

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 G	
	IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 3X Individual)	\$1,000	\$1,000
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 2X Individual)	\$6,850	Unlimited
Office Visit Cost Share	\$35 Copay, applies to the \$6,850 Out of Pocket Maximum	\$1,000 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	\$35 Copay, applies to the \$6,850 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Inpatient Professional Services	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Contraceptive Management Services (Unlimited)	Covered In Full	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

MEDICAL PLAN	PLAN G	
	IN-NETWORK	OUT-OF-NETWORK
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Imaging	Waive Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Professional Diagnostic Major Imaging	Waive Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Other Professional Diagnostic Laboratory/Pathology	Waive Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$1,000 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	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Outpatient Surgery Facility	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$1,000 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)	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$1,000 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 \$1,000 Deductible and 20% Coinsurance; all cost shares apply to the \$6,850 Out of Pocket Maximum	\$200 Copay then \$1,000 Deductible and 20% Coinsurance; all cost shares apply to the \$6,850 Out of Pocket Maximum
Emergency Room Physician	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum
Urgent Care Center	\$35 Copay, applies to the \$6,850 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Ambulance Transportation (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum
Air Ambulance (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum
OTHER SERVICES		
Allergy/Therapeutic Injections	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Inpatient Facility Care (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Mental Health Outpatient Professional Care (Unlimited)	\$35 Copay, applies to the \$6,850 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Chemical Dependency Inpatient Facility Care (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum

MEDICAL PLAN	PLAN G	
	IN-NETWORK	OUT-OF-NETWORK
Chemical Dependency Outpatient Professional Care (Unlimited)	\$35 Copay, applies to the \$6,850 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Inpatient Facility (30 days PCY)	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$1,000 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)	\$35 Copay, applies to the \$6,850 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	\$35 Copay, applies to the \$6,850 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Medical Supplies, Equipment, Prosthetics (Unlimited)	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Foot Orthotics, Orthopedic Shoes and Accessories (\$300 PCY; Includes orthotics and orthopedic shoes)	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Home Health Visits (130 visits PCY)	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$1,000 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)	\$1,000 Deductible, then 20% Coinsurance, applies to \$6,850 Out of Pocket Maximum	\$1,000 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)	\$35 Copay, applies to the \$6,850 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
Acupuncture (12 visits PCY)	\$35 Copay, applies to the \$6,850 Out of Pocket Maximum	\$1,000 Deductible, then 50% Coinsurance, applies to Unlimited Out of Pocket Maximum
SUPPLEMENTAL BENEFITS		
Routine Hearing Exam (1 PCY)	\$35 Copay	\$1,000 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 G - RX - 10/40/80/250	
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/\$40/\$80/\$250	
Mail Cost Shares	\$20/\$80/\$160/\$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 race 805-502-4505, Fax 405-918-5092, TTV 800-842-5357
Tell race 805-502-4505, Fax 405-918-5092, 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 طومات فضاء أن يعوني هذا الإنسران معارضات مهمة بخصوص طلك أو منظماً التي ترابد المصراب طبيا من خلال (Fremera Blue Cross نا كون هناك تواري مهمة في هنا الإنجلس وقال عضاح الانجاز إداء في تواريخ معينة المعاملة على تطفيك الصمية أو المساحدة ومن التكافيات بها العصوال على هذا المعارضات والاساحدة بالمثال الدون التي الم 1805. التصل

中文 (Chinese):
- 本國和有意學的原義,本書知可能有關於思語論 Premera Blue Cross 提交的中語或指數的重要訊息,本書知可能允重之日末。 巴罗德爾森在森上日期 - 公司院政府第。以保留的的健康被認為者實用結局。 於中華兴秀皇以您的自 品得別本訊息和策勢。 與豫電話 800-722-1471 (TTY: 800-842-5357)。

한국의 (Moraelli 보통 한자교육의 업업이다. 속이 본지에는 가장의 신경에 보통 전시에는 현대를 보면 경기를 받아 없었다. 속이 본지에는 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 되습니다. 가장는 가장의 구강 가장이기를 가게 되었다고 보통을 받아가 기계를 위한 가장의 구강 가장이기를 가게 되었다고 보통을 받아가 기계를 위한 가장이 구강 가장이기를 받아 되었다고 보통을 받아 기계를 되었다고 있다. 기계를 가장이 되었다고 보통을 받았다고 있는 가장이다. 가장이 이어를 당성을 모음을 구하는 것이 보내를 받으면 어떻게 수 있는 모든 가장이다. 이어를 가장이 가장이 되었다면 보통을 받으면 어떻게 수 있는 등 가장이 되었다. 이어를 가장이 되었다면 보통을 받으면 어떻게 되었다.

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 salaada. Tarii kaffaitiohaan deeggarmudi
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oderffannoo argabuut diregapaan aganbuut miigan a qabaattu.
Lakkoofsa bibliaa 800-722-1471 (TTY: 800-842-5357) tii bibliaa.

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 asidaran ana lang ou pale a, san ou pa gen pou peye pou sa. Rele nan 600-722-1471
(Trr. 500-442-542)

Detasche (Bernachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wirder Umständen wichtige Informationen bedüglich höres Arträgig auf Krankenversichenungsschrätz durch Phremeta Benachrichtigung, sie beinriche bis zu bestämmten Söchätigen handelin müssen, um Ihren Krankenversicherungsschutzt oder Hille mit den Kosten zu behalten. Bis haben das Recht, kostenloss Hille und Informationen in ihrer Sprache zu erhalten. Bis den das Secht, kostenloss Hille und Informationen in ihrer Sprache zu erhalten. Rufen Sie an unter 600-722-1471 (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 vera gran ahav dam ntawy no mas koj tilais
yuav tsu tash kev pab cuam kho mob los yogi kev pab them tej ngi kho mob
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tilais hom nua koji kho mob
(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 dagiti importanta a petas tai daytoy a pakdaar. Mabalin nga adda rumbeng nga aramidenyo nga addang sakbay dagiti partikular a natividing nga addem sporm mapagalianedyo i coverage it salun-alyo wenno tulong kadagiti gastos. Adda karbenganyo a magala 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).

Raliano (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 nagalannan na muhalasgang impormasyor panawan na fin ay nagalasnan na muhalasgang impormasyor panawan na fin ay managang nagalasnan na pamamagang na pinawa tangala sa yang salikasyon na pagasian sa pamamagang na Pinawan nangalangsa har na managangan na Palasian i na lamin palasian salikasyon nangalangsa har na managangan na Palasian i na lamin palasian pamama nangalangsa har na managangan na Palasian i na lamin palasian salikasyon nangalangsa har nangangan na kalasian na kalasian salikasian nangalangsa hari nangalangsa hari nangalangsa na kalasian na kalasian salikasian nangalangsa hari nangalangsa n

les (Thai): (constituy