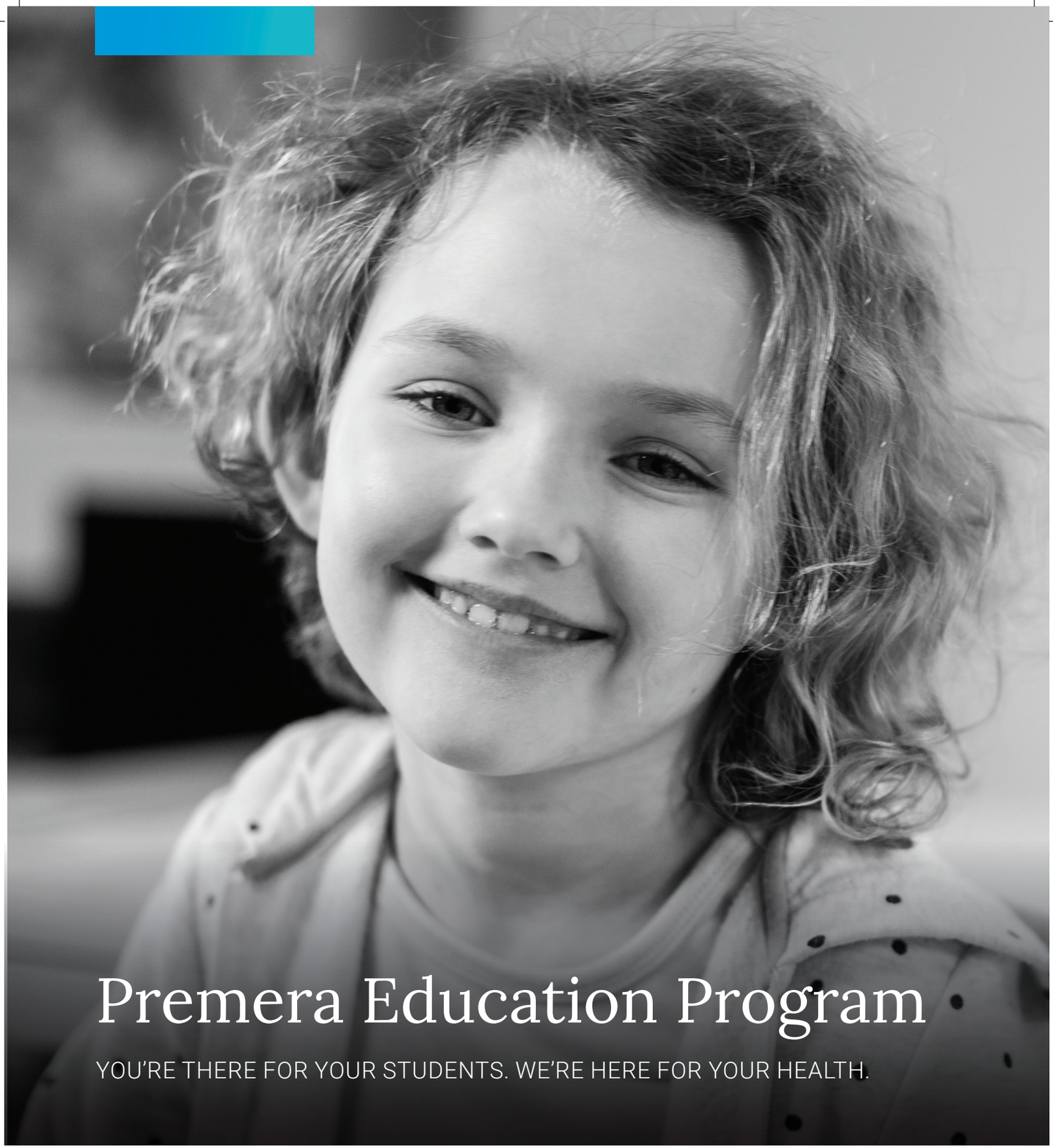


Premera Education Program

YOU'RE THERE FOR YOUR STUDENTS. WE'RE HERE FOR YOUR HEALTH.

PREMERA | BLUE CROSS

Making healthcare work better for you

Dear Premera Blue Cross customer,

We're honored to serve you as your health plan for the next benefit year, just as we've served Washington school employees and their families for more than 50 years.

Having Premera as your health plan means you will have access to outstanding benefits, the broadest provider network in Washington, and a better experience, which makes it easy for you to get the care you need.

We look forward to providing you with exceptional support and customer service, as well as finding even more ways to make healthcare work better for you. It's a commitment we've delivered to Washington educators since 1962.

Sincerely,

Jeffrey Roe
President and CEO
Premera Blue Cross

Simple and easy

AT PREMERA BLUE CROSS, OUR PASSION IS TAKING GREAT CARE OF OUR CUSTOMERS.

With a Premera health plan, you have our commitment to make it simple and easy to understand and use your benefits and coverage.

It all starts with our depth of experience. We've been a part of the lives of teachers, administrators, and support staff in Washington schools for more than 50 years, and we've served millions of customers as a local not-for-profit company for more than 80 years.

With Premera, you get:

- The same great health plans that school districts and their families have depended on–plus added benefits and enhancements. All our plans are designed to keep costs low for you
- Access to Premera's Heritage network, the largest network of doctors and medical facilities in Washington. (When outside of Washington, you can take your healthcare benefits with you across the country through the BlueCard® program and around the world with the Blue Cross Blue Shield Global Core.)
- Specialized care programs and personal health support clinicians to help you navigate an often complex healthcare system
- Encouragement for healthy living through the Premera Wellness Program's health survey, online tools, and lifestyle guidance resources
- Exclusive discounts on fitness club memberships, weight loss programs, and vision hardware
- Mobile apps and web-based tools that help you compare the costs of healthcare services and prescription drugs, find care on the go, and manage your benefits online
- Virtual care options that can save you time and money by providing access to a doctor via video or phone
- Free, confidential, and around-the-clock advice from a registered nurse through the 24-Hour NurseLine
- Local, dependable customer service with extended hours that make it convenient for you to contact Premera when you have time
- A simple and easy transition from the end of your current benefit year to the start of your next one

We're proud to be local and in your corner.

Healthcare coverage wherever you go

AT HOME, ACROSS THE COUNTRY, AND AROUND THE WORLD—
THE POWER OF BLUE IS WITH YOU.

Your Premera provider network: Heritage

Your medical benefits allow you to get care from a broad array of physicians and specialists without the need for referrals.

All medical plans in the Premera Education Program provide access to the Heritage network, the largest network of doctors, facilities, and hospitals in Washington.

As a Premera Blue Cross enrollee, you can see a network provider anywhere in the United States through the BlueCard® program. Our expansive national network is built on our strong relationships with providers, hospitals, and specialists.

With the Blue Cross Blue Shield Global Core program, you take your healthcare benefits with you when traveling or living abroad. You have access to medical assistance services, doctors, and hospitals in nearly 200 countries and territories around the world, at no extra cost to you.

Using doctors and primary care providers in the Premera network—including family doctors, internal medicine doctors, pediatric doctors, physician assistants, and nurse practitioners—can help you get the most from your health plan. Using an in-network provider offers the following benefits:

- Your provider gets to know you and your health history, making it easier to catch health problems early or manage an ongoing condition.
- Your provider can coordinate your care with other specialists as needed and stay informed about all aspects of your care.
- Your out-of-pocket costs are lower. You also save money when you use in-network pharmacies and hospitals.

24-Hour NurseLine

With your Premera plan, you can call the free and confidential 24-Hour NurseLine anytime, 24 hours a day, 7 days a week, 365 days a year. You'll get thoughtful, accurate health information from a registered nurse who can help you decide the right level of medical care for your health need.

Visit a doctor without leaving home

Virtual care (Teladoc®) gives you immediate and convenient access to care whenever and wherever you need it by phone or online video. It's easier than walking into an office to get care face to face.

Teladoc* doctors have an average of 15 years experience and can diagnose, recommend treatment, and prescribe medication (when appropriate) for many of your urgent medical issues.

Common conditions a Teladoc physician can help you handle include sinus problems, respiratory infection, allergies, urinary tract infection, cold and flu symptoms, and many other non-emergency illnesses.

Teladoc doctors offer consultation similar to what you get in a face-to-face office visit, but without the extra travel time or potential high cost of visiting an urgent care or emergency room. (It's not meant to replace your primary care provider, though.)

There is no cost for an enrollee and their covered dependents to have a Teladoc visit. Deductible and coinsurance will apply to those with a Qualified High Deductible Health Plan.

TELADOC PHONE AND VIDEO CONSULTATIONS

24 HOURS A DAY, 7 DAYS A WEEK

* Teladoc operates subject to state regulation and may not be available in certain states .

Teladoc is an independent company that provides virtual medical care services on behalf of Premera Blue Cross. Teladoc does not replace the primary care physician. Teladoc does not guarantee that a prescription will be written. Teladoc does not prescribe DEA controlled substances, non-therapeutic drugs, and certain other drugs which may be harmful because of their potential for abuse. Teladoc physicians reserve the right to deny care for potential misuse of services.

What your plan covers

Your plan covers medical services and prescriptions, plus some services that might surprise you.

Understand your medical benefits

Your plan covers essential benefits, such as:

- Office visits
- Urgent and emergency care
- Lab tests
- Maternity and newborn care
- Hospitalization
- Mental health care
- Prescription medications
- Preventive care

Preventive care: Strengthen your defenses

When you catch health issues early, lifestyle changes you make and medical treatment you receive can be more effective. That's why your plan covers preventive care and tests, including:

- Regular checkups
- Vaccines, such as flu and tetanus shots
- Screenings, such as blood pressure and cholesterol tests

Is it preventive or diagnostic?

Tests to monitor a previously diagnosed condition are considered diagnostic, not preventive, and will be covered according to your health plan benefits. Your doctor may order tests that are not covered as preventive.

After you have been diagnosed with a medical condition, tests to monitor that condition are no longer considered preventive benefits.

Are you covered? Know before you go

For some care to be covered by your plan, you need to get it approved beforehand.

