

# Highlights of your Health Care Coverage

## WASHINGTON ALLIANCE FOR HEALTH INSURANCE TRUST

HERITAGE PLUS 1

**Effective Date: 07/01/2017**

\*Premera Blue Cross believes this plan is a “grandfathered health plan” under the Affordable Care Act. For more information, please refer to your Benefit Booklet.

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	*GRANDFATHERED		2017 CHOICE 3A - GOOD FAITH	
			HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
<b>MEDICAL COST SHARE OPTIONS</b>				
Individual Deductible PCY (Family embedded deductible 2X 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 PCY, excludes copay (Family embedded OOP max 2X Individual)			\$2,300 PCY	\$4,300 PCY
Office Visit Cost Share			\$20 Copay	Out of Network Deductible, then 40%
<b>PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION</b>				
Preventive Office Visit (Unlimited)			Covered In Full	Not Covered
Immunizations (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
<b>PROFESSIONAL CARE</b>				
Professional Office Visit			\$20 Copay	Out of Network Deductible, then 40%
Inpatient Professional Services			In Network Deductible, then 20%	Out of Network Deductible, then 40%
<b>DIAGNOSTIC SERVICE OPTIONS</b>				
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA			Covered In Full	Out of Network Deductible, then 40%
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			Waive Deductible, then 20%	Deductible, then 40%
<b>FACILITY CARE OPTIONS</b>				
Inpatient Facility			In Network Deductible, then 20%	Out of Network Deductible, then 40%
Outpatient Surgery Facility			In Network Deductible, then 20%	Out of Network Deductible, then 40%
Hospice Inpatient Facility (Unlimited; within the 6 month lifetime maximum)			In Network Deductible, then 20%	Out of Network Deductible, then 40%
<b>EMERGENCY CARE AND TRANSPORTATION OPTIONS</b>				
Emergency Care (If applicable, waive copay if admitted to inpatient facility)			\$200 Copay, then In Network Deductible, 20%	\$200 Copay, then In Network Deductible, 20%
Emergency Room Physician			In Network Deductible, then 20%	In Network Deductible, then 20%
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%

# Highlights of your Health Care Coverage

## WASHINGTON ALLIANCE FOR HEALTH INSURANCE TRUST

HERITAGE PLUS 1

Effective Date: 07/01/2017

\*Premera Blue Cross believes this plan is a "grandfathered health plan" under the Affordable Care Act. For more information, please refer to your Benefit Booklet.

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	*GRANDFATHERED	2017 CHOICE 3A - GOOD FAITH	
		HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
<b>OTHER SERVICES</b>			
<b>Allergy/Therapeutic Injections</b>		In Network Deductible, then 20%	Out of Network Deductible, then 40%
<b>Mental Health Inpatient Facility Care (Unlimited)</b>		In Network Deductible, then 20%	Out of Network Deductible, then 40%
<b>Mental Health Outpatient Professional Care (Unlimited)</b>		\$20 Copay	Out of Network Deductible, then 40%
<b>Chemical Dependency Inpatient Facility Care (Unlimited)</b>		In Network Deductible, then 20%	Out of Network Deductible, then 40%
<b>Chemical Dependency Outpatient Professional Care (Unlimited)</b>		\$20 Copay	Out of Network Deductible, then 40%
<b>Rehab Inpatient Facility (15 Days PCY)</b>		In Network Deductible, then 20%	Out of Network Deductible, then 40%
<b>Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac &amp; Pulmonary Rehab.; and Chronic Pain (30 Visits PCY)</b>		\$20 Copay	Out of Network Deductible, then 40%
<b>Medical Supplies, Equipment, Prosthetics (Unlimited)</b>		In Network Deductible, then 20%	Out of Network Deductible, then 40%
<b>Foot Orthotics, Orthopedic Shoes and Accessories (Unlimited)</b>		In Network Deductible, then 20%	Out of Network Deductible, then 40%
<b>Home Health Visits (130 visits PCY)</b>		In Network Deductible, then 20%	Out of Network Deductible, then 40%
<b>Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)</b>		In Network Deductible, then 20%	Out of Network Deductible, then 40%
<b>Transplants (Unlimited; \$7,500 travel and lodging limits)</b>		Covered as any other service	Not Covered
<b>ALTERNATIVE CARE</b>			
<b>Manipulations (Spinal and other) (12 Visits PCY)</b>		\$20 Copay	Deductible, then 40% Coinsurance
<b>Acupuncture (12 Visits PCY)</b>		\$20 Copay	Deductible, then 40% Coinsurance
<b>Nutritional Therapy (Unlimited)</b>		Covered In Full	Deductible, then 40% Coinsurance
<b>ANNUAL PLAN MAXIMUM</b>			
<b>Annual Plan Maximum</b>		Unlimited	Unlimited

Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross. Members are responsible for amounts in excess of the allowable charge.

*This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms under which the program may be continued in force. This benefit highlight is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.*

# Highlights of your Health Care Coverage

## WASHINGTON ALLIANCE FOR HEALTH INSURANCE TRUST

HERITAGE PLUS 1

### Pharmacy Benefits

Below is a brief overview of what you can expect to pay for a prescription drug, depending on which "tier" category it falls under in the Preferred Drug List for your plan when using an In-Network Pharmacy. For more information on your pharmacy benefits, including Out-of-Network benefits, see your benefit booklet. To find out what tier applies to a specific medication, see our Preferred Drug List in your pharmacy packet or at [www.premera.com](http://www.premera.com).

