PREMERA BLUE CROSS

Highlights of your Health Care Coverage

Advantage IQ, Inc.

Group Number: 1037341

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

Effective date: 1/1/2011

MEDICAL PLAN	Your Choice - Core	
MEDICAL COST SHARE OPTIONS	**HERITAGE IN-NETWORK**	**HERITAGE OUT-OF-NETWORK**
Individual Deductible PCY (Family Deductible 3x Individual)	$1,000 PCY	$3,000 PCY
Coinsurance (Member's percentage of costs after deductible based on allowable charges)	20%	50%
Individual Out of Pocket Maximum PCY, Excludes Copay (Family OOP Max 3x Individual)	$4,000 PCY	Not Applicable
Office Visit Cost Share	$30 Copay	Deductible/Coinsurance
COVERED SERVICES		
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit	Office Visit Cost Share	Not Covered
Immunizations (Unlimited)	Covered in Full	Not Covered
Health Education (HE) ($250 PCY)	Covered in Full	Not Covered
Community Wellness, Prevention and Safety Programs (CW) (Shared with Health Education)	Covered in Full	Not Covered
Nicotine Dependency Programs (ND) (Shared with Health Education)	Covered in Full	Not Covered
Diabetes Health Education (DE) (Unlimited)	Covered in Full	Not Covered
PROFESSIONAL CARE		
Professional Office Visit Including Urgent Care	$30 Copay	Deductible/Coinsurance
Inpatient Professional Services	Deductible/Coinsurance	Deductible/Coinsurance
Contraceptive Management (Unlimited)	$30 Copay	Deductible/Coinsurance
DIAGNOSTIC SERVICE OPTIONS		
Other Professional Diagnostic Imaging and Laboratory Services	Waive Deductible, Subject to Coinsurance	Deductible/Coinsurance
Preventive Professional Diagnostic Imaging and Laboratory Services - Including PAP/PSA	Waive Deductible, Subject to Coinsurance	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 (60 days PCY)	Deductible/Coinsurance	Deductible/Coinsurance
EMERGENCY CARE OPTIONS		
Emergency Care (Waive copay if admitted, always subject to deductible and coinsurance.)	$150 Copay, Deductible/Coinsurance	$150 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.

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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OTHER SERVICES	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
Acupuncture (15 visits PCY)	$30 Copay	Deductible/Coinsurance
Chemical Dependency (Unlimited)	Covered as Any Other Service	Covered as Any Other Service
Home Health Care (130 visits PCY)	Deductible/Coinsurance	Deductible/Coinsurance
Hospice (Inpatient: 10 days; Respite: 240 hours; 6 month limit)	Deductible/Coinsurance	Deductible/Coinsurance
Manipulations (spinal and other) (15 visits PCY)	$30 Copay	Deductible/Coinsurance
Medical Supplies (MS), Equipment (ME), Prosthetics (Pro) and Orthotics (Orth) (MS: Unlimited; ME: $10,000 PCY; Pro: Unlimited; Orth: $300 PCY, Shared with ME)	Deductible/Coinsurance	Deductible/Coinsurance
Mental Health Inpatient Facility Care (Unlimited)	Covered as Any Other Service	Covered as Any Other Service
Mental Health Outpatient Professional Care (Unlimited)	$30 Copay	Deductible/Coinsurance
Orthognathic/Maxillofacial Care ($5,000 Lifetime)	Covered as Any Other Service	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 (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 (1 PCY)	Office Visit Cost Share	In-Network Office Visit Cost Share
Vision Hardware ($150 PCY)	Covered in Full	Covered in Full
LIFETIME MAXIMUM	Unlimited	

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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	**RX**
OUTPATIENT PRESCRIPTION DRUGS	**Cost Share Category Tier 1/ Tier 2/ Tier 3**
Retail Cost Shares Up to 30 day supply per prescription	$10/$30/$60
Mail Cost Shares Up to 90 day supply per prescription	$20/$60/$120
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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