

# Balance Gold PCP 1000

## Washington plans for groups 1-50

Beginning January 1, 2016

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.

MEDICAL PLAN		BALANCE GOLD PCP 1000	
	HERITAGE SIGNATURE IN-NETWORK	HERITAGE SIGNATURE OUT-OF-NETWORK	
<b>Deductible</b> (In-network only - Family embedded deductible 2X Individual)	\$1,000 PCY	\$2,000 PCY	
<b>Coinsurance</b>	20%	50%	
<b>Out of Pocket Maximum (includes deductible, copays, coinsurance and pharmacy)</b> (Family embedded OOP max 2X Individual)	\$5,000 PCY	Not Applicable	
<b>Office Visit Cost Share</b>	First 2 visits PCP Covered In Full, then \$10 designated PCP, applies to the Out of Pocket Maximum; \$40 Specialist and non designated PCP, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%	
<b>Annual Maximum</b>	Unlimited	Unlimited	
<b>1 Ambulatory Patient Services</b>			
<b>Professional Office Visits</b>	First 2 visits PCP Covered In Full, then \$10 designated PCP, applies to the Out of Pocket Maximum; \$40 Specialist and non designated PCP, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%	
<b>Urgent Care Office Visits</b>	First 2 visits PCP Covered In Full, then \$10 designated PCP, applies to the Out of Pocket Maximum; \$40 Specialist and non designated PCP, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%	
<b>Outpatient Professional Services</b>	In Network Deductible, then 20%	Out of Network Deductible, then 50%	
<b>Contraceptive Management Services</b> (Unlimited)	Covered In Full	Out of Network Deductible, then 50%	
<b>2 Emergency and Transportation Services</b>			
<b>Emergency Room - facility</b>	\$200 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20%	\$200 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20%	
<b>Ambulance Service - ground</b> (Unlimited)	In Network Deductible, then 20%	In Network Deductible, then 20%	
<b>Ambulance Service - air</b> (Unlimited)	In Network Deductible, then 20%	In Network Deductible, then 20%	
<b>3 Hospitalization</b>			
<b>Inpatient Medical and Surgical Room and Board</b> (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then 50%	
<b>Hospice Inpatient Facility</b> (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then 50%	
<b>Inpatient Professional Services</b>	In Network Deductible, then 20%	Out of Network Deductible, then 50%	
<b>Organ Transplants</b> (Unlimited; \$5,000 travel and lodging limits)	Covered as any other service	Not Covered	
<b>4 Maternity &amp; Newborn Care</b>			
<b>Prenatal, Delivery, Postnatal</b> (Coverage for subscriber, spouse, dependent)	In Network Deductible, then 20%	Out of Network Deductible, then 50%	
<b>5 Mental Health &amp; Substance Use Disorder Services, including Behavioral Health Treatment</b>			
<b>Chemical Dependency Office Visit</b> (Unlimited)	\$40 Specialist and non designated PCP, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%	
<b>Chemical Dependency Outpatient Facility</b> (Unlimited)	Waive In Network Deductible, then 20%	Out of Network Deductible, then 50%	
<b>Chemical Dependency Inpatient Facility</b> (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then 50%	

