

Highlights of your Health Care Coverage

WA TECHNOLOGY INDUSTRY ASSOCIATION EMPLOYEE BENEFIT TRUST

Effective Date: 12/01/2021

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 | | |
|---|--|--|
| | 2021 TECH 80 \$350 | |
| | HERITAGE PRIME IN-NETWORK | OUT-OF-NETWORK |
| MEDICAL COST SHARE OPTIONS | | |
| Individual Deductible PCY (Family embedded deductible 3X Individual) | \$350/\$1,050 PCY | Shared with In-Network |
| Coinsurance (Member's percentage of costs after deductible based on allowable charges) | 20% | 50% |
| Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family embedded Out Of Pocket maximum 3X Individual) | \$3,500/\$10,500 PCY | Shared with In-Network |
| Office Visit Cost Share | \$25 Copay, applies to the \$3,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |
| 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 | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network OOP Max |
| PROFESSIONAL CARE | | |

| MEDICAL PLAN | | |
|---|--|--|
| 2021 TECH 80 \$350 | | |
| | HERITAGE PRIME IN-NETWORK | OUT-OF-NETWORK |
| Telemedicine with Traditional Providers - General Medical | \$25 Copay, applies to the \$3,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |
| VIRTUAL CARE SERVICES | | |
| Telemedicine - General Medical (Virtual Care Only) | \$20 copay, applies to the Out Of Pocket Maximum | Not Covered |
| Telemedicine - Mental Health (Virtual Care Only) | Subject to Mental Health Outpatient Professional Care In-Network Cost Share | Not Covered |
| Telemedicine - Chemical Dependency (Virtual Care Only) | Subject to Chemical Dependency Outpatient Office Visit | Not Covered |
| DIAGNOSTIC SERVICE OPTIONS | | |
| 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 |
| Professional Diagnostic Major 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 | \$350 PCY Deductible, then 20% Coinsurance, applies to \$3,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |
| Inpatient Professional Services | \$350 PCY Deductible, then 20% Coinsurance, applies to \$3,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |
| Outpatient Surgery Facility | \$350 PCY Deductible, then 20% Coinsurance, applies to \$3,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |
| Skilled Nursing Facility (60 days PCY; includes room and board, and facility billed professional and ancillary fees) | \$350 PCY Deductible, then 20% Coinsurance, applies to \$3,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |
| HOSPICE & HOME HEALTH CARE | | |

| MEDICAL PLAN | | |
|---|---|---|
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| | HERITAGE PRIME IN-NETWORK | OUT-OF-NETWORK |
| Hospice Inpatient Facility (30 days Inpatient; within the 6 month lifetime maximum) | \$350 PCY Deductible, then 20% Coinsurance, applies to \$3,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |
| Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum) | \$350 PCY Deductible, then 20% Coinsurance, applies to \$3,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |
| MATERNITY & REPRODUCTIVE CARE | | |
| Contraceptive Management Services (Unlimited) | Covered in Full | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |
| Sterilization - Female (Unlimited) | Covered in Full | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |
| Sterilization - Male (Unlimited) | Covered in Full | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |
| PREMERA DESIGNATED CENTERS OF EXCELLENCE | | |
| Centers of Excellence Packaged Services (Heritage Prime Network - No Eligible Services) | Covered as any other service | Covered as any other service |
| EMERGENCY CARE AND TRANSPORTATION OPTION | | |
| Emergency Care (If applicable, waive copay if admitted to inpatient facility) | \$200 Copay then \$350 PCY Deductible and 20% Coinsurance; all cost shares apply to the \$3,500 Out of Pocket Maximum | \$200 Copay then \$350 PCY Deductible and 20% Coinsurance; all cost shares apply to the \$3,500 Out of Pocket Maximum |
| Emergency Room Physician | \$350 PCY Deductible, then 20% Coinsurance, applies to \$3,500 Out of Pocket Maximum | \$350 PCY Deductible, then 20% Coinsurance, applies to \$3,500 Out of Pocket Maximum |
| Urgent Care Center | \$25 Copay, applies to the \$3,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |
| Ambulance Transportation (Unlimited) | \$350 PCY Deductible, then 20% Coinsurance, applies to \$3,500 Out of Pocket Maximum | \$350 PCY Deductible, then 20% Coinsurance, applies to \$3,500 Out of Pocket Maximum |
| ALTERNATIVE CARE | | |
| Acupuncture (12 visits PCY) | \$25 Copay, applies to the \$3,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |
| Manipulations (Spinal and other) (12 visits PCY) | \$25 Copay, applies to the \$3,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |

