

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 E	
	IN-NETWORK	OUT-OF-NETWORK	
MEDICAL COST SHARE OPTIONS			
Individual Deductible PCY (Family embedded deductible 3X Individual)	\$500	\$500	
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)	\$4,500	Unlimited	
Office Visit Cost Share	\$30 Copay, applies to the \$4,500 Out of Pocket Maximum	\$500 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	\$30 Copay, applies to the \$4,500 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Inpatient Professional Services	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Contraceptive Management Services (Unlimited)	Covered In Full	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	

MEDICAL PLAN		PLAN E	
	IN-NETWORK	OUT-OF-NETWORK	
DIAGNOSTIC SERVICE OPTIONS			
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Other Professional Diagnostic Imaging	Waive Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Professional Diagnostic Major Imaging	Waive Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Other Professional Diagnostic Laboratory/Pathology	Waive Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$500 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	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Outpatient Surgery Facility	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$500 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)	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$500 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 \$500 Deductible and 20% Coinsurance; all cost shares apply to the \$4,500 Out of Pocket Maximum	\$200 Copay then \$500 Deductible and 20% Coinsurance; all cost shares apply to the \$4,500 Out of Pocket Maximum	
Emergency Room Physician	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	
Urgent Care Center	\$30 Copay, applies to the \$4,500 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Ambulance Transportation (Unlimited)	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	
Air Ambulance (Unlimited)	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	
OTHER SERVICES			
Allergy/Therapeutic Injections	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Mental Health Inpatient Facility Care (Unlimited)	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Mental Health Outpatient Professional Care (Unlimited)	\$30 Copay, applies to the \$4,500 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Chemical Dependency Inpatient Facility Care (Unlimited)	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	

MEDICAL PLAN		PLAN E	
	IN-NETWORK	OUT-OF-NETWORK	
Chemical Dependency Outpatient Professional Care (Unlimited)	\$30 Copay, applies to the \$4,500 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Rehab Inpatient Facility (30 days PCY)	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$500 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 \$4,500 Out of Pocket Maximum	\$500 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 \$4,500 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Medical Supplies, Equipment, Prosthetics (Unlimited)	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Foot Orthotics, Orthopedic Shoes and Accessories (\$300 PCY; Includes orthotics and orthopedic shoes)	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Home Health Visits (130 visits PCY)	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$500 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)	\$500 Deductible, then 20% Coinsurance, applies to \$4,500 Out of Pocket Maximum	\$500 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)	\$30 Copay, applies to the \$4,500 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
Acupuncture (12 visits PCY)	\$30 Copay, applies to the \$4,500 Out of Pocket Maximum	\$500 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum	
SUPPLEMENTAL BENEFITS			
Routine Hearing Exam (1 PCY)	\$30 Copay	\$500 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 E - RX 10/35/70/250
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/\$35/\$70/\$250	
Mail Cost Shares	\$20/\$70/\$140/\$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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