

Highlights of your Health Care Coverage

WA TECHNOLOGY INDUSTRY ASSOCIATION EMPLOYEE BENEFIT TRUST

Effective Date: 12/01/2017

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		
2017 TECH 90 \$350		
	IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 3X Individual)	\$350 PCY	Shared with In-Network
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	10%	50%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded OOP max 3X Individual)	\$3,000 PCY	Shared with In-Network
Office Visit Cost Share	\$20 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited, subject to standard medical guidelines)	Covered In Full	Covered In Full
Immunizations (Unlimited, subject to standard medical guidelines)	Covered In Full	Covered In Full
Health Education (HE) (Unlimited)	Covered In Full	Not Covered
Nicotine Dependency Programs (ND) (Unlimited)	Covered In Full	Covered In Full
Diabetes Health Education (DE) (Unlimited)	Covered In Full	Out of Network Deductible, then 50%
PROFESSIONAL CARE		
Professional Office Visit	\$20 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%
Inpatient Professional Services	In Network Deductible, then 10%	Out of Network Deductible, then 50%
Contraceptive Management Services (Unlimited)	Covered In Full	Out of Network Deductible, then 50%
DIAGNOSTIC SERVICE OPTIONS		

MEDICAL PLAN		
2017 TECH 90 \$350		
	IN-NETWORK	OUT-OF-NETWORK
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	Covered In Full
Other Professional Diagnostic Imaging	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance
Other Professional Diagnostic Laboratory/Pathology	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance
Diagnostic Mammography	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance
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%
Skilled Nursing Facility (60 days PCY)	In Network Deductible, then 10%	Out of Network Deductible, then 50%
Hospice Inpatient Facility (30 days Inpatient; within the 6 month lifetime maximum)	In Network Deductible, then 10%	Out of Network Deductible, then 50%
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	\$200 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 10%	\$200 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 10%
Emergency Room Physician	In Network Deductible, then 10%	In Network Deductible, then 10%
Urgent Care Center	\$20 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%
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%
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, applies to the Out of Pocket Maximum	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, applies to the Out of Pocket Maximum	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, and Chronic Pain (25 Visits PCY)	\$20 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%
Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer	\$20 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%
Medical Supplies, Equipment, Prosthetics (MS: Unlimited, ME: Unlimited, Pro: Unlimited)	In Network Deductible, then 10%	Out of Network Deductible, then 50%

MEDICAL PLAN		
2017 TECH 90 \$350		
	IN-NETWORK	OUT-OF-NETWORK
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, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%
Acupuncture (12 visits PCY)	\$20 Copay, applies to the Out of Pocket Maximum	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 Premiera 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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Below is a brief overview of your Pharmacy Benefits. For more information on your benefits, please refer to your benefit booklets. To find out what tiers apply to a specific medication, refer to our Preferred Drug List at www.premera.com

PHARMACY PLAN	
2017 TECH 90 \$350 - RX	
PRESCRIPTION DRUGS	
Drug List	Preferred B3 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands
Retail Cost Shares	\$10/\$30/\$60
Mail Cost Shares	\$30/\$90/\$180
Day Supply	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days
Individual Deductible PCY	\$0
Family Deductible PCY	No Family Deductible
Out of Network (Non-participating retail pharmacies)	Retail Pharmacy & Preventive Generic Drug List Same as INN; OON Mail Order Not Covered
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Annual Benefit Maximum	Unlimited

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