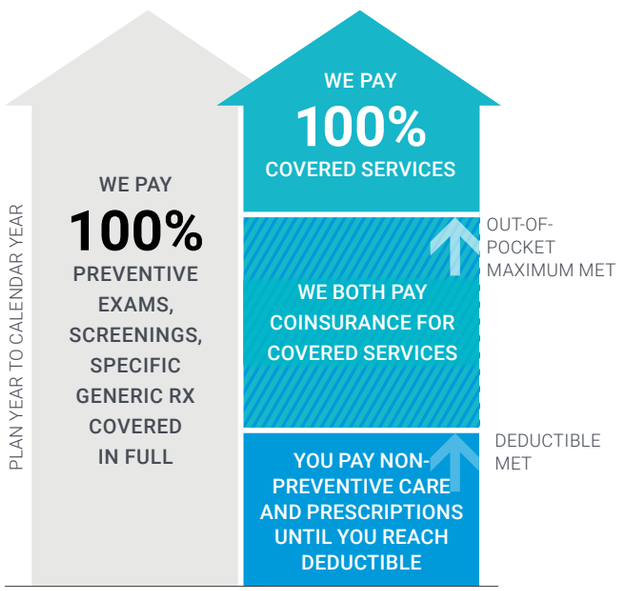
For this care, your provider needs to get pre-approval, an OK from Premera before you get the care. Otherwise, you may need to pay part or all of the cost, above your usual cost shares. (Your doctor has the most current list of services.)

For example, you need pre-approval for:

- Planned hospital admissions
- Some medicines
- Non-emergency ambulance
- Advanced imaging such as MRIs and CT scans

How your health plan works

To get the most out of your health plan, it's important to understand the lingo



This is an example only. See your health plan benefits for coverage details.

Deductible

You'll pay for most covered care and medical services until what you spend totals the amount of your deductible.

Charges for covered procedures, prescriptions, and items such as crutches, may count toward your deductible. Amounts you pay toward services and prescriptions your plan does not cover won't count toward your deductible. Some care might be covered in full—the plan pays 100 percent—regardless of whether you've met your deductible.

Coinsurance

After you meet your deductible, you pay coinsurance—the percentage of cost that is your responsibility.

For example, if your plan has a 20 percent coinsurance, that would mean for a $100 service you pay $20 and the plan pays $80. For actual numbers, check the plan highlights.

Copay

Copay is the amount you'll pay at the front desk when you arrive for your appointment, usually. The copay is set by your plan—and is paid whether you've met your deductible or not.

Out-of-pocket maximum

Your plan will also have an annual out-of-pocket maximum. That means that if the total amount you spend for your care—such as deductible and coinsurance—totals the amount of your out-of-pocket maximum, the plan will pay 100 percent of your covered care for the rest of the calendar year.

Services the plan does not cover, and amounts over the allowable charge, won't apply to the out-of-pocket maximum. Copays apply to your out-of-pocket maximum and once you spend that total amount on care, you will no longer have to pay them.

How your plan works at renewal

Any deductible and out-of-pocket amounts previously satisfied or day/visit limitations used under your current or previous plan stay with you through the end of the calendar year, even if you change plans. These amounts/limitations will be restored on January 1.

If your new or current plan has a higher deductible and/or out-of-pocket maximum, you may need to satisfy the difference for the remainder of the calendar year.

The number of visits used during the calendar year cannot exceed the visit limit under the new plan. For example: You are currently enrolled on Plan 3 with unlimited chiropractic visits and have already used 15 visits. If you move to EasyChoice B, which is limited to 12 visits, you will have already exceeded the number of visits allowed on your new plan. The plan will not cover any additional visits until benefits reset on January 1.

Compare and contrast: Non-specialists versus Specialists

Non-specialists

When medically appropriate and to lower your out-of-pocket cost, we encourage you to obtain care from a provider type listed below. These provider types are not considered specialists, so you'll pay the lower non-specialist copay.

- Family practice physician
- General practice physician
- Internist
- Gynecologist
- Naturopath
- Advanced registered nurse practitioner (ARNP)
- Obstetrician
- Pediatrician
- Physician assistant
- Chiropractor
- Acupuncturist

The specialist copay will apply to all other provider types, except for mental health services.

Specialists

All Premera Education Program health plans, except the Qualified High Deductible Health Plan (QHDHP), include a separate copay for office visits with a specialist. This applies each time you see a specialist, as well as when you receive outpatient rehabilitation services.

You'll find each plan's specialist copay amount on the benefit highlights.

Get to know your prescription coverage

Premera Blue Cross prescription drug benefits provide you with cost-saving choices and easy pharmacy access.

Pharmacy benefits are coordinated through Express Scripts,* an independent company that gives you access to:

- Retail pharmacies participating in the Express Scripts nationwide network
- Pharmacy home delivery services from the Express Scripts Pharmacy℠

Manage your medications online or on the go

When your plan is active, you can track your prescriptions at premera.com or by downloading the mobile app where you will be able to:

- Check which prescriptions are covered
- Compare costs
- Find in-network pharmacies
- Order and refill prescriptions

Generic drugs can save you money

Generics are less expensive than brand-name drugs and are an excellent value. By law, active ingredients in generic drugs must meet the same level of quality, strength, effectiveness, and purity as their brand-name equivalents.

Specialty Drugs

Many people with complex conditions like multiple sclerosis, rheumatoid arthritis, and cancer require specialty medications. These drugs are usually self-injected, can be very expensive, may not be readily available at retail pharmacies, and often require special handling.

$	**TIER 1**	Generics
$$	**TIER 2**	Most brand name drugs
$$$	**TIER 3**	Other brand name drugs, more expensive than their alternatives in Tier 1 or 2
$$$$	**TIER 4**	Specialty drugs for complex medical conditions

The specialty pharmacy program focuses on the delivery of specialty drugs and the specific needs of enrollees who require them, including:

- Training on self-injection
- Educational materials, counseling, and product information
- 24-hour access to clinical assistance from pharmacists and nurses
- Refill reminders
- Free delivery

Home delivery saves you time and money

The home delivery service offered by Express Scripts Pharmacy is convenient, reduces trips to the local pharmacy, and can save you money with discounted prices.

You can receive prescriptions up to the maximum supply allowed by your plan—typically 90 days—usually at a lower out-of-pocket cost than what you would pay at a retail pharmacy.

Your prescriptions arrive by mail in sealed, insulated (when necessary), and tamper-evident packaging.

* Express Scripts is an independent company that provides pharmacy benefit services on behalf of Premera Blue Cross.

What's a health savings account?

It's an account where you can save money tax-free to pay for IRS-approved healthcare expenses. You can also invest your money variety of mutual funds once you reach a minimum balance and let it grow tax free over time to use in the future. The Qualified High Deductible Health Plan (QHDHP) is designed to work with a health savings account (HSA).

The HSA belongs to you

It's your money and you decide when and how to spend it. It does not belong to your employer, even if your employer contributes money to your account. Plus the HSA is yours even if you decide to change jobs or health plans or retire. And there's no "use it or lose it" rule with the HSA, meaning your balance rolls over year-to-year and can continue to grow.

You can also use your HSA funds to pay for expenses incurred by your spouse or dependents, even if they are not on your plan.

Are you eligible for an HSA?

This is an IRS rule. You're likely eligible if you answer "no" to all of these questions:

- Are you claimed as a tax dependent on another person's taxes?
- Are you enrolled in Medicare?
- Are you covered by your own or your spouse's flexible spending account (FSA), health reimbursement arrangement (HRA) or a non-HSA health plan? (Exceptions: limited purpose FSA or post-deductible HRA.

Paying healthcare bills with your HSA

You can use the money in your HSA to pay for IRS-approved healthcare expenses—including your deductible and coinsurance. And this money will not be taxed.

Some expenses you can pay for with your HSA:

- Coinsurance and deductible
- Dental care
- Eye exams, glasses, and contacts
- Orthodontia
- Prescription drugs

Some expenses you cannot pay for with your HSA:

- Health plan premiums
- Gym fees
- Cosmetic surgery
- Teeth whitening

Go to premera.com/HSA to learn more about eligible healthcare expenses.

Keeping you healthier

YOUR PLAN COVERS SERVICES THAT HELP YOU GET HEALTHY AND STAY HEALTHY

Get free of tobacco

Your health plan covers:

- Nicotine dependency programs
- Certain nicotine dependency drugs with a written prescription

These are covered at no cost to you from approved doctors, counselors, and pharmacies in your plan's network. Plus, there's no annual maximum.

Enrollee-only discounts

Premera Blue Cross enrollees save money with special discount offers:*

- Diet, nutrition, and supplements
- Eye care services and hardware
- Fitness center memberships
- Hearing aids and screenings
- Newborn services and products

It's easy to get your discounts:

- No extra fees
- Make purchases in person, over the phone, or online

* This is a discount program only. Discounts cannot be used to reduce your costs for a product or service covered by your health plan. Discounts do not affect your premiums. Your costs for program services and products do not count toward calendar year coinsurance maximums, lifetime maximums, and/or plan deductibles. Discounts may vary by location.

Personal health support when you need it

WE'RE HERE TO HELP YOU WITH THE CONCERNS THAT IMPACT YOUR PHYSICAL, SOCIAL, AND MENTAL HEALTH

We can help you:

- Manage complex symptoms and illnesses
- Navigate the system of care
- Get access to the care you need
- Address personal, social, or financial needs
- Respond to changes in your functioning

We can support you during transitions in your care

We collaborate with you and/or your family to help you get back home after you leave an in-patient stay facility. We can help you:

- Coordinate care between your specialists and your routine care providers
- Develop a plan for follow-up care
- Understand how to take care of yourself and know what to expect
- Get help with changes in your condition

We can support you with ongoing conditions

We help you manage the conditions you're living with by helping you accomplish your health goals. Our program provides support for people living with diabetes, heart failure, chronic obstructive pulmonary disease, asthma, or coronary artery disease.

BestBeginnings Maternity

HEALTHIER OUTCOMES FOR MOMS AND BABIES

Are you expecting?

Get a head start on ensuring the good health of you and your baby with BestBeginnings. This Premera Blue Cross maternity program provides:

- Pregnancy support with the free BestBeginnings mobile app
- Newborn support for babies who need care in the neonatal intensive care unit (NICU)

Start smart with the BestBeginnings app

- Access health plan tools, including 24-Hour NurseLine and Find a Doctor
- Review customized maternity information
- Get alerts on pregnancy-related issues
- Create a personalized birthing plan
- Set reminders for appointments, medications, exercise, and more
- Access a direct line to Premera's maternity specialists if issues arise

Special care for baby

For those who qualify, if your baby is admitted to the Neonatal Intensive Care Unit (NICU), BestBeginnings provides you with a dedicated maternity clinician. As your advocate, BestBeginnings will help you understand what is happening and help with any special needs when your baby comes home.

You can invite a partner or friend to join you on BestBeginnings. It's a great way to get support on your pregnancy journey.

BestBeginnings
BROUGHT TO YOU BY PREMERA

Health assessment

PREMERA WELLNESS PROGRAM

Your roadmap to improved well-being

The Premera Wellness Program's online health assessment gives you a picture of your overall health. This allows you to see what you're doing well and what areas may need some extra attention. With this information, you're on the road to success as you work toward your health goals.

