### Highlights of your Health Care Coverage

**The University of Puget Sound High Deductible Medical Plan**

**Group Number:** 1003592  
**Effective Date:** 01/01/2015

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.

<table>
<thead>
<tr>
<th>MEDICAL PLAN</th>
<th>BASE HYC HRA</th>
<th>HERITAGE IN NETWORK</th>
<th>HERITAGE OUT OF NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDICAL PLAN COST SHARE OPTIONS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Deductible PCY (Family deductible 2X Individual)</td>
<td>$1,500 PCY</td>
<td>$3,000 PCY</td>
<td></td>
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<tr>
<td>Coinsurance (Member’s percentage of costs after deductible based on allowable charges)</td>
<td>20%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>Individual Out of Pocket Maximum PCY, includes deductible, coinsurance, copay and pharmacy if applicable (Family OOP max 2X Individual)</td>
<td>$4,000 PCY</td>
<td>$8,500 PCY</td>
<td></td>
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<tr>
<td>Office Visit Cost Share</td>
<td>Deductible, then 20%</td>
<td>Deductible, then 40%</td>
<td></td>
</tr>
</tbody>
</table>

**PREVENTIVE CARE OPTIONS AND HEALTH EDUCATION**

- Preventive Office Visit (Unlimited)  
  - Covered in Full  
  - Covered in Full
- Immunizations (Unlimited)  
  - Covered in Full  
  - Covered in Full
- 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  
  - Deductible, then 20%  
  - Deductible, then 40%
- Inpatient Professional Services  
  - Deductible, then 20%  
  - Deductible, then 40%
- Contraceptive Management Services (Unlimited)  
  - Covered in Full  
  - Deductible, then 40%

**DIAGNOSTIC SERVICE OPTIONS**

- Preventive Professional Diagnostic Imaging and Laboratory Services - Including Mammogram and PAP/PSA  
  - Covered in Full  
  - Deductible, then 40%
- Other Professional Diagnostic Imaging  
  - Deductible, then 20%  
  - Deductible, then 40%
- Other Professional Diagnostic Laboratory/Pathology  
  - Deductible, then 20%  
  - Deductible, then 40%
- Diagnostic Mammography  
  - Deductible, then 20%  
  - Deductible, then 40%

**FACILITY CARE OPTIONS**

- Inpatient Facility  
  - Deductible, then 20%  
  - Deductible, then 40%
- Outpatient Surgery Facility  
  - Deductible, then 20%  
  - Deductible, then 40%
- Skilled Nursing Facility (60 days PCY)  
  - Deductible, then 20%  
  - Deductible, then 40%
- Hospice Inpatient Facility (10 days Inpatient; within the 6 month lifetime maximum)  
  - Deductible, then 20%  
  - Deductible, then 40%

**EMERGENCY CARE AND TRANSPORTATION OPTIONS**

- Emergency Care (If applicable, waive copay if admitted to inpatient facility)  
  - $150 Copay, applies to the Out of Pocket Maximum; then Deductible, 20%  
  - $150 Copay, applies to the Out of Pocket Maximum; then Deductible, 20%
- Emergency Room Physician  
  - Deductible, then 20%  
  - Deductible, then 20%
- Ambulance Transportation (Unlimited)  
  - Deductible, then 20%  
  - Deductible, then 20%
- Air Ambulance (Unlimited)  
  - Deductible, then 20%  
  - Deductible, then 20%

**OTHER SERVICES**

- Allergy/Therapeutic Injections  
  - Deductible, then 20%  
  - Deductible, then 40%
- Mental Health Inpatient Facility Care (Unlimited)  
  - Deductible, then 20%  
  - Deductible, then 40%
- Mental Health Outpatient Professional Care (Unlimited)  
  - Deductible, then 20%  
  - Deductible, then 40%
- Chemical Dependency Inpatient Facility Care (Unlimited)  
  - Deductible, then 20%  
  - Deductible, then 40%
- Chemical Dependency Outpatient Professional Care (Unlimited)  
  - Deductible, then 20%  
  - Deductible, then 40%
- rehab Inpatient Facility (60 days PCY)  
  - Deductible, then 20%  
  - Deductible, then 40%
- Rehab Outpatient Care, Including Physical, Occupational, Speech and Massage Therapy; Cardiac & Pulmonary Rehab.; and Chronic Pain (60 visits PCY)  
  - Deductible, then 20%  
  - Deductible, then 40%
- Medical Supplies, Equipment, Prosthetics (MS: Unlimited, ME: Unlimitted, Pro: Unlimited)  
  - Deductible, then 20%  
  - Deductible, then 40%
- Foot Orthotics, Orthopedic Shoes and Accessories ($300 PCY (Unlimited Diabetes Related))  
  - Deductible, then 20%  
  - Deductible, then 40%
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The University of Puget Sound High Deductible Medical Plan
Group Number: 1003592

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<tr>
<th>MEDICAL PLAN</th>
<th>BASE - HYC HRA - $1500-$3000</th>
<th>20% - 40%</th>
<th>$4000</th>
<th>$150 ER NGF</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HERITAGE IN-NETWORK</td>
<td>HERITAGE OUT-OF-NETWORK</td>
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### OTHER SERVICES (continued)

- **Home Health Visits** (130 visits PCY) - Deductible, then 20%
- **Hospice Care** (Hospice Home Visits: Unlimited; Respite: 240 hours; within the 6 month lifetime maximum) - Deductible, then 20%
- **TMJ (Temporomandibular Joint Disorders)** (Unlimited (Medical and Dental services – Medical & Dental cost shares based on type of service)) - Covered as any other service
- **Transplants** (Unlimited; $7,500 travel and lodging limits) - Covered as any other service

### ALTERNATIVE CARE

- **Manipulations (Spinal and other)** (12 visits PCY) - Deductible, then 20%
- **Acupuncture** (12 visits PCY) - Deductible, then 20%
- **Nutritional Therapy** (Unlimited) - Covered In Full

### SUPPLEMENTAL BENEFITS

- **Routine Vision Exam** (1 PCY) - Deductible, then 20%
- **Pediatric Vision Exam** (1 PCY under age 19) - Waive Deductible, then 20%
- **Routine Hearing Exam** (1 PCY) - Waive Deductible, then 20%
  - Exam: Subject to Office Visit Cost Share; Test: Covered in Full

### ANNUAL PLAN MAXIMUM

- **Annual Plan Maximum** - Unlimited
- **Annual Plan Maximum** - Unlimited

Copays are not subject to the deductible unless otherwise noted.
Prior Authorization is required for many services to be covered. For more information please refer to your benefit booklet.

**Pharmacy Benefits**

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

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**Effective Date: 01/01/2015**

<table>
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<tr>
<th>PHARMACY PLAN</th>
<th>BASE RX - Retail $10/$30/$60; MO:2X</th>
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<tbody>
<tr>
<td></td>
<td>Cost Share Category</td>
</tr>
<tr>
<td></td>
<td>Tier1/Tier2/Tier3</td>
</tr>
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</table>

### PRESCRIPTION DRUGS

- **Retail Cost Shares** - Tier 1 = Generic
- **Mail Cost Shares** - Tier 2 = Preferred Brand Name
- **Day Supply** - Tier 3 = Non Preferred Brand Name

- **Individual Deductible PCY** - Tier 1 = Generic
- **Out of Network (Non-participating retail pharmacies)** - Tier 2 = Preferred Brand Name
- **Out of Pocket Maximum** - Tier 3 = Non Preferred Brand Name

<table>
<thead>
<tr>
<th>Drug List</th>
<th>Preferred B3</th>
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</table>

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.