

Balance Bronze PCP 6350

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 BRONZE PCP 6350	
	HERITAGE SIGNATURE IN-NETWORK	HERITAGE SIGNATURE OUT-OF-NETWORK	
Deductible (In-network only - Family embedded deductible 2X Individual)	\$6,350 PCY	\$12,700 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	\$25 designated PCP, applies to the Out of Pocket Maximum; In Network Deductible, \$50 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	\$25 designated PCP, applies to the Out of Pocket Maximum; In Network Deductible, \$50 Specialist and non designated PCP, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%	
Urgent Care Office Visits	\$25 designated PCP, applies to the Out of Pocket Maximum; In Network Deductible, \$50 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)	In Network Deductible, \$50 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%	

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 BRONZE PCP 6350	
	HERITAGE SIGNATURE IN-NETWORK	HERITAGE SIGNATURE OUT-OF-NETWORK	
Mental Health Office Visit (Unlimited)	In Network Deductible, \$50 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	X1	Not Covered	
Retail (generic/preferred/non-preferred) (Retail & Specialty drugs 30 day Supply/Mail Order 90 day and Specialty 30 day supply)	In Network Deductible, then 20%	Not Covered	
Mail Order (generic/preferred/non-preferred) (Retail & Specialty drugs 30 day Supply/Mail Order 90 day and Specialty 30 day supply)	In Network Deductible, then 20%	Not Covered	
Specialty Rx (Retail & Specialty drugs 30 day Supply/Mail Order 90 day and Specialty 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 20%	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 20%	Out of Network Deductible, then 50%	
Massage Therapy (Applies to rehab)	In Network Deductible, then 20%	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			
Pediatric Vision Exam (1 PCY Under age 19)	In Network Deductible, \$50 Specialist and non designated PCP, applies to the Out of Pocket Maximum	In Network Deductible, \$50 Specialist and non designated PCP, applies to the Out of Pocket Maximum	

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 BRONZE PCP 6350	
	HERITAGE SIGNATURE IN-NETWORK	HERITAGE SIGNATURE OUT-OF-NETWORK	
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 0%	Deductible, then 40%	
Pediatric Dental (major)	Deductible, then 0%	Deductible, then 50%	
Orthodontia (Unlimited if Medically Necessary With Prior Auth)	Deductible, then 0%	Deductible, then 50%	
Alternative Care			
Chiropractic (10 visits PCY)	\$25 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%	
Acupuncture (12 visits PCY)	\$25 Copay, applies to the Out of Pocket Maximum	Out of Network Deductible, then 50%	
Naturopath (Unlimited)	\$25 designated PCP, applies to the Out of Pocket Maximum; In Network Deductible, \$50 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.