To reach the assessment:

- Once your plan year begins, you can sign into your account at **premera.com**
- Select **Stay Healthy** in the left navigation bar
- Select **Wellness Tools** and Start Wellness Tools
- Confirm your address when prompted. You're now ready to use the wellness tools.
- Select **Take the Health Assessment**

To complete the assessment:

The health assessment is a questionnaire that will take 15 to 20 minutes to complete. Answer the questions as accurately as possible for the best results. Your answers and results are confidential.

What to expect after the assessment:

After completing the assessment, you'll get an interactive My Plan for Wellness report. The report shows your risk for common health conditions. It also provides tips for how to improve your health and reduce your risk for disease.

Other wellness tools at **premera.com** include a Personal Health Record and My Tracker, which lets you measure health data over time.

Lifestyle guidance resources

PREMERA WELLNESS PROGRAM

Sometimes we all need a little extra support

Whether your work-life balance is out of whack, finances are rocky, relationships have hit a snag, or you need some legal advice, we're here for you.

Masters- and PhD-level experts and online resources offer confidential help 24/7 for:

- Managing stress
- Family/spousal relationships
- Child and elder care
- Surviving grief and loss
- Energizing a career
- Dealing with illness or trauma
- Legal concerns
- Financial problems or planning

This employee assistance program is offered as part of your Premera Blue Cross health plan, at no additional cost to you.

When your plan is active, you'll be able to sign in online for articles, podcasts, videos, and slideshows. Use Ask the Expert for personal responses to your questions!

Tools to help you manage your care and your account

You're on the go—and so is your health plan. You can access premera.com or the Premera app on your mobile device to:

- Track your care and your spending, including your deductible
- Find in-network doctors, hospitals, and pharmacies
- Refill prescriptions and get dose reminders
- Find the forms you need
- Learn more about your benefits

Premera Mobile app

Get it done on the go with Premera Mobile:

- Find doctors and other providers
- See deductible and out-of-pocket balances at a glance
- Show proof of coverage—no ID card required
- Contact the 24-Hour NurseLine

Express Scripts app

With just a tap of a button, you can use the Express Scripts* mobile app to:

- View current medications
- Set dosing time and refill reminders
- Order and track medications
- Find a pharmacy based on GPS location, address, or ZIP code
- Receive personalized alerts of possible health risks related to medications

Find a Doctor tool

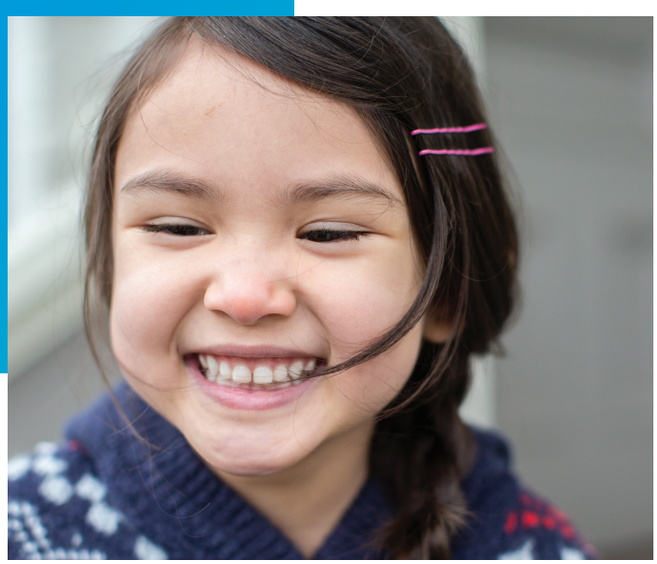
When your health plan is active, sign into premera.com or the Premera Mobile app to search for in-network doctors, hospitals, and other providers. Check out the Find a Doctor tool by visiting **premera.com** to see if your favorite provider is currently in our network.

* Express Scripts is an independent company that provides pharmacy benefit services on behalf of Premera Blue Cross.

Compare medical prices

BE AN INFORMED SHOPPER

You likely do some research before shopping for a car or computer to get the best value for your money. In the same way, it's good to do some research before making a healthcare purchase.



Find a Doctor is your go-to research tool to help you take control of your healthcare costs. Use it to compare prices of medical services from doctors and hospitals in your plan's network. Since you share in the costs of your healthcare, this kind of information can help you spend your money wisely.

It pays to be transparent

With your plan, you have access to an important online cost transparency tool that provides estimated treatment costs.

With the Estimate Treatment Costs tool, you can select from a list of common treatments or search for a procedure. You can see a list of in-network providers in your area who perform this procedure, plus estimated costs for each provider. You'll receive a range of prices—from lowest to highest—you can expect to pay based on your plan's coverage and the amount remaining to meet your deductible.

Health plan highlights

GOOD TO KNOW

Check out the enhancements

If you currently have one of the Premera health plans shown on the following pages, pay attention to the **plan enhancements** at the top of each plan summary. You might be surprised at the new benefits.

For all plans

- Customers get access to Heritage, Premera's broadest provider network.
- The enrollee receives up to $25,000 term life and accidental death and dismemberment (AD&D) insurance at no cost.
- No prior approval is needed for massage, physical, and occupational therapy.
- Virtual care with a Teladoc® doctor – via video or phone – have no cost share to the customer, except those on a Qualified High Deductible Health Plan.
- In-network care for prenatal services is now covered in full.
- Customers get access to an online health assessment and lifestyle guidance resources, including 3 consultation sessions.
- The out-of-pocket maximum for pharmacy and medical is shared for all plans except the Qualified High Deductible Health Plan. That means you reach your out-of-pocket maximum faster.
- Deductible expenses incurred in the last two months of a calendar year will be applied toward or "carried over" to the next calendar year's deductible.
- In the event of the enrollee's death, the surviving dependent benefit covers up to 12 months of COBRA coverage paid in full for eligible enrolled dependents.

Highlights of your Healthcare Coverage: EasyChoice A

Effective Date: 11/01/2017

PREMERA EDUCATION PROGRAM

Plan enhancements:

- First $1,000 of diagnostic services paid in full before deductible and coinsurance apply.
- Pharmacy out-of-pocket maximum is shared with the medical out-of-pocket maximum, meaning you reach your out-of-pocket maximum faster.
- Temporomandibular joint (TMJ) disorders are covered in medical benefits like any other service.

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	EASYCHOICE A: $1,250/20%/$4,000/$25 - HERITAGE	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible Per Calendar Year (PCY) (Family embedded deductible 3X Individual)	$1,250 PCY	$2,000 PCY
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	50%
Individual Out-of-Pocket Maximum (OOP) PCY, includes deductible, coinsurance, copay, and pharmacy if applicable (Family embedded OOP max 2X Individual)	$4,000 PCY	Not applicable
Office Visit Cost Share	Non-Specialist: $25 copay, applies to OOP max; Specialist: $35 copay, applies to OOP max	Out-of-network deductible, then 50%
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited)	Covered in full	Not covered
Vaccinations (Unlimited)	Covered in full	Not covered
Health Education (HE) (Unlimited)	Covered in full	Not covered
Nicotine Dependency Programs (ND) (Unlimited)	Covered in full	Out-of-network deductible, then 50%
Diabetes Health Education (DE) (Unlimited)	Covered in full	Not covered
PROFESSIONAL CARE		
Professional Office Visit	Non-Specialist: $25 copay, applies to OOP max; Specialist: $35 copay, applies to OOP max	Out-of-network deductible, then 50%
Maternity; Prenatal Care	Covered in full	Out-of-network deductible, then 50%
Inpatient Professional Services	In-network deductible, then 20%	Out-of-network deductible, then 50%
Contraceptive Management Services (Unlimited)	Covered in full	Out-of-network deductible, then 50%
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in full	Out-of-network deductible, then 50%
Other Professional Diagnostic Imaging	First $1,000 paid in full, then in-network deductible, 20%	First $1,000 paid in full, then out-of-network deductible, 50%
Other Professional Diagnostic Laboratory/Pathology	First $1,000 paid in full, then in-network deductible, 20%	First $1,000 paid in full, then out-of-network deductible, 50%
Diagnostic Mammography	Covered in full	Out-of-network deductible, then 50%
FACILITY CARE OPTIONS		
Inpatient Facility	In-network deductible, then 20%	Out-of-network deductible, then 50%
Outpatient Surgery Facility	In-network deductible, then 20%	Out-of-network deductible, then 50%
Hospice Inpatient Facility (10 days inpatient; within the 6 month lifetime maximum)	In-network deductible, then 20%	Out-of-network deductible, then 50%
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$100 copay applies to the OOP max, then in-network deductible, 20%	$100 copay applies to the OOP max, then in-network deductible, 20%
Emergency Room Physician	In-network deductible, then 20%	In-network deductible, then 20%
Urgent Care Center	Non-Specialist: $25 copay, applies to OOP max; Specialist: $35 copay, applies to OOP max	Out-of-network deductible, then 50%

	EASYCHOICE A: $1,250/20%/$4,000/$25 - HERITAGE	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Ambulance Transportation (Unlimited)	In-network deductible, then 20%	In-network deductible, then 20%
Air Ambulance (Unlimited)	In-network deductible, then 20%	In-network deductible, then 20%
OTHER SERVICES		
Allergy/Therapeutic Injections	In-network deductible, then 20%	Out-of-network deductible, then 50%
Mental Health Inpatient Facility Care (Unlimited)	In-network deductible, then 20%	Out-of-network deductible, then 50%
Mental Health Outpatient Professional Care (Unlimited)	Non-Specialist: $25 copay, applies to OOP max	Out-of-network deductible, then 50%
Chemical Dependency Inpatient Facility Care (Unlimited)	In-network deductible, then 20%	Out-of-network deductible, then 50%
Chemical Dependency Outpatient Professional Care (Unlimited)	Non-Specialist: $25 copay, applies to OOP max	Out-of-network deductible, then 50%
Rehab Inpatient Facility (30 days PCY)	In-network deductible, then 20%	Out-of-network deductible, then 50%
Rehab Outpatient Care, Including Physical, Occupational, Speech, and Massage Therapy (30 visits PCY)	Specialist: $35 copay, applies to OOP max	Out-of-network deductible, then 50%
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, Chronic Pain, and Cancer	Specialist: $35 copay, applies to OOP max	Out-of-network deductible, then 50%
Medical Supplies, Equipment, Prosthetics (MS: Unlimited, ME: Unlimited, Pro: Unlimited)	In-network deductible, then 20%	Out-of-network deductible, then 50%
Foot Orthotics, Orthopedic Shoes, and Accessories ($300 PCY (Unlimited Diabetes Related))	In-network deductible, then 20%	Out-of-network deductible, then 50%
Home Health Visits (130 visits PCY)	In-network deductible, then 20%	Out-of-network deductible, then 50%
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	In-network deductible, then 20%	Out-of-network deductible, then 50%
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
ALTERNATIVE CARE		
Manipulations (Spinal and other) (12 visits PCY)	$25 copay (applies to OOP max)	Out-of-network deductible, then 50%
Acupuncture (12 visits PCY)	$25 copay (applies to OOP max)	Out-of-network deductible, then 50%
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited
PRESCRIPTION DRUGS		
Drug List	A2	
Retail Cost Shares	$10/30% w/Specialty 30%	
Mail Cost Shares	$20/30% w/Specialty 30%	
Day Supply	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days	
Individual Deductible PCY	$500 deductible waived for generics	
Out of Pocket Maximum	Applies to the medical out of pocket maximum	
Annual Benefit Maximum	Unlimited	
SYMETRA LIFE AND AD&D INSURANCE	$25,000 Term Life and AD&D for employee only	

Copays are not subject to the deductible unless otherwise noted.
Pre-approval 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 highlights is not a contract. For full coverage provisions, including a description of waiting periods, limitations, and exclusions please contact Customer Service.

