

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	OPT 2 'HIC CORE PLAN	
	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 3X Individual)	\$750 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 - \$7,250 PCY)	Individual: \$3,250 PCY	Not Applicable
Office Visit Cost Share	\$30 Copay, applies to the Out of Pocket Maximum	██████████ Deductible, then 40%
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
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%
PROFESSIONAL CARE		
Professional Office Visit Including Urgent Care	\$30 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%
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	██████████ Deductible, then 40%
Other Professional Diagnostic Imaging	██████████ Deductible, then 20%	██████████ Deductible, then 40%
Other Professional Diagnostic Laboratory/Pathology	██████████ Deductible, then 20%	██████████ Deductible, then 40%
Diagnostic Mammography	Covered in Full	Deductible, then 30%
FACILITY CARE OPTIONS		
Inpatient Facility	██████████ Deductible, then 20%	Deductible, then 40%
Outpatient Surgery Facility	\$100 Outpatient Hospital Copay, then Deductible, then 20%; includes surgical services and supplies	\$100 Outpatient Hospital Copay, then Deductible, then 40%; includes surgical services and supplies
Hospice Inpatient Facility (Unlimited; within the 6 month lifetime maximum)	Deductible, then covered in full	Deductible, then 20%
EMERGENCY CARE AND TRANSPORTATION OPTIONS		
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%

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



Highlights of your Health Care Coverage

Grant County

Group Number: 1037338

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.

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

Effective Date: 01/01/2016

PHARMACY PLAN		RX RETAIL \$20/40/75 MAIL \$40/80/150 SPEC \$125 CORE
		Cost Share Category Tier1/Tier2/Tier3/Tier4
PRESCRIPTION DRUGS		
Retail Cost Shares		\$20/\$40/\$75/\$125
Mail Cost Shares		\$40/\$80/\$150/\$125
Day Supply		Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days
Individual Deductible PCY		\$0
Out of Network (Non-participating retail pharmacies)		Cost Share, then 40% (to allowable)
Out of Pocket Maximum		Applies to the medical out of pocket maximum
Specialty Pharmacy Out of Pocket Maximum		Applies to the medical out of pocket maximum
Annual Benefit Maximum		Unlimited
Drug List		Preferred B4

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.