 함복 수 있는 지하는 이라는 감치도 구름 우리는 인이 번 또를 부산인이 함복 수 있는 2017 입습니다. 0012년 4년 (1717) 4004년 4013 전 등 401년 10.

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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.

Français (French): Cefe aris a composition formations. Ost avis paut avoir d'importantes caracteristica de la concentre par l'Internetations de Plemmos Blue Cross. La présent aux pout content rés dats cles. Vous devrez peut-être prendre des mesures par centains délais pour maintenir votre couverture de santé our afaie avoir la concentra della pour maintenir votre couverture de santé our afaie avoir la concentra della pour maintenir votre couverture de santé our afaie avoir les concentra della pour d'obtenir cette information et de l'alab dans votre langue à aucun cod. Apprilez le 80-722-1471 (117: 800-62-8057).

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 kolskon 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 la krisitans naih degena yo. Sé dva w pou reneva efformasyon a a la krisitans naih degena yo. Sé dva w pou reneva efformasyon a a la krisitans naih degena yo. Sé dva w pou resvé atformasyon a a la krisitans naih degena yo. Sé dva w pou resvástforma si a krisitans naih degena yo.

(111: Sources-Casor). Detaches (German): Detaches (German): Benachrichigung enhalt unter Umständen wichtige Informationen betzglich here Artings auf Kransenversicherengischutz durch freien Benachrichigung, Sie könten bis zu bestimmten Stöcklagen handeln müssen, um Ihren Krankenversicherungsschutz der Hille mit den Kosten zu behalten. Sie sollten bein der Aschlage auf unter Artiker (111: Stör-462-657).

(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 caan 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 u stisj pub dhau cov caj nyog aus teve traga pra havu daim ntavu o man koj tabi judav tau talis 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 pagasao nga awo til salun-siyo wenno tulong kadagti gastos. Adda kurbenganyo a mangala til daytoy nga impormasio ken tulong ti biculodya a pagasao 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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Русский (Яизаlan): Настоящие уведом уведовление искот заявлении или стра содержит важную информацие. Это нать важную информацию о вашти порытик через Promera Bise Cross. В когл быть указоны клечение даты. Вие, секть инры к опредстание радастиные ракевол порачти вать отво в принить шеры к определенные пределья к пракового покрытий или поноции с реск коллагиес получение этой информации и не. Закните по пелефону 800-722-5471 TOMOLOGIC IN BOLLING HIS (TTY: 800-842-5357)

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Haghen Lamar # 1800-722 kH² (TTT 800-94-83-807) Tagdeg (Tagata) Mag Panawan na fa sy nagilalama ng muhalagan impormasyon hangka lang asilangon agalawan ng muhalagan impormasyon bagka la lang asilangon agalawan ng muhalagan impormasyon hangka lang asi naganang ng hang asilang ng human magalamga ka sa naganang ng halama ja bang mg hangka panahon yang mapawati nag yang pagakato sa kalawagan s taing panahon yang mapawati nag yang pagakato sa kalawagan s taing panahon yang mapawati nag yang pagakato sa kalawagan si taing panahon yang mapawati nag yang pagakato sa kalawagan si taing at bang a taing uko a gu waing ganto. Tumang as 805/722-467 (TTT 80046-635)

les (Thai): convibiage

Yspalinczość (Krzatkar): Us notposowani w krzenie zastrzego jedpopacajim. Up notpo oraz szczeni zastrzego jedpopacajim typi boli tetrzych na usu oraz szczeni zastrzego jedpopacajim typi boli tetrzych na usu orazona jedno zastrzego jedpopacajim za usup zastrzego jedpo na usupicno zastrzego jedno szczego jedpopacajim tetrzych na usupicno zastrzego jedno szczego jedpopaca i tetrzych na usupicno zastrzego jedno szczego jedno szczego jedno szczego na usupicno zastrzego jedno szczego jedno szczego jedno szczego na usupicno zastrzego jedno szczego jedno szczego jedno szczego na usupicno szczego jedno szczego jedno szczego jedno szczego na usupicno szczego jedno szczego jedno szczego jedno szczego na usupicno szczego jedno szczego jedno szczego jedno szczego na usupicno szczego jedno szczego jedno szczego jedno szczego na usupicno szczego jedno szczego jedno szczego jedno szczego jedno szczego na usupicno szczego jedno s

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