Highlights of your Healthcare Coverage: EasyChoice B

Effective Date: 11/01/2017

PREMERA EDUCATION PROGRAM

Plan enhancements:

- Pharmacy out-of-pocket maximum is shared with the medical out-of-pocket maximum, meaning you reach your out-of-pocket maximum faster.
- Temporomandibular joint (TMJ) disorders are covered in medical benefits like any other service.

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	EASYCHOICE B: $750/25%/$3,500/$30 - HERITAGE	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible Per Calendar Year (PCY) (Family embedded deductible 3X Individual)	$750 PCY	$1,500 PCY
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	25%	50%
Individual Out-of-Pocket Maximum (OOP) PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$3,500 PCY	Not applicable
Office Visit Cost Share	Non-Specialist: $30 copay, applies to OOP max; Specialist: $40 copay, applies to OOP max	Out-of-network deductible, then 50%
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visits (Unlimited)	Covered in full	Not covered
Vaccinations (Unlimited)	Covered in full	Not covered
Health Education (HE) (Unlimited)	Covered in full	Not covered
Nicotine Dependency Program (ND) (Unlimited)	Covered in full	Out-of-network deductible, then 50%
Diabetes Health Education (DE) (Unlimited)	Covered in full	Not covered
PROFESSIONAL CARE		
Professional Office Visit	Non-Specialist: $30 copay, applies to OOP max; Specialist: $40 copay, applies to OOP max	Out-of-network deductible, then 50%
Maternity; Prenatal Care	Covered in full	Out-of-network deductible, then 50%
Inpatient Professional Services	In-network deductible, then 25%	Out-of-network deductible, then 50%
Contraceptive Management Services (Unlimited)	Covered in full	Out-of-network deductible, then 50%
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in full	Out-of-network deductible, then 50%
Other Professional Diagnostic Imaging	In-network deductible, then 25%	Out-of-network deductible, then 50%
Other Professional Diagnostic Laboratory/Pathology	In-network deductible, then 25%	Out-of-network deductible, then 50%
Diagnostic Mammography	Covered in full	Out-of-network deductible, then 50%
FACILITY CARE OPTIONS		
Inpatient Facility	In-network deductible, then 25%	Out-of-network deductible, then 50%
Outpatient Surgery Facility	In-network deductible, then 25%	Out-of-network deductible, then 50%
Hospice Inpatient Facility (10 days inpatient; within the 6 month lifetime maximum)	In-network deductible, then 25%	Out-of-network deductible, then 50%
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$150 copay applies to OOP max, then in-network deductible, 25%	$150 copay applies to OOP max, then in-network deductible, 25%
Emergency Room Physician	In-network deductible, then 25%	In-network deductible, then 25%
Urgent Care Center	Non-Specialist: $30 copay, applies to OOP max; Specialist: $40 copay, applies to OOP max	Out-of-network deductible, then 50%

	EASYCHOICE B: $750/25%/$3,500/$30 - HERITAGE	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Ambulance Transportation (Unlimited)	In-network deductible, then 25%	In-network deductible, then 25%
Air Ambulance (Unlimited)	In-network deductible, then 25%	In-network deductible, then 25%
OTHER SERVICES		
Allergy/Therapeutic Injections	In-network deductible, then 25%	Out-of-network deductible, then 50%
Mental Health Inpatient Facility Care (Unlimited)	In-network deductible, then 25%	Out-of-network deductible, then 50%
Mental Health Outpatient Professional Care (Unlimited)	Non-Specialist: $30 copay, applies to OOP max	Out-of-network deductible, then 50%
Chemical Dependency Inpatient Facility Care (Unlimited)	In-network deductible, then 25%	Out-of-network deductible, then 50%
Chemical Dependency Outpatient Professional Care (Unlimited)	Non-Specialist: $30 copay, applies to OOP max	Out-of-network deductible, then 50%
Rehab Inpatient Facility (45 days PCY)	In-network deductible, then 25%	Out-of-network deductible, then 50%
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy (45 visits PCY)	Specialist: $40 copay, applies to OOP max	Out-of-network deductible, then 50%
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, Chronic Pain, and Cancer	Specialist: $40 copay, applies to OOP max	Out-of-network deductible, then 50%
Medical Supplies, Equipment, Prosthetics (MS: Unlimited, ME: Unlimited, Pro: Unlimited)	In-network deductible, then 25%	Out-of-network deductible, then 50%
Foot Orthotics, Orthopedic Shoes and Accessories ($300 PCY (Unlimited Diabetes Related))	In-network deductible, then 25%	Out-of-network deductible, then 50%
Home Health Visits (130 visits)	In-network deductible, then 25%	Out-of-network deductible, then 50%
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	In-network deductible, then 25%	Out-of-network deductible, then 50%
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
ALTERNATIVE CARE		
Manipulations (Spinal and other) (12 visits PCY)	$30 copay (applies to OOP max)	Out-of-network deductible, then 50%
Acupuncture (12 visits PCY)	$30 copay (applies to OOP max)	Out-of-network deductible, then 50%
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited
PRESCRIPTION DRUGS		
Drug List	B4	
Retail Cost Shares	$5/$30/$45/30%	
Mail Cost Shares	$10/$75/$112/30%	
Day Supply	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days	
Individual Deductible PCY	$250 deductible waived for generics	
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	
SYMETRA LIFE AND AD&D INSURANCE	$25,000 Term Life and AD&D for employee only	

Copays are not subject to the deductible unless otherwise noted.
Pre-approval 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 highlights is not a contract. For full coverage provisions, including a description of waiting periods, limitations, and exclusions please contact Customer Service.

Highlights of your Healthcare Coverage: Basic

Effective Date: 11/01/2017

PREMERA EDUCATION PROGRAM

Plan enhancements:

- Temporomandibular joint (TMJ) disorders are covered in medical benefits like any other service.

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	BASIC: $2,100/30%/$6,600/$35 - HERITAGE	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible Per Calendar Year (PCY) (Family embedded deductible 2X Individual)	$2,100 PCY	$2,500 PCY
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	30%	50%
Individual Out-of-Pocket Maximum (OOP) PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$6,600 PCY	Not applicable
Office Visit Cost Share	Non-Specialist: $35 copay, applies to OOP max; Specialist: $50 copay, applies to OOP max	Out-of-network deductible, then 50%
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited)	Covered in full	Not covered
Vaccinations (Unlimited)	Covered in full	Not covered
Health Education (HE) (Unlimited)	Covered in full	Not covered
Nicotine Dependency Programs (ND) (Unlimited)	Covered in full	Out-of-network deductible, then 50%
Diabetes Health Education (DE) (Unlimited)	Covered in full	Out-of-network deductible, then 50%
PROFESSIONAL CARE		
Professional Office Visit	Non-Specialist: $35 copay, applies to OOP max; Specialist: $50 copay, applies to OOP max	Out-of-network deductible, then 50%
Maternity; Prenatal Care	Covered in full	Out-of-network deductible, then 50%
Inpatient Professional Services	In-network deductible, then 30%	Out-of-network deductible, then 50%
Contraceptive Management Services (Unlimited)	Covered in full	Out-of-network deductible, then 50%
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in full	Out-of-network deductible, then 50%
Other Professional Diagnostic Imaging	In-network deductible, then 30%	Out-of-network deductible, then 50%
Other Professional Diagnostic Laboratory/Pathology	In-network deductible, then 30%	Out-of-network deductible, then 50%
Diagnostic Mammography	In-network deductible, then 30%	Out-of-network deductible, then 50%
FACILITY CARE OPTIONS		
Inpatient Facility	In-network deductible, then 30%	Out-of-network deductible, then 50%
Outpatient Surgery Facility	In-network deductible, then 30%	Out-of-network deductible, then 50%
Hospice Inpatient Facility (10 days inpatient; within the 6 month lifetime maximum)	In-network deductible, then 30%	Out-of-network deductible, then 50%
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$200 copay applies to the OOP max, then in-network deductible, 30%	$200 copay applies to the OOP max, then in-network deductible, 30%
Emergency Room Physician	In-network deductible, then 30%	In-network deductible, then 30%
Urgent Care Center	Non-Specialist: $35 copay, applies to OOP max; Specialist: $50 copay, applies to OOP max	Out-of-network deductible, then 50%

	BASIC: $2,100/30%/$6,600/$35 - HERITAGE	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Ambulance Transportation (Unlimited)	In-network deductible, then 30%	In-network deductible then 30%
Air Ambulance (Unlimited)	In-network deductible, then 30%	In-network deductible then 30%
OTHER SERVICES		
Allergy/Therapeutic Injections	In-network deductible, then 30%	Out-of-network deductible, then 50%
Mental Health Inpatient Facility Care (Unlimited)	In-network deductible, then 30%	Out-of-network deductible, then 50%
Mental Health Outpatient Professional Care (Unlimited)	Non-Specialist: $35 copay, applies to OOP max	Out-of-network deductible, then 50%
Chemical Dependency Inpatient Facility Care (Unlimited)	In-network deductible, then 30%	Out-of-network deductible, then 50%
Chemical Dependency Outpatient Professional Care (Unlimited)	Non-Specialist: $35 copay, applies to OOP max	Out-of-network deductible, then 50%
Rehab Inpatient Facility (30 days PCY)	In-network deductible, then 30%	Out-of-network deductible, then 50%
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy (30 visits PCY)	Specialist: $50 copay, applies to OOP max	Out-of-network deductible, then 50%
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, Chronic Pain, and Cancer	Specialist: $50 copay, applies to OOP max	Out-of-network deductible, then 50%
Medical Supplies, Equipment, Prosthetics (Unlimited)	In-network deductible, then 30%	Out-of-network deductible, then 50%
Foot Orthotics, Orthopedic Shoes and Accessories (One pair max PCY (no $ limit) (Unlimited Diabetes Related))	In-network deductible, then 30%	Out-of-network deductible, then 50%
Home Health Visits (130 visits PCY)	In-network deductible, then 30%	Out-of-network deductible, then 50%
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	In-network deductible, then 30%	Out-of-network deductible, then 50%
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
ALTERNATIVE CARE		
Manipulations (Spinal and other) (12 visits PCY)	$35 copay (applies to OOP max)	Out-of-network deductible, then 50%
Acupuncture (12 visits PCY)	$35 copay (applies to OOP max)	Out-of-network deductible, then 50%
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited
PRESCRIPTION DRUGS		
Drug List	B4	Not covered
Retail Cost Shares	$15/$30/$50/30%	Not covered
Mail Cost Shares	$30/$60/$100/30%	Not covered
Day Supply	Retail: 30 Days; Mail Order: 90 Days; Specialty: 30 Days	Not covered
Individual Deductible PCY	$750 PCY	Not covered
Family Deductible PCY	Family Deductible 2X Individual	Not covered
Out of Pocket Maximum	Applies to the medical out of pocket maximum	Not covered
Specialty Pharmacy Out of Pocket Maximum	Applies to the medical out of pocket maximum	Not covered
SYMETRA LIFE AND AD&D INSURANCE	$25,000 Term Life and AD&D for employee only	

Copays are not subject to the deductible unless otherwise noted.
Pre-approval 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 highlights is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.

