PREFERRED BRONZE 6350

Washington plan for individuals & families
Beginning January 1, 2016

PREMERA | BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association

			PREFERRED BRONZE 6350	
			Heritage Signature provider network	**Non-Heritage Signature provider network**
	Annual Deductible	Per Calendar Year (PCY) Family = 2x individual *(in-network)*	$6,350	2x individual deductible
	Coinsurance	Amount you pay after your deductible is met	20%	50%
	Out-of-Pocket Maximum	Includes deductible, coinsurance, and copays Family = 2x individual *(in-network)*	$6,850	Unlimited
	10 Essential Benefits Covered Services			
1	**Ambulatory Patient Services** **Office Visits**	Outpatient services	Deductible, then 20%	Deductible, then 50%
		Designated PCP office visit	$20 copay	Deductible, then 50%
		Non-designated PCP & specialist office visit	Deductible, then 20%	Deductible, then 50%
		Urgent care	Deductible, then 20%	Deductible, then 50%
		Virtual care	$20 copay	Not covered
		Spinal manipulation: 10 visits PCY; Acupuncture: 12 visits PCY	$20 copay	Deductible, then 50%
2	**Emergency Services**	Emergency care *(copay waived if directly admitted to an inpatient facility)*	$250 copay, then deductible, then 20%	Same as in-network
		Ambulance	Deductible, then 20%	Same as in-network
3	**Hospitalization**	Inpatient services	Deductible, then 20%	Deductible, then 50%
		Organ and tissue transplants, inpatient	Deductible, then 20%	Not covered
4	**Maternity & Newborn Care**	Prenatal, delivery, postnatal care	Deductible, then 20%	Deductible, then 50%
5	**Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment**	Office visit	Deductible, then 20%	Deductible, then 50%
		Inpatient hospital: mental/behavioral health	Deductible, then 20%	Deductible, then 50%
		Outpatient services	Deductible, then 20%	Deductible, then 50%
6	**Prescription Drugs** *Retail/Specialty: 30-day supply* *Mail Order: 90-day supply*	Generic	Deductible, then 20%	Not covered
		Brand	Deductible, then 20%	Not covered
		Specialty	Deductible, then 20%	Not covered
		Drug formulary	X1	
7	**Rehabilitative & Habilitative Services & Devices**	Inpatient rehabilitation: 30 days PCY	Deductible, then 20%	Deductible, then 50%
		Physical, speech, occupational, massage therapy: 25 visits combined PCY	Deductible, then 20%	Deductible, then 50%
		Durable medical equipment	Deductible, then 20%	Deductible, then 50%
8	**Laboratory Services**	Includes x-ray, pathology, imaging/diagnostic, ultrasound	Deductible, then 20%	Deductible, then 50%
		Major imaging including MRI, CT, PET *(prior authorization required for certain services)*	Deductible, then 20%	Deductible, then 50%
9	**Preventive/Wellness Services**	Screenings	Covered in full	Deductible, then 50%
		Exams and immunizations	Covered in full	Not covered
10	**Pediatric Vision** *Under 19 years of age*	Eye exam: 1 PCY	$30 copay	Same as in-network
		Eyewear: 1 pair of glasses PCY (frames & lenses); 12-month supply of contacts PCY, in lieu of glasses (frames & lenses)	Covered in full	Same as in-network

Definitions

Allowed Amount: When providers have a contract with us, the amount your health plan has agreed to pay healthcare providers for services or supplies. You'll be responsible only for any applicable cost sharing, including deductibles, copays, coinsurance, charges in excess of the stated benefit maximums and charges for services and supplies not covered under this plan. In-network providers cannot bill you for charges over the allowed amount.

Coinsurance: Your share of the cost for a service. If your plan's coinsurance is 20%, you pay 20% of the allowed amount and your plan pays the other 80% of the allowed amount.

Copay: A flat fee you pay for a specific service, such as an office visit, at the time you receive service.

Covered in full: Services of which your plan pays the total cost, at 100% of the allowed amount. You do not pay deductibles, coinsurance or copays for these services.

Deductible: The amount of money you pay every year for covered services before the plan pays for certain benefits.

Formulary: A list of drugs covered by a health plan. Not all generic, brand-name and specialty drugs are included in every formulary.

In-network: Doctors, dentists, hospitals, and other healthcare providers that are contracted to provide services and supplies at negotiated amounts called allowed amounts.

Out-of-pocket maximum: The maximum amount of money you will pay for covered services in a calendar year. After you've paid this amount, your plan pays 100% of the allowed amount for services received from in-network providers.

Primary care provider (PCP): The doctor or other healthcare provider you see for most of your routine healthcare needs, often known as your "family doctor." You can choose a different primary care provider for each family member. Your PCP can be a family practice physician, general practice provider, geriatric practice provider, gynecologist, internist, nurse practitioner, obstetrician, pediatrician, physician assistant or naturopath.

Urgent Care: For conditions that require immediate medical attention when your doctor is not available, but are not severe or life-threatening. Your copay may be lower if care is received from an urgent care center that is affiliated with your PCP. (Use the emergency room only for life-threatening emergencies and trauma requiring immediate medical attention and treatment.).

Note that if you see a non-contracted provider, you will be responsible for the difference between the allowed amount and the provider's billed charges, in addition to the deductible, coinsurance and any applicable copay. The allowed amount for a non-contracted provider is determined by Premera as described in your forthcoming benefit book.

General exclusions and limitations

Benefits are not provided for treatment, surgery, services, drugs, or supplies for any of the following:

- Cosmetic surgery or reconstructive surgery (except as specifically provided)
- Experimental or investigative services
- Infertility
- Obesity/morbid obesity, including surgery, drugs, foods, and exercise programs
- Orthognathic surgery (except when repairing a dependent child's congenital abnormality)
- Service in excess of specified benefit maximums
- Services payable by other types of insurance coverage
- Services received when you are not covered by this program
- Sexual dysfunction
- Sterilization reversal

For a list of services and procedures that require approval for coverage from your plan before you receive them (prior authorization), visit **premera.com**.

Contact Us

For information about how a health plan works, see Health Plan Basics on **premera.com**. You'll find information about:

- Help with monthly healthcare rates for low-income members (government subsidies)
- Penalties for people who don't choose a health plan
- How to find an in-network doctor

For information or questions about Premera Blue Cross:

- Visit **premera.com**
- Call Customer Service at **800-722-1471** from 8 a.m. to 6 p.m. Pacific time, Monday–Friday
- Talk to your producer

This is only a summary of the major benefits provided by our plans. This is not a contract. Please see **premera.com/SBC** for the Summary of Benefits and Coverage and Glossary. On our website, you can also find a Supplemental Guide with information about plan policies and procedures.