

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 750	
		HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK	
MEDICAL COST SHARE OPTIONS				
Individual Deductible PCY (Family embedded deductible 3X Individual)		\$750 PCY		\$1,500 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)		\$4,750 PCY		\$9,500 PCY
Office Visit Cost Share		\$35 Copay		Out of Network Deductible, then 50%
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION				
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
PROFESSIONAL CARE				
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%
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		Covered In Full		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 (Unlimited; within the 6 month lifetime maximum)		In Network Deductible, then 20%		Out of Network Deductible, then 50%
EMERGENCY CARE AND TRANSPORTATION OPTIONS				
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 750	
		HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
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)		\$35 Copay	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)		\$35 Copay	Out of Network Deductible, then 50%
Rehab Inpatient Facility (15 Days PCY)		In Network Deductible, then 20%	Out of Network Deductible, then 50%
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab.; and Chronic Pain (30 Visits PCY)		\$35 Copay	Out of Network Deductible, then 50%
Medical Supplies, Equipment, Prosthetics (Unlimited)		In Network Deductible, then 20%	Out of Network Deductible, then 50%
Foot Orthotics, Orthopedic Shoes and Accessories (Unlimited)		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%
Transplants (Unlimited; \$7,500 travel and lodging limits)		Covered as any other service	Not Covered
ALTERNATIVE CARE			
Manipulations (Spinal and other) (12 Visits PCY)		\$35 Copay	Deductible, then 50% Coinsurance
Acupuncture (12 Visits PCY)		\$35 Copay	Deductible, then 50% Coinsurance
Nutritional Therapy (Unlimited)		Covered In Full	Deductible, then 50% Coinsurance
ANNUAL PLAN MAXIMUM			
Annual Plan Maximum		Unlimited	Unlimited

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

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

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

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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.

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PHARMACY PLAN		2017 SECURE 750 - RX R=\$10/\$40/\$80/30% M= \$25/\$100/\$200/30%
		Cost Share Category Tier1/Tier2/Tier3
PRESCRIPTION DRUGS		
Drug List	Preferred B3 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands	
Retail Cost Shares	\$10/\$40/\$80/30%	
Mail Cost Shares	\$25/\$100/\$200/30%	
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 50% (to allowable); Mail Order OON: Not Covered	
Out of Pocket Maximum	\$6,000 Specialty Pharmacy OOP Maximum	
Annual Benefit Maximum	Unlimited	

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Discrimination is Against the Law

Premera Blue Cross complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Premera:

- 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 የሆኑትን ጉዳዮች ለማወቅ የዚህ ማሳሰቢያ ዋና ዋና ክፍሎችን በደንበኞች ገጽ ላይ ይገኛል።
Premera Blue Cross ለዚህ ማሳሰቢያ ዋና ዋና ክፍሎች ላይ ይገኛል።

Oromoo (Cushite):

Beeksisini 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 irraati 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 kouwèti 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 kouwèti 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 erhalten. 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):

Tsaw ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tej zaum tsaw ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb tuog 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 kho mob los yog kev pab them tej nqi kho mob ntawd. Koj muaj cai kom lawm 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 mabalin nga adda ket naglaon iti napateg nga impomasion maipanggep iti aplikasyonyo 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 saikbay 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).

بجوي هذا الإشعار معلومات هامة. قد يحتوي هذا الإشعار معلومات مهمة بخصوص طلبك أو التغطية التي تزيد الحصول عليها من خلال Premera Blue Cross. قد تكون هناك تواريخ مهمة في هذا الإشعار. وقد تحتاج اتخاذ إجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو المساعدة في دفع التكاليف. بحق لك الحصول على هذه المعلومات والمساعدة بتمك 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)。

