

# Highlights of your Health Care Coverage

WA AUTOMOTIVE INDUSTRY ASSOCIATION HEALTH TRUST

Effective Date: 10/01/2024

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.

<b>MEDICAL PLAN</b>		
	<b>PPO 70% PLAN 1500</b>	
	<b>HERITAGE PRIME IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>MEDICAL COST SHARE OPTIONS</b>		
<b>Individual Deductible PCY</b> (Family embedded deductible 2X Individual)	\$1,500	Shared with In-Network
<b>Coinsurance (Member's percentage of costs after deductible based on allowable charges)</b>	30%	50%
<b>Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable</b> (Family embedded OOP max 2X Individual)	\$6,000	Shared with In-Network
<b>Office Visit Cost Share</b>	\$40 Copay, applies to the \$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum
<b>Kinwell Connect Cost Share Waiver</b> (Excluded)	All services rendered and billed by any Kinwell clinic are subject to standard cost shares	Not Applicable
<b>PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION</b>		
<b>Preventive Office Visit</b> (Unlimited, subject to standard medical guidelines)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to the Out of Pocket Maximum
<b>Immunizations</b> (Unlimited, subject to standard medical guidelines)	Covered In Full	Dep Child up to Age 18 Covered In Full; Members 18 & over Out of Network Deductible, Coinsurance
<b>Health Education (HE)</b> (Unlimited)	Covered In Full	Not Covered
<b>Nicotine Dependency Programs (ND)</b> (Unlimited)	Covered In Full	Out of Network Deductible, then 50%
<b>Diabetes Health Education (DE)</b> (Unlimited)	Covered In Full	Out of Network Deductible, then 50%

MEDICAL PLAN		PPO 70% PLAN 1500	
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<b>CHRONIC CONDITION MANAGEMENT PROGRAMS</b>			
Diabetes Prevention	Excluded	Excluded	
Diabetes Management	Excluded	Excluded	
Hypertension Management	Excluded	Excluded	
Weight Management	Excluded	Excluded	
<b>PROFESSIONAL CARE</b>			
Professional Office Visit	\$40 Copay, applies to the \$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
Telemedicine with Traditional Providers - General Medical	\$40 Copay, applies to the OOP Max	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>VIRTUAL CARE SERVICES</b>			
Telemedicine - General Medical (Virtual Care Only)	\$40 Copay, applies to the OOP Max	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	
<b>DIAGNOSTIC SERVICE OPTIONS</b>			
Preventive Professional Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered In Full	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance	
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	Covered In Full	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance	
Supplemental Breast Exam	Covered In Full	First \$500 PCY Covered In Full Shared Benefit, Subsequent Services Deductible/Coinsurance	
<b>FACILITY CARE OPTIONS</b>			

<b>MEDICAL PLAN</b>		<b>PPO 70% PLAN 1500</b>	
	<b>HERITAGE PRIME IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>Inpatient Facility</b>	\$1,500 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Inpatient Professional Services</b>	\$1,500 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Outpatient Surgery Facility</b>	\$1,500 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Skilled Nursing Facility</b> (90 days PCY; includes room and board, and facility billed professional and ancillary fees)	\$1,500 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>HOSPICE &amp; HOME HEALTH CARE</b>			
<b>Hospice Inpatient Facility</b> (30 days Inpatient; within the 6 month lifetime maximum)	\$1,500 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Hospice Care</b> (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum)	\$1,500 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>MATERNITY &amp; REPRODUCTIVE CARE</b>			
<b>Contraceptive Management Services</b> (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Sterilization - Female</b> (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Sterilization - Male</b> (Unlimited)	Covered in Full	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>MEDICAL TRANSPORTATION BENEFITS</b>			
<b>Transplant Travel &amp; Lodging</b> (\$7,500 per transplant)	\$1,500 Deductible, 0% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$1,500 Deductible, 0% Coinsurance, applies to \$6,000 Out of Pocket Maximum	
<b>EMERGENCY CARE AND TRANSPORTATION OPTION</b>			
<b>Emergency Care (If applicable, waive copay if admitted to inpatient facility)</b>	\$200 Copay then \$1,500 Deductible and 30% Coinsurance; all cost shares apply to the \$6,000 Out of Pocket Maximum	\$200 Copay then \$1,500 Deductible and 30% Coinsurance; all cost shares apply to the \$6,000 Out of Pocket Maximum	
<b>Emergency Room Physician</b>	\$1,500 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum	

