

# 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 SECURE 500	
		HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK	
<b>MEDICAL COST SHARE OPTIONS</b>				
Individual Deductible PCY (Family embedded deductible 3X Individual)		\$500 PCY		\$1,000 PCY
Coinsurance (Member's percentage of costs after deductible based on allowable charges)		20%		50%
Individual Out of Pocket Maximum PCY, excludes copay (Family embedded OOP max 3X Individual)		\$4,500 PCY		\$9,000 PCY
Office Visit Cost Share		\$35 Copay		Out of Network Deductible, then 50%
<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		\$35 Copay		Out of Network Deductible, then 50%
Inpatient Professional Services		In Network Deductible, then 20%		Out of Network Deductible, then 50%
<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 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		Covered In Full		Deductible, then 50%
<b>FACILITY CARE OPTIONS</b>				
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 (Unlimited; within the 6 month lifetime maximum)		In Network Deductible, then 20%		Out of Network Deductible, then 50%
<b>EMERGENCY CARE AND TRANSPORTATION OPTIONS</b>				
Emergency Care (If applicable, waive copay if admitted to inpatient facility)		\$250 Copay then INN Deductible and Coinsurance 20%		\$250 Copay then INN Deductible and Coinsurance 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%

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MEDICAL PLAN	*GRANDFATHERED	2017 SECURE 500	
		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 50%
<b>Mental Health Inpatient Facility Care (Unlimited)</b>		In Network Deductible, then 20%	Out of Network Deductible, then 50%
<b>Mental Health Outpatient Professional Care (Unlimited)</b>		\$35 Copay	Out of Network Deductible, then 50%
<b>Chemical Dependency Inpatient Facility Care (Unlimited)</b>		In Network Deductible, then 20%	Out of Network Deductible, then 50%
<b>Chemical Dependency Outpatient Professional Care (Unlimited)</b>		\$35 Copay	Out of Network Deductible, then 50%
<b>Rehab Inpatient Facility (15 Days PCY)</b>		In Network Deductible, then 20%	Out of Network Deductible, then 50%
<b>Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac &amp; Pulmonary Rehab.; and Chronic Pain (30 Visits PCY)</b>		\$35 Copay	Out of Network Deductible, then 50%
<b>Medical Supplies, Equipment, Prosthetics (Unlimited)</b>		In Network Deductible, then 20%	Out of Network Deductible, then 50%
<b>Foot Orthotics, Orthopedic Shoes and Accessories (Unlimited)</b>		In Network Deductible, then 20%	Out of Network Deductible, then 50%
<b>Home Health Visits (130 visits PCY)</b>		In Network Deductible, then 20%	Out of Network Deductible, then 50%
<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 50%
<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>		\$35 Copay	Deductible, then 50% Coinsurance
<b>Acupuncture (12 Visits PCY)</b>		\$35 Copay	Deductible, then 50% Coinsurance
<b>Nutritional Therapy (Unlimited)</b>		Covered In Full	Deductible, then 50% 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.*

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### 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 out Preferred Drug List in your pharmacy packet or at [www.premera.com](http://www.premera.com).

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<b>PHARMACY PLAN</b>		<b>2017 SECURE 500 - RX R=\$10/\$40/\$80/30% M= \$25/\$100/\$200/30%</b>
		<b>Cost Share Category</b> Tier1/Tier2/Tier3
<b>PRESCRIPTION DRUGS</b>		
<b>Drug List</b>	Preferred B3 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands	
<b>Retail Cost Shares</b>	\$10/\$40/\$80/30%	
<b>Mail Cost Shares</b>	\$25/\$100/\$200/30%	
<b>Day Supply</b>	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days	
<b>Individual Deductible PCY</b>	\$0	
<b>Out of Network (Non-participating retail pharmacies)</b>	Retail OON: Retail Cost Share, then 50% (to allowable); Mail Order OON: Not Covered	
<b>Out of Pocket Maximum</b>	\$6,000 Specialty Pharmacy OOP Maximum	
<b>Annual Benefit Maximum</b>	Unlimited	

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