Highlights of your Healthcare Coverage: Plan 2

Effective Date: 11/01/2017

PREMERA EDUCATION PROGRAM

Plan enhancements:

- Pharmacy out-of-pocket maximum is shared with the medical out-of-pocket maximum, meaning you reach your out-of-pocket maximum faster.
- Temporomandibular joint (TMJ) disorders are covered in medical benefits like any other service.

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 2: $300/20%/$2,000/$25 - HERITAGE	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible Per Calendar Year (PCY) (Family embedded deductible 3X Individual)	$300 PCY	Shared with in-network
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	40%
Individual Out-of-Pocket Maximum (OOP) PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 3X Individual)	$2,000 PCY	$3,400 PCY
Office Visit Cost Share	Non-Specialist: $25 copay, applies to OOP max; Specialist: $35 copay, applies to OOP max	Non-Specialist: $30 copay, applies to OOP max; Specialist: $40 copay, applies to OOP max
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visits (Unlimited)	Covered in full	Waive deductible, then 20%
Vaccinations (Unlimited)	Covered in full	Waive deductible, then 20%
Health Education (HE) (Unlimited)	Covered in full	Waive deductible, then 20%
Nicotine Dependency Program (ND) (Unlimited)	Covered in full	Out-of-network deductible, then 40%
Diabetes Health Education (DE) (Unlimited)	Covered in full	Waive deductible, then 20%
PROFESSIONAL CARE		
Professional Office Visit	Non-Specialist: $25 copay, applies to OOP max; Specialist: $35 copay, applies to OOP max	Non-Specialist: $30 copay, applies to OOP max; Specialist: $40 copay, applies to OOP max
Maternity; Prenatal Care	Covered in full	Out-of-network deductible, then 40%
Inpatient Professional Services	In-network deductible, then 20%	Out-of-network deductible, then 40%
Contraceptive Management Services (Unlimited)	Covered in full	Out-of-network deductible, then 40%
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in full	Waive deductible, then 20%
Other Professional Diagnostic Imaging	In-network deductible, then 20%	Out-of-network deductible, then 40%
Other Professional Diagnostic Laboratory/Pathology	In-network deductible, then 20%	Out-of-network deductible, then 40%
Diagnostic Mammography	In-network deductible, then 20%	Out-of-network deductible, then 40%
FACILITY CARE OPTIONS		
Inpatient Facility	$150/day to $450 PCY (applies to OOP max), then in-network deductible, 20%	$150/day to $450 PCY (applies to OOP max), then out-of-network deductible, 40%
Outpatient Surgery Facility	$100 copay (applies to OOP max) then in-network deductible, 20%	$100 copay (applies to OOP max) then out-of-network deductible, 40%
Hospice Inpatient Facility (10 days inpatient; within the 6 month lifetime maximum)	$50 copay once PCY (applies to OOP max) for all combined services, then covered in full after in-network deductible	$50 copay once PCY (applies to OOP max) for all combined services, then covered in full after out-of-network deductible
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$75 copay applies to the OOP max, then in-network deductible, 20%	$75 copay applies to the OOP max, then in-network deductible, 20%
Emergency Room Physician	In-network deductible, then 20%	In-network deductible, then 20%
Urgent Care Center	Non-Specialist: $25 copay, applies to OOP max; Specialist: $35 copay, applies to OOP max	Non-Specialist: $30 copay, applies to OOP max; Specialist: $40 copay, applies to OOP max

	PLAN 2: $300/20%/$2,000/$25 - HERITAGE	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Ambulance Transportation (Unlimited)	In-network deductible, then 20%	In-network deductible, then 20%
Air Ambulance (Unlimited)	In-network deductible, then 20%	In-network deductible, then 20%
OTHER SERVICES		
Allergy/Therapeutic Injections	In-network deductible, then 20%	Out-of-network deductible, then 40%
Mental Health Inpatient Facility Care (Unlimited)	$150/day to $450 PCY (applies to OOP max) then in-network deductible, 20%	$150/day to $450 PCY (applies to OOP max) then out-of-network deductible, 40%
Mental Health Outpatient Professional Care (Unlimited)	Non-Specialist: $25 copay, applies to OOP max	Non-Specialist: $30 copay, applies to OOP max
Chemical Dependency Inpatient Facility Care (Unlimited)	$150/day to $450 PCY (applies to OOP max) then in-network deductible, 20%	$150/day to $450 PCY (applies to OOP max) then out-of-network deductible, 40%
Chemical Dependency Outpatient Professional Care (Unlimited)	Non-Specialist: $25 copay, applies to OOP max	Non-Specialist: $30 copay, applies to OOP max
Rehab Inpatient Facility (120 days PCY)	$150/day to $450 PCY (applies to OOP max) then in-network deductible, 20%	$150/day to $450 PCY (applies to OOP max) then out-of-network deductible, 40%
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy (45 visits PCY (PT unlimited))	OT/ST/MT: Specialist: $35 copay, applies to OOP max PT: In-network deductible, then 20%	OT/ST/MT: Specialist: $40 copay, applies to OOP max PT: Out-of-network deductible, then 40%
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, Chronic Pain and Cancer	Specialist: $35 copay, applies to OOP max	Specialist: $40 copay, applies to OOP max
Medical Supplies, Equipment, Prosthetics (Unlimited)	In-network deductible, then 20%	Out-of-network deductible, then 40%
Foot Orthotics, Orthopedic Shoes and Accessories (One pair max PCY (no $ limit) (Unlimited Diabetes Related))	In-network deductible, then 20%	Out-of-network deductible, then 40%
Home Health Visits (Unlimited)	$50 copay once PCY (applies to OOPM) for all combined services, then covered in full after in-network deductible	$50 copay once PCY (applies to OOPM) for all combined services, then covered in full after out-of-network deductible
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	$50 copay once PCY (applies to OOPM) for all combined services, then covered in full after in-network deductible	$50 copay once PCY (applies to OOPM) for all combined services, then covered in full after out-of-network deductible
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
ALTERNATIVE CARE		
Manipulations (Spinal and other) (Unlimited)	$25 copay (applies to OOP max)	$30 copay (applies to OOP max)
Acupuncture (12 visits PCY)	$25 copay (applies to OOP max)	$30 copay (applies to OOP max)
SUPPLEMENTAL BENEFITS		
Routine Hearing Exam (Limited to $400 every 3 consecutive calendar years, for 1 hearing exam and hardware combined)	In-network deductible, then 20%	Out-of-network deductible, then 20%
Hearing Hardware (Limited to $400 every 3 consecutive calendar years, for 1 hearing exam and hardware combined)	In-network deductible, then 20%	Out-of-network deductible, then 20%
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited
PRESCRIPTION DRUGS		
Drug List	B4	
Retail Cost Shares	$10/$20/$35/$50	
Mail Cost Shares	$20/$40/$65/$50	
Day Supply	Retail: Up to 34 Days; Mail Order: Up to 100 Days; Specialty: Up to 30 Days	
Individual Deductible PCY	$0	
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	
SYMETRA LIFE AND AD&D INSURANCE	$25,000 Term Life and AD&D for employee only	

Copays are not subject to the deductible unless otherwise noted.
Pre-approval 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 highlights is not a contract. For full coverage provisions, including a description of waiting periods, limitations, and exclusions please contact Customer Service.

Highlights of your Healthcare Coverage: Plan 3

Effective Date: 11/01/2017

PREMERA EDUCATION PROGRAM

Plan enhancements:

- Pharmacy out-of-pocket maximum is shared with the medical out-of-pocket maximum, meaning you reach your out-of-pocket maximum faster.
- Temporomandibular joint (TMJ) disorders are covered in medical benefits like any other service.