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

**Effective Date: 07/01/2017**

PHARMACY PLAN		2017 CHOICE 3A - GOOD FAITH - RX R=\$10/\$25/\$50 M=\$20/\$50/\$100
		Cost Share Category Tier1/Tier2/Tier3
<b>PRESCRIPTION DRUGS</b>		
Drug List	Preferred B3 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands	
Retail Cost Shares	\$10/\$25/\$50	
Mail Cost Shares	\$20/\$50/\$100	
Day Supply	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days	
Individual Deductible PCY	\$0	
Out of Network (Non-participating retail pharmacies)	Retail OON: Retail Cost Share, then 40% (to allowable); Mail Order OON: Not Covered	
Out of Pocket Maximum	Unlimited	
Annual Benefit Maximum	Unlimited	

PCY = Per Calendar Year. Balance billing may apply if a provider is not contracted with Premera Blue Cross. Members are responsible for amounts in excess of the allowable charge.

*This is not a complete explanation of covered services, exclusions, limitations, reductions or the terms under which the program may be continued in force. This benefit highlight is not a contract. For full coverage provisions, including a description of waiting periods, limitations and exclusions please contact Customer Service.*

**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 425-918-5692, 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/ocrportal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services  
 200 Independence Avenue SW, Room 509F, HHH Building  
 Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)  
 Complaint forms are available at  
<http://www.hhs.gov/ocr/office/file/index.html>.

**Getting Help in Other Languages**

**This Notice has Important Information.** This notice may have important information about your application or coverage through Premera Blue Cross. There may be key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 800-722-1471 (TTY: 800-842-5357).

**አማርኛ (Amharic):**

የዚህ ማሳሰቢያ ዋና ዋና ክፍሎች የሆኑት ለሁሉም ግብዓቶች የሚገቡ ሲሆኑ የአማርኛ ማሳሰቢያዎን በአማርኛ ለማግኘት ለግብዓቶችዎ ላይ የሚገኙትን ማሳሰቢያዎች ያንቀጥቡ። የዚህ ማሳሰቢያ ዋና ዋና ክፍሎች የሆኑት ለሁሉም ግብዓቶች የሚገቡ ሲሆኑ የአማርኛ ማሳሰቢያዎን በአማርኛ ለማግኘት ለግብዓቶችዎ ላይ የሚገኙትን ማሳሰቢያዎች ያንቀጥቡ።  
 800-722-1471 (TTY: 800-842-5357) ያንቀጥቡ።

**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 kaffaltiirhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhuma irratti wanti raawiwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf minga ni qabaattu. Lakkoofsa bilbilaa 800-722-1471 (TTY: 800-842-5357) ti bilbilaa.

**Français (French):**

**Cet avis a d'importantes informations.** Cet avis peut avoir d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Premera Blue Cross. Le présent avis peut contenir des dates clés. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez le 800-722-1471 (TTY: 800-842-5357).

**Kreyòl ayisyen (Creole):**

**Avi sila a gen enfòmasyon Enpòtan ladann.** Avi sila a kapab genyen enfòmasyon enpòtan konsènan aplikasyon w lan osvwa konsènan kouvéti 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 kouvéti asirans sante w la osvwa pou yo ka ede w avèk depans yo. Se diva 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 ntshiab lus tseem ceeb thov koj daim ntawv thov kev pab los yog koj qhov kev pab cuam los ntawm Premera Blue Cross. Tej zaum muaj cov hnuv tseem ceeb uas sau rau hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam uas pab kom koj ua tsis pub dhu cov caj niyooq uas teev tseg rau hauv daim ntawv no mas koj thaj yuav tau trais kev pab cuam kmo mob los yog kev pab them tej noj kmo 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 Impomasion.** Daytoy a pakdaar mabaln nga adda ket naglaon iti napateg nga impomasion maipanggep iti aplikasyonyo wenno coverage babaen iti Premera Blue Cross. Daytoy ket mabaln dagiti importante a petsa iti daytoy a pakdaar. Mabaln 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 impomasion 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).

**العربية (Arabic):**  
 يحتوي هذا الإعلان على معلومات هامة. قد يحتوي هذا الإعلان على معلومات هامة بخصوص تلك أو التغطية التي تريد الحصول عليها من خلال Premera Blue Cross. قد تكون هناك تواريخ مهمة في هذا الإعلان. وقد تحتاج اتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو المساعدة في دفع التكاليف. بحق لك الحصول على هذه المعلومات والمساعدة بشكل دون تكلفة أية تكلفة. اتصل بـ 800-722-1471 (TTY: 800-842-5357).

**中文 (Chinese):**  
 本通知有重要的訊息。本通知可能有關於您透過 Premera Blue Cross 提交的申請或保險的重要訊息。本通知內可能有重要日期。您可能需要在截止日期之前採取行動。以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 800-722-1471 (TTY: 800-842-5357)。



