

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 90 \$500	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family embedded deductible 3X Individual)	\$500/\$1,500 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 Out Of Pocket Maximum 3X Individual)	\$3,000/\$9,000 PCY	Shared with In-Network
Office Visit Cost Share	\$20 Copay, applies to the \$3,000 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 90 \$500	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
Telemedicine with Traditional Providers - General Medical	\$20 Copay, applies to the \$3,000 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	\$500 Deductible, then 10% Coinsurance, applies to \$3,000 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	\$500 Deductible, then 10% Coinsurance, applies to \$3,000 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	\$500 Deductible, then 10% Coinsurance, applies to \$3,000 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)	\$500 Deductible, then 10% Coinsurance, applies to \$3,000 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		
2021 TECH 90 \$500		
	HERITAGE IN-NETWORK	OUT-OF-NETWORK
Hospice Inpatient Facility (30 days Inpatient; within the 6 month lifetime maximum)	\$500 Deductible, then 10% Coinsurance, applies to \$3,000 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)	\$500 Deductible, then 10% Coinsurance, applies to \$3,000 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 (Eligible Services Include: Total Joint Replacement (Knee & Hip Replacement))	Covered in Full	Covered as any other service
Travel and Care Coordination (Limited to IRS Guidelines)	Covered in Full	Not Covered
EMERGENCY CARE AND TRANSPORTATION OPTION		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	\$200 Copay then \$500 Deductible and 10% Coinsurance; all cost shares apply to the \$3,000 Out of Pocket Maximum	\$200 Copay then \$500 Deductible and 10% Coinsurance; all cost shares apply to the \$3,000 Out of Pocket Maximum
Emergency Room Physician	\$500 Deductible, then 10% Coinsurance, applies to \$3,000 Out of Pocket Maximum	\$500 Deductible, then 10% Coinsurance, applies to \$3,000 Out of Pocket Maximum
Urgent Care Center	\$20 Copay, applies to the \$3,000 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)	\$500 Deductible, then 10% Coinsurance, applies to \$3,000 Out of Pocket Maximum	\$500 Deductible, then 10% Coinsurance, applies to \$3,000 Out of Pocket Maximum
ALTERNATIVE CARE		
Acupuncture (12 visits PCY)	\$20 Copay, applies to the \$3,000 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)	\$20 Copay, applies to the \$3,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
CHEMICAL DEPENDENCY & MENTAL HEALTH		

MEDICAL PLAN		2021 TECH 90 \$500	
	HERITAGE IN-NETWORK	OUT-OF-NETWORK	
Chemical Dependency Inpatient Facility Care (Unlimited)	\$500 Deductible, then 10% Coinsurance, applies to \$3,000 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)	\$20 Copay, applies to the \$3,000 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)	\$500 Deductible, then 10% Coinsurance, applies to \$3,000 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)	\$20 Copay, applies to the \$3,000 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)	\$500 Deductible, then 10% Coinsurance, applies to \$3,000 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)	\$20 Copay, applies to the \$3,000 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	\$20 Copay, applies to the \$3,000 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	\$500 Deductible, then 10% Coinsurance, applies to \$3,000 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)	\$500 Deductible, then 10% Coinsurance, applies to \$3,000 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 90 \$500 - 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。

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶቻችን በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚክተለው ቁጥር ይደውሉ።
800-722-1471 (መስማት ለተሳናቸው: 711)።

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila 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.