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 3: $500/20%/$3,000/$30 - HERITAGE	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible Per Calendar Year (PCY) (Family embedded deductible 3X Individual)	$500 PCY	Shared with in-network
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	40%
Individual Out-of-Pocket Maximum (OOP) PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 3X Individual)	$3,000 PCY	$5,900 PCY
Office Visit Cost Share	Non-Specialist: $30 copay, applies to OOP max; Specialist: $40 copay, applies to OOP max	Non-Specialist: $40 copay, applies to OOP max; Specialist: $50 copay, applies to OOP max
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visits (Unlimited)	Covered in full	Waive deductible, then 20%
Vaccinations (Unlimited)	Covered in full	Waive deductible, then 20%
Health Education (HE) (Unlimited)	Covered in full	Waive deductible, then 20%
Nicotine Dependency Program (ND) (Unlimited)	Covered in full	Out-of-network deductible, then 40%
Diabetes Health Education (DE) (Unlimited)	Covered in full	Waive deductible, then 20%
PROFESSIONAL CARE		
Professional Office Visit	Non-Specialist: $30 copay, applies to OOP max; Specialist: $40 copay, applies to OOP max	Non-Specialist: $40 copay, applies to OOP max; Specialist: $50 copay, applies to OOP max
Maternity; Prenatal Care	Covered in full	Out-of-network deductible, then 40%
Inpatient Professional Services	In-network deductible, then 20%	Out-of-network deductible, then 40%
Contraceptive Management Services (Unlimited)	Covered in full	Out-of-network deductible, then 40%
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in full	Waive deductible, then 20%
Other Professional Diagnostic Imaging	In-network deductible, then 20%	Out-of-network deductible, then 40%
Other Professional Diagnostic Laboratory/Pathology	In-network deductible, then 20%	Out-of-network deductible, then 40%
Diagnostic Mammography	In-network deductible, then 20%	Out-of-network deductible, then 40%
FACILITY CARE OPTIONS		
Inpatient Facility	$300/day to $900 PCY (applies to OOP max), then in-network deductible, 20%	$300/day to $900 PCY (applies to OOP max), then out-of-network deductible, 40%
Outpatient Surgery Facility	$150 copay (applies to OOP max) then in-network deductible, 20%	$150 copay (applies to OOP max) then out-of-network deductible, 40%
Hospice Inpatient Facility (10 days inpatient; within the 6 month lifetime maximum)	$100 copay once PCY (applies to OOP max) for all combined services, then covered in full after in-network deductible	$100 copay once PCY (applies to OOP max) for all combined services, then covered in full after out-of-network deductible
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$100 copay applies to the OOP max, then in-network deductible, 20%	$100 copay applies to the OOP max, then in-network deductible, 20%
Emergency Room Physician	In-network deductible, then 20%	In-network deductible, then 20%
Urgent Care Center	Non-Specialist: $30 copay, applies to OOP max; Specialist: $40 copay, applies to OOP max	Non-Specialist: $40 copay, applies to OOP max; Specialist: $50 copay, applies to OOP max

	PLAN 3: $500/20%/$3,000/$30 - HERITAGE	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Ambulance Transportation (Unlimited)	In-network deductible, then 20%	In-network deductible, then 20%
Air Ambulance (Unlimited)	In-network deductible, then 20%	In-network deductible, then 20%
OTHER SERVICES		
Allergy/Therapeutic Injections	In-network deductible, then 20%	Out-of-network deductible, then 40%
Mental Health Inpatient Facility Care (Unlimited)	$300/day to $900 PCY (applies to OOP max) then in-network deductible, 20%	$300/day to $900 PCY (applies to OOP max) then out-of-network deductible, 40%
Mental Health Outpatient Professional Care (Unlimited)	Non-Specialist: $30 copay, applies to OOP max	Non-specialist: $40 copay, applies to OOP max
Chemical Dependency Inpatient Facility Care (Unlimited)	$300/day to $900 PCY (applies to OOP max) then in-network deductible, 20%	$300/day to $900 PCY (applies to OOP max) then out-of-network deductible, 40%
Chemical Dependency Outpatient Professional Care (Unlimited)	Non-Specialist: $30 copay, applies to OOP max	Non-Specialist: $40 copay, applies to OOP max
Rehab Inpatient Facility (30 days PCY)	$300/day to $900 PCY (applies to OOP max) then in-network deductible, 20%	$300/day to $900 PCY (applies to OOP max) then out-of-network deductible, 40%
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy (45 visits PCY (PT unlimited))	OT/ST/MT: Specialist: $40 copay, applies to OOP max PT: In-network deductible, then 20%	OT/ST/MT: Specialist: $50 copay, applies to OOP max PT: Out-of-network deductible, then 40%
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, Chronic Pain and Cancer	Specialist: $40 copay, applies to OOP max	Specialist: $50 copay, applies to OOP max
Medical Supplies, Equipment, Prosthetics (Unlimited)	In-network deductible, then 20%	Out-of-network deductible, then 40%
Foot Orthotics, Orthopedic Shoes and Accessories (One pair max PCY (no $ limit) (Unlimited Diabetes Related))	In-network deductible, then 20%	Out-of-network deductible, then 40%
Home Health Visits (Unlimited)	$100 copay once PCY (applies to OOP max) for all combined services, then in-network deductible, 20%	$100 copay once PCY (applies to OOP max) for all combined services, then out-of-network deductible, 40%
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	$100 copay once PCY (applies to OOP max) for all combined services, then covered in full after in-network deductible	$100 copay once PCY (applies to OOP max) for all combined services, then covered in full after out-of-network deductible
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
ALTERNATIVE CARE		
Manipulations (Spinal and other) (Unlimited)	$30 copay (applies to OOP max)	$40 copay (applies to OOP max)
Acupuncture (12 visits PCY)	$30 copay (applies to OOP max)	$40 copay (applies to OOP max)
SUPPLEMENTAL BENEFITS		
Routine Hearing Exam (Limited to $400 every 3 consecutive calendar years, for 1 hearing exam and hardware combined)	In-network deductible, then 20%	Out-of-network deductible, then 20%
Hearing Hardware (Limited to $400 every 3 consecutive calendar years, for 1 hearing exam and hardware combined)	In-network deductible, then 20%	Out-of-network deductible, then 20%
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited
PRESCRIPTION DRUGS		
Drug List	B4	
Retail Cost Shares	$15/$25/$40/$60	
Mail Cost Shares	$30/$50/$70/$60	
Day Supply	Retail: Up to 34 Days; Mail Order: Up to 100 Days; Specialty: Up to 30 Days	
Individual Deductible PCY	$0	
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	
SYMETRA LIFE AND AD&D INSURANCE	$25,000 Term Life and AD&D for employee only	

Copays are not subject to the deductible unless otherwise noted.
Pre-approval 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 highlights is not a contract. For full coverage provisions, including a description of waiting periods, limitations, and exclusions please contact Customer Service.

Highlights of your Healthcare Coverage: Plan 5

Effective Date: 11/01/2017

PREMERA EDUCATION PROGRAM

Plan enhancements:

- Pharmacy out-of-pocket maximum is shared with the medical out-of-pocket maximum, meaning you reach your out-of-pocket maximum faster.
- Non-surgical services for TMJ—both in and out of network—are covered like any other service.

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 5: $200/10%/$1,000/$20 - HERITAGE	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible Per Calendar Year (PCY) (In-network—Family embedded deductible 3X Individual; Out-of-network—no family max)	$200 PCY	$350 PCY
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	10%	30%
Individual Out-of-Pocket Maximum (OOP) PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 3X Individual)	$1,000 PCY	Not applicable
Office Visit Cost Share	Non-Specialist: $20 copay, applies to OOP max; Specialist: $30 copay, applies to OOP max	Out-of-network deductible, then 30%
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited)	Covered in full	Not covered
Vaccinations (Unlimited)	Covered in full	Not covered
Health Education (HE) (Unlimited)	Covered in full	Not covered
Nicotine Dependency Programs (ND) (Unlimited)	Covered in full	Out-of-network deductible, then 30%
Diabetes Health Education (DE) (Unlimited)	Covered in full	Not covered
PROFESSIONAL CARE		
Professional Office Visit	Non-Specialist: $20 copay, applies to OOP max; Specialist: $30 copay, applies to OOP max	Out-of-network deductible, then 30%
Maternity; Prenatal Care	Covered in full	Out-of-network deductible, then 30%
Inpatient Professional Services	In-network deductible, then 10%	Out-of-network deductible, then 30%
Contraceptive Management Services (Unlimited)	Covered in full	Out-of-network deductible, then 30%
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in full	Not covered
Other Professional Diagnostic Imaging	In-network deductible, then 10%	Out-of-network deductible, then 30%
Other Professional Diagnostic Laboratory/Pathology	In-network deductible, then 10%	Out-of-network deductible, then 30%
Diagnostic Mammography	In-network deductible, then 10%	Out-of-network deductible, then 30%
FACILITY CARE OPTIONS		
Inpatient Facility	$150/day to $450 PCY (applies to OOP max), then in-network deductible, 10%	Out-of-network deductible, then 30%
Outpatient Surgery Facility	In-network deductible, then 10%	Out-of-network deductible, then 30%
Hospice Inpatient Facility (10 days inpatient; within the 6 month lifetime maximum)	In-network deductible, then 10%	Out-of-network deductible, then 30%
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$50 copay applies to the OOP max, then in-network deductible, 10%	$50 copay applies to the OOP max, then in-network deductible, 10%
Emergency Room Physician	In-network deductible, then 10%	In-network deductible, then 10%
Urgent Care Center	Non-Specialist: $20 copay, applies to OOP max; Specialist: $30 copay, applies to OOP max	Out-of-network deductible, then 30%

	PLAN 5: $200/10%/$1,000/$20 - HERITAGE	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Ambulance Transportation (Unlimited)	In-network deductible and $50 copay per trip (applies to OOP max), then covered in full	Out-of-network deductible and $50 copay per trip, then covered in full
Air Ambulance (Unlimited)	In-network deductible and $50 copay per trip (applies to OOP max), then covered in full	Out-of-network deductible and $50 copay per trip, then covered in full
OTHER SERVICES		
Allergy/Therapeutic Injections	In-network deductible, then 10%	Out-of-network deductible, then 30%
Mental Health Inpatient Facility Care (Unlimited)	$150/day to $450 PCY (applies to OOP max) then in-network deductible, 10%	Out-of-network deductible, then 30%
Mental Health Outpatient Professional Care (Unlimited)	Non-Specialist: $20 copay, applies to OOP max	Out-of-network deductible, then 30%
Chemical Dependency Inpatient Facility Care (Unlimited)	$150/day to $450 PCY (applies to OOP max) then in-network deductible, 10%	Out-of-network deductible, then 30%
Chemical Dependency Outpatient Professional Care (Unlimited)	Non-Specialist: $20 copay, applies to OOP max	Out-of-network deductible, then 30%
Rehab Inpatient Facility (30 days PCY)	$150/day to $450 PCY (applies to OOP max) then in-network deductible, 10%	Out-of-network deductible, then 30%
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy (45 visits PCY)	Specialist: $30 copay, applies to OOP max	Out-of-network deductible, then 30%
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, Chronic Pain and Cancer	Specialist: $30 copay, applies to OOP max	Out-of-network deductible, then 30%
Medical Supplies, Equipment, Prosthetics (Unlimited)	In-network deductible, then 10%	Out-of-network deductible, then 30%
Foot Orthotics, Orthopedic Shoes and Accessories ($600 PCY (Unlimited Diabetes Related))	In-network deductible, then 10%	Out-of-network deductible, then 30%
Home Health Visits (130 visits PCY)	In-network deductible, then 10%	Out-of-network deductible, then 30%
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	In-network deductible, then 10%	Out-of-network deductible, then 30%
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
ALTERNATIVE CARE		
Manipulations (Spinal and other) (Unlimited)	$20 copay (applies to OOP max)	Out-of-network deductible, then 30%
Acupuncture (Unlimited)	$20 copay (applies to OOP max)	Out-of-network deductible, then 30%
SUPPLEMENTAL BENEFITS		
Routine Hearing Exam (1 PCY; Accrues to $ limit (Out-of-Pocket includes in-network/out-of-network))	$30 copay (applies to OOP max)	Out-of-network deductible, then 30%
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited
PRESCRIPTION DRUGS		
Drug List	B4	
Retail Cost Shares	$10/$15/$30/$50	
Mail Cost Shares	$20/$30/$60/$50	
Day Supply	Retail: Up to 30 Days; Mail Order: Up to 90 Days; Specialty: Up to 30 Days	
Individual Deductible PCY	$0	
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	
SYMETRA LIFE AND AD&D INSURANCE	$25,000 Term Life and AD&D for employee only	

Copays are not subject to the deductible unless otherwise noted.
Pre-approval 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 highlights is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.

