PREMERA | BLUE CROSS

Highlights of your Health Care Coverage

Fred Hutchinson Cancer Research Center

Group Number: 9000090

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.

Effective Date: 07/01/2014

MEDICAL PLAN	Your Choice	
	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family deductible 3X Individual)	$400 PCY	$600 PCY
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	10%	30%
Individual Out of Pocket Maximum PCY, includes deductible, coinsurance and copay if applicable (Family OOP max 3X Individual)	$1,600 PCY	$3,600 PCY
Office Visit Cost Share	$25 Copay, applies to the Out of Pocket Maximum	Deductible, then 30%
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited)	Covered In Full	Not Covered
Immunizations (Unlimited)	Covered in Full	Covered in Full, paid at Billed Charges
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	$25 Copay, applies to the Out of Pocket Maximum	Deductible, then 30%
Inpatient Professional Services	Deductible, then 10%	Deductible, then 30%
Contraceptive Management Services (Unlimited)	Covered In Full	Deductible, then 30%
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	Deductible, then 30%
Other Professional Diagnostic Imaging	Deductible, then 10%	Deductible, then 30%
Other Professional Diagnostic Laboratory/Pathology	Deductible, then 10%	Deductible, then 30%
Diagnostic Mammography	Covered in Full	Deductible/Coinsurance
FACILITY CARE OPTIONS		
Inpatient Facility	Deductible, then 10%	Deductible, then 30%
Outpatient Surgery Facility	Deductible, then 10%	Deductible, then 30%
Skilled Nursing Facility (180 days PCY)	Deductible, then 10%	Deductible, then 30%
Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)	Deductible, then 10%	Deductible, then 30%
EMERGENCY CARE OPTIONS		
Emergency Care (If applicable, waive copay if admitted to inpatient facility)	$150 Copay, applies to the Out of Pocket Maximum; then Deductible, 10%	$150 Copay, applies to the Out of Pocket Maximum; then Deductible, 10%
Emergency Room Physician	Deductible, then 10%	Deductible, then 10%
Ambulance Transportation (Unlimited)	Deductible, then 10%	Deductible, then 10%
Air Ambulance (Unlimited)	Deductible, then 10%	Deductible, then 10%

PREMERA BLUE CROSS

Highlights of your Health Care Coverage

Fred Hutchinson Cancer Research Center

Group Number: 9000090

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.

Effective Date: 07/01/2014

MEDICAL PLAN	Your Choice	
	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
OTHER SERVICES		
Allergy/Therapeutic Injections	Deductible, then 10%	Deductible, then 30%
Mental Health Inpatient Facility Care (Unlimited)	Deductible, then 10%	Deductible, then 30%
Mental Health Outpatient Professional Care (Unlimited)	$25 Copay, applies to the Out of Pocket Maximum	Deductible, then 30%
Chemical Dependency Inpatient Facility Care (Unlimited)	Deductible, then 10%	Deductible, then 30%
Chemical Dependency Outpatient Professional Care (Unlimited)	$25 Copay, applies to the Out of Pocket Maximum	Deductible, then 30%
Rehab Inpatient Facility (60 days PCY)	Deductible, then 10%	Deductible, then 30%
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab.; and Chronic Pain (60 visits PCY)	$25 Copay, applies to the Out of Pocket Maximum	Deductible, then 30%
Medical Supplies, Equipment, Prosthetics (MS: Unlimited, ME: Unlimited, Pro: Unlimited)	Deductible, then 10%	Deductible, then 30%
Foot Orthotics, Orthopedic Shoes and Accessories ($300 PCY (Unlimited Diabetes Related))	Deductible, then 10%	Deductible, then 30%
Home Health Visits (130 visits PCY)	Deductible, then 10%	Deductible, then 30%
Hospice Care (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	Deductible, then 10%	Deductible, then 30%
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 up to the member annual maximum; $75,000 donor and $7,500 travel and lodging limits)	Covered as any other service	Not Covered
ALTERNATIVE CARE		
Manipulations (Spinal and other) (12 visits PCY)	$25 Copay, applies to the Out of Pocket Maximum	Deductible, then 30%
Acupuncture (12 visits PCY)	$25 Copay, applies to the Out of Pocket Maximum	Deductible, then 30%
Nutritional Therapy (Unlimited)	Covered In Full	Deductible, then 30%
SUPPLEMENTAL BENEFITS		
Routine Vision Exam (1 PCY)	$25 Copay	Deductible, then 30%
Vision Hardware ($150 every 2 consecutive calendar years)	Covered In Full	Covered In Full
Pediatric Vision Exam (1 PCY Under age 19)	$25 Copay, applies to the Out of Pocket Maximum	$25 Copay, applies to the Out of Pocket Maximum
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
Routine Hearing Exam (1 PCY)	Exam: $25 copay; Test: Covered in Full	Deductible, then 30%
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.

PREMERA BLUE CROSS

Highlights of your Health Care Coverage

Fred Hutchinson Cancer Research Center

Group Number: 9000090

Pharmacy Benefits

Tier 1 = Generic
Tier 2 = Preferred Brand Name
Tier 3 = Non Preferred Brand Name

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.

Any deductibles, copays, and coinsurance percentages shown are amounts for which you're responsible.

Effective Date: 07/01/2014

PHARMACY PLAN	**Your Choice Rx**
	Cost Share Category Tier1/Tier2/Tier3
PRESCRIPTION DRUGS	
Retail Cost Shares	$5/$30/$50
Mail Cost Shares	$10/$60/$100
Day Supply	Retail:30 days(1x copay); 31-60 days(2x copay); 61-90 days(3x copay). 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	Unlimited
Annual Benefit Maximum	Unlimited
Drug List	Preferred

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.