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	<b>HERITAGE PRIME IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>	
<b>Urgent Care Center</b>	\$40 Copay, applies to the \$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Ambulance Transportation</b> (Unlimited)	\$1,500 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum	\$1,500 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum	
<b>ALTERNATIVE CARE</b>			
<b>Acupuncture</b> (12 visits PCY)	\$40 Copay, applies to the \$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Manipulations (Spinal and other)</b> (12 visits PCY)	\$40 Copay, applies to the \$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>CHEMICAL DEPENDENCY &amp; MENTAL HEALTH</b>			
<b>Chemical Dependency Inpatient Facility Care</b> (Unlimited)	\$1,500 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Chemical Dependency Outpatient Professional Care</b> (Unlimited)	\$40 Copay, applies to the \$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Mental Health Inpatient Facility Care</b> (Unlimited)	\$1,500 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Mental Health Outpatient Professional Care</b> (Unlimited)	\$40 Copay, applies to the \$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>REHABILITATION &amp; NEURO</b>			
<b>Rehab Inpatient Facility</b> (30 days PCY combined limit for inpatient services)	\$1,500 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy, and Chronic Pain</b> (25 visits PCY combined limit for outpatient services)	\$40 Copay, applies to the \$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Rehab Outpatient Care Chronic Conditions, Including Cardiac, Pulmonary Rehab, and Cancer</b>	\$40 Copay, applies to the \$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>OTHER SERVICES</b>			
<b>Allergy/Therapeutic Injections</b>	\$1,500 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	

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<b>Medical Supplies, Equipment, Prosthetics</b> (Unlimited)	\$1,500 Deductible, then 30% Coinsurance, applies to \$6,000 Out of Pocket Maximum	Shared with In-Network Deductible, then 50% Coinsurance, applies to Shared with In-Network Out of Pocket Maximum	
<b>Transplants</b> (Unlimited)	Covered as any other service	Not Covered	
<b>SUPPLEMENTAL BENEFITS</b>			
<b>Routine Hearing Exam</b> (1 every 36 months)	\$40 Copay; Test: Covered in Full	OON Deductible, then OON Coinsurance	
<b>Hearing Hardware</b> (WA Mandate \$3,000 per ear with hearing loss every 36 months)	Covered in Full	Covered in Full	
<b>ANNUAL PLAN MAXIMUM</b>			
<b>Annual Plan Maximum</b>	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 of the plan. This benefit highlight is not a contract and may change. Please see your benefit booklet or call Customer Service for full coverage information including a description of waiting periods, limitations, and exclusions.*

# Highlights of your Health Care Coverage

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Effective Date: 10/01/2024

Below is a brief overview of your pharmacy benefit. For more information, please refer to your benefit booklet or sign into [www.premera.com](http://www.premera.com) to find drug costs and coverages specific to your plan.

PHARMACY PLAN	
PPO 70% PLAN 1500 - RX	
PRESCRIPTION DRUGS	
Drug List	Preferred B4 Tier 1 = generic Tier 2 = preferred brand Tier 3 = non-preferred brands Tier 4 = specialty
Annual Benefit Maximum	Unlimited
Individual Deductible PCY	\$0
Family Deductible PCY	No Family Deductible
Out of Network (Non-participating retail pharmacies)	Same as In-Network
Out of Pocket Maximum	Applies to the medical out of pocket maximum
Retail Cost Shares	\$10/\$50/\$80/\$250
Mail Cost Shares	\$30/\$150/\$240/\$250
Day Supply	Retail: 30 Days; Mail: 90 Days; Specialty: 30 Days

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