

# Highlights of your Health Care Coverage

2018 PPO 50% PLAN 2000

Effective Date: 10/01/2018

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	2018 PPO 50% PLAN 2000	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
<b>MEDICAL COST SHARE OPTIONS</b>		
<b>Individual Deductible PCY</b> (Family embedded deductible 2X Individual)	\$2,000/\$4,000 PCY	Shared with In-Network
<b>Coinsurance (Member's percentage of costs after deductible based on allowable charges)</b>	50%	50%
<b>Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable</b> (Family embedded OOP max 2X Individual)	\$5,000/\$10,000 PCY	Shared with In-Network
<b>Office Visit Cost Share</b>	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION</b>		
<b>Preventive Office Visit</b> (Unlimited, subject to standard medical guidelines)	Covered In Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Immunizations</b> (Unlimited, subject to standard medical guidelines)	Covered In Full	Dep Child to Age 18 Covered In Full; Members Over 18 Out of Network Deductible, then 50%
<b>Health Education (HE)</b> (Unlimited)	Covered In full	Not Covered
<b>Nicotine Dependency Programs (ND)</b> (Unlimited)	Covered In Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum

<b>MEDICAL PLAN</b>		<b>2018 PPO 50% PLAN 2000</b>	
	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>Diabetes Health Education (DE)</b> (Unlimited)	Covered In Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>PROFESSIONAL CARE</b>			
<b>Professional Office Visit</b>	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Inpatient Professional Services</b>	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Contraceptive Management Services</b> (Unlimited)	Covered In Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>DIAGNOSTIC SERVICE OPTIONS</b>			
<b>Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA</b>	Covered In Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Other Professional Diagnostic Imaging</b>	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Professional Diagnostic Major Imaging</b>	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Other Professional Diagnostic Laboratory/Pathology</b>	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Diagnostic Mammography</b>	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>FACILITY CARE OPTIONS</b>			
<b>Inpatient Facility</b>	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Outpatient Surgery Facility</b>	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Skilled Nursing Facility</b> (90 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	

<b>MEDICAL PLAN</b>		<b>2018 PPO 50% PLAN 2000</b>	
	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>Hospice Inpatient Facility</b> (30 days Inpatient; within the 6 month lifetime maximum)	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>EMERGENCY CARE AND TRANSPORTATION OPTION</b>			
<b>Emergency Care (If applicable, waive copay if admitted to inpatient facility)</b>	\$200 Copay then \$2,000 Deductible and 50% Coinsurance; all cost shares apply to the \$5,000 Out of Pocket Maximum	\$200 Copay then \$2,000 Deductible and 50% Coinsurance; all cost shares apply to the \$5,000 Out of Pocket Maximum	
<b>Emergency Room Physician</b>	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	
<b>Urgent Care Center</b>	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Ambulance Transportation</b> (Unlimited)	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	
<b>Air Ambulance</b> (Unlimited)	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	
<b>OTHER SERVICES</b>			
<b>Allergy/Therapeutic Injections</b>	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Mental Health Inpatient Facility Care</b> (Unlimited)	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Mental Health Outpatient Professional Care</b> (Unlimited)	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Chemical Dependency Inpatient Facility Care</b> (Unlimited)	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Chemical Dependency Outpatient Professional Care</b> (Unlimited)	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Rehab Inpatient Facility</b> (30 Days PCY)	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain</b> (25 Visits PCY)	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer</b>	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	

<b>MEDICAL PLAN</b>		<b>2018 PPO 50% PLAN 2000</b>	
	<b>HERITAGE IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>Medical Supplies, Equipment, Prosthetics</b> (Unlimited)	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Foot Orthotics, Orthopedic Shoes and Accessories</b> (Unlimited)	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Home Health Visits</b> (130 visits PCY)	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Hospice Care</b> (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>TMJ (Temporomandibular Joint Disorders)</b> (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	
<b>Transplants</b> (Unlimited; \$7,500 travel and lodging limits)	Covered as any other service	Not Covered	
<b>ALTERNATIVE CARE</b>			
<b>Manipulations (Spinal and other)</b> (12 visits PCY)	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Acupuncture</b> (12 visits PCY)	\$2,000 Deductible, then 50% Coinsurance, applies to \$5,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>ANNUAL PLAN MAXIMUM</b>			
<b>Annual Plan Maximum</b>	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

2018 PPO 50% PLAN 2000 - RX

Effective Date: 10/01/2018

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		2018 PPO 50% PLAN 2000 - RX
<b>PRESCRIPTION DRUGS</b>		
<b>Drug List</b>		A1
<b>Retail Cost Shares</b>		50%
<b>Mail Cost Shares</b>		50%
<b>Day Supply</b>		Retail: 90 Days; Mail: 90 Days; Specialty: 30 Days
<b>Individual Deductible PCY</b>		Shared with Medical Deductible
<b>Family Deductible PCY</b>		Family Deductible 2x Individual
<b>Out of Network (Non-participating retail pharmacies)</b>		Retail Pharmacy & Preventive Generic Drug List Same as INN; OON Mail Order Not Covered
<b>Out of Pocket Maximum</b>		Applies to the medical out of pocket maximum
<b>Annual Benefit Maximum</b>		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.

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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:
  - 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](mailto: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 ሊያረው ይችላል። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖች ሊኖሩ ይችላሉ። የጠናን ሽፋን ለመጠበቅና በአስፈላጊ ስርዓት ለማግኘት በተወሰኑ የጊዜ ገደቦች አርምያጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና የለምንም ክፍያ በቋንቋዎ ስርዓት እንዲያገኙ መብት አለዎት። በጠላክ ቁጥር 800-722-1471 (TTY: 800-842-5357) ይደውሉ።

### العربية (Arabic):

يحتوي هذا الإشعار معلومات هامة. قد يحتوي 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. بحق لك الحصول على هذه المعلومات والمساعدة ببلغتك دون تكبد أية تكلفة. اتصل 800-722-1471 (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 kaffaltiidaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhuma 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) ti 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 resewva 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 cajj nyooog 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 mabalín nga adda ket naglaon iti napateg nga impormasion maipanggep iti aplikasyonyo wenno coverage babaen iti Premera Blue Cross. Daytoy ket mabalín dagiti importante a petsa iti daytoy a pakdaar. Mabalín 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).

