

## 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 3	
		HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
<b>MEDICAL COST SHARE OPTIONS</b>			
Individual Deductible PCY (Family 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 and copay if applicable (Family OOP max 3X Individual)		\$3,300 PCY	\$4,300 PCY
Office Visit Cost Share		\$15 Non-Specialist; \$30 Specialist, applies to OOP Max	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	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		\$15 Non-Specialist; \$30 Specialist, applies to OOP Max	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		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%
<b>FACILITY CARE OPTIONS</b>			
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%
<b>EMERGENCY CARE OPTIONS</b>			
Emergency Care (If applicable, waive copay if admitted to inpatient facility)		\$150 Copay (applies to the OOP Max); Deductible, then 20%	\$150 Copay (applies to the OOP Max); 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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	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
<b>OTHER SERVICES</b>		
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)	\$15 Copay (applies OOP Max)	Deductible, then 40%
Chemical Dependency Inpatient Facility Care (Unlimited)	Deductible, then 20%	Deductible, then 40%
Chemical Dependency Outpatient Professional Care (Unlimited)	\$15 Copay (applies OOP Max)	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)	\$30 Copay (applies OOP Max)	Deductible, then 40%
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, Chronic Pain and Cancer (Unlimited)	\$30 Copay (applies OOP Max)	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 lodging limits)	Covered as any other service	Not Covered
<b>ALTERNATIVE CARE</b>		
Manipulations (Spinal and other) (12 visits PCY)	\$15 Copay (applies OOP Max)	Deductible, then 40%
Acupuncture (12 visits PCY)	\$15 Copay (applies OOP Max)	Deductible, then 40%
Nutritional Therapy (Unlimited)	Covered In Full	Deductible, then 40%
<b>SUPPLEMENTAL BENEFITS</b>		
Routine Vision Exam (1 PCY)	\$15 Copay	\$15 Copay
Pediatric Vision Exam (1 PCY under age 19)	\$15 Copay (applies OOP Max)	\$15 Copay (applies OOP Max)
<b>ANNUAL PLAN MAXIMUM</b>		
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.*



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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 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](http://www.premera.com).

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PHARMACY PLAN		PLAN 3 RX
		Cost Share Category Tier1/Tier2/Tier3/Tier 4
<b>PRESCRIPTION DRUGS</b>		
Retail Cost Shares		\$10/\$25/\$40/20%
Mail Cost Shares		\$20/\$50/\$80/20%
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		Your cost shares accrue to your medical plans' out of pocket maximum.
Annual Benefit Maximum		Unlimited
Drug List		Preferred

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