| MEDICAL PLAN | | |
|---|--|--|
| 2021 TECH 80 \$350 | | |
| | HERITAGE PRIME IN-NETWORK | OUT-OF-NETWORK |
| CHEMICAL DEPENDENCY & MENTAL HEALTH | | |
| Chemical Dependency Inpatient Facility Care (Unlimited) | \$350 PCY Deductible, then 20% Coinsurance, applies to \$3,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |
| Chemical Dependency Outpatient Professional Care (Unlimited) | \$25 Copay, applies to the \$3,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |
| Mental Health Inpatient Facility Care (Unlimited) | \$350 PCY Deductible, then 20% Coinsurance, applies to \$3,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |
| Mental Health Outpatient Professional Care (Unlimited) | \$25 Copay, applies to the \$3,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |
| REHABILITATION & NEURO | | |
| Rehab Inpatient Facility (30 days PCY combined limit for inpatient services) | \$350 PCY Deductible, then 20% Coinsurance, applies to \$3,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |
| Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain (25 visits PCY combined limit for outpatient services) | \$25 Copay, applies to the \$3,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |
| Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer | \$25 Copay, applies to the \$3,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |
| OTHER SERVICES | | |
| Allergy/Therapeutic Injections | \$350 PCY Deductible, then 20% Coinsurance, applies to \$3,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |
| Medical Supplies, Equipment, Prosthetics (Unlimited) | \$350 PCY Deductible, then 20% Coinsurance, applies to \$3,500 Out of Pocket Maximum | Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum |
| Transplants (Unlimited; \$7,500 travel and lodging limits) | Covered as any other service | Not Covered |
| 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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WA TECHNOLOGY INDUSTRY ASSOCIATION EMPLOYEE BENEFIT TRUST

Effective Date: 12/01/2021

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 | |
|---|---|
| 2021 TECH 80 \$350 - ESSENTIALS RX - \$10/\$30/\$60/30% - \$25/\$75/\$60/30% | |
| PRESCRIPTION DRUGS | |
| Drug List | E4 Essentials Formulary Tier 1 = preferred generic Tier 2 = preferred brand Tier 3 = preferred specialty Tier 4 = non-preferred all drugs |
| Retail Cost Shares | \$10/\$30/\$60/30% |
| Mail Cost Shares | \$25/\$75/\$60/30% |
| 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) | In Network Cost Shares |
| Out of Pocket Maximum | Applies to the medical out of pocket maximum |
| Annual Benefit Maximum | 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.

Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).

注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-722-1471 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-722-1471 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-722-1471 (телетайп: 711).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃល្អ
គឺអាចមានសំរាប់អ្នក។ ចូរទូរស័ព្ទ 800-722-1471 (TTY: 711)។

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471 (TTY:711) まで、お電話にてご連絡ください。

ማስተዋዎ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚስተለው ቁጥር ይደውሉ
800-722-1471 (መስማት ለተሳናቸው: 711)።

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajjila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).
ملحوظة: إذا كنت تتحدث انكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: 800-722-1471 (TTY: 711).

ប្រៃសណីយ៍: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃល្អ
គឺអាចមានសំរាប់អ្នក។ ចូរទូរស័ព្ទ 800-722-1471 (TTY: 711)។

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-722-1471 (TTY: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-722-1471 (ATS: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-722-1471 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-722-1471 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero
800-722-1471 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-722-1471 (TTY: 711) تماس بگیرید.