PREMERA EDUCATION PROGRAM

Medical Plans

Effective November 1, 2017

PCY = Per Calendar Year **OT** = Occupational Therapy
PT = Physical Therapy **Rx** = Prescription Drugs

		Plan 5 Heritage		Plan 2 Heritage		Plan 3 Heritage	
Provider Network							
Copayments, Deductible, and Coinsurance		**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Copayments							
Non-specialist Copay		$20*	30%	$25*	$30*	$30*	$40*
Specialist Copay		$30*	30%	$35*	$40*	$40*	$50*
Inpatient Copay (per person)		$150 per day, $450 Max PCY	None	$150 per day, $450 Max PCY		$300 per day, $900 Max PCY	
Outpatient Surgery Copay		None		$100		$150	
ER Copay (waived if admitted)		$50		$75		$100	
Deductible							
Deductible PCY	Individual	$200	$350	$300		$500	
	Family	$600	$350/family member	$900		$1,500	
Coinsurance							
Coinsurance		10%	30%	20%	40%	20%	40%
Out-of-Pocket Maximum PCY** includes copays, deductible and coinsurance	Individual	$1,000	No limit	$2,000	$3,400	$3,000	$5,900
	Family	$3,000	No limit	$6,000	$10,200	$9,000	$17,700
Covered Services		**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Office Visits—Professional Care							
Medical and Naturopathic Office Visits unlimited **Spinal and Other Manipulations** unlimited visits (chiropractic) **Acupuncture** 12 visits PCY (Plan 5 unlimited visits)		$20*	30%	$25*	$30*	$30*	$40*
Preventive Care							
Exams/Vaccinations **Preventive Screenings** (includes mammography and colon health screenings)		$0*	Not covered	$0*	20%*	$0*	20%*
Diagnostic Services							
Diagnostic Imaging/Laboratory		Ded + Coin		Ded + Coin		Ded + Coin	
Hospital/Facility Care							
Outpatient		Ded + Coin		Outpatient Surgery Copay+Ded+Coin		Outpatient Surgery Copay+Ded+Coin	
Inpatient		Inpatient Copay + Ded + Coin	Ded + Coin	Inpatient Copay + Ded + Coin		Inpatient Copay + Ded + Coin	
Maternity—Prenatal Care		Covered in full	Ded + Coin	Covered in full	Ded + Coin	Covered in full	Ded + Coin
Maternity—Delivery (newborns have their own copays, deductibles, and coinsurance)		Inpatient Copay + Ded + Coin	Ded + Coin	See Outpatient or Inpatient Hospital / Facility Care		See Outpatient or Inpatient Hospital / Facility Care	
Maternity—Postnatal Care		Ded + Coin		Ded + Coin		Ded + Coin	
Emergency Care							
Professional/Facility		ER Copay + Ded + Coin		ER Copay + Ded + Coin		ER Copay + Ded + Coin	
Ambulance (air and ground)		Deductible +$50		Ded + Coin		Ded + Coin	
Other Services							
Mental Health Outpatient unlimited visits		$20*	30%	$25*	$30*	$30*	$40*
Mental Health Inpatient unlimited days		Inpatient Copay + Ded + Coin	Ded + Coin	Inpatient Copay + Ded + Coin		Inpatient Copay + Ded + Coin	
Rehabilitation Outpatient 45 visits PCY (PT, Massage, Speech, OT) (Plans 2 and 3: PT unlimited)		$30*	30%	$35* PT Ded + Coin	$40* PT Ded + Coin	$40* PT Ded + Coin	$50* PT Ded + Coin
Rehabilitation Inpatient Plans 3 and 5: 30 days PCY, Plan 2: 120 days PCY		Inpatient Copay + Ded + Coin	Ded + Coin	Inpatient Copay + Ded + Coin		Inpatient Copay + Ded + Coin	
Prescription Drugs (participating pharmacies)		Generic / Preferred brand-name / Non-preferred brand-name					
Rx Deductible		None		None		None	
Rx Out-of-Pocket Maximum** includes Rx copays and Rx deductible		Shared with medical OOPM		Shared with medical OOPM		Shared with medical OOPM	
Retail Cost Share		$10 / $15 / $30 (up to 30-day supply)		$10 / $20 / $35 (up to 34-day supply)		$15 / $25 / $40 (up to 34-day supply)	
Mail Order Cost Share		$20 / $30 / $60 (up to 90-day supply)		$20 / $40 / $65 (up to 100-day supply)		$30 / $50 / $70 (up to 100-day supply)	
Specialty Drug Cost Share up to 30-day supply		$50 copay		$50 copay		$60 copay	
Drug List		B-4		B-4		B-4	
Symetra Life and AD&D Insurance		$25,000 Term Life and AD&D for employee only					

PREMERA BLUE CROSS
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* Not subject to the calendar year deductible

** Once the out-of-pocket maximum is met, covered in-network services are paid at 100% of allowable charges for the remainder of the calendar year. There is no out-of-pocket maximum for Plans 5, EasyChoice A, B, and Basic for out-of-network services.

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