Highlights of your Healthcare Coverage: Qualified High Deductible Health Plan

Effective Date: 11/01/2017

PREMERA EDUCATION PROGRAM

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	QHDHP: $1,750/20%/$5,000/DED.COINS - HERITAGE	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible Per Calendar Year (PCY) (Family deductible 2X Individual)	$1,750 PCY/$3,500 PCY	$3,000 PCY/$6,000 PCY
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	50%
Individual Out-of-Pocket Maximum (OOP) PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 2X Individual)	$5,000 PCY	Not applicable
Office Visit Cost Share	In-network deductible, then 20%	Out-of-network deductible, then 50%
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited)	Covered in full	Not covered
Vaccinations (Unlimited)	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	In-network deductible, then 20%	Out-of-network deductible, then 50%
Maternity; Prenatal Care	Covered in full	Out-of-network deductible, then 50%
Inpatient Professional Services	In-network deductible, then 20%	Out-of-network deductible, then 50%
Contraceptive Management Services (Unlimited)	Covered in full	Out-of-network deductible, then 50%
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in full	Out-of-network deductible, then 50%
Other Professional Diagnostic Imaging	In-network deductible, then 20%	Out-of-network deductible, then 50%
Other Professional Diagnostic Laboratory/Pathology	In-network deductible, then 20%	Out-of-network deductible, then 50%
Diagnostic Mammography	In-network deductible, then 20%	Out-of-network deductible, then 50%
FACILITY CARE OPTIONS		
Inpatient Facility	In-network deductible, then 20%	Out-of-network deductible, then 50%
Outpatient Surgery Facility	In-network deductible, then 20%	Out-of-network deductible, then 50%
Hospice Inpatient Facility (10 days inpatient; within the 6 month lifetime maximum)	In-network deductible, then 20%	Out-of-network deductible, then 50%
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	In-network deductible, then 20%	In-network deductible, then 20%
Emergency Room Physician	In-network deductible, then 20%	In-network deductible, then 20%
Urgent Care Center	In-network deductible, then 20%	Out-of-network deductible, then 50%

	QHDHP: $1,750/20%/$5,000/DED.COINS - HERITAGE	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Ambulance Transportation (Unlimited)	In-network deductible, then 20%	In-network deductible then 20%
Air Ambulance (Unlimited)	In-network deductible, then 20%	In-network deductible then 20%
OTHER SERVICES		
Allergy/Therapeutic Injections	In-network deductible, then 20%	Out-of-network deductible, then 50%
Mental Health Inpatient Facility Care (Unlimited)	In-network deductible, then 20%	Out-of-network deductible, then 50%
Mental Health Outpatient Professional Care (Unlimited)	In-network deductible, then 20%	Out-of-network deductible, then 50%
Chemical Dependency Inpatient Facility Care (Unlimited)	In-network deductible, then 20%	Out-of-network deductible, then 50%
Chemical Dependency Outpatient Professional Care (Unlimited)	In-network deductible, then 20%	Out-of-network deductible, then 50%
Rehab Inpatient Facility (30 days PCY)	In-network deductible, then 20%	Out-of-network deductible, then 50%
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy (15 visits PCY)	In-network deductible, then 20%	Out-of-network deductible, then 50%
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, Chronic Pain and Cancer	In-network deductible, then 20%	Out-of-network deductible, then 50%
Medical Supplies, Equipment, Prosthetics (MS: Unlimited, ME: Unlimited, Pro: Unlimited)	In-network deductible, then 20%	Out-of-network deductible, then 50%
Foot Orthotics, Orthopedic Shoes and Accessories ($300 PCY (Unlimited Diabetes Related))	In-network deductible, then 20%	Out-of-network deductible, then 50%
Home Health Visits (130 visits PCY)	In-network deductible, then 20%	Out-of-network deductible, then 50%
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	In-network deductible, then 20%	Out-of-network deductible, then 50%
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
ALTERNATIVE CARE		
Manipulations (Spinal and other) (12 visits PCY)	In-network deductible, then 20%	Out-of-network deductible, then 50%
Acupuncture (12 visits PCY)	In-network deductible, then 20%	Out-of-network deductible, then 50%
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited	Unlimited
PRESCRIPTION DRUGS		
Drug List	Open A1 No Tiers	Open A1 No Tiers
Prescription Drugs - Retail (Specific preventive drugs and legend Retail: 30-day supply/Mail: 90-day supply/Specialty: 30-day supply)	In-network deductible, then 20%	In-network deductible, then 20%
Prescription Drugs - Mail (Specific preventive drugs and legend Retail: 30-day supply/Mail: 90-day supply/Specialty: 30-day supply)	In-network deductible, then 20%	Not covered
Specialty Pharmacy (Mandatory)	In-network deductible, then 20%	Not covered
SYMETRA LIFE AND AD&D INSURANCE	$25,000 Term Life and AD&D for employee only	

Copays are not subject to the deductible unless otherwise noted.
Pre-approval 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 highlights is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.

Choosing a qualified high deductible health plan

A LITTLE RESEARCH GOES A LONG WAY TOWARD SMART PLAN SELECTION

Understand what it is

A qualified high deductible plan (QHDHP) is designed to work with a Health Savings Account (HSA), which can provide tax-wise advantages for you.

- The HSA is designed to help you save for healthcare expenses tax-free.
- Funds can be used to pay for IRS–approved non–taxed medical expenses.
- Your money grows tax–free. The money is always yours. It rolls over from year to year and you take it with you if you change jobs.
- Consult your tax advisor to determine the tax implications of participating in an HSA.

Ask yourself these 2 questions

- Are you able to pay 100 percent of your healthcare costs until your deductible is met?
  - If you cover any dependents, benefits do not begin until your family deductible is met.
- What are your annual healthcare expenses?
  - Review your claims information and spending activity from the previous calendar year.
  - Include any elective services planned in the next calendar year, such as surgeries or maternity care.

Take note

- To enroll on this plan, you cannot have any other active coverage, or be a dependent on any other coverage.
- There is no deductible carryover. That means deductible expenses you incur in the last two months of a calendar year will not apply to the next calendar year's deductible.

Four tips to prepare for a doctor visit

YOU'RE BUSY. AND YOUR DOCTOR IS, TOO. HERE'S HOW YOU CAN MAKE THE MOST OUT OF YOUR TIME TOGETHER.

Write it down

- Your questions
- Your medications
- Your allergies

Be specific

- How long you've had symptoms and how severe they are
- What you've done to treat your condition

Prioritize

- Time may be limited, so focus on what prompted you to make an appointment
- Consider saving general health questions for a wellness checkup
- If you need a procedure, testing, or referral, ask what's covered and if pre-approvals are required

Tip:
Be candid with your doctor. Since you only have a few minutes together, it helps to be direct and forthcoming.

See how much you can save with your health plan

SPENDING ACTIVITY REPORT

When you are a Premera customer, the Spending Activity Report makes it easy for you to understand what's happening with the healthcare dollars you spend.

This online tool at premera.com shows dollar amounts and charts that put your healthcare spending into perspective.

You can create a report for the time period and family member you choose. The results display a summary of your healthcare activity, including

- Amount billed
- Amount paid by your health plan
- Discount information
- Your payment responsibility
- Amount you saved

Want to view your costs by service, such as office visits, exams and screenings, or vaccinations? The report can quickly generate that information, too! And you can download the information as a spreadsheet.

To use the Spending Activity Report, you need to log in to your secure member account on premera.com.

PREMERA | BLUE CROSS

An Independent Licensee of the Blue Cross Blue Shield Association

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

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).

አማሪኛ (Amharic):
ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Premera Blue Cross ሽፋን አስፈላጊ መረጃ ሊኖረው ይችላል። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖች ሊኖሩ ይችላሉ። የጤናን ሽፋንዎን ለመጠበቅና በአከፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያነኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያነኙ መብት አለዎት።በስልክ ቁጥር 800-722-1471 (TTY: 800-842-5357) ይደውሉ።

العربية (Arabic):
يحوي هذا الإشعار معلومات هامة. قد يحوي 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. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك دون تكبد أية تكلفة. اتصل بـ800-722-1471 (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 kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa 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) tii 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 resevwa 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 caij nyoog 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 mabalin nga adda ket naglaon iti napateg nga impormasion maipanggep iti apliksayonyo wenno coverage babaen iti Premera Blue Cross. Daytoy ket mabalin dagiti importante a petsa iti daytoy a pakdaar. Mabalin 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).

日本語 (Japanese):
この通知には重要な情報が含まれています。この通知には、Premera Blue Cross の申請または補償範囲に関する重要な情報が含まれている場合があります。この通知に記載されている可能性がある重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。800-722-1471 (TTY: 800-842-5357)までお電話ください。

한국어 (Korean):
본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Premera Blue Cross 를 통한 커버리지에 관한 정보를 포함하고 있을 수 있습니다. 본 통지서에는 핵심이 되는 날짜들이 있을 수 있습니다. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 800-722-1471 (TTY: 800-842-5357) 로 전화하십시오.

ລາວ (Lao):
ແຈ້ງການນີ້ມີຂໍ້ມູນສຳຄັນ. ແຈ້ງການນີ້ອາດຈະມີຂໍ້ມູນສຳຄັນກ່ຽວກັບຄຳຮ້ອງສະໝັກ ຫຼື ຄວາມຄຸ້ມຄອງປະກັນໄພຂອງທ່ານຜ່ານ Premera Blue Cross. ອາດຈະມີວັນທີສຳຄັນໃນແຈ້ງການນີ້. ທ່ານອາດຈະຈຳເປັນຕ້ອງດຳເນີນການຕາມກຳນົດເວລາສະເພາະເພື່ອຮັກສາຄວາມຄຸ້ມຄອງປະກັນສຸຂະພາບ ຫຼື ຄວາມຊ່ວຍເຫຼືອດ້ານຄ່າໃຊ້ຈ່າຍຂອງທ່ານໄວ້. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໃຫ້ໂທຫາ 800-722-1471 (TTY: 800-842-5357).

