

Seattle Pacific University

Group Number: 1013061

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Effective date: 7/1/2009

MEDICAL PLAN		Your Choice – Option 2	
MEDICAL COST SHARE OPTIONS	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK	
Individual Deductible PCY (Family Deductible 3x Individual)	\$500 PCY	\$700 PCY	
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	40%	
Individual Out of Pocket Maximum PCY, Excludes Copay (Family OOP Max 3x Individual)	\$2,500 PCY	\$10,500 PCY	
Office Visit Cost Share	\$15 copay, then 20% Coinsurance	Deductible/Coinsurance	
COVERED SERVICES			
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION			
Preventive Office Visit (\$750 PCY shared with Immunizations)	Covered in Full	Deductible/Coinsurance	
Immunizations (\$750 PCY shared with Preventive Office Visit)	Covered in Full	Covered in Full	
Health Education (HE) (\$250 PCY)	Covered in Full	Not Covered	
Community Wellness, Prevention and Safety Programs (CW) (\$250 PCY shared with Health Education)	Covered in Full	Not Covered	
Nicotine Dependency Programs (ND) (\$250 PCY)	Covered in Full	Not Covered	
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Not Covered	
PROFESSIONAL CARE			
Professional Office Visit Including Urgent Care	\$15 copay, then 20% Coinsurance	Deductible/Coinsurance	
Inpatient Professional Services	Deductible/Coinsurance	Deductible/Coinsurance	
Contraceptive Management (Unlimited)	\$15 copay, then 20% Coinsurance	Deductible/Coinsurance	
DIAGNOSTIC SERVICE OPTIONS			
Other Professional Diagnostic Imaging and Laboratory Services	Deductible/Coinsurance	Deductible/Coinsurance	
Preventive Professional Diagnostic Imaging and Laboratory Services - Including PAP/PSA	Covered in Full	Deductible/Coinsurance	
Mammography	Covered in Full	Deductible/Coinsurance	
FACILITY CARE OPTIONS			
Inpatient Facility	Deductible/Coinsurance	Deductible/Coinsurance	
Outpatient Surgery Facility	Deductible/Coinsurance	Deductible/Coinsurance	
Skilled Nursing Facility (90 days PCY)	Deductible/Coinsurance	Deductible/Coinsurance	
EMERGENCY CARE OPTIONS			
Emergency Care (Waive copay if admitted, always subject to deductible and coinsurance.)	\$100 Copay, Deductible/Coinsurance	\$100 Copay, Subject to In-Network Deductible/Coinsurance	
Ambulance Transportation	Deductible/Coinsurance	Same as In-Network Deductible/Coinsurance	
Air Ambulance (Unlimited)	Deductible/Coinsurance	Same as In-Network Deductible/Coinsurance	

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.

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OTHER SERVICES	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
Acupuncture (12 visits PCY)	\$15 copay, then 20% Coinsurance	Deductible/Coinsurance
Chemical Dependency (\$14,500 per 24 Months)	Covered as Any Other Service	Deductible/Coinsurance
Home Health Care (130 visits PCY)	Deductible/Coinsurance	Deductible/Coinsurance
Hospice (Inpatient: 14 days; Respite: 240 hours; 6 month limit)	Deductible/Coinsurance	Deductible/Coinsurance
Manipulations (spinal and other) (12 visits PCY)	\$15 copay, then 20% Coinsurance	Deductible/Coinsurance
Medical Supplies (MS), Equipment (ME), Prosthetics (Pro) and Orthotics (Orth) (MS: Unlimited; ME: Unlimited; Pro: Unlimited; Orth: Unlimited)	Deductible/Coinsurance	Deductible/Coinsurance
Mental Health Inpatient Facility Care (Unlimited)	Deductible/Coinsurance	Deductible/Coinsurance
Mental Health Outpatient Professional Care (Unlimited)	Covered as Any Other Service	Deductible/Coinsurance
Orthognathic/Maxillofacial Care (Unlimited)	Deductible/Coinsurance	Deductible/Coinsurance
Rehab Inpatient Facility (30 days PCY)	Deductible/Coinsurance	Deductible/Coinsurance
Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab.; and Chronic Pain (45 visits PCY)	Covered as Any Other Service	Deductible/Coinsurance
TMJ Disorders (\$1,000 PCY/\$5,000 per Lifetime)	Covered as Any Other Service	Deductible/Coinsurance
Transplants (\$250,000 per lifetime; combined inpatient and outpatient limit)	Covered as Any Other Service	Not Covered
SUPPLEMENTAL BENEFITS		
Routine Hearing Exam (1 PCY)	\$15 copay, then 20% Coinsurance	Deductible/Coinsurance
LIFETIME MAXIMUM	\$2,000,000	

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Pharmacy Benefits

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

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		Option 2
OUTPATIENT PRESCRIPTION DRUGS		Cost Share Category Tier 1/ Tier 2/ Tier 3
Retail Cost Shares Up to 30 day supply per prescription		\$10/\$25/\$40
Mail Cost Shares Up to 90 day supply per prescription		\$20/\$50/\$80
Individual Deductible PCY		\$0
Out-of-Network Non-participating retail and mail pharmacies		Cost Share, then 40% (to allowable)
Out of Pocket Max		Unlimited
Annual Benefit Max		Unlimited

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