



Highlights of your Health Care Coverage

Kitsap County

Group Number: 1037245

Effective Date: 01/01/2012

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

MEDICAL PLAN	HCR HERITAGE YOUR CHOICE – CLASSIC Plan	
	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
MEDICAL COST SHARE OPTIONS		
Individual Deductible PCY (Family deductible 3X Individual)	\$300 PCY	Shared with In-Network
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	10%	40%
Individual Out of Pocket Maximum PCY, Excludes Copay (Family OOP max 3X Individual)	\$2,500 PCY (Coinsurance Max)	\$3,000 PCY (Coinsurance Max)
Office Visit Cost Share	\$25 Copay	\$25 Copay, then 40%
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited)	Covered in Full	\$25 Copay, then 40%
Immunizations (Unlimited)	Covered in Full	Waive Deductible, then 40%
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	Covered same as any other service
PROFESSIONAL CARE		
Professional Office Visit Including Urgent Care	\$25 Copay	\$25 Copay, then 40%
Inpatient Professional Services	Deductible, then 10%	Deductible, then 40%
DIAGNOSTIC SERVICE OPTIONS		
Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA	Covered in Full	Waive Deductible, then 40%
Other Professional Diagnostic Imaging and Laboratory Services	Deductible, then 10%	Deductible, then 40%
Diagnostic Mammography	Covered In Full	Waive Deductible, then 40%
FACILITY CARE OPTIONS		
Inpatient Facility	Deductible, then 10%	Deductible, then 40%
Outpatient Surgery Facility	Deductible, then 10%	Deductible, then 40%
Skilled Nursing Facility (60 days PCY)	Deductible, then 10%	Deductible, then 40%
EMERGENCY CARE OPTIONS		
Emergency Care (Waive copay if admitted to inpatient facility)	\$125 Copay, Deductible/Coinsurance	\$125 Copay, Deductible/Coinsurance
Air Ambulance (Unlimited)	Deductible, then 20%	Deductible, then 20%
Ambulance Transportation (Unlimited)	Deductible, then 20%	Deductible, then 20%
ALTERNATIVE CARE		
Manipulations (Spinal and other) (Manipulations: 20 visits PCY)	\$25 Copay	\$25 Copay, then 40%
Acupuncture (Acupuncture: 12 visits PCY)	\$25 Copay	\$25 Copay, then 40%
Nutritional Therapy (NT: Unlimited)	\$25 Copay	\$25 Copay, then 40%

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	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
OTHER SERVICES		
Mental Health Inpatient Facility Care (Unlimited)	Deductible, then 10%	Deductible, then 40%
Mental Health Outpatient Professional Care (Unlimited)	\$25 Copay	\$25 copay, then 40%
Chemical Dependency Inpatient Facility Care (Unlimited)	Deductible, then 10%	Deductible, then 40%
Chemical Dependency Outpatient Professional Care (Unlimited)	\$25 Copay	\$25 copay, then 40%
Rehab Inpatient Facility (60Days PCY)	Deductible, then 10%	Deductible, then 40%
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab.; and Chronic Pain (Outpatient: 35 Visits PCY)	Deductible, then 10%	Deductible, then 40%
Medical Supplies, Equipment, Prosthetics and Orthotics (MS, ME, Pro & Orth: Unlimited)	Deductible, then 10%	Deductible, then 40%
Home Health Visits (130 visits PCY)	Deductible, then 10%	Deductible, then 40%
Hospice Care (Inpatient: 7 days; Respite: Unlimited; 6 month limit)	Deductible, then 10%	Deductible, then 40%
TMJ (Temporomandibular Joint Disorders) (\$1,000 PCY/\$5,000 per Lifetime)	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
SUPPLEMENTAL BENEFITS		
Routine Vision Exam Exam: 1PCY	\$25 Copay	\$25 Copay
Vision Hardware \$250 PCY	Covered In Full	Covered In Full
ANNUAL PLAN MAXIMUM		
Annual Plan Maximum	Unlimited Lifetime Max; \$2,000,000 Aggregate Annual Max	Shared with in-network

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 = 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 our Preferred Drug List in your pharmacy packet or at www.premera.com.

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PHARMACY PLAN		RX CONFIGURE PLANS CLASSIC RETAIL \$10/\$30/\$50 MAIL \$20/\$60/\$100
		Cost Share Category Tier1/Tier2/Tier3
PRESCRIPTION DRUGS		
Retail Cost Shares		\$10/\$30/\$50
Mail Cost Shares		\$20/\$60/\$100
Day Supply		Retail: 30 Days; 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

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