ភាសាខ្មែរ (Khmer):
សេចក្តីជូនដំណឹងនេះមានព័ត៌មានយ៉ាងសំខាន់ៗ សេចក្តីជូនដំណឹងនេះប្រហែលជាមានព័ត៌មានយ៉ាងសំខាន់អំពីទម្រង់បែបបទ ឬការព្រមព្រៀងរបស់អ្នកគាមរយៈ Premera Blue Cross ។ ប្រហែលជាមាន កាលបរិច្ឆេទសំខាន់នៅក្នុងសេចក្តីជូនដំណឹងនេះ។ អ្នកប្រហែលជាត្រូវការបញ្ចេញសមត្ថភាព ដល់កំណត់ថ្ងៃជាក់ច្បាស់នានា ដើម្បីនឹងរក្សាទុកការជានាវ៉ាប់រងសុខភាពរបស់អ្នក ឬប្រាក់ជំនួយចេញថ្លៃ។ អ្នកមានសិទ្ធិទទួលព័ត៌មាននេះ និងជំនួយនៅក្នុងភាសារបស់អ្នកដោយមិនអស់លុយឡើយ។ សូមទូរស័ព្ទ 800-722-1471 (TTY: 800-842-5357)។

ਪੰਜਾਬੀ (Punjabi):
ਇਸ ਨੋਟਿਸ ਵਿਚ ਖਾਸ ਜਾਣਕਾਰੀ ਹੈ. ਇਸ ਨੋਟਿਸ ਵਿਚ Premera Blue Cross ਵਲੋਂ ਤੁਹਾਡੀ ਕਵਰੇਜ ਅਤੇ ਅਰਜੀ ਬਾਰੇ ਮਹੱਤਵਪੂਰਨ ਜਾਣਕਾਰੀ ਹੋ ਸਕਦੀ ਹੈ . ਇਸ ਨੋਜਿਸ ਜਵਚ ਖਾਸ ਤਾਰੀਖਾ ਹੋ ਸਕਦੀਆਂ ਹਨ. ਜੇਕਰ ਤੁਸੀ ਜਸਹਤ ਕਵਰੇਜ ਰਿੱਖਣੀ ਹੋਵੇ ਜਾ ਓਸ ਦੀ ਲਾਗਤ ਜਵਿੱਚ ਮਦਦ ਦੇ ਇਛੁੱਕ ਹੋ ਤਾਂ ਤੁਹਾਨੂੰ ਅੰਤਮ ਤਾਰੀਖ਼ ਤੋਂ ਪਹਿਲਾਂ ਕੁੱਝ ਖਾਸ ਕਦਮ ਚੁੱਕਣ ਦੀ ਲੋੜ ਹੋ ਸਕਦੀ ਹੈ ,ਤੁਹਾਨੂੰ ਮੁਫ਼ਤ ਵਿੱਚ ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ ,ਕਾਲ 800-722-1471 (TTY: 800-842-5357).

فارسی (Farsi):
این اعلامیه حاوی اطلاعات مهم میباشد .این اعلامیه ممکن است حاوی اطلاعات مهم درباره فرم تقاضا و یا پوشش بیمه ای شما از طریق Premera Blue Cross باشد. به تاریخ های مهم در این اعلامیه توجه نمایید .شما ممکن است برای حفظ پوشش بیمه تان یا کمک در پرداخت هزینه های درمانی تان، به تاریخ های مشخصی برای انجام کارهای خاصی احتیاج داشته باشید .شما حق این را دارید که این اطلاعات و کمک را به زبان خود به طور رایگان دریافت نمایید. برای کسب اطلاعات با شماره 800-722-1471 (کاربران TTY تماس باشماره 800-842-5357) تماس برقرار نمایید.

Polskie (Polish):
To ogłoszenie może zawierać ważne informacje. To ogłoszenie może zawierać ważne informacje odnośnie Państwa wniosku lub zakresu świadczeń poprzez Premera Blue Cross. Prosimy zwrócic uwagę na kluczowe daty, które mogą być zawarte w tym ogłoszeniu aby nie przekroczyć terminów w przypadku utrzymania polisy ubezpieczeniowej lub pomocy związanej z kosztami. Macie Państwo prawo do bezpłatnej informacji we własnym języku. Zadzwońcie pod 800-722-1471 (TTY: 800-842-5357).

Português (Portuguese):
Este aviso contém informações importantes. Este aviso poderá conter informações importantes a respeito de sua aplicação ou cobertura por meio do Premera Blue Cross. Poderão existir datas importantes neste aviso. Talvez seja necessário que você tome providências dentro de determinados prazos para manter sua cobertura de saúde ou ajuda de custos. Você tem o direito de obter esta informação e ajuda em seu idioma e sem custos. Ligue para 800-722-1471 (TTY: 800-842-5357).

Română (Romanian):
Prezenta notificare conține informații importante. Această notificare poate conține informații importante privind cererea sau acoperirea asigurării dumneavoastre de sănătate prin Premera Blue Cross. Pot exista date cheie în această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la 800-722-1471 (TTY: 800-842-5357).

Русский (Russian):
Настоящее уведомление содержит важную информацию. Это уведомление может содержать важную информацию о вашем заявлении или страховом покрытии через Premera Blue Cross. В настоящем уведомлении могут быть указаны ключевые даты. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 800-722-1471 (TTY: 800-842-5357).

Fa'asamoa (Samoan):
Atonu ua iai i lenei fa'asilasilaga ni fa'amatalaga e sili ona taua e tatau ona e malamalama i ai. O lenei fa'asilasilaga o se fesoasoani e fa'amatala atili i ai i le tulaga o le polokalame, Premera Blue Cross, ua e tau fia maua atu i ai. Fa'amolemole, ia e iloilo fa'alelei i aso fa'apitoa olo'o iai i lenei fa'asilasilaga taua. Masalo o le'a iai ni feau e tatau ona e faia ao le'i aulia le aso ua ta'ua i lenei fa'asilasilaga ina ia e iai pea ma maua fesoasoani mai ai i le polokalame a le Malo olo'o e iai i ai. Olo'o iai iate oe le aia tatau e maua atu i lenei fa'asilasilaga ma lenei fa'matalaga i legagana e te malamalama i ai aunoa ma se togiga tupe. Vili atu i le telefoni 800-722-1471 (TTY: 800-842-5357).

Español (Spanish):
Este Aviso contiene información importante. Es posible que este aviso contenga información importante acerca de su solicitud o cobertura a través de Premera Blue Cross. Es posible que haya fechas clave en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 800-722-1471 (TTY: 800-842-5357).

Tagalog (Tagalog):
Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay maaaring naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Premera Blue Cross. Maaaring may mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 800-722-1471 (TTY: 800-842-5357).

ไทย (Thai):
ประกาศนี้มีข้อมูลสำคัญ ประกาศนี้อาจมีข้อมูลที่สำคัญเกี่ยวกับการการสมัครหรือขอบเขตประกันสุขภาพของคุณผ่าน Premera Blue Cross และอาจมีกำหนดการในประกาศนี้ คุณอาจจะต้องดำเนินการภายในกำหนดระยะเวลาที่แน่นอนเพื่อจะรักษาการประกันสุขภาพของคุณหรือการช่วยเหลือที่มีค่าใช้จ่าย คุณมีสิทธิที่จะได้รับข้อมูลและความช่วยเหลือนี้ในภาษาของคุณโดยไม่มีค่าใช้จ่าย โทร 800-722-1471 (TTY: 800-842-5357)

Український (Ukrainian):
Це повідомлення містить важливу інформацію. Це повідомлення може містити важливу інформацію про Ваше звернення щодо страхувального покриття через Premera Blue Cross. Зверніть увагу на ключові дати, які можуть бути вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 800-722-1471 (TTY: 800-842-5357).

Tiếng Việt (Vietnamese):
Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng về đơn xin tham gia hoặc hợp đồng bảo hiểm của quý vị qua chương trình Premera Blue Cross. Xin xem ngày quan trọng trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 800-722-1471 (TTY: 800-842-5357).

Glossary

Helpful definitions

Allowable charge The maximum amount Premera will pay for a covered service or supply.

Calendar year A 12-month period, running from January 1 through December 31, when medical expenses are incurred that count toward specific annual benefit maximums (dollar and/or visits), limitations, deductibles, and out-of-pocket maximums.

Coinsurance The percentage of a covered service you pay after your deductible is met and continue to pay until your out-of-pocket maximum is met.

Copay The fixed dollar amount you pay each time you use certain services until your out-of-pocket maximum is met.

Deductible The amount you pay each calendar year before your plan starts to pay benefits toward certain services.

Deductible carryover Deductible expenses you incur in the last two months of a calendar year will be applied toward or "carried over" to the next calendar year's deductible. Note: The Qualified High Deductible Health Plan does not have a deductible carryover provision.

Network The network determines which doctors, hospitals, and other healthcare providers are covered at your plan's in-network benefit level.

Out-of-pocket maximum The maximum amount you pay out of your own pocket for medical and/or prescription drug copays, deductible, and coinsurance in a calendar year.

Plan year The 12-month period in which new plan selections, benefits, and rates are contracted, running from November 1 through October 31.

Pre-approval A pre-service review to determine that a medical, rehabilitative service, or prescription drug is covered by your benefit plan.

Understanding the difference between Plan Year and Calendar Year

Plan Year (or renewal) starts on November 1 and runs through October 31. This is when all rate and/or renewal benefit changes start.

Calendar Year starts on January 1 and runs through December 31. All visit limitations, deductibles, and out-of-pocket maximums are reset on January 1, with the exception of any deductible carryover amount credited to you.

Your quick guide

HOW TO GET THE MOST OUT OF YOUR PREMERA HEALTH PLAN

Keep this information handy
Once your plan year begins, these resources are the link to many of your benefits.

Create an account at premera.com

On the premera.com homepage, click Log In in the upper-right corner and then select Create Account. When you sign into your account, you can:

- View claims
- Find a doctor
- Compare estimated treatment prices
- See discounts
- Manage and order your prescriptions
- Check out health and wellness resources

Customer Service for the Premera Education Program

This is a dedicated line for enrollees and eligible dependents.
855-756-0798

24-Hour NurseLine

800-841-8343

Teladoc®

Set up an account as soon as possible so you'll be able to use virtual care when you need it.
855-332-4059
teladoc.com/premera

Health assessment

To take the assessment, sign into your account on premera.com. Select Stay Healthy, Wellness Tools, and Start Wellness Tools.

Lifestyle guidance resources

844-862-0898
800-687-0353 (TTY)
guidanceresources.com (Register with Organization Web ID: premerawellness)
GuidanceResources® Now (mobile app)

PREMERA | BLUE CROSS

042636 (06-30-2017)