highlights

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American Piledriving Equipment
Group Number: 1038880

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Effective date: 1/1/2011

MEDICAL PLAN	HCR Your Choice - Opt 9 $2000-4000/20-50%/4000/$25/vis$150	
MEDICAL COST SHARE OPTIONS	**HERITAGE IN-NETWORK**	**HERITAGE OUT-OF-NETWORK**
Individual Deductible PCY (Family Deductible 2x Individual)	$2,000 PCY	$4,000 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 2x Individual)	$4,000 PCY	Not Applicable
Office Visit Cost Share	$25 Copay	Deductible/Coinsurance
COVERED SERVICES		
PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION		
Preventive Office Visit (Unlimited)	Covered in Full	Not Covered
Immunizations (Unlimited)	Covered in Full	Not Covered
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	Not Covered
PROFESSIONAL CARE		
Professional Office Visit Including Urgent Care	$25 Copay	Deductible/Coinsurance
Inpatient Professional Services	Deductible/Coinsurance	Deductible/Coinsurance
Contraceptive Management (Unlimited)	$25 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	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 (60 days PCY)	Deductible/Coinsurance	Deductible/Coinsurance
EMERGENCY CARE OPTIONS		
Emergency Care (Waive copay if admitted, always subject to deductible and coinsurance.)	$200 Copay, Deductible/Coinsurance	$200 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

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OTHER SERVICES	HERITAGE IN-NETWORK	HERITAGE OUT-OF-NETWORK
Acupuncture (12 visits PCY)	$25 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) (12 visits PCY)	$25 Copay	Deductible/Coinsurance
Medical Supplies (MS), Equipment (ME), Prosthetics (Pro) and Orthotics (Orth) (MS: Unlimited; ME: Unlimited; Pro: Unlimited; Orth: $300 PCY (Unlimited Diabetes Related))	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)	$25 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 (15 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 Lifetime Max, $2,000,000 Aggregate Annual Max	

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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 CONFIGURE PLANS - RETAIL $15/25/40 MAIL $30/50/80**
OUTPATIENT PRESCRIPTION DRUGS	**Cost Share Category Tier 1/ Tier 2/ Tier 3**
Retail Cost Shares Up to 30 day supply per prescription	$15/$25/$40
Mail Cost Shares Up to 90 day supply per prescription	$30/$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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DENTAL PLAN	DENTAL OPTIMA - $50-150/0-20-50%/$2000
COVERED SERVICES	
Individual/Family Deductible PCY	$50 PCY / $150 PCY
DIAGNOSTIC/PREVENTIVE -cleanings (limited to 2PCY) -emergency exams (unlimited) -fluoride treatments (limited to 2 applications PCY for members under age 20) -routine oral exams (limited to 2 PCY) -routine x-rays (complete series or panoramic x-ray once per 36 consecutive months) -sealants (limited to permanent teeth for members under age 19) -space maintainers (for members under age 20)	0%
BASIC -emergency palliative treatment -endodontic (root canal) treatment (limited to 2 per arch when performed in conjunction with overdentures) -fillings (limited to once per tooth surface every 24 consecutive months) -full mouth debridement -general anesthesia (limited to covered dental procedures at a dental-care provider's office when dentally necessary) -oral surgery (including simple and surgical extractions) -periodontal maintenance (limited to 4 visits per calendar year) -periodontal scaling (limited to 2 every 12 consecutive months) -periodontal surgery -repair & recementing of crowns, inlays, bridgework & dentures	20%
MAJOR -implants, dentures, partial & fixed bridges (replacements limited to once every 5 calendar years) -inlays, onlays & crowns (replacements limited to once per tooth every 5 years)	50%
Annual Maximum	$2,000 PCY

Annual deductible waived for Diagnostic/Preventive services

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