Preferred Bronze

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

Washington plans for individuals & families
Beginning January 1, 2015

		PREFERRED BRONZE	
Network = Heritage Signature		Heritage Signature providers	Non-Heritage Signature providers
Annual Deductible	Per Calendar Year = PCY Family = 2x individual	$5,500 / $6,350	2x individual deductible
Coinsurance	Amount you pay after your deductible is met	20% / 0%	50%
Out-of-Pocket Maximum	Includes deductible, coinsurance, and copays Family = 2x individual	$6,350	Unlimited
10 Essential Benefits *Covered Services*			
1 Ambulatory Patient Services	Outpatient services	Deductible, then coinsurance	Deductible, then 50%
Office visits	Designated PCP office visit	$15 / $20 copay	
	Non-designated PCP or specialist office visit	$45 / $50 copay	
	Spinal manipulation (10 visits PCY); Acupuncture (12 visits PCY)	$15 / $20 copay	
2 Emergency Services	Emergency Care *(Copay waived if directly admitted to an inpatient facility)*	$250 copay, then deductible, then coinsurance Ambulance: deductible, then coinsurance	
3 Hospitalization	Inpatient services	Deductible, then coinsurance	Deductible, then 50%
	Organ and tissue transplants, inpatient		Not covered
4 Maternity & Newborn Care	Prenatal, delivery, postnatal care	Deductible, then coinsurance	Deductible, then 50%
5 Mental Health & Substance Use Disorder Services, including Behavioral Health Treatment	Office visit	$45 / $50 copay	Deductible, then 50%
	Inpatient hospital: mental/behavioral health	Deductible, then coinsurance	
	Outpatient services	Deductible, then coinsurance	
6 Prescription Drugs	**Retail** 30-day supply **Mail Order** 90-day supply (5500 - copay x 3) **Specialty Rx** 30-day supply **Drug Formulary** X1 - 6350 plan X3 - 5500 plan	**5500** - Generic: $25 Brand: Deductible, then 50% Specialty: Deductible, then 20% **6350** - All: Deductible, then 0%	Not covered
7 Rehabilitative & Habilitative Services & Devices	Inpatient rehabilitation: 30 days PCY Physical, speech, occupational, massage therapy: 25 visits PCY Durable medical equipment	Deductible, then coinsurance	Deductible, then 50%
8 Laboratory Services	Includes X-ray, pathology, imaging/diagnostic, MRI, CT, PET *(Prior Authorization for certain services)*	Deductible, then coinsurance	Deductible, then 50%
9 Preventive/Wellness Services & Chronic Disease Management	Screenings	Covered in full	Deductible, then 50%
	Exams and immunizations		Not covered
10 Pediatric Vision *Under 19 years of age*	**Eye exam:** 1 PCY	$45 / $50 copay	
	Eyewear: 1 pair of glasses PCY (frames & lenses); 12-month supply of contacts PCY, in lieu of glasses (frames & lenses)	Covered in full	

Definitions

Allowed amount: The negotiated amount for which a contracted provider agrees to provide service or supplies.

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 benefit 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 your plan pays for in full. Benefits provided at 100% of the allowed amount; not subject to deductible or coinsurance.

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

Formulary: A list of drugs the plan covers for specific uses. Not all generic, name-brand and specialty drugs are included in the formulary. To find the formulary for your plan, go to **premera.com** and select Pharmacy on the Member Services tab.

In-network: A group of doctors, dentists, hospitals, and other healthcare providers that contract with Premera to provide services and supplies at negotiated amounts called allowed amounts.

Out-of-pocket maximum: A preset limit after which your plan pays 100% of the allowed amount for services received in-network. All in-network essential benefits apply to the out-of-pocket maximum.

PCP - Primary care provider: The provider who helps coordinate your care. You can choose a different primary care provider for each family member from: physicians and internists, physician assistants, and nurse practitioners; ob/gyns and women's health specialists, pediatricians, and geriatric specialists; or naturopaths. To get a reduced office visit copay with the PCP plans, you must choose a provider contracted as part of the Premera network and inform us this is your designated PCP. Additionally, if you visit an urgent care facility associated with your primary care doctor, your copay will be lower. If you visit an urgent care facility not affiliated with your primary care doctor, the specialist office visit copay will apply.

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 coinsurance and any applicable copay. The allowed amount for a non-contracted provider is determined by Premera as described in your forthcoming benefit book.

Contact Us

For information about how a health plan works, visit **premera.com** and click the Health Plan Basics tab. You'll find information there about:

- Help with monthly healthcare rates for low-income members (government subsidies)
- Penalties for people who don't choose a health plan

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

General exclusions and limitations

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

- Cosmetic or reconstructive surgery (except as specifically provided)
- Experimental or investigative services
- Infertility
- Learning disorders
- Obesity/morbid obesity, including surgery, drugs, foods, and exercise programs
- Orthognathic surgery (except when repairing a dependent child's congenital abnormality)
- Orthotics, up to $300 PCY; except for treatment of diabetes, unlimited
- Services 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**.

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 privacy policies, provider organization, key utilization management procedures, and pharmaceutical management procedures.

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