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Balance Silver PCP 2500

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 SILVER PCP 2500	
	HERITAGE SIGNATURE IN-NETWORK	HERITAGE SIGNATURE OUT-OF-NETWORK
Deductible (In-network only - Family embedded deductible 2X Individual)	$2,500 PCY	$5,000 PCY
Coinsurance	20%	50%
Out of Pocket Maximum (includes deductible, copays, coinsurance and pharmacy) (Family embedded OOP max 2X Individual)	$6,850 PCY	Not Applicable
Office Visit Cost Share	First 2 visits PCP Covered In Full, then $20 designated PCP, applies to the Out of Pocket Maximum; $45 Specialist and non designated PCP, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%
Annual Maximum	Unlimited	Unlimited
1 Ambulatory Patient Services		
Professional Office Visits	First 2 visits PCP Covered In Full, then $20 designated PCP, applies to the Out of Pocket Maximum; $45 Specialist and non designated PCP, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%
Urgent Care Office Visits	First 2 visits PCP Covered In Full, then $20 designated PCP, applies to the Out of Pocket Maximum; $45 Specialist and non designated PCP, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%
Outpatient Professional Services	In Network Deductible, then 20%	Out of Network Deductible, then 50%
Contraceptive Management Services (Unlimited)	Covered In Full	Out of Network Deductible, then 50%
2 Emergency and Transportation Services		
Emergency Room - facility	$250 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20%	$250 Copay applies to the Out of Pocket Maximum, then In Network Deductible, 20%
Ambulance Service - ground (Unlimited)	In Network Deductible, then 20%	In Network Deductible, then 20%
Ambulance Service - air (Unlimited)	In Network Deductible, then 20%	In Network Deductible, then 20%
3 Hospitalization		
Inpatient Medical and Surgical Room and Board (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then 50%
Hospice Inpatient Facility (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then 50%
Inpatient Professional Services	In Network Deductible, then 20%	Out of Network Deductible, then 50%
Organ Transplants (Unlimited; $5,000 travel and lodging limits)	Covered as any other service	Not Covered
4 Maternity & Newborn Care		
Prenatal, Delivery, Postnatal (Coverage for subscriber, spouse, dependent)	In Network Deductible, then 20%	Out of Network Deductible, then 50%
5 Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment		
Chemical Dependency Office Visit (Unlimited)	$45 Specialist and non designated PCP, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%
Chemical Dependency Outpatient Facility (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then 50%
Chemical Dependency Inpatient Facility (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then 50%

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	HERITAGE SIGNATURE IN-NETWORK	HERITAGE SIGNATURE OUT-OF-NETWORK
Mental Health Office Visit (Unlimited)	$45 Specialist and non designated PCP, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%
Mental Health Outpatient Facility (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then 50%
Mental Health Inpatient Facility (Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then 50%
6 Prescription Drug		
Drug List	X4	Not Covered
Retail (generic/preferred/non-preferred) (Retail and Specialty drugs 30 day supply/Mail Order 90 day and Specialty drugs 30 day supply)	Waive Deductible, then $25/ Waive Deductible, then $65/ Waive Deductible, then $100; All cost shares apply to the Out of Pocket Maximum	Not Covered
Mail Order (generic/preferred/non-preferred) (Retail and Specialty drugs 30 day supply/Mail Order 90 day and Specialty drugs 30 day supply)	Waive Deductible, then $75/ Waive Deductible, then $195/ Waive Deductible, then $300; All cost shares apply to the Out of Pocket Maximum	Not Covered
Specialty Rx (Retail and Specialty drugs 30 day supply/Mail Order 90 day and Specialty drugs 30 day supply)	In Network Deductible, then 20%	Not Covered
7 Rehabilitative & Habilitative Services & Devices		
Inpatient Rehabilitation (30 days PCY combined limit for inpatient services)	In Network Deductible, then 20%	Out of Network Deductible, then 50%
Inpatient Habilitation (30 days PCY combined limit for inpatient services)	In Network Deductible, then 20%	Out of Network Deductible, then 50%
Rehab Outpatient Professional - physical, speech, occupational therapy (25 visits PCY combined limit for outpatient services)	In Network Deductible, then $45 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%
Habilitation Outpatient Professional - physical, speech, occupational therapy (25 visits PCY combined limit for outpatient services)	In Network Deductible, then $45 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%
Massage Therapy (Applies to rehab)	In Network Deductible, then $45 Specialist and non designated PCP, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%
Durable Medical Equipment (MS: Unlimited, ME: Unlimited, Pro: Unlimited)	In Network Deductible, then 20%	Out of Network Deductible, then 50%
8 Laboratory/Imaging Services		
Pathology	In Network Deductible, then 20%	Out of Network Deductible, then 50%
Imaging - basic	In Network Deductible, then 20%	Out of Network Deductible, then 50%
Imaging - major (MRI, CT, PET)	In Network Deductible, then 20%	Out of Network Deductible, then 50%
Diagnostic Mammography	In Network Deductible, then 20%	Out of Network Deductible, then 50%
9 Preventive/Wellness Services & Chronic Disease Management		
Preventive Office Visit (Unlimited)	Covered In Full	Not Covered
Immunizations (Unlimited)	Covered In Full	Not Covered
Preventive Laboratory Screens	Covered In Full	Out of Network Deductible, then 50%
Preventive Imaging	Covered In Full	Out of Network Deductible, then 50%
Preventive Routine Mammography	Covered In Full	Out of Network Deductible, then 50%
10 Pediatric Services, including Oral & Vision Care		

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	HERITAGE SIGNATURE IN-NETWORK	HERITAGE SIGNATURE OUT-OF-NETWORK
Pediatric Vision Exam (1 PCY Under age 19)	$45 Specialist and non designated PCP, applies to the Out of Pocket Maximum	$45 Specialist and non designated PCP, applies to the Out of Pocket Maximum
Pediatric Eyewear (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
Pediatric Dental (preventive)	Covered In Full	Deductible, then 30%
Pediatric Dental (basic)	Deductible, then 20%	Deductible, then 40%
Pediatric Dental (major)	Deductible, then 50%	Deductible, then 50%
Orthodontia (Unlimited if Medically Necessary With Prior Auth)	In Network Deductible, then 50%	Out of Network Deductible, then 50%
Alternative Care		
Chiropractic (10 visits PCY)	$20 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%
Acupuncture (12 visits PCY)	$20 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%
Naturopath (Unlimited)	First 2 visits PCP Covered In Full, then $20 designated PCP, applies to the Out of Pocket Maximum; $45 Specialist and non designated PCP, applies to the Out of Pocket Maximum	Out-of-network Office Visit Cost Share

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.