PREMERA | BLUE CROSS

Highlights of your Health Care Coverage

PCC Aerostructures

Group Number: 1031655

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	PLAN 1	
	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family aggregate deductible)	$2,500 PCY/$5,000 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 and copay if applicable (Family embedded OOP max)	Individual Plan: $6,000 PCY Family Plan: $6,850 PCY/$12,000 PCY	Not Applicable
Office Visit Cost Share	Deductible, then 20%	Deductible, then 40%
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited)	Covered in Full	Deductible, then 40%
Immunizations (Unlimited)	Covered in Full	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	Deductible, then 20%	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	Deductible, then 20%	Deductible, then 40%
FACILITY CARE OPTIONS		
Inpatient Facility	Deductible, then 20%	Deductible, then 40%
Outpatient Surgery Facility	Deductible, then 20%	Deductible, then 40%
Skilled Nursing Facility (60 days PCY)	Deductible, then 20%	Deductible, then 40%
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	Deductible, then 20%	Deductible, then 40%
EMERGENCY CARE OPTIONS		
Emergency Care	Deductible, then 20%	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	PLAN 1	
	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
OTHER SERVICES		
Allergy/Therapeutic Injections	Deductible, then 20%	Deductible, then 40%
Mental Health Inpatient Facility Care (Unlimited)	Deductible, then 20%	Deductible, then 40%
Mental Health Outpatient Professional Care (Unlimited)	Deductible, then 20%	Deductible, then 40%
Chemical Dependency Inpatient Facility Care (Unlimited)	Deductible, then 20%	Deductible, then 40%
Chemical Dependency Outpatient Professional Care (Unlimited)	Deductible, then 20%	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; Cardiac & Pulmonary Rehab.; and Chronic Pain (45 visits PCY)	Deductible, then 20%	Deductible, then 40%
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, Chronic Pain and Cancer (Unlimited)	Deductible, then 20%	Deductible, then 40%
Medical Supplies, Equipment, Prosthetics (MS: Unlimited, ME: Unlimited, Pro: Unlimited)	Deductible, then 20%	Deductible, then 40%
Foot Orthotics, Orthopedic Shoes and Accessories ($300 PCY (Unlimited Diabetes Related))	Deductible, then 20%	Deductible, then 40%
Home Health Visits (130 visits PCY)	Deductible, then 20%	Deductible, then 40%
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	Deductible, then 20%	Deductible, then 40%
TMJ (Temporomandibular Joint Disorders) (Unlimited (Medical and Dental services - 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
Prescription Drugs - Retail (generic/preferred/non-preferred)	Deductible, then 20%	Deductible, then 20%
Prescription Drugs - Mail (generic/preferred/non-preferred) (No charge for specific preventive drugs. Retail: 90 day supply/Mail: 90 day supply/Specialty: 30 day supply)	Deductible, then 20%	Deductible, then 20%
Specialty Pharmacy (Mandatory)	Deductible, then 20%	Not Covered
Drug List	Open A1	Open A1
ALTERNATIVE CARE		
Manipulations (Spinal and other) (12 visits PCY)	Deductible, then 20%	Deductible, then 40%
Acupuncture (12 visits PCY)	Deductible, then 20%	Deductible, then 40%
Nutritional Therapy (Unlimited)	Covered In Full	Deductible, then 40%
SUPPLEMENTAL BENEFITS		
Routine Vision Exam (1 Exam PCY)	Deductible, then 20%	Deductible, then 20%
Pediatric Vision Exam (1 PCY under age 19)	Deductible, then 20%	Deductible, then 20%
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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