PREMERA | BLUE CROSS

Highlights of your Health Care Coverage

City of Spokane

Group Number: 1018813

Effective Date: 01/01/2015

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	CPIII $10/$20 RX NGF PLAN	
	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family deductible 3X Individual)	$100 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, copay and pharmacy if applicable (Family OOP max 3X Individual)	$625 PCY	Not Applicable
Office Visit Cost Share	Waive Deductible on first 3 OV Covered In Full for Illness or Injury; Subject to Deductible and Coinsurance thereafter. Exclude Office Surgery	Deductible, then 40%
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited)	Covered In Full	Not Covered
Immunizations (Unlimited)	Covered In Full	Not Covered
Health Education (HE) (Unlimited)	Covered In Full	Not Covered
Nicotine Dependency Programs (ND) (Unlimited)	Covered In Full	Not Covered
Diabetes Health Education (DE) (Unlimited)	Covered In Full	Not Covered
PROFESSIONAL CARE		
Professional Office Visit Including Urgent Care	Waive Deductible on first 3 OV Covered In Full for Illness or Injury; Subject to Deductible and Coinsurance thereafter. Exclude Office Surgery	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	First $100 Covered In Full. Deductible and Coinsurance thereafter. Excludes TMJ	Deductible, then 40%
Other Professional Diagnostic Laboratory/Pathology	First $100 Covered In Full. Deductible and Coinsurance thereafter. Excludes TMJ	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 (180 days PCY)	Deductible, then 20%	Deductible, then 40%
Hospice Inpatient Facility (Unlimited; within the 6 month lifetime maximum)	Deductible, then Covered in Full	Deductible, then 40%
EMERGENCY CARE AND TRANSPORTATION OPTIONS		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	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	CPIII $10/$20 RX NGF PLAN	
	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)	Waive Deductible on first 3 OV Covered In Full for Illness or Injury; Subject to Deductible and Coinsurance thereafter. Exclude Office Surgery	Deductible, then 40%
Chemical Dependency Inpatient Facility Care (Unlimited)	Deductible, then 20%	Deductible, then 40%
Chemical Dependency Outpatient Professional Care (Unlimited)	Waive Deductible on first 3 OV Covered In Full for Illness or Injury; Subject to Deductible and Coinsurance thereafter. Exclude Office Surgery	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%
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 Covered in Full	Deductible, then 40%
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	Deductible, then Covered in Full	Deductible, then 40%
TMJ (Temporomandibular Joint Disorders) (Unlimited)	Deductible, then Covered in Full	Deductible, then 40%
Transplants (Unlimited; $7,500 travel and lodging limits)	Covered as any other service	Not Covered
ALTERNATIVE CARE		
Manipulations (Spinal and other) (30 Visits PCY)	Deductible, then 20%	Deductible, then 40%
Acupuncture (24 Visits PCY)	Deductible, then 20%	Deductible, then 40%
Nutritional Therapy (Unlimited)	Covered in Full	Deductible, then 40%
SUPPLEMENTAL BENEFITS		
Routine Vision Exam (1 PCY)	Covered In Full	Deductible, then 40%
Vision Hardware ($200 every 2 years)	Covered In Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)	Covered In Full	Covered In Full
Pediatric Vision Hardware (Under age 19; Lenses 1 pair of contacts or lenses PCY includes polycarbonate lenses and scratch resistant coating; Frames 1 pair PCY)	Covered In Full	Covered In Full
ANNUAL PLAN MAXIMUM		
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 = Brand Name

Below is a brief overview of what you can expect to pay for a generic prescription drug when using an In-Network Pharmacy. For more information on your pharmacy benefits, including Out-of-Network benefits, see your benefit booklet. To locate an In-Network Pharmacy, go to www.premera.com.

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PHARMACY PLAN	RX RETAIL $10/$20 RX, NO MAIL ORDER (CPIII NGF)
	Cost Share Category Tier1/Tier2
PRESCRIPTION DRUGS	
Retail Cost Shares	$10 / $20
Mail Cost Shares	No Mail Order
Day Supply	30 days or 100 units, whichever is greater
Individual Deductible PCY	$0
Out of Network (Non-participating retail pharmacies)	Cost Share, then 40% (to allowable)
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Annual Benefit Maximum	Unlimited
Drug List	Preferred A2

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