

# Highlights of your Health Care Coverage

## Grant County

Group Number: 1037338

Effective Date: 01/01/2016

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	HIC BUY-UP PLAN	
	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
<b>MEDICAL COST SHARE OPTIONS</b>		
Individual Deductible 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 PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family - \$6,500 PCY)	\$3,000 PCY	Not Applicable
Office Visit Cost Share	\$25 Copay, applies to the Out of Pocket Maximum	Deductible, then 40%
<b>PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION</b>		
Preventive Office Visit (Unlimited)	Covered in Full	Deductible, then 40%
Immunizations (Unlimited)	Covered in Full	Waive Deductible, then 40%
Health Education (HE) (Unlimited)	Covered in Full	Deductible, then 40%.
Nicotine Dependency Programs (ND) (Unlimited)	Covered in Full	Deductible, then 40%.
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Deductible, then 40%.
<b>PROFESSIONAL CARE</b>		
Professional Office Visit Including Urgent Care	\$25 Copay, applies to the Out of Pocket Maximum	Deductible, then 40%
Inpatient Professional Services	Deductible, then 20%	Deductible, then 40%
Contraceptive Management Services (Unlimited)	Covered In Full	Deductible, then 40%
<b>DIAGNOSTIC SERVICE OPTIONS</b>		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	Deductible, then 40%
Other Professional Diagnostic Imaging	Covered In Full	Deductible, then 40%
Other Professional Diagnostic Laboratory/Pathology	Covered In Full	Deductible, then 40%
Diagnostic Mammography	Covered in Full	Deductible, then 30%
<b>FACILITY CARE OPTIONS</b>		
Inpatient Facility	Deductible, then 20%	Deductible, then 40%
Outpatient Surgery Facility	\$100 Outpatient Hospital Copay, then Deductible and 20%; includes surgical services and supplies;	\$100 Outpatient Hospital Copay, then Deductible and 40%; includes surgical services and supplies;
Hospice Inpatient Facility (Unlimited; within the 6 month lifetime maximum)	Deductible, then Covered in Full	Deductible, then 20%
<b>EMERGENCY CARE AND TRANSPORTATION OPTIONS</b>		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	\$200 Copay applies to the Out of Pocket Maximum, then Deductible, then 20%	\$200 Copay applies to the Out of Pocket Maximum, then Deductible, then 20%
Emergency Room Physician	Deductible, then 20%	Deductible, then 20%
Ambulance Transportation (Unlimited)	Deductible, then 20%	Deductible, then 20%
Air Ambulance (Unlimited)	Deductible, then 20%	Deductible, then 20%

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MEDICAL PLAN	HIC BUY-UP PLAN	
	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
<b>OTHER SERVICES</b>		
<b>Allergy/Therapeutic Injections</b>	Covered In Full	Deductible, then 40%
<b>Mental Health Inpatient Facility Care (Unlimited)</b>	Deductible, then 20%	Deductible, then 40%
<b>Mental Health Outpatient Professional Care (Unlimited)</b>	\$25 Copay, applies to the Out of Pocket Maximum	Deductible, then 40%
<b>Chemical Dependency Inpatient Facility Care (Unlimited)</b>	Deductible, then 20%	Deductible, then 40%
<b>Chemical Dependency Outpatient Professional Care (Unlimited)</b>	\$25 Copay, applies to the Out of Pocket Maximum	Deductible, then 40%
<b>Rehab Inpatient Facility (30 days PCY)</b>	Deductible, then 20%	Deductible, then 40%
<b>Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy (60 visits PCY)</b>	\$25 Copay, applies to the Out of Pocket Maximum	Deductible, then 40%
<b>Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, Chronic Pain and Cancer</b>	\$25 Copay, applies to the Out of Pocket Maximum	Deductible, then 40%
<b>Medical Supplies, Equipment, Prosthetics (Unlimited)</b>	Deductible, then 20%	Deductible, then 40%
<b>Foot Orthotics, Orthopedic Shoes and Accessories (Therapeutic shoes / Medically Necessary casted foot orthotics - 1 pair (2 units) PCY)</b>	Deductible, then 20%	Deductible, then 40%
<b>Home Health Visits (130 visits PCY (shared w/ Home Infusion))</b>	Deductible, then Covered in Full	Deductible, then 20%
<b>Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)</b>	Deductible, then Covered in Full	Deductible, then 20%
<b>TMJ (Temporomandibular Joint Disorders) (Unlimited (Medical and Dental services - Medical and Dental cost shares based on type of service))</b>	Covered as any other service	Covered as any other service
<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) (Unlimited)</b>	\$25 Copay, applies to the Out of Pocket Maximum	Deductible, then 40%
<b>Acupuncture (24 visits PCY)</b>	\$25 Copay, applies to the Out of Pocket Maximum	Deductible, then 40%
<b>Nutritional Therapy (Unlimited)</b>	Covered In Full	Deductible, then 40%
<b>ANNUAL PLAN MAXIMUM</b>		
<b>Annual Plan Maximum</b>	Unlimited	Unlimited

Copays are not subject to the deductible unless otherwise noted.

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

Tier 1 = Generic  
 Tier 2 = Preferred Brand Name  
 Tier 3 = Non Preferred Brand Name  
 Tier 4 = Specialty Drugs

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 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).

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<b>PHARMACY PLAN</b>		<b>RX RETAIL \$15/25/50 MAIL \$30/50/100 SPEC \$125 BUY-UP</b>
		<b>Cost Share Category</b>
		<b>Tier1/Tier2/Tier3/Tier4</b>
<b>PRESCRIPTION DRUGS</b>		
<b>Retail Cost Shares</b>		\$15/\$25/\$50/\$125
<b>Mail Cost Shares</b>		\$30/\$50/\$100/\$125
<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>		Cost Share, then 40% (to allowable)
<b>Out of Pocket Maximum</b>		Applies to the medical out of pocket maximum
<b>Specialty Pharmacy Out of Pocket Maximum</b>		Applies to the medical out of pocket maximum
<b>Annual Benefit Maximum</b>		Unlimited
<b>Drug List</b>		Preferred B4

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