

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 WELLNESS 2	
			HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS				
Individual Deductible PCY (Family embedded deductible 3X Individual)			\$250 PCY	\$500 PCY
Coinsurance (Member's percentage of costs after deductible based on allowable charges)			10%	50%
Individual Out of Pocket Maximum PCY, excludes copay (Family Deductible 3X's Individual Ded; Family Coinsurance Maximum 2X's Individual Coinsurance Max)			Individual \$2,250 PCY; Family \$4,750 PCY	Individual Max \$4,500 PCY; Family \$9,500 PCY
Office Visit Cost Share			\$20 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			\$20 Copay	Out of Network Deductible, then 50%
Inpatient Professional Services			In Network Deductible, then 10%	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 10%	Out of Network Deductible, then 50%
Other Professional Diagnostic Laboratory/Pathology			In Network Deductible, then 10%	Out of Network Deductible, then 50%
Diagnostic Mammography			Covered in Full	Deductible, then 50%
FACILITY CARE OPTIONS				
Inpatient Facility			In Network Deductible, then 10%	Out of Network Deductible, then 50%
Outpatient Surgery Facility			In Network Deductible, then 10%	Out of Network Deductible, then 50%
Hospice Inpatient Facility (Unlimited; within the 6 month lifetime maximum)			In Network Deductible, then 10%	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 10%	\$250 Copay, then INN Deductible and Coinsurance 10%
Emergency Room Physician			In Network Deductible, then 10%	In Network Deductible, then 10%
Ambulance Transportation (Unlimited)			In Network Deductible, then 10%	In Network Deductible, then 10%
Air Ambulance (Unlimited)			In Network Deductible, then 10%	In Network Deductible, then 10%

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MEDICAL PLAN	*GRANDFATHERED	2017 WELLNESS 2	
		HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
OTHER SERVICES			
Allergy/Therapeutic Injections		In Network Deductible, then 10%	Out of Network Deductible, then 50%
Mental Health Inpatient Facility Care (Unlimited)		In Network Deductible, then 10%	Out of Network Deductible, then 50%
Mental Health Outpatient Professional Care (Unlimited)		\$20 Copay	Out of Network Deductible, then 50%
Chemical Dependency Inpatient Facility Care (Unlimited)		In Network Deductible, then 10%	Out of Network Deductible, then 50%
Chemical Dependency Outpatient Professional Care (Unlimited)		\$20 Copay	Out of Network Deductible, then 50%
Rehab Inpatient Facility (30 days PCY)		In Network Deductible, then 10%	Out of Network Deductible, then 50%
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab.; and Chronic Pain (45 visits PCY)		\$20 Copay	Out of Network Deductible, then 50%
Medical Supplies, Equipment, Prosthetics (Unlimited)		In Network Deductible, then 10%	Out of Network Deductible, then 50%
Foot Orthotics, Orthopedic Shoes and Accessories (Unlimited)		In Network Deductible, then 10%	Out of Network Deductible, then 50%
Home Health Visits (130 visits PCY)		In Network Deductible, then 10%	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 10%	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
Transplants (Unlimited; \$7,500 travel and lodging limits)		Covered as any other service	Not Covered
ALTERNATIVE CARE			
Manipulations (Spinal and other) (12 Visits PCY)		\$20 Copay	Deductible, then 50% Coinsurance
Acupuncture (12 Visits PCY)		\$20 Copay	Deductible, then 50% Coinsurance
Nutritional Therapy (Unlimited)		Covered In Full	Deductible, then 50% Coinsurance
SUPPLEMENTAL BENEFITS			
Routine Hearing Exam (1 PCY)		Exam: Subject to Office Visit Cost Share; Test: Covered in Full	Out of Network Deductible, then 50%
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 our Preferred Drug List in your pharmacy packet or at www.premera.com.

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PHARMACY PLAN		2017 WELLNESS 2 - RX R=\$10/\$25/\$50 M=\$20/\$50/\$100
		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/\$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 50% (to allowable); Mail Order OON: Not Covered	
Out of Pocket Maximum	Unlimited	
Annual Benefit Maximum	Unlimited	

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