

# 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.

<b>MEDICAL PLAN</b>		
	<b>PLAN D</b>	
	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>MEDICAL COST SHARE OPTIONS</b>		
Individual Deductible PCY (Family embedded deductible 3X Individual)	\$300	\$300
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 3X Individual)	\$4,300	Unlimited
Office Visit Cost Share	\$30 Copay, applies to the \$4,300 Out of Pocket Maximum	\$300 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	\$30 Copay, applies to the \$4,300 Out of Pocket Maximum	\$300 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Inpatient Professional Services	\$300 Deductible, then 20% Coinsurance, applies to \$4,300 Out of Pocket Maximum	\$300 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Contraceptive Management Services (Unlimited)	Covered In Full	\$300 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

<b>MEDICAL PLAN</b>		<b>PLAN D</b>	
	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>DIAGNOSTIC SERVICE OPTIONS</b>			
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	\$300 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Other Professional Diagnostic Imaging	Waive Deductible, then 20% Coinsurance, applies to \$4,300 Out of Pocket Maximum	\$300 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Professional Diagnostic Major Imaging	Waive Deductible, then 20% Coinsurance, applies to \$4,300 Out of Pocket Maximum	\$300 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Other Professional Diagnostic Laboratory/Pathology	Waive Deductible, then 20% Coinsurance, applies to \$4,300 Out of Pocket Maximum	\$300 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Diagnostic Mammography	Covered in Full	Out of Network Deductible, then 50%	
<b>FACILITY CARE OPTIONS</b>			
Inpatient Facility	\$300 Deductible, then 20% Coinsurance, applies to \$4,300 Out of Pocket Maximum	\$300 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Outpatient Surgery Facility	\$300 Deductible, then 20% Coinsurance, applies to \$4,300 Out of Pocket Maximum	\$300 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)	\$300 Deductible, then 20% Coinsurance, applies to \$4,300 Out of Pocket Maximum	\$300 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	\$300 Deductible, then 20% Coinsurance, applies to \$4,300 Out of Pocket Maximum	\$300 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
<b>EMERGENCY CARE AND TRANSPORTATION OPTION</b>			
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	\$200 Copay then \$300 Deductible and 20% Coinsurance; all cost shares apply to the \$4,300 Out of Pocket Maximum	\$200 Copay then \$300 Deductible and 20% Coinsurance; all cost shares apply to the \$4,300 Out of Pocket Maximum	
Emergency Room Physician	\$300 Deductible, then 20% Coinsurance, applies to \$4,300 Out of Pocket Maximum	\$300 Deductible, then 20% Coinsurance, applies to \$4,300 Out of Pocket Maximum	
Urgent Care Center	\$30 Copay, applies to the \$4,300 Out of Pocket Maximum	\$300 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Ambulance Transportation (Unlimited)	\$300 Deductible, then 20% Coinsurance, applies to \$4,300 Out of Pocket Maximum	\$300 Deductible, then 20% Coinsurance, applies to \$4,300 Out of Pocket Maximum	
Air Ambulance (Unlimited)	\$300 Deductible, then 20% Coinsurance, applies to \$4,300 Out of Pocket Maximum	\$300 Deductible, then 20% Coinsurance, applies to \$4,300 Out of Pocket Maximum	
<b>OTHER SERVICES</b>			
Allergy/Therapeutic Injections	\$300 Deductible, then 20% Coinsurance, applies to \$4,300 Out of Pocket Maximum	\$300 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Mental Health Inpatient Facility Care (Unlimited)	\$300 Deductible, then 20% Coinsurance, applies to \$4,300 Out of Pocket Maximum	\$300 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Mental Health Outpatient Professional Care (Unlimited)	\$30 Copay, applies to the \$4,300 Out of Pocket Maximum	\$300 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Chemical Dependency Inpatient Facility Care (Unlimited)	\$300 Deductible, then 20% Coinsurance, applies to \$4,300 Out of Pocket Maximum	\$300 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	

MEDICAL PLAN	PLAN D	
	IN-NETWORK	OUT-OF-NETWORK
Chemical Dependency Outpatient Professional Care (Unlimited)	\$30 Copay, applies to the \$4,300 Out of Pocket Maximum	\$300 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Inpatient Facility (30 days PCY)	\$300 Deductible, then 20% Coinsurance, applies to \$4,300 Out of Pocket Maximum	\$300 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)	\$30 Copay, applies to the \$4,300 Out of Pocket Maximum	\$300 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	\$30 Copay, applies to the \$4,300 Out of Pocket Maximum	\$300 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Medical Supplies, Equipment, Prosthetics (Unlimited)	\$300 Deductible, then 20% Coinsurance, applies to \$4,300 Out of Pocket Maximum	\$300 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Foot Orthotics, Orthopedic Shoes and Accessories (\$300 PCY; Includes orthotics and orthopedic shoes)	\$300 Deductible, then 20% Coinsurance, applies to \$4,300 Out of Pocket Maximum	\$300 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Home Health Visits (130 visits PCY)	\$300 Deductible, then 20% Coinsurance, applies to \$4,300 Out of Pocket Maximum	\$300 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)	\$300 Deductible, then 20% Coinsurance, applies to \$4,300 Out of Pocket Maximum	\$300 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
<b>ALTERNATIVE CARE</b>		
Manipulations (Spinal and other) (12 visits PCY)	\$30 Copay, applies to the \$4,300 Out of Pocket Maximum	\$300 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Acupuncture (12 visits PCY)	\$30 Copay, applies to the \$4,300 Out of Pocket Maximum	\$300 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>SUPPLEMENTAL BENEFITS</b>		
Routine Hearing Exam (1 PCY)	\$30 Copay	\$300 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
<b>ANNUAL PLAN MAXIMUM</b>		
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](http://www.premera.com)

PHARMACY PLAN		PLAN D - RX - 10/35/70/250
PRESCRIPTION DRUGS		
<b>Drug List</b>		Preferred B4 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands Tier 4 = specialty
<b>Retail Cost Shares</b>		\$10/\$35/\$70/\$250
<b>Mail Cost Shares</b>		\$20/\$70/\$140/\$250
<b>Day Supply</b>		Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days
<b>Individual Deductible PCY</b>		\$0
<b>Family Deductible PCY</b>		No Family Deductible
<b>Out of Network (Non-participating retail pharmacies)</b>		Cost Share, then 40% (to allowable)
<b>Out of Pocket Maximum</b>		Applies to the medical out of pocket maximum
<b>Specialty Pharmacy Out of Pocket Maximum</b>		Applies to the medical out of pocket maximum
<b>Annual Benefit Maximum</b>		Unlimited

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