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<b>MEDICAL PLAN</b>		<b>BALANCE GOLD PCP 1000</b>	
	<b>HERITAGE SIGNATURE IN-NETWORK</b>	<b>HERITAGE SIGNATURE OUT-OF-NETWORK</b>	
<b>Mental Health Office Visit</b> (Unlimited)	\$40 Specialist and non designated PCP, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%	
<b>Mental Health Outpatient Facility</b> (Unlimited)	Waive In Network Deductible, then 20%	Out of Network Deductible, then 50%	
<b>Mental Health Inpatient Facility</b> (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then 50%	
<b>6 Prescription Drug</b>			
<b>Drug List</b>	X4	Not Covered	
<b>Retail (generic/preferred/non-preferred)</b> (Retail & Specialty drugs 30 day Supply/Mail Order 90 day and Specialty 30 day supply)	Waive Deductible, then \$10/ Waive Deductible, then \$40/ Waive Deductible, then \$80; All cost shares apply to the Out of Pocket Maximum	Not Covered	
<b>Mail Order (generic/preferred/non-preferred)</b> (Retail & Specialty drugs 30 day Supply/Mail Order 90 day and Specialty 30 day supply)	Waive Deductible, then \$30/ Waive Deductible, then \$120/ Waive Deductible, then \$240; All cost shares apply to the Out of Pocket Maximum	Not Covered	
<b>Specialty Rx</b> (Retail & Specialty drugs 30 day Supply/Mail Order 90 day and Specialty 30 day supply)	Waive In Network Deductible, then 20%	Not Covered	
<b>7 Rehabilitative &amp; Habilitative Services &amp; Devices</b>			
<b>Inpatient Rehabilitation</b> (30 days PCY combined limit for inpatient services)	In Network Deductible, then 20%	Out of Network Deductible, then 50%	
<b>Inpatient Habilitation</b> (30 days PCY combined limit for inpatient services)	In Network Deductible, then 20%	Out of Network Deductible, then 50%	
<b>Rehab Outpatient Professional - physical, speech, occupational therapy</b> (25 visits PCY combined limit for outpatient services)	\$40 Specialist and non designated PCP, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%	
<b>Habilitation Outpatient Professional - physical, speech, occupational therapy</b> (25 visits PCY combined limit for outpatient services)	\$40 Specialist and non designated PCP, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%	
<b>Massage Therapy</b> (Applies to rehab)	\$40 Specialist and non designated PCP, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%	
<b>Durable Medical Equipment</b> (MS: Unlimited, ME: Unlimited, Pro: Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then 50%	
<b>8 Laboratory/Imaging Services</b>			
<b>Pathology</b>	Waive In Network Deductible, then 20%	Out of Network Deductible, then 50%	
<b>Imaging - basic</b>	Waive In Network Deductible, then 20%	Out of Network Deductible, then 50%	
<b>Imaging - major (MRI, CT, PET)</b>	In Network Deductible, then 20%	Out of Network Deductible, then 50%	
<b>Diagnostic Mammography</b>	Waive In Network Deductible, then 20%	Out of Network Deductible, then 50%	
<b>9 Preventive/Wellness Services &amp; Chronic Disease Management</b>			
<b>Preventive Office Visit</b> (Unlimited)	Covered In Full	Not Covered	
<b>Immunizations</b> (Unlimited)	Covered In Full	Not Covered	
<b>Preventive Laboratory Screens</b>	Covered In Full	Out of Network Deductible, then 50%	
<b>Preventive Imaging</b>	Covered In Full	Out of Network Deductible, then 50%	
<b>Preventive Routine Mammography</b>	Covered In Full	Out of Network Deductible, then 50%	
<b>10 Pediatric Services, including Oral &amp; Vision Care</b>			

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<b>MEDICAL PLAN</b>		<b>BALANCE GOLD PCP 1000</b>	
	HERITAGE SIGNATURE IN-NETWORK	HERITAGE SIGNATURE OUT-OF-NETWORK	
<b>Pediatric Vision Exam</b> (1 PCY Under age 19)	\$40 Specialist and non designated PCP, applies to the Out of Pocket Maximum	\$40 Specialist and non designated PCP, applies to the Out of Pocket Maximum	
<b>Pediatric Eyewear</b> (Under age 19: One pair of glasses PCY (frames & lenses). 12 month supply of contacts PCY, in lieu of glasses (frames & lenses).)	Covered In Full	Covered In Full	
<b>Pediatric Dental (preventive)</b>	Covered In Full	Deductible, then 30%	
<b>Pediatric Dental (basic)</b>	Deductible, then 20%	Deductible, then 40%	
<b>Pediatric Dental (major)</b>	Deductible, then 50%	Deductible, then 50%	
<b>Orthodontia</b> (Unlimited if Medically Necessary With Prior Auth)	In Network Deductible, then 50%	Out of Network Deductible, then 50%	
<b>Alternative Care</b>			
<b>Chiropractic</b> (10 visits PCY)	\$10 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%	
<b>Acupuncture</b> (12 visits PCY)	\$10 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%	
<b>Naturopath</b> (Unlimited)	First 2 visits PCP Covered In Full, then \$10 designated PCP, applies to the Out of Pocket Maximum; \$40 Specialist and non designated PCP, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%	

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.  
 PCP: A lower cost share may apply if a designated PCP is used. For more information please refer to your benefit booklet.

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.*